Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting

Hospital Boardroom
Chair: Prof. Sir Christopher Edwards
Date: 17 September 2009
Time: 3 pm

Agenda

		Lead
1	**GENERAL BUSINESS**	
1.1	Welcome & Apologies	CE
1.2	Declaration of Interests	CE
1.3	Minutes of Previous Meeting held on 18 June 2009	CE
1.4	Matters Arising	CE
1.5	Chairman's Report (oral)	CE
2	**ITEMS FOR DISCUSSION/DECISION/APPROVAL**	
2.1	Report of the Task and Finish Group – Name of Members' Council and Members of the Council	CE
2.2	Report of the Task and Finish Group – governance arrangements (including Terms of reference agenda sub committee)	CE
2.3	Meeting times (oral)	CE
2.4	Re-appointment of Non-Executive Directors	CE
2.5	Policy for the Composition of the Non-Executive Directors[1]	CE
2.6	Report on Chair Appraisal	CW
2.7	Membership Development and Communication work plan	AMC
2.8	Complaints Policy	AMC
2.9	Presentation of Annual Report & Accounts 2008/09[2]	LB
2.10	External Auditors' Report	HB
2.11	Report of the Audit Committee[3]	AH
2.12	Re-Appointment of the Auditor[4]	AH
2.13	Single Equality Scheme	AP
2.14	Funding Report and request for allocation for website	MA

[1] Constitution 12.5.1
[2] Constitution 17.6
[3] Code F.3.2
[4] Code F.3.5 / Constitution 16.4

development

3	**ITEMS FOR INFORMATION**	
3.1	Finance Report – July 2009	LB
3.2	Performance Report – July 2009	LB
3.3	Membership Report	SN
4	**ANY OTHER BUSINESS**	
5	**DATE OF THE NEXT MEETING 3rd December 2009 (time to be confirmed)**	

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 17 September 2009

AGENDA ITEM NO.	1.3/Sep/09
PAPER	Minutes of the meeting of the Members' Council held on 18 June 2009
AUTHOR	Dianne Holman, Interim Foundation Trust Secretary/Head of Corporate Governance
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper outlines a record of proceedings at the previous meeting.
DECISION/ ACTION	1. To agree the minutes as a correct record. 2. The chairman to sign the minutes.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council General Meeting
Hospital Boardroom
Chair: Prof. Sir Christopher Edwards
Date: 18 June 2009
Time: 4:30 – 6:30 pm

Present:

Constituency	Class	Name	
Chairman		Prof. Sir Christopher Edwards	CE
Public	Kensington and Chelsea 2	Lady Sandra Smith-Gordon	SSG
Public	Hammersmith and Fulham 1	Martin Bradford	MB
Public	Hammersmith and Fulham 2	Christine Blewett	CBle
Public	Westminster 1	Ann Mills-Duggan	AMD
Patient		June Bennett	JB
Patient		Walter Balmford	WB
Patient		Jane King	JK
Patient		Jim Smith	JS
Patient		Chris Birch	CBir
Staff	Contracted	Alison Delamare	AD
Staff	Medical and Dental	Brian Gazzard	BG
Appointed	Royal Borough of Kensington and Chelsea	Cllr. Frances Taylor	FT
Appointed	Royal Brompton and Harefield NHS Trust	Duncan Macrae	DM

In attendance:

Trust Board	Non-Executive	Charles Wilson	CW
Trust Board	Non-Executive	Prof. Richard Kitney	RK
Trust Board	Director of Finance	Lorraine Bewes	LB
Trust Board	Medical Director	Dr. Mike Anderson	MA
Trust Board	Director of Nursing	Andrew MacCallum	AMC
Trust Board	Deputy Chief Executive	Amanda Pritchard	AP
Trust Executive	Director of Strategy	Amit Khutti	AK
Trust Executive	Director of Governance & Corporate Affairs	Catherine Mooney	CM
	Interim FT Secretary	Dianne Holman *Recording Minutes*	DH
	Head of Communications	Matt Akid *For Papers 2.4 & 2.5*	MAk

1.1 Welcome & Apologies **CE**

CE called the meeting to order, welcomed all Council Members and confirmed that the meeting was quorate.

CE noted the apologies tendered.

Constituency	Class	Name
Public	Wandsworth 1	Mary Symons
Public	Westminster 2	Martin John Lewis
Patient		Martin Rowell
Staff	Nursing and Midwifery	Sue P Smith
Appointed	Westminster PCT	Catherine Longworth
Appointed	Wandsworth PCT	Dr David Finch
Appointed	Imperial College, London	Prof. Mervyn Maze
Appointed	The Royal Marsden NHS Foundation Trust	Nicky Browne
Trust Board	Non-Executive	Colin Glass
Trust Board	Chief Executive	Heather Lawrence
Trust Board	Interim Director of Human Resources	Mark Gammage

CE informed the Members' Council of appointments and retirements in Q1 of 2009-10:

- PCT – K&C PCT: Edgar Moyo (nominated 9/6/09) to fill the vacancy left by Peter Molyneux (resigned 31/3/09)
- PCT – NHS Wandsworth: Dr. David Finch (appointed 21/5/09) replaces Prof. Salman Rawaf (resigned 20/5/09)
- PCT – NHS Hammersmith & Fulham: Vacancy following resignation of Ben Westmancott (15/6/09). A replacement will be provided.
- Patients' Constituency: Sue B Smith (resigned 15/6/09). The vacancy will be filled at the next election.
- King's College London to be invited to appoint a representative to the Members' Council as a major nursing and midwifery education provider. This seat has been vacant since the changes to the constitution in November 2008.

CE informed the meeting that Sue B Smith cited problems with receiving email communications from the Trusts as one of the reasons for her resignation. CE wanted to be satisfied that this was not a universal problem and asked Council Members if they also had this problem. No members present reported having similar problems.

At the invitation of CE, Members of the Board of Directors and the

Trust's Executive present introduced themselves to the Members' Council.

1.2 Declaration of Interests **CE**

CE invited declarations of interest. None were tendered.

1.3 Minutes of Previous Meeting held on 19 March 2009 **CE**

The minutes of previous meeting held on 19 March 2009 were agreed as a correct record of proceedings.

1.4 Matters Arising **CE**

The meeting noted the actions and subsequent outcomes. Item referenced as 2.4/Mar/09, Members' Council Funding Report, was to be discussed at item 2.7 on the agenda rather than 2.4 as listed on the paper.

1.5 Review of Action Points from Joint Away Day 4 December 2008 **CE**

It was noted that:

- The technical problem of failing kiosks had been resolved.
- A new Membership & Engagement Manager, Sian Nelson, had been appointed to start in July 2009. Chris Birch sat on the interview panel.
- The Membership & Engagement Manager will be doing some key work around linking PALS with the membership
- The dedicated meeting with the Council (11th September) on the long term vision and strategy for the hospital was very important for the Members' Council. This has been set for the afternoon session of Friday 11th September. The exact times are to be confirmed. **Council Members' are asked to let the Chief executive's PA know if they can attend. Email: Louise.Starkey@chelwest.nhs.uk Phone: 0208 846 6711** **ALL**
- Computershare is the membership database administrator.
- Council Members interested in joining a Task & Finish Group to respond to the Monitor Consultation 'Guide for NHS foundation trust governors: meeting your statutory responsibilities' should contact Dianne Holman.

AMD suggested that teleconferencing facilities should be used as a standard practice to facilitate participation in meetings and suggested that there were alternatives to delivering meeting papers including the use of secure e-rooms.

CE informed the group that there had been a similar discussion at the Board of Directors on the function and organisation of meetings. BG suggested a Task & Finish Group be set up to look at this issue.

FT was of the view that there was still a need for printed papers and felt that Council Members should not bear the cost of paper and cartridges.

It was agreed that a Task & Finish group would be set up to look at the various options for the organisation of meetings. **ALL**

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

CE thanked the Members' Council for their support with the Open Day 2009. It was a good example of demonstrating to the public what the hospital is all about and what we can achieve.

2.1 Update on Developments – Major Trauma / Stroke & Paediatrics **CE**

Report on Major Trauma and Stroke

Responses were submitted by both the Board of Directors and the Members' Council. The Hyper-Acute Stroke Unit was likely to go to Charing Cross Hospital.
JB asked if there was likely to be four trauma centres instead of three. CE responded that Chelsea & Westminster was not interested in becoming a Trauma Centre and that it was difficult to justify setting up another.

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

CE reported that Chelsea & Westminster had achieved a very healthy bid score beating Imperial College on every aspect of the bid and he noted that a lot of work had gone into the bid. CE thanked everyone involved on behalf of the Members' Council. It was not yet known if there would be a public consultation. The recommendation is good news for the Trust and is in keeping with the overall strategy to be majoring in Women & Children's services.

CE reported on the Trust's concerns of affordability of the development. There was a need to balance the Trust's aspirations against the impending financial crisis in 2010/11 onwards when it will be faced with lower funding given the level of public debt. CE reported on the 5% annual decrease in funding year on year and stressed the importance of the strategy meeting.

2.2 Members' Council Membership Development & Communications Sub-committee **CBir**

CBir led in Martin Rowell's absence.

Minutes of the meeting held in May 2009

CBir reported on the 4 main points to note from the meeting:

1) The Terms of Reference of the sub-committee was reviewed.
2) The constitutional arrangements for membership was reviewed.
3) The strategy document was reviewed.
4) The paper on Diversity was not discussed due to the

absence of AMC and DH. This will come up again at the next meeting in August.

SSG noted that there were no public members at the meeting. JB noted that Martin Lewis was a public member but was not present at the meeting. **It was agreed to look further into the issue of public membership.** **DH**

Review of Terms of Reference

The meeting's attention was drawn to the phrase 'when requested' in paragraph 2.1d. CM noted that the Trust's policy on leaflets did not refer to this Committee but to any member of the Members' Council and this was a compromise. **It was agreed that this phrase should be deleted from paragraph 2.1d of the Terms of Reference and the Trust's policy should be amended.** **DH/ CM**

CBir suggested that the membership of the sub-committee should be restricted to Council Members and the Trust's staff should be in attendance. CBir drew the analogy of the Members' Council.

CE also suggested powers of co-option. DM suggested a quota for Trust employees. **It was agreed that membership of the sub-committee would be restricted to Council Members, all others would be in attendance, and the Terms of Reference would be amended to reflect this.** **DH**

Subject to the above amendments, the Terms of Reference were approved. **DH**

Membership Tracker

CE noted that the tracker was a tool for monitoring the sub-committee's work. CE made reference to objective 3.2 and noted that the there was a need to encourage more members to stand for election to the Members' Council. This is something the new Membership and Engagement Manager should focus on.

JB referred to objective 3.5 and was of the view that it was not appropriate for the Members' Council to be involved in Mystery Shopping and asked if the Trust had a whistleblowers' policy. CE confirmed that the Trust did have a whistleblowers' policy.

Both FT and BG felt that Mystery Shopping was a beneficial activity. AMC felt that Mystery Shopping was a beneficial activity but it was not helpful for the Members' Council to be involved in this activity. CBle agreed that the role was inappropriate for the Members Council and should be reserved for professionals. CBle thought that one way that the Members' Council could be involved is in ensuring that it is properly set up.

CE noted the sensitivities around Mystery Shopping and the possibility of interface with clinicians leading to inappropriate

circumstances.

Draft Membership Development & Communications Strategy

CBir reported on the updated strategy document and was of the view that it was more realistic than previous versions. CBir asked for an 's' to be added to 'communication' in the title of the document and paragraph 5.2 needed a bit of tidying up.

AMD commented that the strategy did not address the question, 'Why the public should be engaged with this hospital as opposed to another FT?'

CE noted that, until recently, the Trust was among a small number of FTs, however, we now have neighbours who are Foundation Trusts. JB commented that the public's loyalty is somewhat based on loyalty to the Trust's predecessors, in particular St. Stephens, and that loyalty will diminish as the association with St. Stephens is forgotten.

Subject to the above amendments, the Strategy was approved. **DH**

2.3 Experience

2.3a Patient **AMC**

AMC gave a presentation on the Patient experience. He pointed out the key players involved in understanding the patient experience and sources of information. AMC noted that engagement was a core activity and invited the Members' Council to join the work to ensure that the Trust does what it says it will do.

AMC discussed the results of the survey and explained that the focus for improvement in the patient environment included noise at night, safety for personal belongings and food. More work was needed to understand the reasons for delayed discharges. AMC discussed the Patient Tracker which asks patients to rate their hospital experience and explained how this tool complemented the survey with real-time feedback to staff.

AMC asked the Members' Council for their views on the Patient Tracker questions. CBle said that they were very subjective. AMC agreed but noted that personal experience is subjective. AMC explained that the questions were selected a bank provided by Dr. foster. He also explained that there are overlaps in other languages.

The meeting also discussed the best person to give the tracker to patients. It was felt that patients may be hesitant to rate a poor experience and may fear repercussions from the staff.

AMC also reported that the Trust was trying to recruit 2,000 staff and patients to be surveyed 4 times per year.

2.3b Staff **AP**

AP gave a presentation on the 2008 staff survey and the results for the key findings in relation to the previous year and the national average.

AP noted that there were some anomalies in the findings. AP noted that the percentage of staff witnessing potentially harmful errors, near misses or incidents in last month had increased. The national Patient Safety Agency considered this to be a favourable indicator as it indicated staff awareness. The Health Care Commission viewed it unfavourably as an indicator of harm.

AP reported on the Trust's action plan based on Trust wide issues and Directorate action plans. Every member of staff will have an annual appraisal by September 2009. All staff are being trained in Equality and Diversity over a 3-year period. The focus will also include building on effective communication.

2.3c GP **AK**

AK gave a presentation on a Survey of GPs which was undertaken to identify ways to improve the service that the Trust offers patients and understand factors affect the decision of GPs to recommend C&W. AK reported on the areas where the Trust performed well and noted that the gaps remained around administrative issues in the responsiveness of departments, discharge, booking follow ups and appointments. AK noted that the speed required may have affected the administrative processes and this is being investigated.

AK reported that in light of the positive response to the Directory of Paediatric Services, it would be proposed to the Members' Council later in the agenda, that a complementary directory is produced for care services for adults.

CBir noted that the title 'Directory of Adult Services' could be misinterpreted.

2.4 Open Day 2009 – Evaluation Report **MAk**

This report was taken as read.

2.5 The Annual Members' Meeting 2009 **MAk**

The Members' Council agreed on the proposed aims and themes of the Annual Members' Meeting and the proposed content of the statutory presentations.

Members' Council representatives should indicate to Dianne Holman if they are interested in presenting the membership report at the Annual Members' Meeting. **ALL**

It was agreed that there would be focus group to get input from mothers. JB suggested that there should a two late morning groups – one for mothers of babies and another mother of children aged 2 to 5.

CBir proposed that the Annual Members Meeting be used to encourage members to stand for election. JB proposed a meeting one week before the Annual Members' Meeting to encourage members who may want to stand for elections.

2.6 Membership Report **DH**

This report was taken as read.

2.7 Funding Report **DH**

The meeting noted how the 2008-09 allocation had been spent and agreed to fund the GP Directory of Services.

2.8 Review of Constitution **CE**

The title of the Members' Council

CE introduced the discussion citing the distinction between the title of the collective body and the title of individual members of the body.

WB proposed that the name of individual members of the Members' Council is changed to 'governors'. SSG supported this, reporting that at the recent Spring Seasonal Working conference many people did not know if they were members of the Members' Council or just plain members.

The meeting looked at the research into names prepared by SSG.

CBir asked that the cost of re-producing literature to accommodate a name change was quantified. WB and CBle were of the view that cost should not be taken into account in this matter as it was about the principle. BG commented that it was the role of the body that was important rather than its name.

CM informed the Chairman that FT had left the meeting and as a consequence, the meeting was no longer quorate. The meeting was adjourned. The next meeting will be held on 17th September 2009 at 3:00pm.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 17 September 2009

AGENDA ITEM NO.	1.4/Sep/09
PAPER	Matters Arising from the meeting of the Members' Council held on 18 June 2009
AUTHOR	Dianne Holman, Interim Foundation Trust Secretary/Head of Corporate Governance
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper lists matters arising from previous meeting(s) and the action taken or subsequent outcomes.
DECISION/ ACTION	The Members' Council is asked to note the matters arising and the updates.

MATTERS ARISING
Members' Council General Meeting
Hospital Boardroom
Chair: Prof. Sir Christopher Edwards
Date: 18 June 2009
Time: 4:30 – 6:30 pm

Ref	Description	Lead	Subsequent Actions or Outcomes
1.5	**Review of Action Points from Joint Away Day 4 December 2008** **It was agreed that a Task & Finish group would be set up to look at the various options for the organisation of meetings.**	**ALL**	
2.2	**Members' Council Membership Development & Communications Sub-committee** **Minutes of the meeting held in May 2009** **It was agreed to look further into the issue of public membership.**	**DH**	All public members can join the group as the Terms of Reference state that the Sub-committee shall comprise elected Council Members from the public, patient and staff constituencies who are concerned with the implementation and development of the Strategy. All elected Council Members were circulated with papers for September's meeting in order to encourage the

			participation of public members. This led to some confusion about required attendance and in future only those elected members who indicate that they wish to be part of the group will receive papers.
	Review of Terms of Reference		
	It was agreed that this phrase 'when requested' should be deleted from paragraph 2.1d of the Terms of Reference and the Trust's policy should be amended.	**DH**	Completed
	It was agreed that membership of the sub-committee would be restricted to Council Members, all others would be in attendance, and the Terms of Reference would be amended to reflect this.	**DH**	Completed
	Draft Membership Development & Communications Strategy		
	Amendments required: **for an 's' to be added to 'communication' in the title of the document and paragraph 5.2 needed a bit of tidying up.** **address the question, 'Why the public should be engaged with this hospital as opposed to another FT?'**	**DH**	Completed.
2.5	**The Annual Members' Meeting 2009**		
	Members' Council representatives should indicate to Dianne Holman if they are interested in presenting the membership report at the Annual Members' Meeting.	**ALL**	Dr. Ann Mills-Duggan will present on behalf of the Members' Council.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 17 September 2009

AGENDA ITEM NO.	2.1/Sep/09
PAPER	Report of the Task and Finish Group – Name of Members' Council and Members of the Council
AUTHOR	Dianne Holman, Interim Foundation Trust Secretary/Head of Corporate Governance
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper gives an account of the issues raised by the Task & Finish Group and the recommendations proposed to address these concerns.
DECISION/ ACTION	To Council is asked to note the issues and adopt the recommendations made to address the concerns raised.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Task & Finish Group, 29th July 2009

PRESENT:

Prof. Sir Christopher Edwards	Chairman		CE
Lady Sandra Smith-Gordon	Public	Kensington and Chelsea 2	SSG
Martin John Lewis	Public	Westminster 2	ML
Walter Balmford	Patient		WB
Chris Birch	Patient		CBir
Brian Gazzard	Staff	Medical and Dental	BG
Cllr. Frances Taylor	Appointed	Royal Borough of Kensington and Chelsea	FT

APOLOGIES:

Mary Symons	Public	Wandsworth 1	MS
Ann Mills-Duggan	Public	Westminster 1	AMD
June Bennett	Patient		JB
Jim Smith	Patient		JS
Nicky Browne	Appointed	The Royal Marsden NHS Foundation Trust	NB

IN ATTENDANCE:

Catherine Mooney	Director Of Governance	CM
Dianne Holman	Interim FT Secretary	DH
Sian Nelson	Membership & Engagement Manager	SN

Report of the Members' Council Task & Finish Group, 29th July 2009

1.0 BACKGROUND

The Members' Council at its meeting on 18th June 2009 agreed that a Task & Finish group would be set up to look at the various options for the organisation of meetings.

As the Council did not have the opportunity to fully discuss 2.8a 'The title of the Members' Council' at its last meeting, the Chairman proposed to expand the remit of the Task & Finish Group on the function and organisation of meetings in order to revisit this issue of the title of the Members' Council.

The group was asked to consider the issues and, if required, make a recommendation for the name of both the collective body and its individual members for a vote at the Annual Members' Meeting.

2.0 ISSUES

CE re-introduced the paper presented to the Members' Council earlier in June and noted that Chelsea & Westminster is among a minority of Foundation Trusts using the title Members' Council.

It was noted that although there were strong sentiments both by the Board and the Members' Council they both shared the same concern, that is, that the name of the body and its members ensures that its role is understood. CE concurred that with the passage of time there was less ambiguity about the roles of the different organs of the Trust but, notwithstanding, he considered that it was appropriate to reserve the term 'Board' for the Board of Directors to avoid confusion.

CE also cited the mutual interdependence of the Board of Directors and the Members' Council and the need for consultation on any recommendation proposed.

The group agreed to proceed by first suggesting the most appropriate name for the individual members and then suggesting an extended name for the collective body.

The group was reminded about previous confusion over 'members' and 'Council Members' at a recent event and discussed the term 'Representative' but it was thought that this could be confused with staff-side representatives. Likewise, it thought that 'Councillor' could also be confusing.

WB moved that the title for the individuals should be 'Governor'. This was seconded by CBir. There were no objections from the group.

3.0 RECOMMENDATIONS

It was proposed that the names 'Governor' and 'Council of 'Governors' should be put to the Annual Members' Meeting for a vote after consulting the Board of Directors and then the Members' Council.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 17 September 2009

AGENDA ITEM NO.	2.2/Sep/09
PAPER	Report of the Task and Finish Group – governance arrangements
AUTHOR	Dianne Holman, Interim Foundation Trust Secretary/Head of Corporate Governance
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper gives an account of the issues raised by the Task & Finish Group and the recommendations proposed to address these concerns. Also attached are the draft Terms of Reference for the sub-committees proposed at paragraph 2.1.2(e).
DECISION/ ACTION	To Council is asked to: ▪ note the report and adopt the recommendations made to address the concerns raised; and ▪ approve the draft Terms of Reference for the sub-committees proposed at 2.1.2 (e). .

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Task & Finish Group, 29th July 2009

PRESENT:

Prof. Sir Christopher Edwards	Chairman		CE
Lady Sandra Smith-Gordon	Public	Kensington and Chelsea 2	SSG
Martin John Lewis	Public	Westminster 2	ML
Walter Balmford	Patient		WB
Chris Birch	Patient		CBir
Brian Gazzard	Staff	Medical and Dental	BG
Cllr. Frances Taylor	Appointed	Royal Borough of Kensington and Chelsea	FT

APOLOGIES:

Mary Symons	Public	Wandsworth 1	MS
Ann Mills-Duggan	Public	Westminster 1	AMD
June Bennett	Patient		JB
Jim Smith	Patient		JS
Nicky Browne	Appointed	The Royal Marsden NHS Foundation Trust	NB

IN ATTENDANCE:

Catherine Mooney	Director Of Governance	CM
Dianne Holman	Interim FT Secretary	DH
Sian Nelson	Membership & Engagement Manager	SN

1.0 BACKGROUND

The Members' Council at its meeting on 18th June 2009 agreed that a Task & Finish group would be set up to look at the various options for the organisation of meetings. The Task & Finish Group met on 29th July 2009 at 4.30pm and, to facilitate the discussion, the Chairman prepared a paper on the organisation of meetings.

SSG asked what the powers of a Task & Finish Group were and CE confirmed that that they were to make recommendations to the Members Council.

2.0 ISSUES and RECOMMENDATIONS

2.1 General – Organisation of Meetings

CE discussed what he considered were the main issues to be addressed which were outlined in more detail in his paper:

- The excessive length of the meetings given the start time of 5pm
- The need for the Council to focus on the most important issues so that the meeting could get through the agenda
- The importance of actively involving Council members in setting the agenda so that both lay and professional members are encouraged to contribute
- Mechanisms to facilitate the optimal contribution of the Council and its members

Recommendation: It was proposed that

a) **the recommendations set out in the paper be adopted. The group also proposed further recommendations based on discussions on the following related issues.**

2.1.1 Roles and responsibilities of individual members

Clarification was sought on the roles and responsibilities of individual members.

CE suggested that individuals could take on roles on working committees or focus groups aligned with their personal interests, for example, complaints or cleanliness.

Recommendation: It was proposed that

b) a list of the various focus groups which will need a contribution from the Members' Council is compiled by SN and circulated at the next Members' Council meeting so that individual members are able to identify opportunities to become involved beyond the quarterly meetings of the Council.

2.1.2 Time and frequency of meetings

Some members were concerned that limiting meetings to 2 hours restricted their ability to contribute effectively. It was thought that members could feel side-lined as they were volunteering their time and experience and suggested that if longer meetings were inconvenient for the directors, there could be a rota. It was also thought that it was frustrating to see items like the hospital's budget at the bottom of the agenda.

CE said that the Council should go for quality rather than quantity and take control of the agenda in order to meet its objectives.

Recommendation: It was proposed that in order manage the length of the meetings

- **c) personal anecdotes are left out of meetings**
- **d) there should be some time before each meeting for members to have refreshments, catch up and discuss issues informally**
- **e) there should be an Agenda Sub-Committee to meet in advance of each meeting to agree on the agenda in consultation with the Secretary who will advise on the statutory items – draft terms of reference to be prepared and circulated at the next Members' Council meeting.**

2.1.3 Communication, sharing information about members and transfer of knowledge

Some members felt that is was desirable for members to be in contact with one other outside of meetings and, as there was much variability among different members, to know what skills, abilities and experience each member brings to the Council.

Members felt that there could be improvements to the induction process and that focus should shift from top-down transmission of knowledge to a flatter system where council members participate in inducting their peers. Members also voiced concerns that the role of Council was written in vague managerial-style language.

Recommendations: It was proposed that

- **f) Individual members authorise the sharing of their contact details as well as relevant biographical details**
- **g) The role of the Council is re-written in a more user-friendly style**
- **h) A Task & Finish Group is set up to design the 2009 Induction Programme**

2.1.4 The Quality Agenda

CM informed the group that the new legislation on quality was likely to require stakeholder involvement and that a smaller group could be more effective in teasing out the issues.

Recommendation: It was proposed that

- **i) there should be a Quality Sub-Committee – draft terms of reference would be prepared and circulated at the next Members' Council meeting.**

Members' Council Agenda Sub-Committee

DRAFT TERMS OF REFERENCE

1.0 Authority

1.1 The Members' Council Agenda Sub-Committee is constituted as a Sub-Committee of the Members' Council under a resolution passed at a General Meeting of the Members' Council held on 17th September 2009 pursuant to the recommendations of the Members' Council Task & Finish Group on the Organisation & Function of Meetings.

1.2 Its terms of reference shall be as set out below and shall not be amended, revoked or replaced except by a resolution passed at a general meeting of the Members' Council.

2.0 Aim

2.1 This sub-committee is intended to facilitate more productive and effective meetings of the Members' Council and to maximize the contribution at meetings of both individual Council Members and the Executives by enabling the Members' Council to be more pro-active and to take a lead on issues of interest and importance to the Members' Council including devising work plans and agendas for their meetings.

3.0 Role

3.1 The role of this sub-committee is to:

- Specify the non-statutory business to be carried out at the four statutory general meetings of the Members' Council in each financial year; and
- Inform the Secretary who will send written notice to all Council Members as soon as possible after the receipt of such a request.

3.2 Exclusions

The role of this sub-committee does **not** extend to:

- Statutory business which is to be specified by the Secretary or Chairman of the Foundation Trust; or
- Any business to be carried out at meetings which may be called by ten Council Members in accordance with section 11.17.2 of the Constitution.

4.0 Key Relationships

4.1 This sub-committee, by virtue of the composition of its membership, recognises and accommodates the distinct needs and aspirations of the appointed and elected Council Members.

4.2 This sub-committee is reliant on the services of the Foundation Trust's Secretariat to undertake its role.

4.3 This sub-committee is informed by the Chief Executive and Lead Executives for the other duly constituted sub-committees of the Members' Council.

5.0 Membership of the Sub-Committee

5.1 The membership of the Sub-committee shall comprise:

- The Chairman of the Foundation Trust (or in his absence the Vice-Chairman of the Board of Directors or in their absence one of the non-executive directors);
- Three (3) elected Council Members (public - 1 / patient – 1 / staff – 1); and
- One (1) appointed Council Member
- The Chief Executive (or in her absence the Deputy Chief Executive).

5.2 The following members of the Trust's executive are invited to attend meetings to provide advice to the sub-committee when appropriate:

- The Director of Nursing (as Lead Executive for the Members' Council Communications Sub-Committee)
- The Director of Human Resources (as Lead Executive for the Nominations Committee).
- The Director of Governance and Corporate Affairs
- The Lead Executive for any other duly constituted sub-committee of the Members' Council.

5.3 The Foundation Trust Secretary shall attend meetings of the sub-committee to provide advice and support services to the sub-committee and to be informed of the programme of business requested for the four (4) general meetings of the Members' Council.

6.0 Quorum

6.1 A Quorum shall comprise:

1) The Chairman of the Foundation Trust (or in his absence the Vice-Chairman of the Board of Directors or in their absence one of the non-executive directors); and
2) One (1) other Council Member.

7.0 Frequency of meetings:

7.1 Meetings will normally be held twenty-eight (28) days before the scheduled date for each of the four (4) general meetings called by the Secretary under section 11.17.1 of the Constitution.

8.0 Review

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

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 17 September 2009

AGENDA ITEM NO.	2.4/Sep/09
PAPER	Re-appointment of Non-Executive Directors
AUTHOR	Dianne Holman, Interim Foundation Trust Secretary/Head of Corporate Governance
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper reports on the outcome of the appraisals conducted on non-executive directors seeking re-appointment following the expiration of their term of office on 30th September 2009.
DECISION/ ACTION	To Council is asked to note the reports and to approve the re-appointments as recommended.

Report on Non-Executive Director Appraisal

Name	**Charles Wilson**
Date of First Appointment	**11th September 2000**
End Date of Current Term	**30th October 2009**
Date of Appraisal	**September 2009**

Introduction

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

In compliance with the Constitution and Monitor's Code of Governance which stipulates that the board of directors undertakes a formal and rigorous annual evaluation of its individual directors, the Chairman has conducted this evaluation which involves a face-to-face meeting to discuss the director's statement setting out his views of her past performance and the extent to which he has achieved the stated criteria for delivering results.

Results of Evaluation

.
The result of this evaluation is that Charles Wilson continues to contribute effectively and to demonstrate commitment to the role which includes commitment of time for Board, chairing the Assurance Committee meetings and other duties, in particular, the roles of Vice-Chairman of the Board and Senior Independent Director.

His length of service (nine years from date of first election) has been considered as part of the evaluation in the context of independence and the need for progressively refreshing the Board of Directors.

Charles is found to have remained independent and to possess the skills, knowledge, experience and unique personal qualities which are required for the particular roles of leading the Board and Members' Council should the Chairman be absent, unavailable or otherwise unable to discharge his duties and acting as an independent point of contact for the Board of Directors and the Members' Council.

There have been no significant changes to his other commitments.

Recommendation

The Members' Council is asked to approve the re-appointment of Charles Wilson as non-executive director for a term of one year ending on 30th October 2010.

Report on Non-Executive Director Appraisal

Name	**Karin Norman**
Date of First Appointment	**1st July 2005**
End Date of Current Term	**30th October 2009**
Date of Appraisal	**August 2009**

Introduction

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

In compliance with the Constitution and Monitor's Code of Governance which stipulates that the board of directors undertakes a formal and rigorous annual evaluation of its individual directors, the Chairman has conducted this evaluation which involves a face-to-face meeting to discuss the director's statement setting out her views of his past performance and the extent to which she has achieved the stated criteria for delivering results.

Results of Evaluation

.
The result of this evaluation is that Karin Norman continues to contribute effectively and to demonstrate commitment to the role which includes commitment of time for Board, including membership of the Assurance Committee, Finance & Investment Committee and Audit Committee; and other duties.

Karin is found to have remained independent and possesses expertise in the area of Finance and should continue to play a very important role as the Board faces the challenges of achieving its growth and development objectives against the background of an economic downturn over the next three years.

There have been no significant changes to her other commitments.

Recommendation

The Members' Council is asked to approve the re-appointment of Karin Norman as non-executive director for a term of three years ending on 30th October 2012.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Quarterly Meeting
17 September 2009

AGENDA ITEM NO.	2.5/Sep/09
PAPER	Policy for Board Composition of Non-Executive Directors
AUTHOR	Dianne Holman, Interim FT Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	The Trust's Constitution at section 12.5.1 provides *'The Members' Council will maintain a policy for the composition of the non-executive directors which takes account of relevant Trust strategies, and which they shall review from time to time and not less than every three years'.* The Trust was authorised in October 2006 and a formal review of the policy is now required. No formal policy is in force and the attached draft is proposed for consideration. It is also proposed that, in future, the Nominations Committee will review this policy and make recommendations to the Members' Council.
DECISION / ACTION	The Members' Council is asked to agree the draft policy.

Report on Chairman's Appraisal

Name	**Prof. Sir Christopher Edwards**
Date of First Appointment	**1st November 2007**
Date of Appraisal	**June 2009**

Introduction

In compliance with Monitor's Code of Governance which stipulates that the board of directors undertakes a formal and rigorous annual evaluation of its individual directors, the Senior Independent Director has conducted this evaluation in accordance with the process approved by the Members' Council in December 2008. This involves collaboration between the Senior Independent Director and the Deputy Chairman of the Members' Council to seek the views of both directors and the Council Members in response to the Chairman's statement setting out his views of the extent to which he has fulfilled his stated responsibilities.

Council Members met in a private session in June 2009 to feed back their views to the Deputy Chairman of the Members' Council on the Chairman's performance including any suggestions for improvement. The Deputy Chairman of the Members' Council shared this feedback with the Senior Independent Director.

Role of Chairman

The Members Council's attention is drawn to the duality of the role:

1. Chairmanship of the Foundation Trust Board of Directors; and
2. Chairmanship of the Members' Council.

It is a statutory requirement that both roles are filled by the same person. The focus of the Chairman's appraisal is his performance as Chairman of the Board of Directors. This is largely because the legislation states that it is the Chairman of the Board of Directors that chairs the Members Council (not the other way around). The primary aim of the Chairman's work will be leading the directors.

Results of Evaluation

.

The result of this evaluation is that Prof. Sir Christopher Edwards continues to contribute effectively and to demonstrate commitment to the role. Since his appointment Sir Christopher has taken on the chairmanship of Medical Education England; however, this does not present a conflict of interest and he continues to remain independent.

Recommendation

The Members' Council is asked note the results of the evaluation.

Members' Council

DRAFT Policy for Board Composition of Non-Executive Directors

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

1.0 ELIGIBILITY

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

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

2.0 COMPOSITION

2.1 Size

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

2.2 Independence

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

2.3 Role of Vice-Chairman

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

2.4 Role of Senior Independent Director

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

2.5 Attributes

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

2.6 Time Commitment

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

3.0 APPOINTMENTS

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

4.0 RE-APPOINTMENTS

4.1 Pre-requisites

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

4.2 Disclosures

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

4.3 Retirement from Board

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

5.0 COMPENSATION

The Members' Council sets the terms and conditions of office. The Members Council is aware that all money paid to non-executive directors is taxpayers' money and ensures that value for public money is obtained. **DH 09 06 08**

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 17 September 2009

AGENDA ITEM NO.	2.6/Sep/09
PAPER	Report on Chair Appraisal
AUTHOR	Dianne Holman, Interim Foundation Trust Secretary/Head of Corporate Governance
LEAD	Charles Wilson, Vice Chairman and Senior Independent Director
EXECUTIVE SUMMARY	This paper reports on the outcome of the Chairman's appraisal.
DECISION/ ACTION	To Council is asked to note the report.

Report on Chairman's Appraisal

Name	**Prof. Sir Christopher Edwards**
Date of First Appointment	**1st November 2007**
Date of Appraisal	**June 2009**

Introduction

In compliance with Monitor's Code of Governance which stipulates that the board of directors undertakes a formal and rigorous annual evaluation of its individual directors, the Senior Independent Director has conducted this evaluation in accordance with the process approved by the Members' Council in December 2008. This involves collaboration between the Senior Independent Director and the Deputy Chairman of the Members' Council to seek the views of both directors and the Council Members in response to the Chairman's statement setting out his views of the extent to which he has fulfilled his stated responsibilities.

Council Members met in a private session in June 2009 to feed back their views to the Deputy Chairman of the Members' Council on the Chairman's performance including any suggestions for improvement. The Deputy Chairman of the Members' Council shared this feedback with the Senior Independent Director.

Role of Chairman

The Members Council's attention is drawn to the duality of the role:

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Results of Evaluation

.

The result of this evaluation is that Prof. Sir Christopher Edwards continues to contribute effectively and to demonstrate commitment to the role. Since his appointment Sir Christopher has taken on the chairmanship of Medical Education England; however, this does not present a conflict of interest and he continues to remain independent.

Recommendation

The Members' Council is asked note the results of the evaluation.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 17 September 2009

AGENDA ITEM NO.	2.7/Sep/09
PAPER	Membership Development and Communications Annual Work Plan 2009/10
AUTHOR	Sian Nelson, Membership and Engagement Manager
LEAD	Andrew MacCallum, Director of Nursing
EXECUTIVE SUMMARY	This paper outlines the direction for the growth and development of the Members Council Governors and the constituencies they represent.
DECISION/ ACTION	To Council is asked to adopt the work plan.

Membership Development and Communications Annual Work Plan 2009/10

1. Introduction

The Members Council Work Plan for September 2009-April 2010 outlines the direction for the growth and development of the Members Council Governors and the constituencies they represent. In response to the Membership Development and Communications Strategy (June 2009) this document forms a framework to demonstrate existing membership activities and presents the plan of activities to ensure that growth, vibrancy and motivation of the members council is encouraged through 2010 and beyond.

2. Background

The work plan is formulated to respond to and meet the objectives of the Membership Development and Communications Strategy (June 2009). The strategy focuses on increasing membership and ensuring a seamless system is in place to support this.

The Trust and Membership Council must ensure that it reflects the diverse communities it represents. Therefore working alongside the Equality and Diversity Group will assure the Members Councils activities are vigorous in delivering equality to its membership.

The work plan will ensure we meet agreed objectives within an achievable framework; both practically and within a realistic time frame. It delivers accountability and aims to distribute responsibilities collectively and individually to the Members Council Governors.

2.1 Current engagement with membership

Chelsea and Westminster Hospital Foundation Trust inform members about the activities of the Trust and engage their interest and support in a number of ways:

- Chelsea and Westminster Hospital Annual Open day for Foundation Trust members.
- Biannual membership mailings, including the Trust News
- Two recruitment weeks for potential new Trust members.
- Quarterly Members Council meetings
- Quarterly Members Council Sub-Communications meetings

3.0 Progress to date

The Membership and Engagement Manager has been appointed and responsibilities within the role are to create stronger links between the Members' Council, Foundation Trust Members, staff, and patients.

3.1 Rebranding of PALS

The Patient Advice and Liaison Service (PALS) has expanded its responsibilities to collaborate with and support the Members' Council and its Members. Therefore the

PALS title has changed to Membership – Patient Advice and Liaison Service (M-PALS). M-PALS officers will take an active role in engaging with patients and the public to encourage membership and promote membership events. The team will receive training to ensure that correct information is communicated to existing and potential members.

3.2 M-PALS comments cards

M-PALS have re-designed its comment cards which are now more user friendly. The cards will be distributed to every clinical area in the Trust (with the exception of maternity services which has a specific maternity design). This will encourage patient feedback so that themes can be registered at M-PALS and fed back to the clinical environments and the Patient Experience Improvement Group.

3.3 Improved collaboration with Chelsea and Westminster Hospital Health Care Charity

The Membership and Engagement Manager has developed an association with Chelsea and Westminster Hospital Health Care Charity. The charity has agreed to allow a Members stand at the Duathlon event in September 2009. This will provide the members council the opportunity to enhance its profile and engage and recruit members from a wider community, especially those within the age group 16-40 years.

The charity has won the bid of 'charity of the year' with Sainsbury's supermarket. The Cromwell Road and Fulham Road branches will support the Chelsea and Westminster Health Care Charity. The charity has agreed to erect a member's stand at the Cromwell Road branch. Again this will help us reach a wider community group, specifically families and the younger age group less than forty years old.

3.4 Annual Members' Meeting

The Annual Member's Meeting and Member's Council Meeting will be held on the 17th of September 2009. Leading to this will be a recruitment campaign held inside the Information Zone. From Monday to Friday 'patient experience' volunteers and M-PALS Officers will engage with the public, staff and patients to explain about the elections, becoming a Foundation Trust Member and how to stand for election. Those persons wishing to stand for election can attend a workshop session (held Mon-Fri 12-2pm) with a Council Governor, who will discuss the role and explain the application process.

3.5 Members' Council Elections

The Council Member's election is fixed for November 2009. Prior to this there will be a process of electoral preparations. Electoral mail will be sent to Trust members in each constituency. We will use this mailing opportunity to send other relevant information regarding the Trust.

The Equality and Diversity group plan an open day to celebrate its single equality scheme. There will be a wide range of demonstrations and exhibitions from all areas of representations, such as disability groups, gender, age groups etc.

This will create an opportunity for the Members council to support Equality and Diversity; to establish links with diverse groups, and to exhibit the importance that Equality and Diversity plays in the Members Council and its quest for representation within its membership.

3.6 Governors Induction and Training

Induction and training for new or existing Members Governors will be developed and external groups will be sought to establish this. The training will comprise of modules relating to issues around health, its affects on society and on individuals, and how to

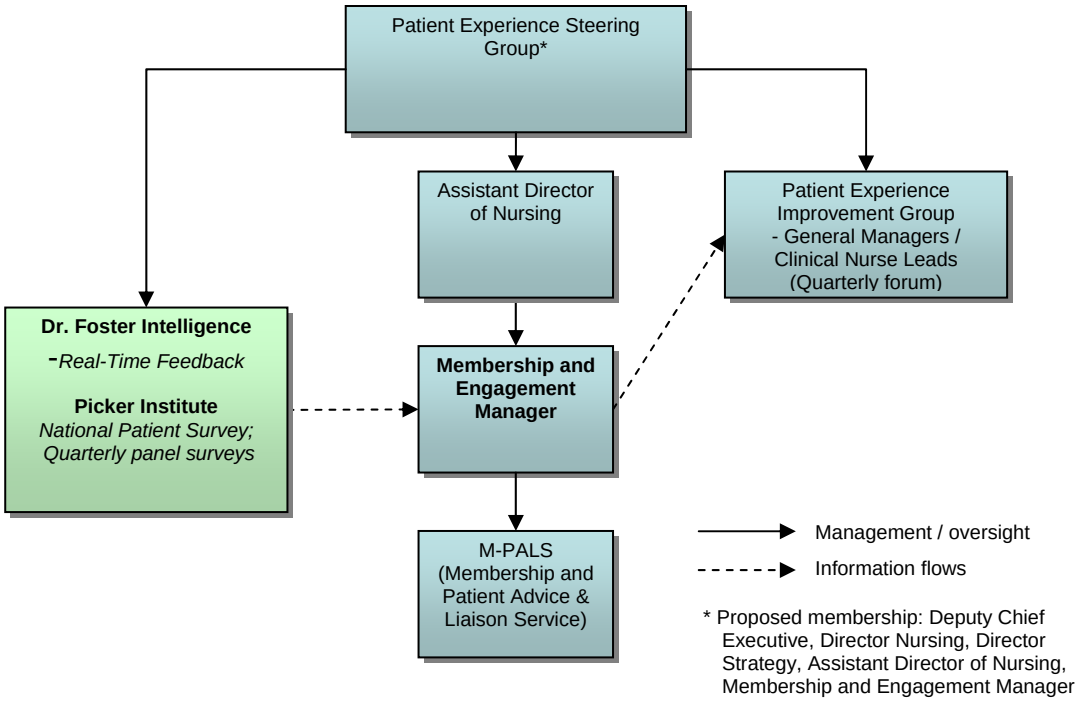
develop this knowledge further by identifying focus groups to develop projects aimed at improving services.

3.7 Improving the patient experience

Improving the patient experience is of prime importance to the care we deliver at Chelsea and Westminster Hospital Foundation Trust. The Membership and Engagement Manager coordinates patient feedback to improve quality of services. Chelsea and Westminster Hospital participates in the national survey programme, and has implemented a unique patient feedback questionnaire, called a patient experience tracker (PET). The hand-held electronic questionnaire captures the patients experience before leaving hospital. The results are analysed immediately, which gives staff the opportunity to evaluate and improve services.
In synchronisation, M-PALS comment cards are circulated throughout the Trust. The comments are registered at M-PALS; themes of this feedback are recorded and fed back to the relevant clinical areas.

Management of feedback is coordinated across the hospital. The Patient Experience Steering Group (PESG) has been established to direct the Trust's strategy and objectives of the patient experience. The Patient Experience Improvement Group (PEIG) has been developed to deliver the patient experience strategy and coordinates the ongoing management of feedback. This structure is outlined in Figure 1. The PEIG actively track and take actions in response to feedback.

Figure 1. Managing patient feedback



4.0 Ideas/proposals
Potential activities will be put forth to the Members' Council.

4.1 Increasing activities with patient forums
There are currently numerous patient forums set up within the hospital that represent specific clinical areas of care (Table 1 below) Linking the Members Council governors with a patient forum will enable the governor to represent patients and connect with activities within the Trust. Patient forums will be presented at Members Council meetings and those governors who wish to become involved with a specific forum will be introduced to that patient forum group.

Table 1. Trust wide patient forums

Maternity Services Liaison committee (MSLC)	HIV forum	Heart failure	Breastfeeding Forum	Policy and Procedure forum
Bariatric forum	Intensive Care Unit forum	Rheumatoid arthritis forum	Menopause forum	Joint Research Committee

4.2 Annual Plan
In previous years there has been limited involvement of the Members' Council in development of the Trust's Annual Plan.
Development of the Annual Plan is an opportunity to involve the Members' Council in shaping the strategic direction of the Trust and would be suitable because the role of the Members' Council should be to add value to strategic, not operational issues.

Specifics should be discussed with the Trust Board, but the key is to involve the Members' Council at an earlier stage where they can genuinely influence the Trust's strategic direction – not inviting them to attend feedback sessions after the strategy has been decided.

There is also scope to involve and engage the wider Foundation Trust membership – for example by asking members to vote on their top three priorities from a list of perhaps 5-10 and/or by running sessions where members can meet their representatives on the Members' Council and give their views on the Trust's strategy.

4.3 Increasing events
Increasing events will ensure we engage with our members and create a more beneficial and interactive relationship. Collaboration with other events in the Trust will be advantageous; helping the Members Council to network with the Trust and reaching to wider social groups that we may otherwise not have contact with. Sharing of events will also ease costs.

4.4 improved collaboration with Health Care Charity
Chelsea and Westminster Hospital Health Care Charity support various community projects throughout London and are pro-active with health promotion. This reflects positively on the Trust. By association, the Members Council can reach to wider and diverse groups in the community that we may not otherwise have access to.

Involvement with the charities events will lead to enhanced publicity of the Members Council and encourage greater numbers of Foundation Trust members.

5. Summary

The Annual Work Plan 2009/10 for the Members Council is our opportunity as a Trust to outline the current and potential contribution of both Governors and our Membership to improving the services we deliver at Chelsea and Westminster Hospital. The plan will be reviewed at each meeting of the Members Council Sub-Communication meeting and a quarterly progress report will be presented to the Members Council meeting.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members Council Meeting - 17th September 2009

AGENDA ITEM NO.	2.8/Sep/09
PAPER	NHS Complaints Reform - Local Resolution - the Regulations Reform of Second Stage of NHS Complaints Procedure
AUTHOR	Carol Davis, Acting Patient Affairs Manager
EXECUTIVE LEAD	Andrew MacCallum, Director of Nursing
SUMMARY	The purpose of this paper is to inform the Members Council of the reform of both the local resolution and second stage of the complaints process.
ACTION	For discussion and comment

NHS Complaints Reform

1.0 Reform of the NHS Complaints Procedure – Local Resolution

1.1 In June 2007 the DH issued a consultation document "Making Experience Count" which proposed a new approach to the way that health and social care services respond to complaints. This was followed in February 2008 by the publication of their conclusions after considering the submissions made to them during the consultation period. 'Organisations will be expected to resolve any complaints made against it quickly and effectively – there will be a more personal and flexible approach to handling complaints. Organisations will be expected to ensure that people who raise complaints about services provided have access to effective support – this is important for people who find it difficult to make their views heard. It is also important that safeguards and assurances are provided to any complainant who is receiving ongoing treatment that it will not affect their treatment. Organisations will be expected to ensure effective governance arrangements to underpin and support this approach and ensure that learning from complaints is shared. The changes aim to make the process more accessible, responsive, independent and more closely linked to improving services. The regulations arising from the joint consultation were published in February 2009. "The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009" these regulations supersede the National Health Service [complaint] Regulations 2004. Based on public feedback the government is streamlining the current complaints system from a three-stage to a two-stage one, to make it quicker and simpler for a complainant to have their concerns dealt with.

1.2 At the Chelsea and Westminster, many of the new recommendations are implicit in our existing good practice around complaint management. Both the Chief Executive and the Director of Nursing regularly meet with complainants to try and resolve concerns.

1.3 Under the new regulations there will be a greater emphasis on face to face meetings with complainants by Clinical Staff, Directorate Managers and Directorate Complaint Leads. At the time of acknowledgement the Trust will offer to discuss the manner in which complaint is to be handled. A timescale for the investigation will be agreed and will reflect the type of investigation taking place.

2.0 Local Resolution Changes

2.1 The key elements of the new arrangements are :

- continued accountability at the most senior level of the organisation;
- responsiveness by the organisation and an ability to demonstrate improvements in response to complaints;
- information on complaints to be provided to commissioners who will use it to influence commissioning decisions;
- a commitment that the organisation will publicise how to raise a concern or complaint.;
- the Care Quality Commissioner will have a role in looking at the responsiveness to complaints;

2.2 The table below lists the main changes for complaint handling following the introduction of the "The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009" regulations:

Table 1.0 Summary of Changes

	Previous Guidance	Current Guidance
1.	Time limit for making a complaint 6 months from Incident or becoming aware of the problem	Time limit increased to 12 months
2.	25 working day time limit for responding to complaints.	There will be no set time limit. The time for responding to the complaint will be agreed with the complainant taking into account the complexity, detail and the agreed outcomes.
3.	Receipt of a complaint to be acknowledged within 2 working days no requirement to have preliminary discussion with the complainant before the investigation commenced.	Acknowledge receipt of a complaint and offer to discuss at a mutually convenient time with the complainant to agree on concerns raised, the proposed way forward for the investigation and a timescale for response within 3 working days.
4.	No requirement to consider redress, though it was considered good practice in some instances.	The Trust is required to consider redress in terms of financial compensation such as for direct or indirect financial loss, loss of opportunity, inconvenience, distress or any combination of these. - The Parliamentary and Health Service Ombudsman. Principles for Remedy (2007).
5.	Written response to be sent from the Chief Executive or in their absence nominated deputy.	The complainant should be sent a written response signed by the "responsible person," which describes how the complaint has been considered, what conclusions have been reached and what actions, if any, have or will be taken as a result. The "responsible person" in the NHS is the chief executive, however, "the functions of the responsible person may be performed by any person authorised by the responsible body to act on behalf of the responsible person."
6.	In the previous legislation the Trust was obliged to liaise with other healthcare providers where concerns were raised in order to ensure a joint complaint response was sent to the complainant.	If a complaint spans across other organisations such as healthcare providers and social services, a decision needs to be taken in regard to the lead for the drafting of the final response that will need to incorporate the findings of all organisations involved. The new legislation adds a further requirement which includes working with social services and local government.
7.	Complainant required to complain directly to the Trust	The complainant can complain to the PCT as commissioner and request them to investigate.
8.	Three stage complaint process	The Ombudsman replaces the Healthcare Commission for all second stage reviews

3.0 Complaint Types

3.1 The Trust is committed to the effective resolution of complaints and concerns and to ensuring that the views expressed are taken into account when decisions are made regarding the future direction of Trust services. It is important to remember that all concerns identified by a client are real to them, whatever the staffs view of the situation. It is essential to restore that person's confidence in our organisation and that a non judgemental approach is taken to resolving the problem. The new complaints arrangements require that responses to complainants need to be proportional to the nature of the complaint and accurate in focus on the issues they deal with. The use of the terms 'Informal' and 'Formal' in regards to complaints has now been replaced with the terms 'Concerns', 'Comments', 'Complaints' and 'Compliments' All issues being referred to by these terms will be resolved in a manner and time agreed between the Trust and the complainant.

3.2 The earlier an issue is addressed, the more satisfactory the resolution is likely to be for the complainant and staff. It is expected that all staff will listen to any concerns raised by service users and where possible take action to resolve their concern. The new "complaints regulations" no longer stipulate a time-scale for responding to complaints. The Trust has determined three levels of response to complainants, to be applied proportionately with regard to the nature of each complaint.

3.3 **Type One Concern or Complaint: Resolution Within 10 days**

A type 1 complaint is either a verbal complaint that is made in person by the complainant (whilst attending hospital or an out-patient clinic), or by telephone and where the complainant has indicated that they would be happy to receive a quick response or where the staff member believes they are able to resolve the issue rapidly, or a written and simple complaint made directly to a ward sister, team manager or department head, which is easily resolved. Most complaints can be dealt with immediately by a member of staff in a way that is satisfactory to the complainant. Most complainants wish to be satisfied that action is being taken with regard to the issue raised in their complaint and that steps will be taken to prevent a recurrence of the problem. Members of staff are expected to take ownership and resolve problems brought to them personally if they have the necessary knowledge and experience. More detailed information about dealing with complaints, comments and concerns at the front line level is given in the associated guidance document "Local Resolution of Patient Concerns"

3.4 **Type Two Complaint: Resolution Between 11 and 24 days**

A type 2 complaint requires an investigation that by its degree of organisational complexity or nature of the issues involved needs longer than 10 days to produce the required resolution and the ability of the organisation to provide a full response of high quality. In the acknowledgement letter the Trust needs to offer the complainant an opportunity to contact the complaint lead in regard to an action plan for local resolution. Complaint leads to liaise with complainant in regard to the progress of the investigation and likely timescale for completion, negotiating an extension of time where necessary with the complainant.

A type 2 complaint might be resolved through a meeting or an investigation and a written response. It may require a review by a clinician or nurse not involved in the investigation.

3.5 Type Three Complaint: Resolution taking 25 days or Longer

A type 3 complaint will require a thorough investigation and statements from staff. The investigation may take up to three months to conclude and this should be discussed with the complainant when the action plan is agreed. It may be necessary to obtain an external report from a clinical adviser. If a complaint is graded as orange or red according to the Risk Evaluation Matrix, the incident procedure should take preference in terms of the investigation. A written response will be provided with the incident report; the response will also include an offer to meet with senior staff to discuss the report and any outstanding concerns in more detail.

4.0 Annual Reports

Annual reports will be required stating the numbers of complaints received, the number of complaints which the Trust considers well founded and the number of complaints where the Trust has been informed of referral to Parliamentary and Health Service Ombudsman. The Annual report should summarise the subject matter of complaints, any matters of general importance arising out of complaints or the way that they were handled, and any matters where action has been taken to improve the services.

5.0 Referral to Parliamentary and Health Service Ombudsman

The national evaluation of the procedure undertaken in 2006 highlighted widespread dissatisfaction with both the independence and the length of time taken to conclude the second stage of the procedure. In response to this concern, the independent stage of the procedure will be undertaken by the ombudsman from the 1st April 2009. Any complainant whose complaint relates to NHS funded care will have the right to have their complaint reviewed by the Ombudsman. The Ombudsman has different powers and duties and a wider discretion than the Healthcare Commission.

6.0 Next Steps

The new Complaints Policy and Procedure will be approved by the Trusts Board of Directors and an implementation plan agreed, involving the communication with staff, patients and the public.

Annual Report & Accounts 2008/09

Choose Chelsea and Westminster

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

About this report

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

The report has a clear and simple structure:

- **Introduction**
  Statements by the Chairman and Chief Executive
- **Strategy**
  Including performance against corporate objectives 2008/09 and details of our corporate objectives 2009/10
- **Quality Report**
  Outlining our commitment to providing quality care for all patients
- **Performance Report**
  Including our performance against national targets
- **Statutory Information**
  Other information required for inclusion in the annual report in line with official guidance from Monitor, the independent regulator of Foundation Trusts
- **Finance**
  Including the accounts

This year for the first time Monitor requires all Foundation Trusts to include a Quality Report as a key element of the annual report and accounts.

A commitment to quality and quality improvement underpins our corporate strategy and this annual report. We hope you enjoy reading it.

Credits

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

Content & Articles
Matt Akid

Design & Layout
George Vasilopoulos

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

Chelsea and Westminster Hospital NHS Foundation Trust

Annual Report & Accounts 2008/09

Introduction

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Finance

Trust Chairman, Professor Sir Christopher Edwards and Chief Executive, Heather Lawrence pictured outside 56 Dean Street—our new HIV and sexual health centre in Soho—with Health Minister Lord Darzi at the official opening in May 2009

Chairman's statement

I believe passionately that Chelsea and Westminster Hospital belongs to patients who use its services, members of the public who live locally, and staff who work in the hospital.

This ethos is encapsulated by the slogan of our annual hospital Open Day—"Your hospital, your health, your say".

More than 1,500 people attended the Open Day in May 2009 which demonstrates that we already have a close relationship with our local community that I hope will develop further during the coming year.

Positive engagement with our community so that local people feel a sense of ownership over and pride in their hospital is vital to the future success of Chelsea and Westminster, especially at a time of economic uncertainty.

Our Members' Council and more than 15,000 patients, members of the public and staff who have chosen to be members of our Foundation Trust play an increasingly important role in the life of Chelsea and Westminster.

During 2008/09 Members' Council representatives provided strong support of the Trust's strategic aims including our successful bid to be recommended as the lead centre for neonatal and specialist paediatric surgery in North West London and our bid to be a 'hyper-acute' stroke unit.

Many Foundation Trust members and Members' Council representatives attended our Annual Members' Meeting in September 2008, our Seasonal Working Conference with Trust staff in March 2009, and the Open Day.

Strategically the Trust is not only a provider of general acute services for our local community but also a specialist centre for services including HIV and sexual health, paediatrics and burns, and a focal point for academic teaching and research.

The official opening in May 2009 of our new HIV and sexual health centre at 56 Dean Street by Health Minister Lord Darzi is indicative of what we are trying to achieve—a state-of-the-art modern facility providing healthcare where and when patients want it.

Another success story is the award to Chelsea and Westminster and its partners of £20 million to establish a Collaboration for Leadership in Applied Health Research and Care (CLAHRC) in North West London to enable the rapid introduction of new, effective treatments for a wide range of medical conditions.

Quality is the cornerstone of all that we are striving to achieve as a Foundation Trust in line with Lord Darzi's report *High Quality Care For All*. It underpins our 3 corporate objectives for 2009/10 and it is also the foundation of this annual report.

I look forward to working closely during the year ahead with patients, members of the public, and staff to achieve our aim of providing high quality care for all patients.

Professor Sir Christopher Edwards
Chairman

Chief Executive's statement

2008/09 was a successful year for the Trust. We treated 95% of outpatients and 90% of inpatients within 18 weeks of referral, saw 8% more patients than in 2007/08, and 94% of respondents to the annual NHS patient survey rated their care as 'Excellent', 'Very good' or 'Good'.

However, we recognise that our care is not always of a consistently high standard for all patients. We have invested in initiatives to improve the patient experience as a learning organisation committed to quality improvement.

These include the Patient Experience Tracker to get 'real-time' patient feedback, a patient experience improvement project run by Monitor and McKinsey which was piloted in maternity services, and the *Releasing Time to Care* programme to help frontline clinical staff spend more time with patients.

We met, and indeed exceeded, Healthcare Commission targets to reduce MRSA bacteraemia and *Clostridium difficile*. No patient admitted for planned surgery contracted MRSA bacteraemia. We will now focus on other infections by, for example, reducing the number of days that patients have urinary catheters because we know these are associated with infection.

We were disappointed that our 'Quality of Services' rating was reduced from 'Excellent' to 'Good' in the annual NHS performance ratings and we aim to regain an 'Excellent' rating this year through our strong performance in 2008/09.

The Trust believes that it was in the best interests of patients to safeguard patient confidentiality by delaying our rollout of the national Choose and Book programme following the discovery of a technical fault, even though this meant we 'failed' this target and lost our 'Excellent' rating.

Strategic changes to the NHS in London present us with opportunities to provide more services in the community and to reinforce our reputation as a provider of high quality specialist services.

Our new HIV and sexual health centre at 56 Dean Street—located in the heart of Soho—opened in March 2009 and we were recommended as the lead centre for neonatal and specialist paediatric surgery in North West London in May 2009.

The strategic 'provider landscape' work being undertaken by North West London Primary Care Trusts is likely to lead to a reduction in the number of providers and we are well placed to explore future opportunities as the only acute Foundation Trust in North West London.

We recognise that the economic downturn means we may need to reduce our expenditure by up to 15% over the next 3 years. We will expand the use of service line reporting and focus on increased productivity and efficiency to ensure that we continue to provide high quality patient care within the resources available to us.

I look forward to working with colleagues on the Trust Board and all staff at Chelsea and Westminster to achieve this goal.

Heather Lawrence

Heather Lawrence
Chief Executive

Strategy

Our strategic vision

Foundation Trust status—the first 3 years

The Trust's strategic vision was formed through consultation with the Board of Directors during our application for Foundation Trust status in May 2006:

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

The Trust has achieved a smooth transition from NHS Trust to Foundation Trust status following authorisation by Monitor in October 2006.

We have consistently met national performance targets, achieved financial surpluses to reinvest in patient care, and delivered high quality clinical services which are increasingly popular with patients.

Strategic developments 2008/09

The Trust reinforced its reputation as a provider of high quality specialist services in 2008/09, in particular as a centre of excellence in women's and children's health, HIV and sexual health services, and stroke care.

We secured the future of our specialist paediatric services by winning a competitive process. In May 2009 we were recommended as the lead centre for neonatal and specialist paediatric surgery in North West London.

This was an important milestone for paediatrics at Chelsea and Westminster and for the Trust as a whole because paediatrics is a core Trust service and fundamental to our strategic vision.

High quality maternity services are also vital to the success of the Trust's overall strategy as a centre of excellence in women's and children's health.

Our maternity services piloted a patient experience improvement project run by Monitor and McKinsey. The Trust Board has agreed that increasing the percentage of women who have an excellent experience of our maternity services to 90% in the next year should be among the Trust's top 3 priorities for quality improvement in 2009/10.

The opening of our new HIV and sexual health centre at 56 Dean Street in March 2009 was a strategic milestone because, by locating the centre in Soho, we demonstrated our commitment to taking these services to the community.

The Trust operates the only HIV and sexual health services in London that offer Saturday clinic opening times—56 Dean Street and the West London Centre for Sexual Health at Charing Cross Hospital—which demonstrates that we aim to provide what patients want at a time convenient to them in an accessible location.

Our stroke service is now recognised as a leading centre after being ranked 3rd best nationally in the National Sentinel Stroke Audit which was published in March 2009.

Healthcare for London recommended us for designation as a stroke unit and we expect the Joint Committee of Primary Care Trusts in London to make a decision in summer 2009 about the future location of 'hyper-acute' stroke units in London following a 3-month consultation in spring 2009.

We have submitted a bid to provide this 'hyper-acute' service.

Refreshing our strategic vision

We recognise that the landscape of the NHS environment within which we operate has changed markedly and we require a robust strategy to cope with the effects of the economic downturn on the public sector.

Therefore the Board of Directors will refresh the Trust's current strategic vision during 2009/10 and we expect to engage with the Members' Council, Foundation Trust members, and many other stakeholders during this process.

Our view of the future

The Trust is moving into challenging economic times for the NHS. We will work with our staff to deliver greater efficiency and productivity while focusing on quality, in line with Lord Darzi's report *High Quality Care for All*.

We will continue to pursue our strategic vision to be a provider of specialist services, as outlined above in our review of strategic developments during 2008/09.

We recognise that there are likely to be less acute providers in North West London and that more care will move into the community.

We will explore collaborations with other providers and look to work across the hospital and community sectors, particularly in order to tackle chronic long-term conditions.

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

Performance against corporate objectives 2008/09

Corporate Objective 1: Focus on patient safety & quality

- We met targets for the reduction of MRSA bacteraemia and *Clostridium difficile*—5 cases of MRSA (against a target of 19 cases set by the Healthcare Commission) and 41 cases of *C. difficile* (against a target of 114 cases set by the Healthcare Commission)
- We achieved NHS Litigation Authority risk management standards at Level 2
- We introduced clinical quality benchmarks, starting with monthly monitoring of Sentinel audit data for stroke care which resulted in improved patient outcomes
- Directorates identified clinical quality indicators at specialty level which will be monitored and reported in 2009/10

Corporate Objective 2: Deliver effective & efficient pathways of care

- We met a national target to treat 95% of outpatients and 90% of inpatients within 18 weeks of GP referral by March 2009 (this target was achieved by December 2008)
- We achieved a bigger financial surplus than predicted—£9.6 million—which will be reinvested to improve patient care, largely due to increased demand for clinical services
- We worked closely with PCTs, including our host commissioner NHS Kensington & Chelsea, to implement recommendations from Lord Darzi's report *Healthcare for London: A Framework for Action* including a public consultation on the future of stroke services in London

Corporate Objective 3: Be the provider & employer of choice

- 94% of patients in the annual NHS patient survey 2008 rated their care as 'Excellent', 'Very good' or 'Good' (compared with 90% in 2007)
- We agreed contracts for the provision of a 'real-time' electronic patient feedback tool, the Patient Experience Tracker, and the formation of a Patients' Panel—both projects will be rolled out Trustwide in 2009/10
- We were selected as a pilot site for a patient experience improvement project run by Monitor and McKinsey—the project was piloted in maternity services and will be rolled out Trustwide in 2009/10
- 61% of staff took part in the annual NHS staff survey 2008 (compared with 53% in 2007)—we improved or maintained our performance for 85% of the survey's 26 key findings
- We were 95% compliant with the European Working Time Directive of a maximum 48-hour week for all doctors in training by March 2009—we expect to be 100% compliant by the deadline of August 2009

Corporate Objective 4: Deliver excellence in teaching & research

- 70% of medical students who spent time with the Trust rated their experience as 'Excellent' after an internal system for gaining feedback was introduced
- We agreed a new partnership with King's College London and London South Bank University to provide clinical placements for undergraduate nursing and midwifery students
- We were actively involved in the implementation of the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) in North West London, based at Chelsea and Westminster, through participation in Round 1 research projects
- A Research Strategy Board was formed to drive forward delivery of the Trust's Research & Development Strategy

Corporate Objective 5: Create a robust infrastructure for the future

- We undertook infrastructure mapping leading to increased investment in service line reporting information and a review of corporate structure
- We revised our governance structure by, for example, creating a single Assurance Committee to provide a more rigorous, streamlined assurance system in conjunction with the Audit Committee
- We brought in-house ownership of the Lastword electronic patient record system and its team of support staff to allow us to maintain the system until a national programme is agreed

Corporate objectives 2009/10

Corporate Objective 1: Improve patient safety & clinical effectiveness

Cause no avoidable harm to patients

- Define patient safety indicators with local targets and design a measurement system

Reduce healthcare associated infections

- No elective patient to be infected with MRSA bacteraemia whilst in the hospital

Achieve consistent improvement in key indicators of clinical effectiveness

- Define clinical indicators with local targets and design a measurement system

Corporate Objective 2: Improve the patient experience

Develop methods to understand and improve the patient experience

- Ensure that 90% of women have an 'Excellent' experience of maternity services
- Achieve a progressive improvement in key issues identified by the annual NHS patient survey

Provide excellent administrative processes for all patients

- Deliver an improvement in key areas of administrative efficiency, as measured by a reduction in complaints relating to appointments and admissions

Develop a motivated, trained, capable and competent workforce

- Increase staff satisfaction by achieving 100% of staff completing appraisals and personal development plans and a year-on-year improvement in sickness absence, vacancy rates and uptake of mandatory training

Corporate Objective 3: Deliver excellence in teaching and research

Deliver excellence in teaching

- Deliver an agreed improvement in students' overall rating of their teaching
- Develop at least 2 further simulation training programmes linked to Trust priorities

Achieve status as a hub for a Health Innovation Education Cluster (HIEC)

- Achieve status as a hub for a Health Innovation Education Cluster (HIEC)

Deliver the Research Strategy including the CLAHRC programme

- Complete the Research Strategy to include how to enhance the Trust's research profile and income, and to deliver the CLAHRC programme

These corporate objectives to be underpinned by a strong financial and performance position

Quality Report

Sister Lesley-Anne Marke with patient Josephine Sinclair on David Erskine Ward which was chosen to pilot the *Releasing Time To Care—The Productive Ward* initiative to help frontline staff spend more time on direct patient care

Introduction

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

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

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

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

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

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

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

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

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

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

Other quality objectives include:

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

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

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

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

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

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

Heather Lawrence

Heather Lawrence
Chief Executive

Quality

Indicators to measure the Trust's performance 2009/10—selected by the Trust Board

Patient safety

1. Reduce our preventable venous thromboembolism (VTE) rate by 15% in the next year (Data source: Internal Trust data and national Dr Foster data).

2. Reduce in-hospital cardiac arrest and mortality through earlier recognition and treatment of the deteriorating patient (Data source: Internal Trust data in line with measures recommended by the national Patient Safety First Initiative).

3. Reduce the risk of selected high risk medicines (Data source: Internal Trust data in line with measures recommended by the national Patient Safety First Initiative).

Patient experience

4. Ensure that 90% of women have an 'Excellent' experience of our maternity services (Data source: Internal Trust data and Healthcare Commission [now the Care Quality Commission] maternity patients survey).

5. Achieve a progressive improvement in key issues identified in the annual NHS patients survey relating to communication, information and customer service (Data source: Healthcare Commission [now the Care Quality Commission] annual NHS patients survey).

6. Reduce the number of complaints relating to appointments and admissions (Data source: Internal Trust data).

Clinical effectiveness

7. Reduce delays of more than 24 hours to selected non-elective urgent surgery (Data source: Internal Trust data).

8. Reduce Hospital Standardised Mortality Ratio (HSMR) by 10% (Data source: National Dr Foster data).

9. Reduce the number of urinary catheter days, ie the number of days that patients in the Trust have a urinary catheter—excluding patients who require lifelong urinary catheters (Data source: Internal Trust data).

Priorities for quality improvement 2009/10—agreed by the Trust Board

Priority 1: Patient safety

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

Why is this a priority?

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

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

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

What actions are we planning to improve our performance?

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

How will improvement be measured?

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

Priority 2: Patient experience

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

Why is this a priority?

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

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

What actions are we planning to improve our performance?

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

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

How will improvement be measured?

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

Priority 3: Clinical effectiveness

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

Why is this a priority?

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

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

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

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

What actions are we planning to improve our performance?

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

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

How will improvement be measured?

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

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

Annual performance ratings

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

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

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

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

Kensington & Chelsea Residents' Panel

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

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

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

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

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

Performance against regulatory requirements and national targets

Regulatory requirements

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

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

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

National targets
(excluding cancer waiting time targets)

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

Cancer waiting time targets
1 Apr–31 Dec 2008 (Q1–Q3)

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

Cancer waiting time targets
1 Jan–31 Mar 2009 (Q4)

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

Performance Report

A panoramic view from the roof of the hospital

Key facts

There was increased demand for Trust services in 2008/09:

Number of patients treated

	2008/09	2007/08
Inpatients	**40,836**	39,405
Outpatients	**395,919**	357,907
Day cases	**19,410**	17,955
A&E	**97,640**	97,685
Total	**553,805**	**512,952**

There were increased levels of satisfaction with Trust services among patients and independent assessors in 2008/09:

- 94% of patients rated their care at Chelsea and Westminster as 'Excellent', 'Very good' or Good' in the annual NHS patient survey 2008 (compared with 90% in 2007)
- Stroke services at Chelsea and Westminster were rated as the 3rd best nationally in the National Sentinel Stroke Audit 2008 (compared with 6th best in 2006)
- Standards of hospital hygiene and food were both rated 'Excellent' in the National Patient Safety Agency's Patient Environment Action Team (PEAT) assessment 2008 (compared with ratings of 'Good' and 'Excellent' in 2007)

Principal activities of the Trust

The Trust is a Central London teaching hospital, providing general acute hospital services to the local population and specialist tertiary services in a range of specialties including HIV, Burns and Paediatrics to patients from a wider area. It is a main campus of Imperial College School of Medicine.

Most services are at Chelsea and Westminster Hospital but HIV/GUM services are provided at the St Stephen's Centre next to the hospital, 56 Dean Street, W1 (services transferred from the Victoria Clinic, SW1—March 2008), and the West London Centre for Sexual Health, Charing Cross Hospital.

Clinical services are divided into 5 directorates, each led by a General Manager and Clinical Director. Support services include pharmacy, therapy services, and facilities management. Facilities services are contracted out to ISS Mediclean and Balfour Beatty.

Review of financial performance

In 2008/09 the Trust reported a maximum financial risk rating of 5 out of 5, where 5 is 'low risk', and delivered a surplus of £9.6 million which was well ahead of the planned surplus of £7.9 million—the Trust expects to be 'Excellent' for 'Use of Resources' in the annual performance ratings published in October 2009. The Trust's annual income and expenditure performance is set out in Table 1.

Table 1: Summary 2008/09 Income and Expenditure Outturn vs Plan (£m)

	Plan 2008/09	Actual 2008/09	Variance 2008/09
Income			
Clinical Income	223.6	**233.2**	9.6
Non-Clinical Income	43.5	**47.5**	4
Total Income	**267.1**	**280.7**	**13.6**
Expenses			
Pay Costs	-141.2	**-148.1**	-6.9
Non-Pay Costs	-101.7	**-106.1**	-4.4
Total Expenses	**-242.9**	**-254.2**	**-11.3**
EBITDA	**24.2**	**26.6**	**2.4**
Depreciation	-8.7	**-8.7**	0
Dividend on PDC	-8.7	**-8.7**	0
Interest	1.2	**0.6**	-0.6
Net surplus	**7.9**	**9.6**	**1.7**
CIPs	**6.4**	**5.4**	**-1.0**

56 Dean Street—our new HIV and sexual health centre in Soho which was funded by our financial surplus in 2007/08

Key variances from plan in 2008/09

1. NHS clinical income was £9.6 million above plan because of increased clinical activity due to unplanned increases in referrals across most specialties not included in contracts with PCTs.

2. Non-clinical income was £4 million above plan because of income from private maternity services which were retained under the Trust's management, increased income from facilities charges to recover higher energy costs, and additional income from research and development and education and training.

3. Pay costs were £6.9 million higher than plan because of increased spending on agency staff, £11.4 million in total. This was partly due to increased clinical activity which was in excess of plans. This resulted in the use of short-term staffing solutions. The Trust has put in place plans to ensure that managers maintain robust day-to-day controls on temporary staffing expenditure and to provide up-to-date information on staffing to ensure that services are delivered cost effectively.

4. Non-pay costs were £4.4 million higher than plan because of the costs of increased clinical activity and higher energy charges.

5. Net interest received was £0.6 million less than plan because of falling interest rates associated with the economic downturn.

6. 84% of the planned cost improvement programme was delivered. This shortfall was offset by the release of balance sheet provisions no longer required. The Trust has put in place plans to ensure that managers monitor and deliver cost improvements.

There were no exceptional items charged to the accounts in 2008/09.

The Trust's cash balances at the end of the financial year were £15.28 million ahead of plan due to the following factors:

- Planned loan drawdown of £6.8 million deferred until after the conclusion of the Trust's bid to be the lead centre for neonatal and specialist paediatric surgery in North West London

- Working capital improvement of £7.7 million during 2008/09

- Capital expenditure of £15.3 million unspent in 2008/09 as a result of planned deferral of capital schemes

- Net interest receivable of £0.6 million below plan in 2008/09 as a result of the economic downturn

The capital plan of £37.2 million underachieved by £17.7 million (48%) because of significant capital slippage in 2008/09, mostly relating to large building schemes such as the planned development of specialist paediatrics and provision of single room ward accommodation.

Review of non-financial performance

The Trust was rated 'Good' for 'Quality of Services' in the annual performance ratings published by the Healthcare Commission in October 2008.

We met all core standards and met all national targets with a single exception, resulting in a reduction of our rating from 'Excellent' in 2007 to 'Good' in 2008.

The Trust did not fully meet a national target relating to the national Choose and Book system after uncovering a technical fault during the pilot stage in April 2007 which could have compromised patient confidentiality.

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

We believe it was right to put the best interests of patients above the requirements of meeting a target.

The Trust met all national targets in 2008/09 including the challenging target to treat 95% of outpatients and 90% of inpatients within 18 weeks of GP referral by March 2009.

The Trust also significantly outperformed key targets to treat 98% of A&E patients within 4 hours and to reduce healthcare associated infections.

The increasing popularity of the Trust's services was confirmed by the results of the annual NHS patient survey—94% of patients rated our services as 'Excellent', 'Very good' or 'Good' (compared with 90% in the previous year).

However, the Trust is striving to improve its services so that all patients have a consistently excellent experience at Chelsea and Westminster.

Improving the patient experience is a corporate objective for 2009/10.

Developments since the end of 2008/09 financial year

There have been a number of key developments affecting paediatric services since 31 March 2009:

- North West London PCTs recommended Chelsea and Westminster as the lead centre for neonatal and specialist paediatric surgery, and associated critical care, in North West London—subject to approval by NHS London and possible public consultation, the new arrangements will be in place from April 2010
- We will work with, and be supported by, our partners at Great Ormond Street Hospital and the Evelina Children's Hospital at St Thomas'
- A planning application for an extension to the hospital was approved by the local authority, which is intended to house a new paediatric centre including 4 new paediatric operating theatres, an extended High Dependency Unit, and 18 day surgery bays, in a child-friendly environment

Future developments

Future developments in paediatric services are outlined in the previous section.

Potentially another key service development for the Trust in 2009/10 is designation as a 'hyper-acute' stroke unit (HASU), as well as a stroke unit and transient ischaemic attack (TIA) centre.

A 3-month public consultation by Healthcare for London (HfL) about proposed centralisation of stroke and major trauma services ended in May 2009 and the Joint Committee of PCTs in London is due to make a final decision about the future configuration of services in July 2009.

We were recommended by HfL as a stroke unit and TIA centre. Charing Cross Hospital, part of Imperial College Healthcare NHS Trust, was recommended as a HASU due to geographical location and neurosurgery links.

However, if St Mary's Hospital—also part of Imperial College Healthcare NHS Trust—was designated as a major trauma centre by HfL, the HASU would be located at St Mary's rather than Charing Cross.

The Trust launched a campaign urging patients, members of the public and staff to support our bid to be a HASU because this called into question the reasons why Charing Cross was recommended as a HASU.

St Mary's is only a mile away from another proposed HASU at University College Hospital and Chelsea and Westminster's excellent reputation for stroke care was confirmed by the National Sentinel Stroke Audit 2008, published in April 2009, which ranked our services as the 3rd best in the country.

As a result of our campaign, HfL has acknowledged that, if the HASU moves from Charing Cross to St Mary's, this change of service would require public consultation.

We have also bid to provide community musculoskeletal services in Hammersmith & Fulham. NHS Hammersmith & Fulham tendered for these services and the Trust expects a decision in June 2009.

Healthcare for London is expected to designate urgent care centres in 2009/10. We intend to bid to provide an urgent care centre in A&E at Chelsea and Westminster when a tender is issued. Reconfiguration of HIV inpatient services is expected in 2009/10—the Trust has a national and international reputation in this specialty and is in a strong position to bid to be designated as an inpatient facility if this approach is taken by the commissioners.

We will explore opportunities to work more closely with other providers in North West London, particularly as cuts in Government spending on the NHS are expected because of the economic downturn.

Principal risks & uncertainties facing the Trust

The Trust considers there are key performance risks in 2009/10 for 2 national targets:

- Maximum 14-day wait from decision to treat to start of treatment extended to cover cancer treatments
- 18-week wait from referral to treatment for 90% of inpatients and 95% of outpatients to be measured at specialty level

A risk assessment has been completed for both these key performance risks and plans are either in place or are being put in place to mitigate them. The Trust has effective mechanisms in place to manage risk, in accordance with its risk management policy and strategy, supported by 2 committees with Board accountability—the Audit Committee and the Assurance Committee.

In light of the economic downturn, the Trust has considered a number of downside scenarios for the period 2009–12 and developed mitigating options to ensure that the Trust can deliver 'Excellent' ratings for both 'Quality of Services' and 'Use of Resources'.

The transfer of services to the community is a risk to the Trust.

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

National trends

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

The Trust will redesign patient pathways to deliver streamlined care, ensure that patient referrals are as smooth as possible by improving administrative processes, and help specialties plan for peaks in demand.

The Trust is planning for a slowdown in public sector spending as a result of the economic downturn. It is developing mitigating options for a number of downside scenarios and making service line reporting information widely available to managers and clinicians to aid understanding of the economics of different specialties and scope for efficiency savings.

All NHS trusts must comply with a maximum 48-hour week for doctors in training by August 2009. We are confident that we will be fully compliant.

Regional trends

The ongoing implementation of Lord Darzi's report—*Healthcare for London: A Framework for Action*—will continue to have a significant impact.

The Joint Committee of PCTs in London is due to make a final decision about the future configuration of stroke services in July 2009.

Healthcare for London is also expected to designate urgent care centres in 2009/10 and the Trust intends to bid to provide this service at Chelsea and Westminster.

We expect that Londonwide reviews of cancer and cardiovascular services will have consequences for the Trust.

Local trends

Preparations to ensure that the Trust is ready to 'go live' as the provider of neonatal and specialist paediatric surgery in April 2010—subject to agreement by NHS London and possible public consultation—will be a key local focus this year.

We are well placed to explore future opportunities as the only acute Foundation Trust in North West London if the strategic 'provider landscape' work being undertaken by local Primary Care Trusts leads to a reduction in the number of providers.

The development of polyclinics and the transfer of services to the community is a growing trend that will affect the Trust.

Research & Development

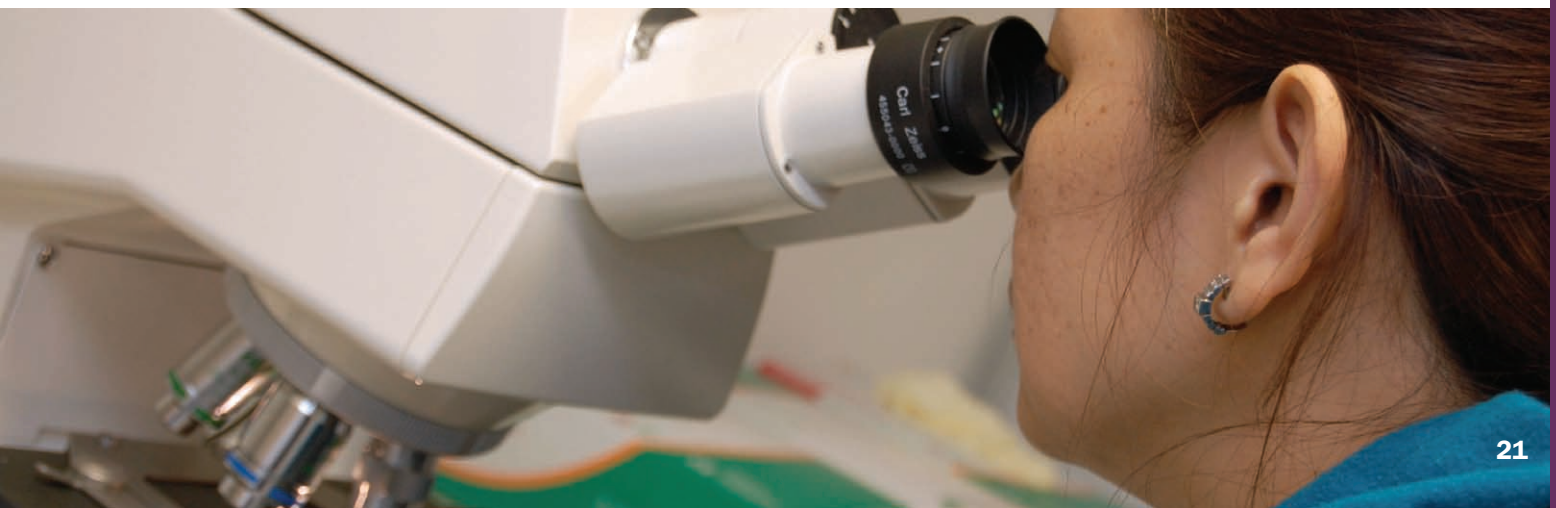
Delivering excellence in teaching and research was a key corporate objective in 2008/09 (as it is in 2009/10).

The focus of the Trust's research programme in 2008/09 was the implementation of the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) in North West London which is based at Chelsea and Westminster.

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

The Trust participated actively in round 1 research projects including chronic obstructive pulmonary disorder (COPD) discharge, pneumonia admissions to hospital, medicines management in acute care, case management in the community, and HIV/Hepatitis C testing in A&E and primary care.

The Trust held its inaugural Research & Development Open Day for patients, the public and staff in July 2008, and formed a Research Strategy Board to drive forward delivery of the Trust's Research & Development Strategy.



Our staff

The Trust employs more than 2,700 staff. The Trust's corporate objectives for 2008/09 included an objective to be not only a provider but also an employer of choice, as well as an objective to deliver excellence in teaching.

There was a marked increase in the response rate to the annual NHS staff survey—61% of staff took part in the survey which put the Trust in the top 20% of acute NHS trusts in England for response rates.

The Trust was ranked in the top 20% of NHS trusts nationally for a number of areas including good communication between senior management and staff, as well as staff recommending the Trust as an employer.

The Trust was also ranked in the top 20% of NHS trusts nationally for staff feeling able to contribute towards decisions that affect them and their services. This was an area of concern in the previous year's survey.

Areas for improvement included the number of staff who had an up-to-date appraisal and personal development plan.

The Trust is committed to learning lessons from the survey and communicating progress made towards implementing specific actions in response to the survey through Trustwide and directorate action plans and a "You Talked—We Listened" campaign in the monthly Team Briefing for staff.

The Trust has a commitment to staff development and celebrating the achievements of our staff. Customer service training is provided for all new staff joining the Trust at corporate induction. The Trust has an annual Christmas Cheer Awards and a monthly Team/Employee of the Month award to recognise the efforts of all staff.

We were delighted that Niamh Geoghegan, Paediatric Continence and Stoma Nurse Specialist, won a special award at the prestigious NHS Champions Awards in December 2008 in recognition of her outstanding care for children and their families.

We agreed a new partnership with King's College London and London South Bank University to provide clinical placements for undergraduate nursing and midwifery students as part of our role as a major London teaching hospital.

Patient care

Foundation Trust status

A key benefit of Foundation Trust status is that the Trust can retain its financial surplus—£14.6 million in 2007/08—to reinvest in services.

The surplus was used to develop 56 Dean Street, the Trust's new £2 million state-of-the-art HIV and sexual health centre which opened in March 2009.

56 Dean Street, which replaced services at the Victoria Clinic, SW1, offers Saturday and evening opening hours in an excellent environment and location.

Patient numbers have increased by approximately 20% as a direct result.

The Trust also invested part of its surplus in 2 new CT scanners which enable the Trust to provide a flexible service for both emergency patients who require instant diagnostic scans and patients with more routine imaging needs.

Performance against key patient targets

The Trust met all key national targets in 2008/09 and improved patient care by, for example, reducing waiting times and infection rates.

We met a challenging national target of treating 95% of outpatients and 90% of inpatients within 18 weeks of GP referral thanks to the hard work of staff.

We also achieved a national target of treating 98% of A&E patients within 4 hours—the Trust was asked by NHS London and NHS Kensington & Chelsea to treat 99% of A&E patients within 4 hours from January–March 2009 to help London as a whole achieve 97.9% for 2008/09.

The Trust consistently achieved weekly performance of 98.5–99.1% during this period, despite record attendances, to help London achieve 97.9%.

The Trust was thanked personally for its contribution and NHS London has asked to visit Chelsea and Westminster to understand how we achieve consistently high performance so that lessons can be shared with other hospitals.

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

The Trust had just 5 cases of MRSA bacteraemia—against a target of 19 cases set by the Healthcare Commission—and 41 cases of *C. difficile*—against a target of 114 cases set by the Healthcare Commission.

Monitoring quality improvements

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

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

New or significantly revised services

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

The Trust's private maternity unit—The Kensington Wing—was significantly enlarged from 6 to 16 rooms and the patient environment enhanced.

The Kensington Wing was officially opened by Sophie Ellis-Bextor, singer-songwriter and service user, during the hospital Open Day in May 2009.

Service improvements following comments from patients

Our Patient Advice and Liaison Service (PALS) received 3,872 enquiries in 2008/09. Improvements made in response to comments received through PALS include:

- In the Treatment Centre 'quiet cubicles' have been introduced for patients suffering from anxiety and privacy booths have been introduced for patients undergoing sensitive procedures
- Amendments have been made to information on the Trust website in response to user feedback
- Font sizes have been enlarged on information posters as a direct response to clients who are partially sighted

Service improvements following complaints

The Trust received 458 formal complaints in 2008/09. 93% of complaints were responded to within 25 working days, as required by NHS guidelines. Improvements made in response to formal complaints include:

- All Trust laptops, Personal Digital Assistants, Blackberries and mobile devices have been encrypted
- The HIV & Sexual Health Directorate is developing a discharge summary for all patients who are travelling and might need to access healthcare whilst abroad
- Plans have been developed for a triage area on the antenatal ward to assess women in early labour

Improvements in patient/ carer information

An Information Zone has been developed on the ground floor of the hospital, incorporating an LCD screen and 2 electronic self-service kiosks, with news and useful information about the Trust. This project was funded by the Members' Council.

A DVD has been produced to be sent to children and young people before admission to hospital. This initiative was also funded by the Members' Council.

The Trust website was enhanced during 2008/09. A redesigned section for the new 56 Dean Street HIV and sexual health centre was developed. This design will be rolled out across the website in 2009/10.

Stakeholder relations

The Trust has maintained and strengthened its relationships with key stakeholders including PCTs, local authorities and education partners. These organisations are represented on the Members' Council.

We work closely with our host commissioner, NHS Kensington & Chelsea, and increasingly we look to forge strong links with the new acute commissioning alliance under development in North West London which is led by Michael Scott, Chief Executive of NHS Westminster.

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

In March 2009 a Memorandum of Understanding was signed between the Trust and the Royal Brompton & Harefield NHS Trust to explore opportunities for closer co-operation and collaboration in the future.

North West London PCTs recommended Chelsea and Westminster as the lead centre for neonatal and specialist paediatric surgery in the sector in May 2009 following a bidding process during the 2008/09 financial year. The new arrangements will start in April 2010 subject to approval by NHS London. The Trust bid proposed a federated network model involving Great Ormond Street Hospital, the Evelina Children's Hospital at St Thomas', and other hospitals throughout North West London.

The Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for North West London is hosted by Chelsea and Westminster and involves joint working with Imperial College London and all NHS organisations in North West London.

Statutory Information

Directors

The Trust has a Board of Directors including the Chairman, 5 other Non-Executive Directors and 5 Executive Directors.

Non-Executive Directors

The Chairman is Professor Sir Christopher Edwards.

The 5 other Non-Executive Directors are Colin Glass, Andrew Havery, Professor Richard Kitney, Karin Norman and Charles Wilson.

Charles Wilson is the Senior Independent Director.

Executive Directors

Executive Directors are Heather Lawrence (Chief Executive), Dr Mike Anderson (Medical Director), Lorraine Bewes (Director of Finance & Information), Andrew MacCallum (Director of Nursing) and Amanda Pritchard (Deputy Chief Executive/ Director of Service Integration & Modernisation—maternity leave December 2007–July 2008). Mariella Dexter joined the Trust from January–July 2008 as Interim Director of Service Integration & Modernisation to cover Amanda Pritchard's maternity leave. Catherine Mooney (Director of Governance & Corporate Affairs) attends Board meetings as Company Secretary.

Brief history of the Trust

Chelsea and Westminster Hospital opened in May 1993 on the former site of St Stephen's Hospital. It replaced 5 hospitals—St Stephen's, St Mary Abbots, Westminster Children's, Westminster and West London.

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

Environmental matters

The Trust pledged to reduce its carbon footprint by joining the Carbon Trust's NHS Carbon Management programme in May 2007. All staff are encouraged to help cut carbon emissions and reduce energy bills by taking simple steps to be more energy efficient.

Financial information

Disclosure of audit information

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

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

Better Payment Practice Code

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

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

Remuneration Report
for the period 1 Apr 2008 to 31 Mar 2009

Remuneration Committee

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

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

The membership of the Remuneration Committee includes the Trust Chairman, Professor Sir Christopher Edwards, and 5 Non-Executive Directors—Colin Glass, Andrew Havery, Professor Richard Kitney, Karin Norman and Charles Wilson.

The Remuneration Committee met once in 2008/09—in December 2008. Professor Sir Christopher Edwards, Karin Norman and Charles Wilson were in attendance. Colin Glass, Andrew Havery and Professor Richard Kitney were absent.

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

The Committee agreed to modest adjustments in the year under review having regard to the challenges facing the economy and in keeping with the standard pay inflation of 2.75% awarded to staff under Agenda for Change. The Committee was guided in its deliberations by background pay information including a comparative pay study, which benchmarks comparable roles in NHS trusts of similar size and complexity to ensure that rates of pay are competitive, represent value for money and provide stability in senior manager roles.

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

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

The Members' Council meeting on 23 November 2006 ratified the initial appointments of the Non-Executive Directors under powers outlined in item 27.2 of the Transition Schedule. Employment contracts for Executive Directors are not normally limited to a fixed duration, except where it is intended to cover an extended period of leave. The normal notice period ranges between 3 and 6 months.

The fixed term contract of Mariella Dexter, Interim Director of Integrated Service Delivery & Modernisation, expired in July 2008.

For a breakdown of salary and pension entitlements of senior managers, please see page 49.

Heather Lawrence

Heather Lawrence, Chief Executive
(on behalf of the Board)
4 Jun 2009

Singer-songwriter Sophie Ellis-Bexter with her baby son Kit and midwife Amy Pierce at the official opening of The Kensington Wing, our revamped and enlarged private maternity unit

NHS Foundation Trust Code of Governance

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

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

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

For the year ending 31 March 2009 Chelsea and Westminster Hospital NHS Foundation Trust complied with all the provisions of the Code of Governance published by Monitor in September 2006 with the following exception which the Board of Directors considers to be sound and justified in the circumstances:

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

Reappointment by the Non-Executive Directors followed by re-approval by the Members' Council thereafter should be made at intervals of no more than 5 years.

All other Executive Directors should be appointed by a committee of the Chief Executive, the Chairman and Non-Executive Directors and subject to reappointment at intervals of no more than 5 years.

Response: The Trust does not comply with this provision in so far as the Chief Executive and other Executive Directors are not subject to reappointment at intervals of not more than 5 years.

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

The Board of Directors conducts robust annual appraisals of its Chief Executive and other Executive Directors and does not consider that 5-year contracts will be competitive and enable the Trust to recruit and retain the best talent.

On this page: Hospital staff and visitors at the Open Day in May 2009

Board of Directors

Composition of the Board

The Board has 6 Non-Executive Directors (including the Chairman) and 5 Executive Directors (including the Chief Executive)—the Director of Governance & Corporate Affairs attends Board meetings as Company Secretary.

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

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

Balance of Board membership & independence

In anticipation of authorisation as a Foundation Trust in 2006, the Trust Board performed a comprehensive review of its skills, experience and attributes against Foundation Trust competencies. The Board updates its review as part of the appointments process. The most recent review was undertaken in July 2008. As a result of this review, the Board of Directors is satisfied that its balance of knowledge, skills and experience is appropriate to the Board and its sub-committees.

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

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

Performance evaluation

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

Access to register of Directors' interests

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

Board meetings

The Board meets regularly, on average once a month. Special meetings are convened as and when required.

There were 12 ordinary meetings and 1 special meeting in 2008/09.

Directors' attendance at Board meetings 2008/09

Non-Executive Directors	Ordinary Meetings	Special Meetings
Prof Sir Christopher Edwards	12/12	1/1
Colin Glass	11/12	1/1
Andrew Havery	12/12	0/1
Prof Richard Kitney	11/12	1/1
Karin Norman	7/12	1/1
Charles Wilson	10/12	1/1

Executive Directors	Ordinary Meetings	Special Meetings
Heather Lawrence, Chief Executive	11/12	1/1
Amanda Pritchard, Deputy Chief Executive (Director of Integrated Service Delivery & Modernisation) [1]	7/7	0/1
Dr Mike Anderson, Medical Director	9/12	1/1
Lorraine Bewes, Director of Finance & Information	11/12	1/1
Mariella Dexter, Interim Director of Integrated Service Delivery & Modernisation [2]	3/5	1/1
Andrew MacCallum, Director of Nursing	12/12	1/1
Catherine Mooney, Director of Governance & Corporate Affairs [3]	11/12	1/1

[1] On maternity leave until July 2008
[2] Interim Director of Integrated Service Delivery & Modernisation until July 2008
[3] Attends Foundation Trust Board meetings as Company Secretary

Significant commitments of the Trust Chairman

The Chairman is a Senior Research Fellow at Imperial College London and Chairman of Geothermal Plus. In December 2008 he was appointed as the first Chairman of a new organisation called NHS Medical Education England which provides independent advice to the Government on workforce planning, education and training for medicine, dentistry, pharmacy and healthcare sciences.

Board of Directors—Who's Who

Non-Executive Directors

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

Charles Wilson, Vice Chair: Charles was appointed in September 2000. He was reappointed for 4 years in October 2003. His term ended in October 2007 but the Members' Council voted to reappoint him for a further 2 years, his term ends in October 2009. He is the Senior Independent Director and Chair of the Assurance Committee. Charles spent 50 years in the newspaper industry, serving as editor of a number of papers including The Times. He retired as Managing Director of the Mirror Group plc.

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

Andrew Havery: Andrew was reappointed for 3 years in November 2007, his term ends in November 2010. He has been a councillor in Westminster since 2002. A Non-Executive Director since December 2003, Andrew is a chartered accountant and worked for KPMG for 8 years before becoming a compliance officer to investment banks.

Professor Richard Kitney OBE: Professor Kitney was appointed for 4 years in May 2006, his term ends in April 2010. He is Professor of Biomedical Systems Engineering and Dean of the Faculty of Engineering at Imperial College. A leading authority on the use of IT in healthcare, Professor Kitney is Chairman and Director of Visbion Ltd.

Karin Norman: Karin was appointed for 4 years in July 2005, her term ends in October 2009. She worked in investment banking in London and New York as a fixed income specialist, advising on investments, risk and capital management, and structured finance. She was a Non-Executive Director of the NHS Pensions Agency and is currently a member of the Audit Committee for the Parkinson's Disease Society, and a Trustee of both the Nursing and Midwifery Council and My Generation, a community and youth charity that she co-founded.

Executive Directors

Heather Lawrence, Chief Executive: Heather has almost 20 years' experience at NHS Trust Board level, as Chief Executive of Hounslow and Spelthorne Community and Mental Health Trust and North Hertfordshire NHS Trust before being appointed Chief Executive at Chelsea and Westminster in May 2000. Her management experience spans all sectors of healthcare and includes major service change, including the development of innovative services, service re-design, developing an academic department, and closure of services. Heather chairs the North West London Critical Care Network and was NHS Employers' lead negotiator on the Staff and Associate Specialist doctors contract. Most recently she has been appointed as a member of the Government's Nursing and Midwifery Commission through which she and 15 other members will advise the Government on the future roles of nurses and midwives. Heather is a Chartered Fellow of the Institute of Personnel and Development.

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

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

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

Mariella Dexter, Interim Director of Integrated Service Delivery & Modernisation: Mariella provided interim cover during Amanda Pritchard's maternity leave from January–June 2008. Previously she was Chief Executive of Gloucestershire Royal NHS Trust and Chief Executive of Avon, Gloucestershire & Wiltshire Workforce Development Confederation.

Andrew MacCallum, Director of Nursing: Andrew was appointed in August 2003, having previously been Director of Nursing at Queen Mary's Sidcup NHS Trust and Deputy Director of Nursing at Guy's and St Thomas' NHS Trust.

Catherine Mooney, Director of Governance & Corporate Affairs: Before being appointed in March 2006, Catherine was Chief Pharmacist at St Mary's NHS Trust for 15 years until March 2004 when she joined Hammersmith Hospitals NHS Trust as Clinical Governance Director. She attends Foundation Trust Board meetings as Company Secretary.

Audit Committee

Membership & attendance

The Audit Committee is chaired by Andrew Havery, a Non-Executive Director, and includes 2 other Non-Executive Directors, Karin Norman and Charles Wilson. It met 5 times in 2008/09. Andrew Havery and Charles Wilson attended all meetings and Karin Norman attended 3 meetings.

How the Committee discharges its responsibilities

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

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

Policy for safeguarding the external auditors' independence

In so far as the Trust has not purchased work from its external auditors outside the audit code in 2008/09, the external auditors' objectivity and independence have been safeguarded.

Responsibility for preparing the annual accounts

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

Nominations Committees

Both the Board of Directors and the Members' Council have their own Nominations Committee:

Nominations Committee of the Members' Council for the appointment of Non-Executive Directors

The members of the Nominations Committee of the Members' Council are Professor Sir Christopher Edwards (Chair) and Professor Brian Gazzard (Staff: Medical & Dental).

There are now 2 vacancies on this Committee following the resignation from the Members' Council of an elected Council Member, Valerie Arends (Public: Kensington & Chelsea 2) and an appointed Council Member, Andrew Kenworthy (NHS Kensington & Chelsea).

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

It makes recommendations about suitable candidates for approval by the Members' Council.

This Nominations Committee also reviews the policy for the size, structure and composition of Non-Executive Director membership of the Board of Directors. This takes account of relevant Trust strategies from time to time, and not less than every 3 years, and makes recommendations to the Members' Council.

There were no meetings of the Nominations Committee of the Members' Council in the 2008/09 financial year.

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

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

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

This Nominations Committee identifies appropriate candidates for Executive Director vacancies through a process of open competition which takes account of an evaluation of the balance of skills, knowledge and experience of the Board and makes recommendations for shortlisted candidates to the Board's Appointments Panel.

The Nominations Committee of the Board of Directors was constituted following the end of the 2008/09 financial year.

Members' Council

How the Board of Directors and the Members' Council operate

The Members' Council represents the interests of the local community—patients, public and staff who are Foundation Trust members—and shares information about key decisions with Foundation Trust members. The Members' Council is not responsible for the day-to-day management of the organisation which is the responsibility of the Board of Directors.

Key roles of the Members' Council are to:

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

Composition of the Members' Council

There are 35 Council Members including:

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

The Members' Council meets quarterly. There were 4 meetings in 2008/09.

Executive and Non-Executive Directors are invited to attend. Details of their attendance are in the table 'Directors' attendance at Members' Council meetings 2008/09'. Details of Council Members' attendance at meetings are in the table 'Council Members—Who's Who'.

Council Members' initial terms of office commenced on the day that the Foundation Trust was licensed, 1 October 2006. Both elected and appointed Council Members normally hold office for a period of 3 years and are eligible for re-election or reappointment at the end of that period. Council Members may not hold office for more than 9 consecutive years.

Elections held during 2008/09

An election was held in 2008/09 to fill a vacant seat in the constituency Public: Kensington & Chelsea Area 2. Sandra Smith-Gordon was elected.

Access to register of Council Members' interests

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

How the Board have acted to understand the views of Council Members and Foundation Trust Members

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

A joint Away Day for the Board and the Members' Council was held in December 2008 and workshops on specific issues, for example development of the Trust's corporate objectives for 2009/10, have been arranged for the Board to gain the input of Council Members.

Council Members and Foundation Trust Members were invited to attend the Annual Members' Meeting in September 2008 and the Seasonal Working Conference with staff in March 2009 to give their views on the Trust.

Directors' attendance at Members' Council meetings 2008/09

Non-Executive Directors	Attendance
Prof Sir Christopher Edwards	4/4
Colin Glass	3/4
Andrew Havery	1/4
Prof Richard Kitney	1/4
Karin Norman	1/4
Charles Wilson	4/4

Executive Directors	Attendance
Heather Lawrence, Chief Executive	4/4
Amanda Pritchard, Deputy Chief Executive (Director of Integrated Service Delivery & Modernisation) [1]	3/3
Dr Mike Anderson, Medical Director	2/4
Lorraine Bewes, Director of Finance & Information	4/4
Mariella Dexter, Interim Director of Integrated Service Delivery & Modernisation [2]	0/1
Andrew MacCallum, Director of Nursing	4/4
Catherine Mooney, Director of Governance & Corporate Affairs [3]	4/4

[1] On maternity leave until July 2008
[2] Interim Director of Integrated Service Delivery & Modernisation until July 2008
[3] Attends Foundation Trust Board meetings as Company Secretary

Council Members—Who's Who

Name Constituency/Organisation	Date elected or appointed	Attendance at Council Meetings 2008/09*
Prof Sir Christopher Edwards (Chairman)	Nov 2007	4/4
Arana, Maria-Elena (Patient)	Mar 2006	2/4
Arends, Valerie (Public—Kensington & Chelsea 2)	Mar 2006 [1]	0/1
Balmford, Walter (Patient)	Dec 2007	4/4
Bennett, June (Patient)	Dec 2007	4/4
Billing, Nathan (Staff—Allied Health Professionals, Scientific & Technical)	May 2007 [2]	3/3
Birch, Chris (Patient)	May 2007	4/4
Blewett, Christine (Public—Hammersmith & Fulham 2)	Mar 2006	4/4
Bradford, Martin (Public—Hammersmith & Fulham 1)	Dec 2007	2/4
Browne, Nicky (The Royal Marsden NHS Foundation Trust)	Dec 2006	3/4
Delamare, Alison (Staff—Contracted)	Mar 2006	4/4
Fitzgerald, Hugo (Patient)	Mar 2006	1/4
Foulkes, Lionel (Public—Wandsworth 2)	Mar 2006	1/4
Gazzard, Prof Brian (Staff—Medical & Dental and Deputy Chairman)	Mar 2006	3/4
Henry, Michael (Patient)	Mar 2006	0/4
James, Cathy (Staff—Support, Admin & Clerical)	Mar 2006	3/4
Jowett, Prof Sandra (Thames Valley University)	Mar 2006 [3]	0/2
King, Jane (Patient)	Oct 2006	3/4
Levy, Mr Raymond (Public—Kensington & Chelsea 1)	Dec 2007 [4]	0/2
Lewis, Martin (Public—Westminster 2)	Dec 2007	3/4
Longworth, Catherine (NHS Westminster)	Oct 2006	4/4
Macrae, Dr Duncan (Royal Brompton & Harefield NHS Trust)	Oct 2006	2/4
Maze, Prof Mervyn (Imperial College London)	Oct 2006	2/4
Mills-Duggan, Ann (Public—Westminster 1)	May 2007	3/4
Molyneux, Peter (NHS Kensington & Chelsea)	Nov 2007 [5]	3/4
Rawaf, Prof Salman (Wandsworth Teaching PCT)	Oct 2006	0/4
Rowell, Martin (Patient)	Mar 2006	3/4
Smith, Jim (Patient)	Mar 2006	4/4
Smith, Sue (Staff—Nursing & Midwifery)	Dec 2007	1/4
Smith, Sue B (Patient)	Dec 2007	1/4
Smith-Gordon, Sandra (Public—Kensington & Chelsea 2)	Oct 2008	2/2
Symons, Mary (Public—Wandsworth 1)	Dec 2007	3/4
Taylor, Cllr Frances (Royal Borough of Kensington & Chelsea)	Oct 2006	3/4
Wood, Vivian (NHS Hammersmith & Fulham)	Mar 2007 [6]	0/2
Westmancott, Ben (NHS Hammersmith & Fulham)	Q2 (Jul–Sep 2008)	0/2

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

1 left the Council in Q1 (Apr–Jun 2008)
2 left the Council in Q3 (Oct–Dec 2008)
3 appointment terminated Nov 2008 when Foundation Trust constitution amended and constituencies changed
4 left the Council in Q2 (Jul–Sep 2008)
5 left the Council in Mar 2009
6 left the Council in Q2 (Jul–Sep 2008)

Foundation Trust membership

Who can be a member?

- **Patient constituency:** Any patient treated at the hospital in the last 3 years, or the carer of a patient
- **Public constituency:** Anyone living in the local boroughs of Kensington & Chelsea, Hammersmith & Fulham, City of Westminster, and Wandsworth—each borough is divided into 2 areas for Members' Council elections
- **Staff constituency:** Any member of staff—this constituency is divided into 6 staff groups which are Allied Health Professionals, Scientific & Technical; Contracted; Management; Medical & Dental; Nursing & Midwifery; Support, Administrative & Clerical

How many people are members?

Number of members	31 Mar 2009
Patients	6,136
Public	6,372
Staff	2,930
Total	**15,438**

How are we developing a representative membership?

The Membership Development and Communication Sub-Committee of the Members' Council develops and reviews the Membership Development and Communications Strategy.

Membership grew by 18% in 2008/09, largely due to a decision taken by the Members' Council to move to an 'opt-out' system for staff which means that all staff are automatically members unless they opt out—this resulted in staff membership increasing from 465 in March 2008 to 2,930 in March 2009.

Initiatives to increase membership recruitment in 2008/09 included publishing a membership application form in a booklet given to all adult patients discharged from hospital, recruitment campaigns in advance of the Annual Members' Meeting and the Open Day, and the development of an Information Zone including LCD screen and electronic kiosks in the hospital.

Analysis of the membership database by age, gender and ethnicity to ensure that it is representative of the community we serve identified 3 areas for development:

- Low penetration in the Public: Wandsworth Area 1 constituency
- Significantly lower membership in the under-40 age group
- Significantly lower membership in the highest socio-economic group

In 2009/10 the Trust aims to maintain the current level of public members and increase the number of patient members by 5%.

Members' Council representatives and Foundation Trust members were invited to attend the Annual Members' Meeting in September 2008 and the Seasonal Working Conference with staff in March 2009 to give their views on the Trust.

Get in touch

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

The Information Zone on the ground floor of the hospital—funded by the Members' Council

Public interest disclosures

Action to inform, involve & consult with staff

The Trust is committed to keeping staff fully informed about everything that has an impact on their working lives at Chelsea and Westminster by providing them with information, consulting them on key decisions, and listening to their concerns.

A range of initiatives are in place to provide staff systematically with information on matters of concern to them, consult staff or their representatives so that their views are taken into account in making decisions that are likely to affect their interests, encourage the involvement of staff in the Trust's performance, and raise staff awareness of financial and economic factors affecting the Trust's performance:

- Executive Directors meet Staffside (Trade Union) representatives at monthly meetings of the Joint Management and Trade Union Consultative Committee (JMTUC)
- Quarterly meetings of the Members' Council include elected staff representatives
- Communication with staff includes a monthly staff magazine, a monthly face-to-face Team Briefing with Executive Directors, Daily Noticeboard email bulletin, and one-off briefings on issues of importance
- Staff are invited to be involved in the annual business planning process and development of Trust objectives

The Trust was ranked among the top 20% of NHS trusts in the annual NHS staff survey for effective communication between senior managers and staff.

Policies in relation to equal opportunities

The Trust aims to be an employer of choice for all. We have an Equal Opportunities Policy to ensure there is no direct or indirect discrimination and to build a workforce whose diversity reflects the community we serve.

A draft Single Equality Scheme (SES) has been developed to demonstrate how the Trust intends to meet the duties placed upon it by equal opportunities legislation. It aims to promote equality of opportunity and prevent discrimination. Consultation on the draft SES has included drop-in sessions for staff from April–June 2009 and an information stand at the Open Day in May 2009.

The Trust has joined the Stonewall Workplace Diversity Champions Programme, and established a network of staff groups including a Disability Action Group, a Black and Minority Ethnic Staff Network, and a Gay, Lesbian, Bisexual and Transgender (GLBT) Staff Network.

Policies in relation to disabled staff

Policies for giving full and fair consideration to applications for employment from disabled people

The Trust has an Equal Opportunities Policy and a Recruitment and Selection Policy and Procedure so that applications by disabled candidates receive full and fair consideration. Support for Trust staff is provided by recruitment training days which are compulsory for staff who participate in recruitment panels.

Policies for continuing the employment of, and arranging appropriate training for, staff who have become disabled

Disabled staff, managers, Human Resources and Occupational Health staff advise on adjustments to support disabled staff including adjustments to job roles, working hours and environment, and additional training.

Policies for training, career development and promotion of disabled staff

Staff should have regular performance development reviews and training needs support through the Knowledge and Skills Framework.

Health & Safety performance

The number of incidents reported to the Health & Safety Executive reduced from 18 in 2007/08 to 9 in 2008/09.

Occupational Health performance

The Occupational Health department provides services including fitness for work assessments, screening for infectious and communicable diseases, and moving and

handling training. In 2008/09, the department contributed to the Trust's achievement of NHS Litigation Authority risk management standards at Level 2 by producing and monitoring implementation of new Trustwide policies for Stress Management, Moving and Handling, and the Prevention and Management of Body Fluid Exposures.

Counter-Fraud policies & procedures

The Trust has a Counter-Fraud Policy for dealing with suspected fraud and corruption, and other illegal acts involving dishonesty or damage to property.

If Trust staff suspect a fraudulent act they can contact the Director of Finance & Information or the Local Counter-Fraud Specialist.

Sickness absence data

The annual sickness absence level in the Trust in 2008/09 was 3.7%.

Serious Untoward Incidents involving data loss or confidentiality breach

A Serious Untoward Incident was reported to the Information Commissioner, Monitor, NHS London and NHS Kensington & Chelsea in August 2008 when a member of staff reported the loss of a data stick containing person identifiable information.

This incident identified the need to improve the Trust's data security.

Patients whose data was on the stick were informed and an investigation panel was established, chaired by the Chief Executive and including a Non-Executive Director, the Medical Director (Caldicott Guardian) and the Chairman of the relevant patient representative group.

As a result of this incident, the Trust has put in place additional data security initiatives and agreed a detailed action plan which is monitored by the Board. Actions completed include a programme of internal communications to remind staff about the importance of data security, encryption of hard disk drives on Trust laptops, encryption of USB data sticks, and the introduction of mandatory information governance training for all Trust staff.

Finance

Statement of Accounting Officer's responsibilities

Statement of the Chief Executive's responsibilities as the Accounting Officer of Chelsea and Westminster Hospital NHS Foundation Trust

The National Health Service Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the Accounting Officer Memorandum issued by Monitor, the independent regulator of NHS Foundation Trusts.

Under the National Health Service Act 2006, Monitor has directed Chelsea and Westminster Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Chelsea and Westminster NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the NHS Foundation Trust Financial Reporting Manual have been followed, and disclose and explain any material departures in the financial statements
- Prepare the financial statements on a going concern basis

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable her to ensure that the accounts comply with requirements outlined in the above mentioned Act.

The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.

Heather Lawrence,
Chief Executive and Accounting Officer
4 Jun 2009

Statement on Internal Control

Statement on Internal Control for the Period 1 April 2008 to 31 March 2009

1. Scope of Responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me.

I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.

2. Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Chelsea and Westminster Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in Chelsea and Westminster Hospital NHS Foundation Trust for the year ended 31 March 2009 and up until the date of approval of the annual report and accounts.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments to the scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the regulations.

3. Capacity to Handle Risk

The Trust has a risk management strategy and operational policies approved by the Trust Board. The accountability for clinical and corporate governance, including risk management, rests with the Director of Governance & Corporate Affairs. This post facilitates an integrated model of risk management.

All Directors working in the Trust take responsibility for risk mitigation within their areas of work and practice, in line with the management and accountability arrangements in the Trust. The delivery of risk management occurs through management action and accountability arrangements and risk mitigation is monitored through the Trust's Operational Risk Management Committee. This reports to the Trust Executive for Clinical Governance and also provides reports to the Assurance Committee (formerly the Clinical Governance Assurance Committee and Facilities Assurance Committee), which reports to the Board.

The risk management team within the Trust provides support to directorates and departments on all aspects of effective risk assessment and management. Directorates have an identified senior lead for risk management. The Trust risk management team maintains the Trust's incident/risk reporting system and risk and incident review registers. The team also has a vital role in training, the dissemination of good practice and lessons learned from incidents or near misses. This is also achieved through sharing incidents at relevant committees, for example the Risk Management Committee and Trust Executive for Clinical Governance.

Risk management training is given to staff on induction and regular training opportunities are provided within the hospital to staff at all levels, including root cause analysis training.

The Trust achieved CNST Level 2 in the maternity standards in January 2006. The Trust achieved Level 2 in the revised general NHS Litigation Authority Risk Management Standards in December 2008.

4. Risk and Control Framework

The risk management strategy identifies the key elements to managing risk. This includes reactive risk management through analysis of incidents, identification of trends, investigations of serious incidents, and identification of action plans to reduce risk. These actions are monitored through the incident monitoring database. Risk is identified in the Trust proactively in a number of different ways. Directorates and departments undertake an annual comprehensive risk review using a risk assessment tool. Key gaps in meeting risks are identified and action plans developed. Risks are also identified on an ad hoc basis and evaluated using the Trust risk assessment form. This captures risk information for clinical and non-clinical risks and supports risk evaluation and action planning. Risks may also be identified from incidents, complaints and claims.

A coloured risk matrix is used to rate risks. Risk assessments are peer reviewed to include an assessment of the risk rating to ensure validity. Risks that are red or orange are entered into the centrally held risk register, which is managed by the corporate risk team. This register is reviewed at the Operational Risk Management Committee and if appropriate by other committees, for example those with capital implications are reviewed at the Capital Board. Current Assurance Framework risks are monitored by the Board. Leads for risk areas provide updates either as risks are mitigated or by default every 3 months. Risk assessments and the directorate risk register are part of the quarterly Clinical Governance Reports which are reviewed by the directorates. Risks that are red are notified to the Trust Board and these are monitored quarterly.

Risk management is embedded in the activity of the organisation in a number of ways. The strategy describes

local risk management processes which reflect the overall strategy of the Trust. In addition, directorates and departments are required to identify risks associated with objectives; risk identification is part of the business planning template; and risk identification is included in application forms for capital expenditure. The capital plan is regularly compared with the risk register to ensure significant risks requiring funding are prioritised.
Risks which may prevent the Trust from achieving its corporate objectives are identified during the development of the Trust's Assurance Framework.

The Board reviewed the systems and procedures for securing personal data in 2008/09, including patient data in transit, and was satisfied that these have been and remain compliant with relevant information governance guidance and the Data Protection Act 1998, with some exceptions. These exceptions have largely been addressed:

- In outpatient and ward areas, paper medical records are potentially accessible to the public during clinics. Lockable trolleys have been installed and training in information governance for all staff is being monitored regularly by the Information Governance Committee.

- The medical records library is open and security has been improved by the addition of CCTV.

- There is a software problem with the national PACS system which affects the security of passwords. The resolution of this is outside the Trust's control.

A serious incident in August 2008 involving the loss of a data stick containing person identifiable information was reported to the Information Commissioner and Monitor. As a result of this incident, additional data security initiatives have been put in place and there is a detailed action plan which is monitored by the Board. Actions completed include encryption of disk drives on portable PCs in accordance with NHS guidance; PointSec for encryption of USB storage devices has been installed with strong password authentication; IT security in the Trust has been investigated through ethical security testing and found to be of a high standard.

The Audit Committee now receives a regular update on information governance at each meeting and will assure the Board through reports to the Board.

The lead PCT is involved in risks which affect them through negotiation on the contract. In addition there is liaison and partnership work with relevant bodies on risks which affect them or which they can mitigate, for example ISS Mediclean for transport, Balfour Beatty for estates, the local safeguarding children's board for children's issues and various organisations for safeguarding vulnerable adults. The Trust also works with local agencies on emergency and business continuity planning.

Risk appetites are determined by the Board. This is usually based on risk assessments as part of a business case. The definition of consequences as part of the risk rating tool outlines risk levels and what the Trust considers major and extreme. Red risks are notified to the Board and progress on mitigation reported quarterly.

5. Review of Economy, Efficiency and Effectiveness of the Use of Resources

The development and reporting of patient level costing and service level reporting ensures that the Board is cognisant of relative profitability and efficiency.

Monthly finance and performance reports are provided to the Board. The Trust has exceeded the target for EBITDA and generation of surplus.

It is within Internal Audit's remit to make recommendations on the effective use of resources and they have undertaken a review of cost improvement processes.

The Audit Committee reviews performance against the Auditors' Local Evaluation despite being a Foundation Trust as the Trust considers it is good practice. Operational efficiency indicators are set at the top quartile of performance.

6. Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board and the Audit Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board ensures the effectiveness of the system of internal control through clear accountability arrangements.

The Audit Committee is a formal sub-committee of the Board and is accountable to the Board for reviewing the establishment and maintenance of an effective system of internal control and risk management. The committee meets at least 5 times per year. The Audit Committee approves the annual audit plans for internal and external audit activities and ensures that recommendations to improve weaknesses in control arising from audits are actioned by executive management.

The Audit Committee ensures the robustness of the underlying process used in developing the Assurance Framework. The Board monitors the Assurance Framework and objectives quarterly, ensuring actions to address gaps in control and gaps in assurance are progressed.

The Finance and Investment Committee conducts an objective review of financial and investment policy issues and reports to the Board.

The Assurance Committee is a formal sub-committee of the Board and has replaced the Clinical Governance Assurance Committee and Facilities Assurance Committee from December 2008. This committee is accountable for the assurance of the organisation's clinical governance and

associated risk arrangements, including infection control and for assurance of the maintenance of a safe, clean hospital environment. The Trust Executive committees report into the Assurance Committee.

Internal Audit services are outsourced to RSM Bentley Jennison Risk Management Ltd, who provide an objective and independent opinion to the Chief Executive, the Board and the Audit Committee on the degree to which risk management, control and governance support the achievement of the organisation's agreed objectives. Each assignment is discussed with the appropriate line manager or Director and a report including management responses and proposed action plan is presented to the Audit Committee. Internal Audit routinely follows up action with management to establish the level of compliance and the results are reported to the Audit Committee.

Executive Directors are accountable to the Board, the Audit Committee and the Assurance Committee (formerly the Clinical Governance and Facilities Assurance Committees) for ensuring management arrangements are in place to develop relevant strategies, policies, systems and procedures to maintain internal control and to take action to address any gaps identified from the review of these systems. Executive Directors are responsible for setting team objectives to ensure the delivery of corporate objectives and the management of risk. Any need to change priorities or controls is clearly recorded and actioned as appropriate. There is a quarterly report to the Board on progress on objectives, including a review of the risks.

The Trust declared full compliance with the Standards for Better Health for 2008/09 with one exception. The exception was standard 13c ('Healthcare organisations have systems in place to ensure that staff treat patient information confidentially, except where authorised by legislation to the contrary') where the Trust had a significant lapse in year, but achieved full compliance by year end.

A significant internal control issue was highlighted by a serious incident involving the loss of a data stick containing person identifiable information. The incident was reported to the Information Commissioner and Monitor. Actions have been taken as outlined above in section 4 and the action plan is being monitored by the Board.

A risk relating to maternity services has been identified recently, linked to the high use of agency staff. Recruitment, training and levels of usage of temporary staff will be a key issue in 2009/10.

The initial concerns about data quality have been addressed, with significant improvements in timeliness, completeness and accuracy of data. There is however a remaining risk related to high levels of agency staff in an environment of recruitment difficulties for coders.

7. Conclusion

Other than the control issues specified above, of which all have been mitigated or robust plans are in place to do so, there are no other significant control issues.

Heather Lawrence

Heather Lawrence,
Chief Executive
4 Jun 2009

Independent Auditors' Report

Independent Auditors' Report to the Members' Council and Board of Directors of Chelsea and Westminster Hospital NHS Foundation Trust

We have audited the financial statements of Chelsea and Westminster Hospital NHS Foundation Trust for the year ended 31 March 2009 under the National Health Service Act 2006 ("the Act") which comprise the Income and Expenditure Account, Balance Sheet, Statement of Total Recognised Gains and Losses, Cash Flow Statement and the related notes 1 to 26. These financial statements have been prepared in accordance with the accounting policies set out therein.

This report is made solely to the Members' Council and Board of Directors ("the Boards") of Chelsea and Westminster Hospital NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditors' report and for no other purpose. To the fullest extent permitted by law, we do not, in giving our opinion, accept or assume responsibility to anyone other than the Trust and the Boards, as a body, for this report, or for the opinions we have formed.

Respective Responsibilities of the Accounting Officer and Auditors

The Accounting Officer's responsibilities for preparing the financial statements in accordance with directions issued by Monitor, the independent regulator of NHS Foundation Trusts, are set out in the Statement of Accounting Officer's Responsibilities.

Our responsibility is to audit the financial statements in accordance with relevant legal and regulatory requirements (including statute and the Audit Code of NHS Foundation Trusts) and International Standards on Auditing (UK and Ireland).

We report to you our opinion as to whether the financial statements give a true and fair view in accordance with the accounting policies directed by Monitor, the independent regulator of NHS Foundation Trusts. We also report to you whether in our opinion the information given in the Directors' Report is consistent with the financial statements.

In addition, we report to you if, in our opinion, the financial statements have not been prepared in accordance with directions made under paragraph 25 of Schedule 7 of the Act, the financial statements do not comply with the requirements of all other provisions contained in, or having effect under, any enactment applicable to the financial statements, or proper practices have not been observed in the compilation of the financial statements.

We review whether the statement on internal control reflects compliance with the requirements of Monitor contained in the NHS Foundation Trust Financial Reporting Manual. We report if it does not meet the requirements specified by Monitor or if the statement is misleading or inconsistent with other information we are aware of from our audit of the financial statements. We are not required to consider, nor have we considered, whether the statement on internal control covers all risks and controls. We are also not required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures.

We read the other information contained in the Annual Report as described in the contents section and consider whether it is consistent with the audited financial statements. We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with the financial statements. Our responsibilities do not extend to any further information outside the Annual Report.

Basis of Audit Opinion

We conducted our audit in accordance with the Audit Code for NHS Foundation Trusts issued by Monitor, which requires compliance with International Standards on Auditing (UK & Ireland) issued by the Auditing Practices Board. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements. It also includes an assessment of the significant estimates and judgements made by the Directors in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Trust's circumstances, consistently applied and adequately disclosed.

We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error. In forming our opinion we also evaluated the overall adequacy of the presentation of information in the financial statements.

Opinion

In our opinion:

- The financial statements give a true and fair view of the state of affairs of Chelsea and Westminster Hospital NHS Foundation Trust as at 31 March 2009 and of its income and expenditure for the year then ended in accordance with the accounting policies directed by Monitor, the independent regulator of NHS Foundation Trusts
- The information given in the Directors' Report is consistent with the financial statements.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts.

Heather Bygrave
5 June 2009

Heather Bygrave FCA BA (Hons)
(Senior Statutory Auditor)
For and on behalf of Deloitte LLP
Chartered Accountants
St Albans
5 Jun 2009

Foreword to the accounts

These accounts for the year ended 31 March 2009 have been prepared by Chelsea and Westminster Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

Heather Lawrence

Heather Lawrence,
Chief Executive
4 Jun 2009

Income and expenditure account for the year ended 31 March 2009

	Note	2008/09 £000	2007/08 £000
Income from activities	3	**243,355**	221,636
Other operating income	4	**37,370**	36,574
Operating expenses	5	**(262,911)**	(235,414)
Operating surplus		**17,814**	22,796
Loss on disposal of fixed assets		**(118)**	0
Operating surplus		**17,696**	22,796
Finance income	9.1	**1,438**	2,018
Finance costs—interest expense	9.2	**(813)**	(880)
Surplus for the financial year		**18,321**	23,934
Public Dividend Capital dividends payable	15.1	**(8,687)**	(9,309)
Retained surplus for the year		**9,634**	14,625

The notes on pages 43 to 55 form part of these accounts. All income and expenditure is derived from continuing operations.

Balance sheet as at 31 March 2009

	Note	31 Mar 2009 £000	31 Mar 2008 £000
Fixed assets			
Tangible assets	10	**289,240**	278,701
Current assets			
Stocks and work in progress	11	**6,588**	6,002
Debtors	12	**11,418**	9,990
Cash at bank and in hand	16.3	**32,053**	35,894
Total current assets		**50,059**	51,886
Creditors: amounts falling due within one year	13.1	**(36,524)**	(32,376)
Net current assets		**13,535**	19,510
Total assets less current liabilities		**302,775**	298,211
Creditors: Amounts falling due after more than one year	13.1	**(11,705)**	(13,222)
Provisions for liabilities and charges	14	**(440)**	(4,212)
Total assets employed		**290,630**	280,777
Financed by:			
Taxpayers' equity			
Public dividend capital	15.2	**162,549**	162,549
Revaluation reserve	15.3	**91,320**	91,040
Donated asset reserve	15.3	**7,472**	7,533
Income and expenditure reserve	15.3	**29,289**	19,655
Total taxpayers' equity		**290,630**	280,777

Heather Lawrence

Heather Lawrence, Chief Executive
4 Jun 2009

Statement of total recognised gains and losses for the year ended 31 March 2009

	2008/09 £000	2007/08 £000
Surplus for the financial year before dividend payments	**18,321**	23,934
Unrealised surplus on fixed asset revaluation	**280**	0
Increase in the donated asset reserve due to receipt of donated assets	**240**	0
Reductions in the donated asset reserve due to depreciation, impairment and/or disposal of donated assets	**(301)**	(310)
Total recognised gains for the financial year	**18,540**	23,624

Cash Flow Statement for the Year Ended 31 March 2009

	Note	Year ended 31 Mar 2009 £000	Year ended 31 Mar 2008 £000
Operating activities			
Net cash inflow from operating activities	16.1	**27,845**	27,841
Returns on investments and servicing of finance			
Interest received		**1,493**	1,977
Interest paid		**(717)**	(800)
Interest element of finance leases		**(100)**	(80)
Net cash inflow from returns on investments and servicing of finance		**676**	1,097
Capital expenditure			
Payments to acquire tangible fixed assets		**(19,231)**	(10,694)
Net cash outflow from capital expenditure		**(19,231)**	(10,694)
Dividends paid		**(8,687)**	(9,309)
Net cash inflow before financing		**603**	8,935
Financing			
New public dividend capital received		**0**	2,151
Public dividend capital repaid		**0**	(2,204)
Loans received from Foundation Trust Financing Facility		**0**	4,706
Loans repaid to Foundation Trust Financing Facility		**(1,470)**	0
Other loans repaid		**(3,124)**	(3,126)
Other capital receipts		**197**	0
Capital element of finance lease rental payments		**(47)**	(37)
Net cash (outflow)/inflow from financing		**(4,444)**	1,490
(Decrease)/increase in cash		**(3,841)**	10,425

Notes to the accounts

1. Accounting policies and other information

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the *NHS Foundation Trust Financial Reporting Manual* which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2008/09 *NHS Foundation Trust Financial Reporting Manual* issued by Monitor. The accounting policies contained in that manual follow UK generally accepted accounting practice for companies (UK GAAP) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of tangible fixed assets at their value to the business by reference to their current costs. NHS foundation trusts, in compliance with HM Treasury's Financial Reporting Manual, are not required to comply with the FRS 3 requirements to report "earnings per share" or historical profits and losses.

1.2 Income Recognition

Income is accounted for by applying the accruals convention. The main source of income for the Trust is from commissioners in respect of healthcare services. Income is recognised in the period in which services are provided. Income relating to episodes of care which are partially complete at the end of an accounting period is divided pro rata across the periods in which episodes take place. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

1.3 Expenditure

Expenditure is accounted for by applying the accruals convention.

1.4 Tangible fixed assets

Capitalisation

Tangible assets are capitalised if they are capable of being used for a period which exceeds one year and they:

- individually have a cost of at least £5,000; or
- collectively have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

1.5 Valuation

Tangible fixed assets are stated at the lower of replacement cost and recoverable amount. On initial recognition they are measured at cost (for leased assets, fair value) including any costs such as installation directly attributable to bringing them into working condition. The carrying values of tangible fixed assets are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable. The costs arising from financing the construction of the fixed asset are not capitalised but are charged to the income and expenditure account in the year to which they relate.

All land and buildings are restated to current value using professional valuations in accordance with FRS15 every five years. A three yearly interim valuation is also carried out.

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The last asset valuations were undertaken in 2006 as at the prospective valuation date of 1 April 2006. The revaluation undertaken at that date was accounted for on 1 April 2006. The next valuation will take place on 31st March 2010.

The valuations are carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property. The value of land for existing use purposes is assessed at existing use value. For non-operational properties, including surplus land, the valuations are carried out at open market value.

Assets in the course of construction are valued at cost and are valued by professional valuers as part of the five or three-yearly valuation or when they are brought into use.

Operational equipment is valued at net current replacement cost. Equipment surplus to requirement is valued at net recoverable amount.

1.6 Depreciation, amortisation & impairments

Tangible fixed assets are depreciated at rates calculated to write them down to estimated residual value on a straight-line basis over their estimated useful lives. No depreciation is provided on freehold land and assets surplus to requirements.

Assets in the course of construction and residual interests in off-balance sheet PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as assessed by the NHS Foundation Trust's professional valuers. Leaseholds are depreciated over the primary lease term.

Equipment is depreciated on current cost evenly over the estimated life of the asset. The useful economic life for equipment assets is deemed as 5 years for short life assets, 10 years for medium life assets and 15 years for long life assets.

Fixed asset impairments resulting from losses of economic benefits are charged to the income and expenditure account. All other impairments are taken to the revaluation reserve and reported in the statement of total recognised gains and losses to the extent that there is a balance on the revaluation reserve in respect of the particular asset.

1.7 Donated fixed assets

Donated fixed assets are capitalised at their current value on receipt and this value is credited to the donated asset reserve. Donated fixed assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the donated asset reserve and each year an amount equal to the depreciation charge on the asset is released from the donated asset reserve to the income and expenditure account.

Similarly, any impairment on donated assets charged to the income and expenditure account is matched by a transfer from the donated asset reserve. On sale of donated assets, the net book value of the donated asset is transferred from the donated asset reserve to the income and expenditure reserve.

1.8 Government Grants

Government grants are grants from Government bodies other than income from Primary Care Trusts or NHS Trusts for the provision of services. Any grant from the Department of Health is accounted for as Government grant. Where the Government grant is used to fund revenue expenditure it is taken to the Income and Expenditure account to match that expenditure. Where the grant is used to fund capital expenditure the grant is held as deferred income and released to the income and expenditure account over the life of the asset on a basis consistent with the depreciation charge for that asset.

1.9 Stocks and work-in-progress

Stocks and work-in-progress are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to current cost due to the high turnover of stocks. Work-in-progress comprises goods in intermediate stages of production. Partially completed contracts for patient services are accounted for as NHS debtors and not work-in-progress.

1.10 Cash, bank and overdrafts

Cash, bank and overdraft balances are recorded at the current values of these balances in the Trust's cash book. These balances exclude monies held in the Trust's bank account belonging to patients (see "third party assets" below). Account balances are only set off where a formal agreement has been made with the bank to do so. In all other cases overdrafts are disclosed within creditors. Interest earned on bank accounts and interest charged on overdrafts is recorded respectively as "interest receivable" and "interest payable" in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate.

1.11 Research and development

Expenditure on research is not capitalised. Expenditure on development is capitalised if it meets the following criteria:

- there is a clearly defined project;
- the related expenditure is separately identifiable;
- the outcome of the project has been assessed with reasonable certainty as to its technical feasibility and its likelihood of resulting in a product or services that will eventually be brought into use; and
- adequate resources exist, or are reasonably expected to be available, to enable the project to be completed and to provide any consequential increases in working capital.

Expenditure so deferred is limited to the value of future benefits expected and is amortised through the income and expenditure account on a systematic basis over the period expected to benefit from the project. It is revalued on the basis of current cost. Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred. Where possible, the Trust discloses the total amount of research and development expenditure charged in the income and expenditure account separately. However, where research and development activity cannot be separated from patient care activity it cannot be identified and is therefore not separately disclosed.

Fixed assets acquired for use in research and development are amortised over the life of the associated project.

1.12 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is material, the estimated risk-adjusted cash flows are discounted using the Treasury's discount rate of 2.2% in real terms.

1.13 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 19, where an inflow of economic benefits is probable.

Contingent liabilities are provided for where a transfer of economic benefits is probable. Otherwise, they are not recognised, but are disclosed in note 19 unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

- Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.14 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 14.

Since financial responsibility for clinical negligence cases transferred to the NHSLA at 1 April 2002, the only charge to operating expenditure in relation to clinical negligence in 2008/09 relates to the Trust's contribution to the Clinical Negligence Scheme for Trusts.

1.15 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.16 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.pensions.nhsbsa.nhs.uk. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying Scheme assets and liabilities. Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

The Scheme is subject to a full actuarial valuation every four years (until 2004, based on a five year valuation cycle), and a FRS17 accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date.

The conclusion from the 2004 valuation was that the Scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. However, after taking into account the changes in the benefit and contribution structure effective from 1 April 2008, the Scheme actuary reported that employer contributions could continue at the existing rate of 14% of pensionable pay. On advice from the Scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Up to 31 March 2008, the vast majority of employees paid contributions at the rate of 6% of pensionable pay. From 1 April 2008, employees' contributions are on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

b) FRS17 Accounting valuation

In accordance with FRS17, a valuation of the Scheme liability is carried out annually by the Scheme Actuary as at the balance sheet date by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the Scheme Actuary. At this point the assumptions regarding the composition of the Scheme membership are updated to allow the Scheme liability to be valued.

The valuation of the Scheme liability as at 31 March 2008, is based on detailed membership data as at 31 March 2006 (the latest midpoint) updated to 31 March 2008 with summary global member and accounting data.

The latest assessment of the liabilities of the Scheme is contained in the Scheme Actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

Pension Scheme Provisions

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th of the best of the last 3 years pensionable pay for each year of service. A lump sum normally equivalent to 3 years pension is payable on retirement. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement, less pension already paid, subject to a maximum amount equal to twice the member's final year's pensionable pay less their retirement lump sum for those who die after retirement, is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the income and expenditure account at the time the Trust commits itself to the retirement, regardless of the method of payment.
The Scheme provides the opportunity to members to increase their benefits through money purchase Additional Voluntary Contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the employee/member can make contributions to enhance an employee's pension benefits. The benefits payable relate directly to the value of the investments made.

Scheme provisions from 1 April 2008
From 1 April 2008 changes were made to the NHS Pension Scheme contribution rates and benefits. Further details of these changes can be found on the NHS Pensions website www.pensions.nhsbsa.nhs.uk.

1.17 Value Added Tax
Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.18 Foreign Exchange
Transactions that are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the income and expenditure account.

1.19 Third Party Assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in note 16.4.

1.20 Leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as a tangible fixed asset and a debt is recorded to the lessor of the minimum lease payments discounted by the interest rate implicit in the lease. The interest element of the finance lease payment is charged to the income and expenditure account over the period of the lease at a constant rate in relation to the balance outstanding. Other leases are regarded as operating leases and the rentals are charged to the income and expenditure account on a straight-line basis over the term of the lease.

1.21 Public Dividend Capital (PDC) and PDC Dividend
Public dividend capital (PDC) is a type of public sector equity finance.

A charge, reflecting the forecast cost of capital utilised by the Trust, is paid over as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average relevant net assets less the value of all liabilities, except for donated assets, assets funded by external finance and cash with the Office of the Paymaster General. The average relevant net assets are calculated as a simple mean of opening and closing relevant net assets.

1.22 Financial instruments
Financial instruments are defined as contracts that give rise to a financial asset of one entity and a financial liability or equity instrument of another entity. The Trust will commonly have the following financial assets and liabilities: trade debtors (but not prepayments), current asset investments, cash at bank and in hand, trade creditors (but not deferred income), finance lease obligations, loans, provisions.

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described above.

Regular way purchases or sales are recognised and de-recognised, as applicable, using the trade date.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risk and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement
Financial assets are classified into the following specified categories:

- Financial assets 'at fair value through Income and Expenditure' or
- 'Loans and receivables' or
- 'Available-for-sale' financial assets or
- 'Held-to-maturity' investments.

Financial liabilities are classified as either:

- Financial liabilities 'at fair value through Income and Expenditure' or
- 'Other financial liabilities'.

There are no financial assets classified as 'at fair value through Income and Expenditure', 'Available for sale' or 'Held to maturity' investments. There are no financial liabilities classified as 'at fair value through income and expenditure'.

Financial assets and financial liabilities at 'Fair Value through Income and Expenditure'
Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not 'closely-related' to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the income and expenditure account.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise: cash at bank and in hand, NHS debtors, accrued income and 'other debtors'.

Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the income and expenditure account, except for short-term receivables when the recognition of interest would be immaterial.

Other financial liabilities
All 'other' financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the balance sheet date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to the income and expenditure account.

Impairment of financial assets
At the balance sheet date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' is impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the income and expenditure account and the carrying amount of the asset is reduced through the use of an allowance account/ bad debt provision.

2. Segmental analysis

The Board of Directors is of the opinion that the Trust's operating activities fall under the single heading of healthcare for the purposes of segmental reporting.

3. Income from Activities

3.1 Income from activities by type

	2008/09 £000	2007/08 £000
Elective income	**38,112**	34,058
Non elective income	**61,524**	56,835
Outpatient income	**60,679**	47,038
Other NHS clinical income	**63,129**	73,353
Accident & Emergency income	**9,979**	9,843
Payment by results (clawback)	**0**	(6,428)
Private patient income	**7,969**	6,937
Other non-protected clinical income	**1,963**	0
Total	**243,355**	221,636

3.2 Private patient income

	Base year 2002/03 £000	2008/09 £000	2007/08 £000
Private patient income	5,498	**7,969**	6,937
Total patient related income	157,015	**243,355**	221,636
Proportion (as percentage)	3.50%	**3.27%**	3.13%

3.3 Income from activities by source

	2008/09 £000	2007/08 £000
NHS Trusts	**22**	1,331
Primary Care Trusts	**189,447**	176,207
Department of Health—other	**43,673**	35,516
Non NHS: Private patients	**7,969**	6,937
Non NHS: Overseas patients (non-reciprocal)	**1,026**	718
NHS injury scheme	**838**	692
Non NHS: Other	**380**	235
Total	**243,355**	221,636

4. Other Operating Income

	2008/09 £000	2007/08 £000
Research and development	**2,691**	3,029
Education and training	**22,257**	21,629
Charitable and other contributions to expenditure	**121**	122
Transfers from donated asset reserve in respect of depreciation	**301**	310
Non-patient care services to other bodies	**710**	608
Other income	**11,290**	10,876
Total	**37,370**	36,574

5. Operating Expenses

	2008/09 £000	2007/08 £000
Services from NHS Trusts	**187**	1,191
Purchase of healthcare from non-NHS bodies	**376**	643
Executive directors costs	**736**	727
Non executive directors costs	**116**	116
Staff costs	**147,236**	133,177
Drug costs	**42,240**	36,994
Supplies and services—clinical (excluding drug costs)	**29,060**	25,782
Supplies and services—general	**2,777**	3,697
Establishment	**4,600**	2,931
Transport	**1,446**	601
Premises	**17,120**	17,353
Bad debts	**13**	(1,278)
Depreciation and amortisation	**8,734**	7,587
Audit fees	**105**	106
Clinical negligence	**2,873**	3,015
Other	**5,292**	2,772
Total	**262,911**	235,414

5.2 Operating leases

5.2/1 Operating lease rentals

	2008/09 £000	2007/08 £000
Hire of plant and machinery	**278**	559
Other operating lease rentals	**1,284**	718
Total	**1,562**	1,277

5.2/2 Operating Lease Commitments

Land & Buildings Operating leases which expire:	2008/09 £000	Restated 2007/08 £000
Within 1 year	**0**	0
Between 1 and 5 years	**166**	166
After 5 years	**703**	186
Total	**869**	352

Other Operating leases which expire:	2008/09 £000	Restated 2007/08 £000
Within 1 year	**37**	42
Between 1 and 5 years	**146**	165
After 5 years	**139**	139
Total	**322**	346

2007/08 reflected outstanding lease commitment therefore restated to reflect annual lease commitment

6. Staff costs and numbers

6.1 Staff costs

	2008/09 £000	2007/08 £000
Salaries and wages	**114,416**	107,009
Social security costs	**10,040**	9,713
Employers' contributions to NHS Pension Scheme	**12,113**	10,979
Agency/contract staff	**11,403**	6,203
Total	**147,972**	133,904

6.2 Average number of persons employed

	2008/09 n°	2007/08 n°
Medical and dental	**515**	490
Administration and estates	**535**	519
Healthcare assistants and other support staff	**207**	188
Nursing, midwifery and health visiting staff	**985**	965
Nursing, midwifery and health visiting learners	**4**	9
Scientific, therapeutic and technical staff	**278**	288
Bank and agency staff	**470**	419
Other	**27**	27
Total	**3,021**	2,905

6.3 Employee benefits

During 2008/09 there were no material non-pay benefits which are not attributable to individual employees exceeding £0.1m (year ended 31 March 2008 - nil).

6.4 Retirements due to ill-health

During 2008/09 there were no (year ended 31 March 2008—3) early retirements from the Trust agreed on the grounds of ill-health. (The estimated additional pension liabilities of ill-health retirements year ended 31 March 2008—£0.1m.)

Notes to table 6.5

1. Medical Director moved to the new consultant contract in 2008/09
2. Salary is part year in 2007/08 and 2008/09 due to maternity leave
3. Salary is part year in 2007/08 and 2008/09
4. Salary for part year in 2007/08
5. Salary for part year in 2008/09
6. Salary for Interim Directors reported as full cost to the Trust

As non executive directors do not receive pensionable remuneration there are no entries in respect of pensions for them.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme.

A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figure shown relates to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures include the value of any pension benefits in another scheme or arrangement in which the individual has transferred to the NHS pension scheme. They also include any additional pension benefits accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV—this reflects the increase in CETV effectively funded by the employer . It takes account of the

increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Real increase in CETV for current year may be significantly different from prior year. This is due to a change in the factors used to calculate CETVs, which came into force on 1 October 2008 as a result of the Occupational Pension Scheme (Transfer Value Amendment) regulation. These placed responsibility for the calculation method for CETVs (following actuarial advice) on Scheme Managers or Trustees. Further regulations from the Department for Work and Pensions to determine cash equivalent transfer values (CETV) from Public Sector Pension Schemes came into force on 13 October 2008.

6.5 Salary and Pension Entitlements of Senior Managers

	a) Remuneration		b) Pension				
	Salary for the year ended 31 Mar 2009 bands of **£5,000**	**Salary for the year ended 31 Mar 2008** bands of **£5,000**	**Accrued pension and related lump sum at age 60 as at 31 Mar 2009** bands of **£2,500**	**Real increase/ (decrease) in pension and related lump sum at age 60 as at 31 Mar 2009** bands of **£2,500**	**CETV at 31 Mar 2008** **(£000)**	**CETV at 31 Mar 2009** **(£000)**	**Real increase/ (decrease) in CETV for the year ended 31 Mar 2009** **(£000)**
Executive Directors							
Heather Lawrence, Chief Executive	**170–175**	165–170	**292.5–295.0**	**(10.0)–(7.5)**	1,343	**1,826**	**268**
Mike Anderson, Medical Director [1]	**155–160**	135–140	**275.0–277.5**	**75.0–77.5**	858	**1,651**	**474**
Lorraine Bewes, Director of Finance & Information	**125–130**	120–125	**107.5–110.0**	**7.5–10.0**	352	**487**	**76**
Amanda Pritchard, Deputy Chief Executive (Director of Service Integration & Modernisation) [2]	**85–90**	100–105	**57.5–60.0**	**0–2.5**	125	**158**	**18**
Andrew MacCallum, Director of Nursing	**95–100**	90–95	**125.0–127.5**	**2.5–5.0**	383	**547**	**97**
Mariella Dexter, Interim Director of Service Integration & Modernisation [3, 6]	**20–25**	25–30	**0**	**0**	0	**0**	**0**
Non-Executive Directors							
Professor Sir Christopher Edwards, Chairman [4]	**40–45**	15–20	**0**	**0**	0	**0**	**0**
Andrew Havery, Non-Executive Director	**15–20**	15–20	**0**	**0**	0	**0**	**0**
Karin Norman, Non-Executive Director	**10–15**	10–15	**0**	**0**	0	**0**	**0**
Charles Wilson, Non-Executive Director	**10–15**	10–15	**0**	**0**	0	**0**	**0**
Professor Richard Kitney, Non-Executive Director	**10–15**	10–15	**0**	**0**	0	**0**	**0**
Colin Glass, Non-Executive Director [4]	**10–15**	0–5	**0**	**0**	0	**0**	**0**
Directors							
Catherine Mooney, Director of Governance & Corporate Affairs	**80–85**	80–85	**107.5–110.0**	**2.5–5.0**	361	**496**	**79**
Alex Geddes, Director of Information Management & Technology	**90–95**	90–95	**30.0–32.5**	**2.5–5.0**	0	**0**	**0**
Neil Callow, Deputy Director of Finance [5]	**70–75**	0	**77.5–80.0**	**17.5–20.0**	169	**293**	**66**
Alan Bramhall, Interim Deputy Director of Finance [3, 6]	**35–40**	70–75	**0**	**0**	0	**0**	**0**
Amit Khutti, Director of Strategy & Service Planning	**80–85**	75–80	**7.5–10.0**	**2.5–5.0**	9	**23**	**9**
Mark Gammage, Interim Director of Human Resources [5, 6]	**85–90**	0	**0**	**0**	0	**0**	**0**

7. Better Payment Practice Code

7.1 Better Payment Practice Code—measure of compliance

	2008/09 n°	2008/09 £000	2007/08 n°	2007/08 £000
Total bills paid in the year	**70,804**	**143,549**	65,669	124,372
Total bills paid within the target	**62,628**	**128,136**	61,743	110,805
Percentage of bills paid within target	**88.5%**	**89.3%**	94.0%	89.1%

The Better Payment Practice Code requires the Trust to aim to pay 95% of all valid invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

7.2 The Late Payment of Commercial Debts (Interest) Act 1998

There were no amounts included within interest payable (note 9.2) arising from claims made under this legislation (2007/08—nil).

8. Profit/(Loss) on Disposal of Fixed Assets

The loss on disposal of fixed assets was £0.12m (2007/08—nil) consisting of various pieces of medical equipment decommissioned.

9.1 Finance Income

	2008/09 £000	2007/08 £000
Interest receivable on cash deposits	**1,438**	2,018
Total	**1,438**	2,018

9.2 Finance Costs—Interest Expense

	2008/09 £000	2007/08 £000
Loans from the Foundation Trust Financing Facility	**587**	504
Finance leases	**104**	80
Other Loans	**122**	296
Total	**813**	880

10. Tangible Fixed Assets

10.1 Elements of tangible fixed assets at the balance sheet date

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 Apr 2008	50,000	214,914	1,269	2,237	35,617	65	11,462	471	316,035
Additions—purchased	0	3,430	0	8,050	4,551	0	2,774	66	18,871
Additions—donated	0	0	0	0	240	0	0	0	240
Reclassifications	0	4,592	0	(5,031)	439	0	0	0	0
Other revaluations	0	0	0	0	0	0	280	0	280
Disposals	0	0	0	0	(1,513)	0	0	0	(1,513)
Cost or valuation at 31 Mar 2009	**50,000**	**222,936**	**1,269**	**5,256**	**39,334**	**65**	**14,516**	**537**	**333,913**
Depreciation at 1 Apr 2008	0	11,088	188	0	18,862	63	6,681	452	37,334
Provided during the year	0	5,423	111	0	2,300	2	879	19	8,734
Disposal	0	0	0	0	(1,395)	0	0	0	(1,395)
Depreciation at 31 Mar 2009	**0**	**16,511**	**299**	**0**	**19,767**	**65**	**7,560**	**471**	**44,673**
Net book value									
Purchased at 1 Apr 2008	50,000	196,856	1,081	2,237	16,192	2	4,781	19	271,168
Donated at 1 Apr 2008	0	6,970	0	0	563	0	0	0	7,533
Total at 1 Apr 2008	**50,000**	**203,826**	**1,081**	**2,237**	**16,755**	**2**	**4,781**	**19**	**278,701**
Net book value									
Purchased at 31 Mar 2009	50,000	199,688	970	5,256	18,836	0	6,956	66	281,772
Donated at 31 Mar 2009	0	6,737	0	0	731	0	0	0	7,468
Total at 31 Mar 2009	**50,000**	**206,425**	**970**	**5,256**	**19,567**	**0**	**6,956**	**66**	**289,240**
Net book value									
Protected assets at 31 Mar 2009	50,000	203,068	970	0	0	0	0	0	254,038
Unprotected assets at 31 Mar 2009	0	3,357	0	5,256	19,567	0	6,956	66	35,202
Total at 31 Mar 2009	**50,000**	**206,425**	**970**	**5,256**	**19,567**	**0**	**6,956**	**66**	**289,240**

10.2 Assets held at open market value:

As at 31 March 2009, £50m related to land, £206m related to buildings, excluding dwellings, and £0.97m related to dwellings.

10.3 Net book value of assets held under finance leases and hire purchase contracts at the balance sheet date

	Dwellings £000
At 31 Mar 2009	**970**
At 31 Mar 2008	**1,081**

10.3/1 Total amount of depreciation charged to the income and expenditure account in respect of assets held under finance leases and hire purchase contracts

	Dwellings £000
Depreciation 31 Mar 2009	**111**
Depreciation 31 Mar 2008	**111**

10.4 Net book value of land, buildings and dwellings at 31 March 2009

	Total £000	Protected £000	Unprotected £000
Freehold	**256,425**	**253,068**	**3,357**
Long leasehold	**970**	**970**	**0**
Total at 31 Mar 2009	**257,395**	**254,038**	**3,357**

11. Stocks and Work in Progress

	31 Mar 2009 £000	31 Mar 2008 £000
Raw materials and consumables	**6,588**	6,002

12. Debtors

12.1 Debtors at the balance sheet date

Amounts falling due within one year:	31 Mar 2009 £000	31 Mar 2008 £000
NHS Debtors	**6,565**	6,026
Prepayments	**458**	684
Accrued income	**312**	766
Other debtors	**6,657**	5,016
Provision for irrecoverable debts	**(2,574)**	(2,502)
Total	**11,418**	9,990

Included in NHS debtors is a figure of £0.99m (31 Mar 2008—£0.71m) relating to partially completed spells of clinical activity at 31 Mar 2009.

12.2 Provision for Impairment of NHS Debtors

	31 Mar 2009 £000	31 Mar 2008 £000
At 1 April	**2,502**	3,956
Provision for debtors impairment	**195**	0
Debtors written off during the year as uncollectable	**(123)**	(425)
Unused amounts reversed	**0**	(1,029)
Total at 31 Mar 2009	**2,574**	2,502

12.3 Analysis of Impaired Debtors

Ageing of impaired debtors	31 Mar 2009 £000	31 Mar 2008 £000
Up to three months	**195**	0
In three to six months	**121**	148
Over six months	**2,258**	2,354
Total	**2,574**	2,502
Ageing of non-impaired debtors past their due date		
Up to three months	**3,206**	3,019
In three to six months	**979**	431
Over six months	**1,488**	0
Total	**5,673**	3,450

13. Creditors

13.1 Creditors at the balance sheet date

Amounts falling due within one year	31 Mar 2009 £000	31 Mar 2008 £000
Loans	**1,470**	4,594
NHS creditors	**7,798**	6,116
Other tax and social security costs	**3,182**	3,186
Obligations under finance leases and HP contracts	**47**	43
Capital Creditors	**1,076**	1,235
Other creditors	**7,255**	6,422
Accruals	**10,036**	6,186
Deferred income	**5,660**	4,594
Subtotal	**36,524**	32,376
Amounts falling due after more than one year		
Loans	**9,560**	11,030
Obligations under finance leases and HP contracts	**2,145**	2,192
Subtotal	**11,705**	13,222
Total	**48,229**	45,598

NHS creditors include outstanding pension contributions at 31 Mar 2009 of £1.65m (31 Mar 2008—£1.5m).

13.2 Loans—payment of principal falling due

Amounts falling due	31 Mar 2009 £000	31 Mar 2008 £000
In one year or less	**1,470**	4,594
Between one and two years	**1,470**	1,470
Between two and five years	**4,410**	4,410
Over 5 years	**3,680**	5,150
Total	**11,030**	15,624

13.3 Prudential Borrowing Limit (PBL)

	31 Mar 2009 £000 Authorised	31 Mar 2009 Actual £000	31 Mar 2008 £000 Authorised	31 Mar 2008 Actual £000
Total long term borrowing	**38,100**	**13,222**	29,900	17,859
Working capital facility	**20,000**	**0**	18,000	0
Total	**58,100**	**13,222**	47,900	17,859

13.3/1 Financial Ratios

	Prudential Borrowing Limits	2008/09 Approved PBL Ratio	2008/09 Actual PBL Ratio	2007/08 Approved PBL Ratio	2007/08 Actual PBL Ratio
Maximum debt/capital ratio (%)	**< 40%**	**6%**	**4%**	5%	5%
Minimum dividend cover (times)	**>1.0x**	**2.9x**	**3.1x**	2.2x	3.4x
Minimum interest cover (times)	**>3.0x**	**29.6x**	**34.4x**	25.0x	36.8x
Minimum debt service to revenue (%)	**>2.0x**	**4.8x**	**5.1x**	4.6x	8.0x
Maximum debt service to revenue (%)	**<3.0%**	**2.1%**	**1.9%**	1.9%	1.6%

The Trust is required to comply and remain within a prudential borrowing limit. This is made up of two elements:

- The maximum cumulative amount of long term borrowing. This is set by reference to the five ratio tests set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit.
- The amount of any working capital facility approved by Monitor.

Further information on the NHS Foundation Trust Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the independent Regulator of Foundation Trusts.

13.4 Finance Lease Obligations

	31 Mar 2009 £000	31 Mar 2008 £000
Within one year	**125**	121
Between two and five years	**537**	522
After five years	**2,470**	2,610
	3,132	3,253
Less: finance charges allocated to future periods	**(940)**	(1,018)
Net obligations	**2,192**	2,235

13.5 Finance Lease Commitments

	31 Mar 2009 £000	31 Mar 2008 £000
Minimum payments	**3,132**	3,253
Number of years of commitment (years)	**19**	20

14. Provisions for Liabilities and Charges

	Pensions relating to other staff £000	Agenda for Change payments £000	Total £000
At 1 April 2008	**408**	**3,804**	**4,212**
Arising during the year	**52**	**0**	**52**
Utilised during the year	**(20)**	**(220)**	**(240)**
Reversed unused	**0**	**(3,584)**	**(3,584)**
At 31 Mar 2009	**440**	**0**	**440**

14/1 Expected timing of cash flows

	Pensions relating to other staff £000	Agenda for Change payments £000	Total £000
Within one year	**12**	**0**	**12**
Between one and five years	**48**	**0**	**48**
After five years	**380**	**0**	**380**
Total	**440**	**0**	**440**

Clinical Negligence Liabilities

Amount included in provisions of the National Health Service Litigation Authority at 31 March 2009 in respect of clinical negligence of the Trust is £31.32m (31 March 2008—£27.6m).

15. Movements in Taxpayers' Equity and Public Dividend Capital

15.1 Movement in Taxpayers' Equity

	31 Mar 2009 £000	31 Mar 2008 £000
Taxpayers' equity at 1 April	**280,777**	266,515
Surplus for the financial period	**18,321**	23,934
Public dividend capital dividends	**(8,687)**	(9,309)
Surplus from revaluations of fixed assets	**280**	0
New public dividend capital received	**0**	2,151
Public dividend capital repaid in year	**0**	(2,204)
Reductions in donated asset reserve	**(61)**	(310)
Taxpayers' equity at 31 Mar	**290,630**	280,777

15.2 Movements in Public Dividend Capital

	31 Mar 2009 £000	31 Mar 2008 £000
Public dividend capital at 1 April	**162,549**	162,602
New public dividend capital received	**0**	2,151
Public dividend capital repaid in year	**0**	(2,204)
Public dividend capital at 31 Mar	**162,549**	162,549

15.3 Movements on Reserves

	Revaluation Reserve £000	Donated Asset Reserve £000	Income and Expenditure Reserve £000	Total Reserves £000
At 1 April 2008	**91,040**	**7,533**	**19,655**	**118,228**
Transfer from the income and expenditure account	**0**	**0**	**9,634**	**9,634**
Surplus on revaluations of fixed assets	**280**	**0**	**0**	**280**
Receipt of donated assets	**0**	**240**	**0**	**240**
Transfers to the income and expenditure account for depreciation, impairment and disposal of donated assets	**0**	**(301)**	**0**	**(301)**
At 31 Mar 2009	**91,320**	**7,472**	**29,289**	**128,081**

16. Notes to the Cash Flow Statement

16.1 Reconciliation of operating surplus to net cash inflow from operating activities

	31 Mar 2009 £000	31 Mar 2008 £000
Total operating surplus	**17,814**	22,796
Depreciation	**8,734**	7,587
Transfer from the donated asset reserve	**(301)**	(310)
(Increase) in stocks	**(586)**	(429)
(Increase) in debtors	**(604)**	(1,116)
Increase/(decrease) in creditors	**6,559**	(909)
(Decrease)/increase in provisions	**(3,771)**	222
Net cash inflow from operating activities	**27,845**	27,841

16.2 Reconciliation of net cash flow to movement in net funds

	31 Mar 2009 £000	31 Mar 2008 £000
(Decrease)/increase in cash in the period	**(3,841)**	10,425
Cash (inflow) from new debt	**0**	(4,706)
Cash outflow from debt repaid and finance lease capital payments	**4,637**	3,164
Change in net debt resulting from cash flows	**796**	8,883
Net funds at start of period	**18,035**	9,152
Net funds at 31 Mar	**18,831**	**18,035**

16.3 Analysis of changes in net funds

	Net Funds at 1 Apr 2008 £000	Cash changes in year £000	Net Funds at 31 Mar 2009 £000
Commercial cash at bank and in hand	**16,815**	**(16,748)**	**67**
Office of Paymaster General cash at bank	**19,079**	**12,907**	**31,986**
Debt due within one year	**(4,594)**	**3,124**	**(1,470)**
Debt due after one year	**(11,030)**	**1,470**	**(9,560)**
Finance leases	**(2,235)**	**43**	**(2,192)**
Total	**18,035**	**796**	**18,831**

16.4 Third Party Assets

The Trust held £0.05m cash at bank and in hand at 31 March 2009 (31 March 2008—£0.05m) which relates to monies held by the Trust on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts.

17. Contractual Capital Commitments

Commitments under capital expenditure contracts at 31 March 2009 were £0.97m (31 March 2008—£4.60m)

18. Post Balance Sheet Events

There have been no post balance sheet events since the balance sheet date.

19. Contingencies

There were no contingent liabilities at the balance sheet date.

20. Related Party Transactions

Chelsea and Westminster Hospital NHS Foundation Trust is a public benefit corporation established by the order of the Secretary of State for Health.

Government Departments and their agencies are considered by HM Treasury as being related parties. During the period the Trust has had a significant number of material transactions with the Department of Health and with other entities for which the Department is regarded as the parent department. The main commissioners include Kensington and Chelsea PCT, Hammersmith and Fulham PCT, Westminster PCT and Wandsworth PCT.

In addition, the Trust has had a significant number of material transactions in the ordinary course of its business with other Government Departments and other central bodies. Most of these transactions are with HM Revenue & Customs in respect of deduction and payment of PAYE, NHS Pension Scheme in respect of pension contributions, NHS Logistics Authority and NHS Litigation Authority.

Income and expenditure relating to the above mentioned commissioners and other Government Departments and other central bodies is as follows:

	Income £000	Expenditure £000
Main Commissioners:		
Kensington & Chelsea PCT	**81,416**	273
Hammersmith & Fulham PCT	**23,886**	20
Westminster PCT	**16,266**	239
Wandsworth PCT	**17,823**	
Other Government Departments and central bodies:		
HM Revenue & Customs		37,432
NHS Business Services Authority		17,034
NHS Logistics Authority		4,663
NHS Litigation Authority		2,836

The Trust has also received income from Chelsea and Westminster Health Charity as donations towards revenue and capital expenditure. No funds are held in trust by Chelsea and Westminster Hospital NHS Foundation Trust but are held by the Trustees, who prepare their own annual accounts, as they are independent from the Trust.

None of the Board Directors, Members' Councillors, members of the key management staff or parties related to them have undertaken any material transactions with the Trust.

21. PFI Schemes

The Trust is not party to any PFI Schemes.

22. Losses and Special Payments

There were 81 cases of losses and special payments (2007/08—332 cases) totalling £0.28m (2007/08—£0.8m) for the year ended 31 March 2009.

23. Financial Instruments

FRS 25 (Financial Instruments: Disclosure and Presentation) and FRS 29 (Financial Instruments: Disclosures), require disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. The Trust does not have any complex financial instruments and does not hold or issue financial instruments for speculative trading purposes. Because of the continuing service provider relationship the Trust has with Primary Care Trusts and the way those Primary Care Trusts are financed, the Trust is not exposed to the degree of financial risk faced by business entities.

Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which FRS 25 mainly applies. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Finance and Investment Committee manages the Trust's funding requirements and financial risks in line with the Board approved treasury policies and procedures, and their delegated authorities.

The Trust's financial instruments comprise loans, finance lease obligations, provisions, cash at bank and in hand and various items, such as trade debtors and trade creditors, that arise directly from its operations. The main purpose of these financial instruments is to raise finance for the Trust's operations.

23.1 Categories of Financial Instruments

	31 Mar 2009 £000	31 Mar 2008 £000
Financial assets:		
Loans & receivables (including cash)	**43,013**	45,199
Assets at fair value through the I&E	**0**	0
Held to maturity investments	**0**	0
Total	**43,013**	45,199
Financial liabilities:		
Other financial liabilities (amortised cost)	**39,827**	40,796
Liabilities at fair value through the I&E	**0**	0
Total	**39,827**	40,796

23.2 Fair Values

	Book value £000	Fair value £000
Financial assets:		
Cash	**32,053**	**32,053**
Total	**32,053**	**32,053**
Financial liabilities:		
Finance leases obligation for more than 1 year	**2,145**	**0**
Provisions under contract	**440**	**440**
Loans due in more than 1 year	**9,560**	**9,560**
Total	**12,145**	**10,000**

As allowed by FRS 25, short term trade debtors and creditors measured at amortised cost may be excluded from the above disclosure as their book values reasonably approximate their fair values.

23.3 Liquidity and Interest Risk Tables

	Weighted ave. interest rate %	Less than 1 year £000	1–2 years £000	2-5 years £000	More than 5 years £000	Total £000
Financial assets:						
Non-interest bearing		**10,960**	**0**	**0**	**0**	**10,960**
Fixed interest rate instrument	**5.03%**	**32,053**	**0**	**0**	**0**	**32,053**
Variable interest rate instrument		**0**	**0**	**0**	**0**	**0**
Gross financial assets at 31 Mar 2009		**43,013**	**0**	**0**	**0**	**43,013**
Non-interest bearing		**9,305**	**0**	**0**	**0**	**9,305**
Fixed interest rate instrument	**5.59%**	**35,894**	**0**	**0**	**0**	**35,894**
Variable interest rate instrument		**0**	**0**	**0**	**0**	**0**
Gross financial assets at 31 Mar 2008		**45,199**	**0**	**0**	**0**	**45,199**
Financial liabilities:						
Non-interest bearing		**26,165**	**0**	**0**	**0**	**26,165**
Finance lease liability	**3.50%**	**125**	**129**	**408**	**2,470**	**3,132**
Fixed interest rate instrument	**4.74%**	**1,482**	**1,482**	**4,446**	**4,060**	**11,470**
Variable interest rate instrument		**0**	**0**	**0**	**0**	**0**
Gross financial liabilities at 31 Mar 2009		**27,772**	**1,611**	**4,854**	**6,530**	**40,767**
Non-interest bearing		**21,875**	**654**	**0**	**0**	**22,529**
Finance lease liability	**3.50%**	**121**	**125**	**397**	**2,610**	**3,253**
Fixed interest rate instrument	**4.92%**	**4,616**	**1,492**	**4,476**	**5,448**	**16,032**
Variable interest rate instrument		**0**	**0**	**0**	**0**	**0**
Gross financial liabilities at 31 Mar 2008		**26,612**	**2,271**	**4,873**	**8,058**	**41,814**

24. Interest-Rate Risk

100% of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. Chelsea & Westminster Hospital NHS Foundation Trust was not, therefore, exposed to significant interest-rate risk.

25. Liquidity risk

The Trust's net operating costs are mainly incurred under legally binding contracts with Primary Care Trusts, which are financed from resources voted annually by Parliament. This provides a reliable source of funding stream which significantly reduces the Trust's exposure to liquidity risk.

The Trust also manages liquidity risk by maintaining banking facilities and loan facilities to meet its short and long term capital requirements through continuous monitoring of forecast and actual cash flows.

In addition to internally generated resources the Trust finances its capital programme through a loan facility, while the working capital is backed by a committed facility of £20m, unused at 31 March 2009. Details are included in note 13.3.

26. Credit risk

Credit risk exists where the Trust can suffer financial loss through default of contractual obligations by a customer or counterparty.

Trade debtors consist of high value transactions with Primary Care Trusts under contractual terms that require settlement of obligation within a time frame established generally by the Department of Health. Other trade debtors include private and overseas patients, spread across diverse geographical areas. Credit evaluation is performed on the financial condition of accounts receivable and, where appropriate, sufficient prepayment is required to mitigate the risk of financial loss.

Credit risk exposures of monetary financial assets are managed through the Trust's treasury policy which limits the value that can be placed with each approved counterparty to minimise the risk of loss. The counterparties are limited to the approved financial institutions with high credit ratings. Limits are reviewed regularly by senior management.

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Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 17 September 2009

AGENDA ITEM NO.	2.9/Sep/09
PAPER	Presentation of Annual Report & Accounts 2008/09
AUTHOR	Produced in house by the Chelsea & Westminster Hospital NHS Foundation Trust
LEAD	Lorraine Bewes – Director of Finance & Information
EXECUTIVE SUMMARY	This report sets out the annual accounts for the year ended 31st March 2009 and the auditor's report thereon along with other statutory information required to be disclosed by NHS Foundation Trusts. This report was laid before Parliament in June 2009. In accordance with paragraph 28 of Schedule 7 of the Act and section 17.6 of the Constitution, this report is presented to the Members' Council.
DECISION/ ACTION	The Council is asked to adopt the report.

Deloitte.

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 to 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. A list of all reports issued to Trust management in relation to the 2008/09 audit is provided in Appendix 1.

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 Audit Code issued by Monitor. We have examined and assessed the 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.
Please see Appendix 2 for the key risks identified for the purposes of the audit, findings from our work and our conclusion thereon.

7. We were able to issue an unqualified (or 'clean') opinion on the Trust's accounts for the year to 31 March 2009 by 8 June 2009, 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.

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 2009 and only the key issues are summarised here. No significant audit adjustments were noted.

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

9. 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').

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

Deloitte.

Key recommendations

11. During the year we made a number of recommendations to the Trust for improving internal controls. These were discussed in detail with management and presented to the Audit Committee. Management have formulated an action plan for the implementation our recommendations and we will revisit this over the course of our next audit.

Analysis of Audit Fees

12. The professional fees earned by Deloitte in the period from 1 April 2008 to 31 March 2009 are £97,500. This fee represents solely our work in respect of our audit responsibilities as defined by the Audit Code for Foundation Trusts.

2009/2010

13. Given continued financial pressures across the NHS, especially in the current economic climate, the Trust needs to continue to focus on strict performance and financial management. We will continue to monitor this in the coming year.

14. All NHS organisations will be required to report under International Financial Reporting Standards ("IFRS") for the year ended 31 March 2010. There are expected to be a number of changes in the reporting requirements and accounting methods due to this change. We are currently working with the Trust as they progress through the transitional phase of conversion to IFRS.

    In order to prepare for the transition to IFRS, the comparatives for 2010, which is the year ended 31 March 2009, are being restated in accordance with IFRS. The financial statements for the year ending 31 March 2010 will be prepared under IFRS and finalised in the summer 2010.

Independence and objectivity

15. 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.

Deloitte.

Closing remarks

16. The letter was presented to the September 2009 meeting of the Members' Council, following discussion with the Director of Finance.

17. 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 LLP

10 September 2009

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.

Deloitte.

Appendix 1

Reports issued in relation to the 2008/09 audit

Report	Date Issued
Audit Plan	November 2008
Smart Benefit Review	November 2008
IFRS Opening Balance Sheet Arrangements Review	April 2009
ISA 260 Report to Audit Committee	June 2009
Annual Audit Letter	September 2009

Deloitte.

Appendix 2: Key audit risks

Within our audit plan that was previously presented to the Audit Committee, we discussed a number of key audit risks which were to be addressed during the course of our audit. We have presented below a discussion of our work in each of these areas:

Key Audit risk	Work done by Deloitte	Conclusion
Financial position of the Trust: The Trust reported a £14.6m surplus, after Public Dividend Capital dividend, for the year ended 31 March 2008, which exceeded a planned surplus of £5.5m. The Trust's budget for 2008/09 showed an anticipated surplus of £8.0m. The level anticipated was lower than the actual for 31 March 2008 due to the planned uses of surpluses and cash balances for the financial year. Within the Foundation Trust arena, where there is a high level of scrutiny from Monitor and other stakeholders, it will continue to be increasingly important for the Trust to perform well financially. Now the Trust has more freedom to operate independently and follow its own strategic objectives, it has become more important to be 'forward-looking' and for the Board to be reviewing and approving budgets and cash flow forecasts that are based on robust assumptions and are realistic in terms of expectations.	We have reviewed the financial performance of the Trust for the period under review through our audit testing. We have also considered the Trust's forecasts for future years as part of our going concern assessment.	The Trust has generated a surplus and has a strong reserves position. As part of our going concern review we have considered the 2009/10 plan and have concluded satisfactorily. Thus we have concluded that this risk was satisfactorily covered.
Planned uses of surpluses and cash balances: We understand from the Trust's 2008/09 annual plan that there was an approved budget of £37.2m for capital expenditure in 2008/09. Of this, £20.19m has been approved for building projects with key developments in specialist paediatrics, the relocation of the sexual health clinic to Soho as well as building works to convert ward space to single rooms. £6m has been approved for the purchase of medical equipment and £4.9m for IT projects including the support of Lastword system.	We have conducted a review of the repairs and maintenance expense in the year and agreed any items over a certain threshold to supporting documentation to ensure they have been correctly expensed/capitalised as appropriate. Also, for a sample of additions we have ensured that all appropriate costs have been capitalised by tracing costs to supporting documentation.	No issues were noted with our testing. Thus we have concluded that this risk was satisfactorily covered.
Revenue recognition: Under International Standards on Auditing (UK and Ireland) there is a presumed risk of fraud in revenue recognition. Given the importance of the payment by results regime we shall focus our testing on this area.	We have undertaken a walk through of a payment by results sale and tested a sample of invoices around year end by tracing back to supporting documentation. We have reviewed a sample of the contracts identified to ensure there are no issues in this area.	No issues were noted with our testing. Thus we have concluded that this risk was satisfactorily covered.
Agreement of balances of inter NHS debt: Although the Trust is not required to take part in the Agreement of Balances exercise, we recommend that the Trust continues to participate, to gain further assurance for your own purposes and also to assist with our audit testing in this area. Agreement of inter-NHS debtors and creditors, together with income and expenditure, is a labour intensive exercise. As in the most recent audit, we will consider the risks around recovery of debts and balances relating to over-performance.	We have reviewed a sample of inter NHS confirmation statements at 20/03/09; reconciliations were obtained for any differences. Additional testing was performed to test the movements between 20/03/09 and the year end. A review of cash received after year end was conducted where confirmations were not available for our sample.	No issues were noted with our testing. Thus we have concluded that this risk was satisfactorily covered.

Deloitte.

Level of provisioning of inter NHS debt: Judgement will be required to be applied when assessing the level of provisioning for NHS debt. NHS debtor balances totalled £6,026k of the £9,990k total debtors as at 31 March 2008, making it a material part of the total balance.	We have obtained a breakdown of the bad debt provision and agreed a sample to supporting documentation. We have reviewed the movement in the provision in comparison to changes in the debtor balance and recalculated debtor days. We have compared the level of the provision to that of other Trusts in the area.	No issues were noted with our testing. Thus we have concluded that this risk was satisfactorily covered. A disclosure deficiency was noted in the financial statements where the movements in the provision had been incorrectly disclosed. The adjustment was not material and therefore the Trust chose not to amend the financial statements.
Private patient cap and associated structuring: The private patient cap limits the amount of private patient work that Foundation Trusts can carry out in proportion to their total activity. The level of the cap is defined in each Foundation Trust's terms of authorisation as agreed with Monitor.	We have recalculated the private patient cap and agreed the disclosures in the financial statements.	No issues were noted with our testing. Thus we have concluded that this risk was satisfactorily covered.
Prudential borrowing code: The Code, as it applies to each Foundation Trust following authorisation by Monitor, requires the Trust to remain within their borrowing limit as well as meeting certain covenants, such as the various financial ratios which are reported to Monitor and disclosed in the annual accounts.	We have reviewed the returns to Monitor and recalculated the borrowing ratios to ensure that the Trust remains within the limits set out in The Code.	No issues were noted with our testing. Thus we have concluded that this risk was satisfactorily covered.
Notification of leavers: During our planning work a control weakness was identified in relation to the notification of leavers thus leaving to payroll overpayments.	We have conducted testing on a sample of March and April leavers to ensure validity and completeness of the payroll records. Leaving dates were agreed back to supporting documentation and we have ensured that payments were not made to the leavers after their leaving date.	No issues were noted with our testing. Thus we have concluded that this risk was satisfactorily covered.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 17th September 2009

AGENDA ITEM NO.	2.11/Sept/09
PAPER	Report of the Audit Committee
AUTHOR	Lorraine Bewes, Director of Finance and Information
LEAD	Andrew Havery, Non-Executive Director and Chair of the Audit Committee
EXECUTIVE SUMMARY	The NHS Foundation Trust Code of Governance (section F.3.2) provides that the Audit Committee should report to the Members' Council, identifying any matters in respect of which it considers that action or improvement is needed and to make recommendations as to the steps to be taken. This report outlines key Audit Committee activity for the financial year 2008/09. This was also reported to the Board of Directors in June 2009. It provides evidence for the assurances that have been made to the Board with regard to the Trust's risk management, internal control and governance processes being adequate and effective. The report summarises the external assurance received during the year from internal audit, external audit and the local counter fraud specialist and also identifies issues that have been noted for improvement in these areas. The opinion of the Committee was that the Trust's risk management, control and governance processes are adequate and effective and may be relied upon by the Board.
DECISION/ ACTION	The Members' Council is asked to note the report of the Audit Committee.

CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST

Report of the Audit Committee for financial year 2008/09

1.0 Introduction

1.1 The NHS Foundation Trust Code of Governance (section F.3.2) provides that the Audit Committee should report to the Members' Council, identifying any matters in respect of which it considers that action or improvement is needed and to make recommendations as to the steps to be taken.

1.2 This report outlines key Audit Committee activity for the financial year 2008/09. This was also reported to the Board of Directors in June 2009. It provides evidence for the assurances that have been made to the Board with regard to the Trust's risk management, internal control and governance processes being adequate and effective. The report summarises the external assurance received during the year from internal audit, external audit and the local counter fraud specialist and also identifies issues that have been noted for improvement in these areas.

2.0 Audit Committee's Opinion

2.1 The opinion of the Committee was that the Trust's risk management, control and governance processes are adequate and effective and may be relied upon by the Board. Assurance given can never be absolute. The highest level of assurance that can be provided is a reasonable assurance that there are no major weaknesses in the Trust's risk management, control and governance processes.

3.0 Information supporting Opinion

3.1 Summarised below is the key information / sources of assurance that the Committee has relied upon when formulating their opinion.

3.2 Internal Audit

3.2.1 The Head of Internal Audit has provided his opinion of the overall adequacy and effectiveness of the organisation's risk management, control and governance processes for the year ended 31st March 2009. The opinion was positive and concluded that:

'Based on the work undertaken in 2008/09, significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the inconsistent application of controls put the achievement of particular objectives at risk. The key risks and issues are:-

18 Weeks

Whilst our audit of 18 weeks identified that the 18 week target had been met by the Trust, a number of significant issues were identified in respect of both data validation processes and the use of predictive information to enable the Trust to better monitor the achievement against the 18 week target moving forwards. Testing undertaken identified weaknesses in the processes conducted by the Information Team with regards to the production of predictive information and analysis of any breaches of the target and an agreed action plan has been put in place to make these more robust and to consolidate the performance against the 18 week target.

NHSLA

At the time of our review of the evidence in place to support achievement of NHSLA Level 2, weaknesses were identified with regards to the quality of evidence available with regards to two areas; Corporate Induction and Training. Following our audit, sufficient actions were taken by the Trust to enable an overall pass to be achieved against Level 2, with a 95% pass achieved overall. The Trust has put in place an action plan in place to ensure that full compliance will be achieved in respect of these two areas in the future.'

3.2.2 Internal Audit has commented that the Assurance Framework has developed further from the version used in previous years and there is evidence that this process has been embedded throughout the Trust. This was further supported by Internal Audit's review of the Trust's Risk Maturity arrangements where the Trust is considered to be a risk managed organisation. Whilst a small number of improvements in the process were identified, no significant weaknesses in control were identified.

3.2.3 The Trust has been proactive in utilising Internal Audit resources to focus on areas of weakness or concern within the Trust. Examples of this include; 18 Weeks, NHSLA assessment process and Human Resources administration processes. Where recommendations have been made from audits, these have been accepted by the Trust, and actions taken to implement these.

3.2.4 The tables below show Chelsea and Westminster Hospital NHS Foundation Trust's performance for the 2008/09 year, benchmarked against the 2007/08 year. Whilst there has been a slight deterioration with regards to the average levels of assurance received during the year, this is not significant. The reason for this is due more to the Trust better focussing internal audit resources on areas of concern as opposed to a deterioration in the control environment.

Average Levels of Assurance

Assurance	Substantial	Adequate	Limited
2008/09	**63%**	**27%**	**10%**
2007/08	**66%**	**33%**	**0%**

Number of Recommendations

Recommendations	Fundamental	Significant	Merits Attention
2008/09	**0**	**1.42**	**2.42**
2007/08	**0**	**0.86**	**2.2**

3.2.2 For the year to 31st March 2009, the Head of Internal Audit considered that there were no issues that needed to be brought to the attention of Trust Management that he considered relevant to the Statement of Internal Control.

3.3 External Audit

3.3.1 The financial results for the period delivered a financial risk rating of 5, which provides an excellent Use of Resources rating by the Healthcare Commission for the financial year 2007/08, maintaining the excellent rating awarded in 2006/07.

3.3.2 The external auditors reported to the Audit Committee on 2nd June 2009 on the accounts prepared for the year to 31st March 2009 and a separate report to the Members' Council has been prepared under Agenda item 2.10. The external auditors issued an unqualified opinion and concluded that the accounts prepared to 31st March 2009 represented a true and fair view of the Trust's financial affairs and of the income and expenditure recorded by the Trust during the year. The accounts were approved at a special Board on 4th June and were delivered to Monitor within the required timescale (8th June).

3.3.3 During the audit, the external auditors observed a number of control weaknesses and unadjusted accounting errors. None of these issues was material in terms of signing off an unqualified opinion. The accounting errors have been corrected in 2009/10 accounts and all processes are being improved and will be followed up by the external auditor in the autumn.

3.3.2 Use of Resources: External audit are required to review the Trust's use of resources and to be satisfied that proper arrangements have been made for securing economy, efficiency and effectiveness in the use of resources. Their value for money review did not raise any issues and there were no significant points to note.

3.3.3 International Financial Reporting Standards (IFRS)

i. The Trust is moving to International Financial Reporting Standards (IFRS) for 2009/10. The first phase of this was to restate the 1st April 2008 opening balance sheet. The external auditors carried out a review of the arrangements the Trust put in place to restate the opening balance sheet. The review was based on a format developed by the Audit Commission for NHS Trusts and PCTs, which was recommended for use at Foundation Trusts by Monitor.

ii. No significant matters were identified and an overall assessment of 'Green' was reported by Deloitte based on the Audit Commission's

traffic light system for assessing the adequacy of the Trust's arrangements to support the transition to IFRS. However within this position 2 issues were amber rated:

a. the Trust had not gone through the detailed process of amending its accounting policies to comply with IFRS by the 31 December 08 milestone but since that date a high level review of accounting policies has been carried out and the changes to policies noted. The accounting policies have now been written and reviewed by the Director of Finance.

b. the Trust had not obtained formal confirmation from its valuers that the UK GAAP valuation as at 31 March 2008 remained appropriate under IFRS. The Trust's valuers have now confirmed that there is no material change resulting from the change to IFRS and have provided a formal opinion on the position. The Board, with authority delegated to the Chair of the Audit Committee, approved the certification to Monitor (submitted by 1st May 2009) that the Trust had gained assurance over this process.

iii. The next phase will require the restatement of the 2008/09 accounts (currently prepared under UK accounting standards) which will require submission to Monitor, following review by the external auditors, by 30th October 2009.

iv. As a result of a detailed review of the prospective figures for the 2009/10 revaluation it has come to light that the depreciation charge should be based on a residual value of 50% rather than nil at the end of the life of the building. This is a correction of an error and under IFRS as this is material it is being corrected from the earliest possible period and will result in a prior period adjustment. As a consequence the depreciation charge has been recalculated from April 2006, the date of the last valuation. The impact of this will reduce the annual charge for depreciation in 2009/10 and increase the carrying value of the buildings.

3.4 Other Committees

3.4.1 During the year, the Trust amended its assurance committee structure to disband the Facilities Assurance and Clinical Governance Assurance Committees and merge their responsibilities into one overall Assurance Committee. Therefore in addition to the Audit Committee there are two other committees which provide assurance to the Board. These are the Assurance Committee and the Finance and Investment Committee (FIC).

3.4.2 The Assurance Committee assures the Board that systems, processes and outcomes contribute to the Trust's aims and values and objectives, relating to patient safety and quality, safe and clean hospital environment and staff satisfaction and that there is evidence of robust governance and assurance processes in these areas.

3.4.4 The FIC assures the Trust Board on financial and investment policy issues, including oversight of material capital investment business cases. All these committee minutes are made available to the Audit Committee.

3.5 Local Counter Fraud Service (LCFS)

3.5.1 Each NHS body is required to take necessary steps to counter fraud under instructions from the Secretary of State's Directions. As a Foundation Trust, this is one of our contractual requirements with PCTs. The Trust has complied with these Directions by agreeing an Annual Service Level Agreement with Parkhill for the delivery of the Local Counter Fraud Service for 2008/09, which includes a proactive counter fraud programme to detect fraud as well as investigations in response to alleged frauds. The Audit Committee receives a regular report on progress against the agreed work plan and annual report.

3.5.2 The Counter Fraud and Security management Service (CFSMS) carries out an annual assessment of the strengths and weaknesses of Local Counter Fraud and bands NHS bodies into one of four compound indicators. The ratings achievable are designated 1 – 4, 4 being the highest. The Trust scored a level 2 in 2007/08, which is adequate performance. Within the CI document a level 2 is described as:

'Achieving rating level 2: adequate performance. To achieve level 2, completion of all or the majority of the tasks in the Compound Indicator (CI) Assessment document will need to be evident as these are basic requirements for achieving adequate performance'.

3.5.3 The Compound Indicator assessment for work conducted in 2008/09 has been submitted to CFSMS and will be confirmed later this year.

3.5.4 During the year, the Audit Committee has been concerned at the length of time for closure of some fraud investigations, particularly where this has involved staff on suspension on full pay. In response to this an independent review was carried out by the Interim HR Director on arrangements for co-ordinating effective and timely investigations and management arrangements have been tightened over the co-ordination between the Director of Finance, Director of HR and the LCFS on open investigations. Investigations are now RAG rated according to an expected timeline and draft performance indicators for the local counter fraud service were introduced at the end of the year.

3.5.5 Counter fraud arrangements are compliant with the Secretary of State's Directions.

3.6 Assurance Framework

3.6.1 The Audit Committee approved the process for developing the Assurance Framework for 2008-09 at the meeting in June 2008. The Assurance Framework was also presented and approved in June 2008. The Audit Committee confirmed that it accurately represented the key risks associated with the achievement of objectives for the trust.

3.6.2 Key gaps in control and assurance were identified in the Statement on Internal Control. The Assurance Framework is used to develop the audit strategy for internal audit.

4.0 <u>The Role and Operation of the Audit Committee</u>

4.1 Membership of the Committee

4.1.1 The members of the Committee during the period of the Report were as follows:

Andrew Havery (Chair of the Committee)
Charlie Wilson
Karin Norman

4.1.2 The members of the Committee disclosed their interests, which included the following, in the Trust's register of interests:-

Andrew Havery:

- Councillor, Westminster City Council
- Member of the Board of the CityWest Homes ALMO
- Vice Chair of Governors for Quintin Kynaston Specialist Technology College
- NHS Practice Management, Dr Lee's Surgery
- Finance Director, Mind Sports Olympiad
- SVP, Corporate and Finance, Millennium and Copthorne Hotels plc

Karin Norman:

- Trustee, Nursing and Midwifery Council and Associated Employers Pension Scheme
- Chair, MyGeneration (registered charity)
- Director, Raglan Capital Ltd

Charles Wilson

- Trustee of Addaction, currently vice-chairman. (Addaction is a leading drugs treatment charity)
- Non-Exec Director of the-racehorse.co.uk (a commercial online horseracing news site)
- Trustee Royal Naval Museum
- Member of the Board of the Countryside Alliance

4.1.3 The Committee was supported by Sue Stephens and Paulina Woodberry.

4.2 Operation of the Committee

4.2.1 Meetings and attendance

The Committee is required to meet quarterly in line with the terms of reference. Meetings took place during the period and were attended as follows:

	10th June 2008	**16th Sept 2008**	**20th Nov 2008**	**20th Jan 2009**	**18th Mar 2009**	**TOTALS**	
						No of meetings	**%**
Andrew Havery	*P*	*P*	*P*	*P*	*P*	*5/5*	*100%*
Karin Norman	*A*	*P*	*P*	*A*	*P*	*3/5*	*60%*

Charlie Wilson	*P*	*P*	*P*	*P*	*P*	*5/5*	*100%*
TOTAL	*67%*	*100%*	*100%*	*67%*	*100%*	*13/15*	*87%*

Key – P (Present for meeting) A (Absent from meeting) N/A (Not applicable)

The quorum for meetings of the Committee was 67%. As the table above shows all meetings of the Committee during the period were quorate.

4.2.2 Committee Self Assessment

The Committee has undertaken a self assessment as to its performance using the template recommended in the Audit Committee handbook.

4.2.3 Performance Indicators

During the year the Committee has established performance indicators for External Audit and has considered draft performance indicators for Local Counter Fraud Service. Performance indicators for Internal Audit are already in place and the Internal Audit Service reports on achievement of these indicators within each progress report. Performance indicators for assessing External Audit performance will be reviewed at the Audit Committee scheduled after the accounts are approved, at the September meeting. The Local Counter Fraud Service indicators will be reported in the regular progress reports.

We consider there are no issues about their performance that affects their ability to support this Committee in discharging its duties.

5.0 Conclusions

5.1 Based on the information presented and discussed at the Audit Committee meetings during the year we have concluded:

5.2 Risk Management

5.2.1 The Trust's system of risk management including adequacy of the risk identification, recording, reporting and monitoring arrangements is outlined in the Statement on Internal Control (SIC). The SIC was approved by internal and external audit.

5.3 Governance Arrangements

5.3.1 The Assurance Committee was established this year as agreed by the Board, with the first meeting being undertaken in November 2008. Other changes to the governance arrangements were also put in place, including formal reporting arrangements of key groups to the Trusts executive committees and then to the Assurance Committee. The Trusts Standing orders, Reservations of Powers to the Board and Scheme of Delegation, and standing Financial Instructions were reviewed and updated.

5.4 Standards for Better Health declarations

The Audit Committee noted that the core standards would be signed off by the Assurance Committee, as agreed by the Board as part of the terms of reference of the Assurance Committee. The Assurance Committee which includes members of the Members' Council reviewed all the assurance statements prepared by the executive directors and proposed the statremnet to the Board.

5.5 Statement on Internal Control

5.5.1 The Statement on Internal Controls (SICs) was produced for 2008/09. The SIC was approved by internal and external audit and its content was consistent with the conclusions above.

6.0 Recommendations

6.1. **The opinion of the Committee, based on the issues set out in the above report, is that the Trust's risk management, control and governance processes are adequate and effective and may be relied upon by the Board.**

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 17 September 2009

AGENDA ITEM NO.	2.12/Sep/09
PAPER	Re-appointment of the Auditor
AUTHOR	Lorraine Bewes, Director of Finance
LEAD	Andrew Havery, Non-Executive Director and Chair of the Audit Committee
EXECUTIVE SUMMARY	This paper reports on the outcome of the assessment of the work and fees of the auditors seeking re-appointment following the expiration of their term of office on 30th September 2009.
DECISION/ ACTION	The Council is asked to note the report and to approve the re-appointment as recommended.

Report on re-appointment of auditors

Name	**Deloitte**
Date of First Appointment	**1st October 2006 for Foundation Trust but prior to 2000 for predecessor NHS Trust**
End Date of Current Term	**30th September 2010**
Date of Assessment	**23rd July 2009**

Introduction

The Constitution of the Trust provides for the Members' Council to appoint the financial auditor at a general meeting.

Further guidance is given in the attachment *'Guide for Governors: Audit Code for NHS Foundation Trusts'.*

Results of Evaluation

The Audit Committee has assessed the work of the auditors and considers it to be of a sufficiently high standard and considers that the fees are reasonable.

However, before Chelsea and Westminster Hospital became a Foundation Trust in October 2006, Deloitte was the auditor of the predecessor Trust since at least 2000. Therefore there has been an association for at least 9 years. During this period, although there have been 3 different partners, Monitor recommends that the NHS foundation trust should undertake a market-testing exercise for the appointment of an auditor at least once every five years and best practice guidance dictates that we should market test.

It is important to note that Deloitte has confirmed that it has considered the APB ethical standard 3 'Long Association with the audit engagement' and is satisfied that their policies and safeguards ensure they are independent within the meaning of the all regulatory and professional requirements and that the objectivity of the audit partner and audit staff is not impaired.

Therefore it is the recommendation of the Audit Committee that the Members' Council approve the re-appointment of Deloitte as auditor for the year ending 31st March 2010 for a term of one year ending 30th September 2010 and that the audit for year ended 31st March 2011 should be market tested after the next audit.

Recommendation

The Members' Council is asked to approve the re-appointment of Deloitte as auditor for a term of one year ending 30th September 2010.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 17 September 2009

AGENDA ITEM NO.	2.13/Sep/2009
PAPER	Single Equality Scheme Action Plan
AUTHOR	Priti Bhatt, Equality and Diversity Manager
LEAD	Amanda Pritchard, Deputy Chief Executive and Equality and Diversity Lead
DECISION/ ACTION	The Members' Council are asked to note that there is a Single Equality Scheme action plan, and that their input is requested on any grammatical amendments or comments based on experience/knowledge of a particular area of equality strand by Thursday 8th October 2009. The Members' Council are also asked to volunteer representatives, ideally 4-6 to form a consultation task and finish group with Priti Bhatt, to review the action plan as above. The action plan needs to be complete by 9 October 2009 in preparation for submission to the Board. Copies of the action plan will be available at the meeting and can be provided in advance to any interested Council Members by contacting Priti Bhatt on 020 3315 8926 or email Priti.bhatt@chelwest.nhs.uk

Single Equality Scheme Action Plan

1.0 Introduction

This summary document outlines the rationale supporting the Single Equality Scheme action plan, which has been developed by the Trust's Equality and Diversity Manager to show how the Trust intends to meet the legal duties placed upon it by the Equality Bill (2006).

2.0 Background

The Equality Bill aims to simplify and strengthen the law on equality and is currently scheduled to come into effect from April 2010.

The Trust has consulted with staff, patients, and specialist interest groups such as Action Disability Kensington and Chelsea or Stonewall to ensure that barriers to access are addressed appropriately. A final draft Single Equality Scheme action plan will be submitted to the Trust Board for approval in October 2009. Once approved, the action plan will replace all existing scheme action plans on race, gender and disability.

The key objective areas in the action plan (listed below) will provide a focus for the Trust to concentrate its efforts on addressing equality and diversity issues over the next 3 years. These are:

1. Leadership, Corporate Commitment and Governance,
2. Equality Impact Assessments,
3. Partnership Working, Consultation and Involvement,
4. Accessibility and Communications,
5. Workforce and Training,
6. Commissioning and Procurement,
7. Monitoring Data, Reporting and Publishing,
8. Complaints

3.0 Decision/action required

The Members' Council are asked to note that there is a Single Equality Scheme action plan, and that their input is requested on any grammatical amendments or comments based on experience/knowledge of a particular area of equality strand by Thursday 8th October 2009.

The Members' Council are also asked to volunteer representatives, ideally 4-6 to form a consultation task and finish group with Priti Bhatt, to review the action plan as above. The action plan needs to be complete by 9 October 2009 in preparation for submission to the Board.

Priti Bhatt
Equality & Diversity Manager
8 September 2009

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 17th September 2009

AGENDA ITEM NO.	2.14/Sept/09
PAPER	Funding report and request for allocation for website development
AUTHOR	Part A - Dianne Holman, Interim FT Secretary Part B - Matt Akid, Head of Communications
LEAD	Matt Akid, Head of Communications
EXECUTIVE SUMMARY	This paper illustrates the drawdowns on the budget at Part A and at Part B presents a costed package of proposals which will enhance the Trust website as a key communications resource to market the Trust to patients and other key audiences and to recruit Foundation Trust members.
DECISION/ ACTION	The Members' Council is asked to note the unallocated fund and comment on the proposals and give its approval of the request for funding of website development.

Part A - Members' Council Funding Report

Background

In May 2008, a paper titled 'Members' Council Funding Criteria' was presented to the Members' Council setting out that it was agreed at the November 2007 Members' Council meeting that a recurring budget of £100,000 per financial year be made available to the Members' Council to spend at their discretion on relevant projects. This budget was made available as of the current financial year (1 April 2008 – 31 March 2009).

It also set out that Members' Council funding should be aimed at projects that benefit our membership or specifically patients and the care we provide them. A short business case should be made to this effect including both estimated expenditure and deliverables.

The recurring budget was adjusted in the following financial year (2009/10) for the effect of inflation which is estimated at £500 bringing the total budget available in 2009/10 to £100,500.

Use of Funds 09/10

Item	**Estimates (excl VAT)**
Annual budget 09-10	£100,500
Accrued 08/09 for approved expenditure	£15,079
Information Zone seating, screen & wing art	-£16,085
Information Zone Security Kiosk move	-£305
Recruitment Campaign for Open Day	-£2,574
Open Day	-£15,000
Residual Budget 09-10	**£81,615**
Less Agreed Allocation to 18/6/09	
Information Zone Security Frame to TV, Kiosk move, contingency, Project Management Fees	-£3,763
Recruitment Campaign for Annual Members' Meeting	-£2,574
Discharge Leaflets	-£8,200
Directory of Children's Services	-£19,817
Unallocated Budget 09-10	**£47,261**

The Members' Council is invited to discuss further proposals at Part B and any other proposals for 09/10 budget.

Part B - Development of the Trust website – funding proposal

1. Why does the Trust website matter?

1.1 Marketing the Trust to patients and the public (including existing and potential Foundation Trust members), GPs and other key stakeholders is crucial to the future success of Chelsea and Westminster in an era of Patient Choice.

1.2 A quality website is essential for Chelsea and Westminster to maintain and improve its reputation as a hospital of choice.

1.3 Although the internet still does not reach the entire population, the biggest consumers of healthcare – families and the over 50s – are online in large numbers and they expect to use the internet to find out information about NHS services as consumers of healthcare.

1.4 The Trust's 4 local PCTs are all in the top 10 nationally for broadband density which means that our local area has above average levels of internet usage.

1.5 The number of visitors to the Trust website each month has almost doubled in the last 4 years which demonstrates its importance as a marketing tool:

July 2005	12,986
July 2006	15,610
July 2007	18,559
July 2008	22,738
July 2009	25,434

1.6 A website with reliable, high quality information will help the Trust to achieve its corporate objectives – to improve the patient experience and to improve patient safety and clinical effectiveness.

1.7 The Trust website is also a key communications resource to recruit new Foundation Trust members and to communicate with existing Foundation Trust members.

2. How was the Trust website developed from 2005-2008?

2.1 The Trust website www.chelwest.nhs.uk was launched in February 2005. Development of the site was led by the Trust IT Department because the post of Head of Communications was vacant at the time.

2.2 Responsibility for the website transferred to the current Head of Communications when he joined the Trust in February 2006, with technical support provided by a Web Developer based in the IT Department.

2.3 Due to this limited resource, website developments initially focused on improving sections that statistics showed were most used by visitors – for example, HIV & Sexual Health, Maternity and Paediatrics.

2.4 This focused approach led to increased pageviews of all 3 sections following developments which took place from July 2007 onwards:

	July 2009	July 2008	July 2007
HIV & Sexual Health	21,856	17,327	7,594
Maternity	24,807	25,200	16,485
Paediatrics	4,406	3,474	1, 163

2.5 A further development of the website during this period was the launch of a dedicated section of the site for Foundation Trust members which includes profiles of Members' Council representatives, an online recruitment form, and key documents such as our Foundation Trust constitution.

3. How has the Trust website been developed from September 2008 to date?

3.1 The restructure of the Trust's Communications Department in September 2008 led to the appointment of a member of staff with responsibility for graphic design and web design. He has a key role in implementing proposed improvements to the Trust website, working closely with the Head of Communications and the Web Developer based in the IT Department who will provide technical support and advice.

3.2 A number of improvements been made to the website in the last 12 months:

- A new visual identity - consistent with the Trust brand for printed publications – has been piloted in the new 56 Dean Street section of the website and will be rolled out across the website by October 2009
- The website is now compliant with accessibility standards – for example, it has a tool which enables users to translate web pages
- A 'Healthcare Professionals' section of the website has been launched to target the key audience of GPs and other clinicians who may refer patients to Chelsea and Westminster
- The use of new technology is being piloted by making the new Paediatric DVD available for online viewing or downloading from the site
- A Trust Website Development Steering Group has been established to oversee improvements to the Trust website and the Trust's presence elsewhere on the web (ie Wikipedia and NHS Choices) – the Group met for the first time in September and it includes Members' Council representatives

3.3 These improvements have led to a 12% increase in visitors to the Trust website in the last 12 months.

3.4 Thousands of people already visit our website every month but the site has the potential to become a much more powerful and effective marketing tool for the Trust and to enable the Trust to recruit and retain more Foundation Trust members as part of our overall Membership Development and Communication Strategy.

3.5 A package of 3 costed proposals has been developed to realise this potential - funding is being sought from the Members' Council to make this possible.

3.6 This proposal was discussed and supported by the Members' Council Communications Sub-Committee at its meeting on September 3.

4. How are we proposing to improve the Trust website?

Site optimisation

4.1 Thanks to funding from the Members' Council in 2008, the Trust commissioned MediaCo, a web marketing company whose clients have included The Lancet, Scottish Enterprise and the British Council, to carry out a root and branch analysis of our website.

4.2 MediaCo produced a 'diagnostic' report analysing how easy or difficult it is to find specific information on the Trust website via search engines such as Google, what weblinks exist to and from other websites, and whether visitors can navigate our site once they have located it.

4.3 MediaCo made 5 key recommendations to optimise the website:

- Build text around a few key words or phrases to make it easier to find specific information on the site via search engines such as Google
- Avoid cramming too much text on each web page and use more key words
- Focus on the specific word or phrase that we want each page to rank highly for on search engines like Google
- Ensure all pages have unique, descriptive titles to make it easier for visitors to the site to find their way around
- Simplify individual URLs (website addresses) so that they are shorter, clearer and include key words or phrases we want to be ranked for on Google and other search engines

4.4 The Trust asked MediaCo to develop a proposal for site 'optimisation' (implementation), based on the 5 key recommendations of their site 'diagnostic', which includes:

- Copywriting of text based around key words or phrases that make it easier to find specific information on the site via search engines such as Google
- Copywriting of text to avoid cramming too much text on each web page and using more key words
- Working with the Trust to focus on the specific word or phrase that we want each page to rank highly for on search engines like Google
- Acquiring links to other websites because this is a key way of increasing traffic on sites
- Advising the Trust about how to ensure all pages have unique, descriptive titles to make it easier for visitors to navigate the site and how to simplify individual URLs (website addresses) so that they are shorter, clearer and include key words or phrases we want to be ranked for on Google and other search engines

4.5 The Trust would like to pilot a 12-month package of site 'optimisation' with MediaCo, focused on areas where patients can choose between a number of different hospitals and which we know are well used areas of the website – Maternity and Paediatrics.

4.6 The cost of a 12-month contract with MediaCo to carry out this work with Maternity and Paediatrics would be £7,000 (incl. VAT) – the HIV & Sexual Health directorate are funding a similar package for their area of the website from their own budget.

Staff training

4.7 We aim to create a network of 'web editors' throughout the Trust. These staff will be responsible for monitoring the content of their ward, department or specialty area of the website, and advising the Communications Department of updates, corrections and additional information. They will **not** be able to update the website themselves, this will continue to be done by the Communications Department.

4.8 'Web editors' will ensure ownership of the website by staff and should make it easier to keep information on the site up-to-date – they will be nominated or will nominate themselves through directorate and department representatives on the new Web Development Steering Group which includes Members' Council representatives.

4.9 Staff who volunteer to become 'web editors' will need help to develop the skills they require to produce information for the website which is consistent, of high quality and easily understood by patients and the public.

4.10 The Trust has asked a communications consultancy called Precedent, whose NHS clients have included NHS London, Royal Brompton & Harefield NHS Foundation Trust and the Foundation Trust regulator Monitor, to develop a proposal for staff training.

4.11 The cost of a 1-day 'Writing for the Web' course for 20 staff would be £2,000 – training for a network of 40 'web editors' would therefore be £4,000.

New technology

4.12 We want to use new technology including video and audio podcasts to make the website more accessible and user friendly – this has already been piloted by making the new Paediatric DVD available for online viewing or downloading from the site. This approach could also include video or audio interviews with Members' Council representatives talking about their role and the benefits of Foundation Trust membership in order to support recruitment of new members and retention of existing members.

4.13 The Communications Department requires specialist hardware and software to produce professional audio and video podcasts including:

Hardware

- Video camera - £800
- Headphones for audio/video editing - £170
- Microphone for audio podcasts - £50
- Microphone for video podcasts - £30
- Video editing tool - £30
- Keyboard for video editing - £120

Software

- Apple Final Cut Studio 2 (software package for audio and video podcast production) - £600

4.14 The total cost of this page of hardware and software is therefore £1,800.

5. Actions for decision by the Members' Council

5.1 The Members' Council is invited to comment on this costed package of proposals to improve the Trust website.

5.2 The Members' Council is asked for approval of this request for funding:

- Site optimisation - £7,000
- Staff training - £4,000
- New technology - £1,800
- **Total - £12,800**

Matt Akid
Head of Communications
September 2009

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members Council Meeting 17th September 2009

AGENDA ITEM NO.	3.1/Sep/09
PAPER	Finance Report – Four Months to July 2009
AUTHOR	Kelda Alleyne, Deputy Director of Finance
LEAD	Lorraine Bewes, Executive Director of Finance
EXECUTIVE SUMMARY	The financial position for the Trust as at 31st July 2009 is a surplus of £2.63m, which is £0.02m behind plan. The forecast is still that the financial plan will be achieved. Cash flow is £8.8m behind the plan. This is driven by an increase in debtors of £11.3m offset by a reduction in stocks and slippage in capital expenditure cash flow. The debtor increase relates largely to differences between plan of actual billing and collection of Q4 08-09 and Q1 09-10 PCT over performance and non contracted activities, however this is forecast to come back into line with plan at the end of Q2. The Board has approved a scheme for the expansion of paediatric facilities, the Netherton Grove building project, for £36.28m which will be phased over the next 3 years.
DECISION/ ACTION	The Members Council is asked to note the financial position for the period to 31st July 2009 and the updates in this report.

Financial Summary to July 2009

1. Introduction

1.1 This paper presents the financial position of the Trust for the first four months of 2009-10 focusing on the key issues for income and expenditure, cash flow and balance sheet in the month, year to date and year end forecast.

2. Overall Financial Position (Form F1)

2.1 The income and expenditure position to the end of July is a surplus of £2.63m, which is £0.02m behind plan as can be seen in the table below. The main reason for the deterioration in month is the over spend against pay budgets of £0.91m, split across all pay headings (Medical, Nursing and Other).

	Period to 31st July 2009			
	Budget £m	Actual £m	Variance £m	% Var
Income	100.95	103.55	2.60	2.6%
Expenditure	91.82	94.25	-2.43	-2.6%
EBITDA	9.1	9.3	0.2	
EBITDA Margin %	9.0%	9.0%		
Interest, Dividends & Depreciation	6.49	6.67	-0.18	
Surplus / Deficit (-ve)	2.64	2.63	-0.02	

2.2 The targeted CIP for the period to July is £3.3m and it has been assessed that £2.5m (77%) has been achieved against this target. The main elements of the total target that are considered to be high risk are the central Procurement target of £1.495m and the clinical income coding improvement target of £1.0m within the Medicine Directorate. Alternative plans are being worked up to cover the risk of these CIP targets not being met.

3 Income

3.1 NHS Clinical Contract Income

a) Summary

NHS Income from PCTs was slightly under plan in July (£0.06m adverse). The cumulative position for the four months in 2009/10 is ahead of plan by £1.8m, of which £0.624m relates to in year activity over performance and £1.159m reflecting a prior year income benefit.

The performance against planned contract income by point of delivery is shown in the following table and shows that activity at 545,880 is only 0.05% above plan. The £0.624m surplus which is 0.73% better than plan is due to higher than planned burns critical care bed days, recognition of additional excess bed day income, continued high A&E attendances, higher case mix in some areas and reclassification of single professional attendances to Multi professional attendances.

Activity Type	Currency	Activity Actual	Activity Variance Over/(Under) %	Surplus / (Deficit) July 2009 £000's
Elective (incls RDA, PSD)*	Spells/FCE's	12,023	(2.5)	(46.5)
Non Elective	Spells/FCE's	11,776	12.69	1,027.7
Critical Care – Adult	Bed days	928	0.06	61.6
Critical Care – Burns	Bed days	232	551.6	339.7
Critical Care - NICU/SCBU	Cot days	3,842	4.53	(55.5)
A&E attendances	Attendances	35,370	5.14	134.0
Outpatients(incls procedures and virtual clinics)	Attendances	142,779	(1.22)	(334.9)
Excess Bed Days	Excess bed days	6,255	1.21	208.8
Other	Tests , Tele calls and Provisions	332,675	(0.0)	(711.1)
Total for 2009/10		**545,880**	**0.05**	**623.9**
Prior Year		3,387		1,158.6
Grand Total		**549,267**		**1,782.5**

* RDA = Regular Day Attenders
* PSD = Procedures same day

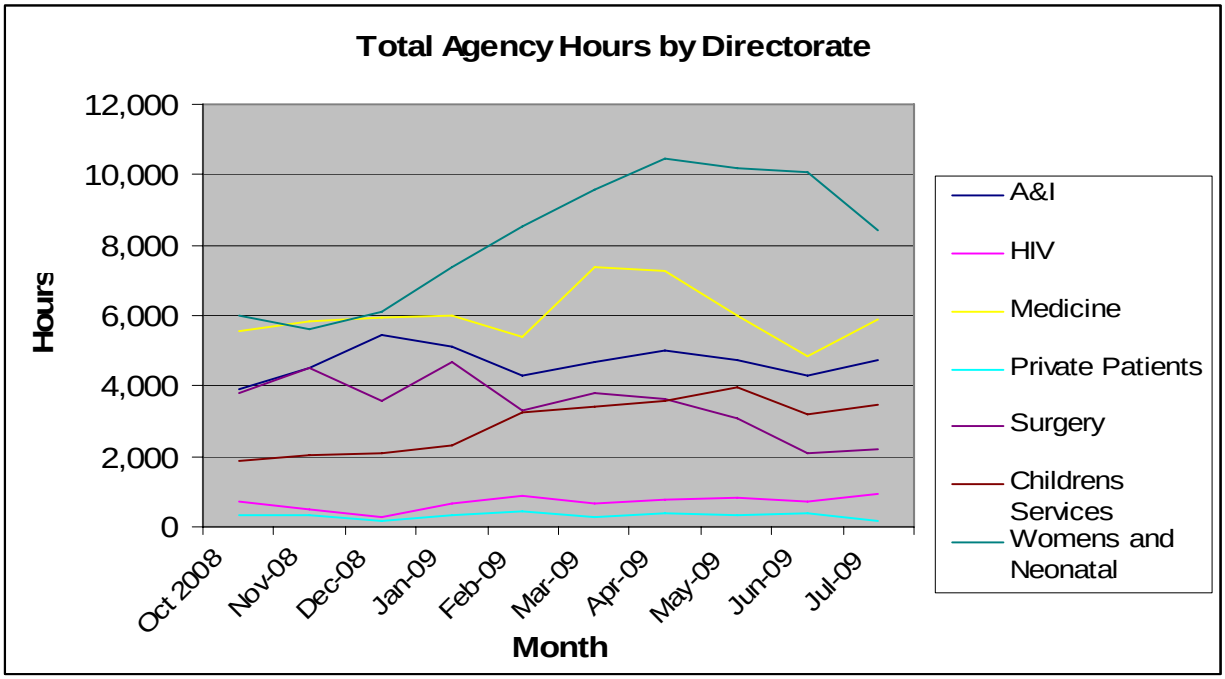
Non Contract Income
a) Summary
All other income outside of NHS Clinical Income is reported here and is represented in the table below.

Description	Budget Year to Date to M4 £000s	Actual Year to Date to M4 £000s	Surplus/(Deficit) Year to Date to M4 £000s
Other NHS Non Tariff Income (incl. charges to other NHS orgs)	281	311	30
Other Non-NHS Clinical revenue (incl. overseas visitors and royalties)	331	499	168
Private Patients	3,062	2,600	(462)
Research & Development	1,020	1,092	72
Education & Training	7,953	8,081	128
Misc Other Operating Income (incl. salary recharges, car parking, catering, etc.)	3,306	4,187	881
Total	**15,953**	**16,770**	**817**

4 Expenditure

4.1 A deficit of £0.39m is reported against expenditure budgets in July, reflecting an overspend of £0.9m on pay and a surplus of £0.5m on non pay.

4.2 The key focus is to reduce agency spend and eliminate use of non-PASA approved agencies. The graph below shows the trend of hours by Directorate over the period from October 2008 – July 2009:



4.3 In terms of medical pay there has been a deterioration in month of £0.14m, taking the YTD budget to an overspend of £0.464m.

4.4 The non-pay budget for the Trust is showing a positive variance of £0.51m in Month 4. Clinical supplies underspent by £0.23m in month and drugs (taking tariff and non tariff drugs together) underspent by £0.05m.

4.5 Balance Sheet

The key working capital key performance indicators are shown in the table below.

				Forecast	Plan
Working Capital KPIs	**Mar 09**	**Jun 09**	**Jul 09**	**Mar 10**	
Stock days	33	41	22	33	35
NHS Trade Debtor days	7	24	24	13	8
Non-NHS Trade Debtor days	13	9	7	12	21
Trade Creditor days	15	17	11	15	16
Liquid Ratio (days)	53	41	41	29	27
Return on Assets Employed	6.4%	5.7%	5.8%	5.2%	5.0%

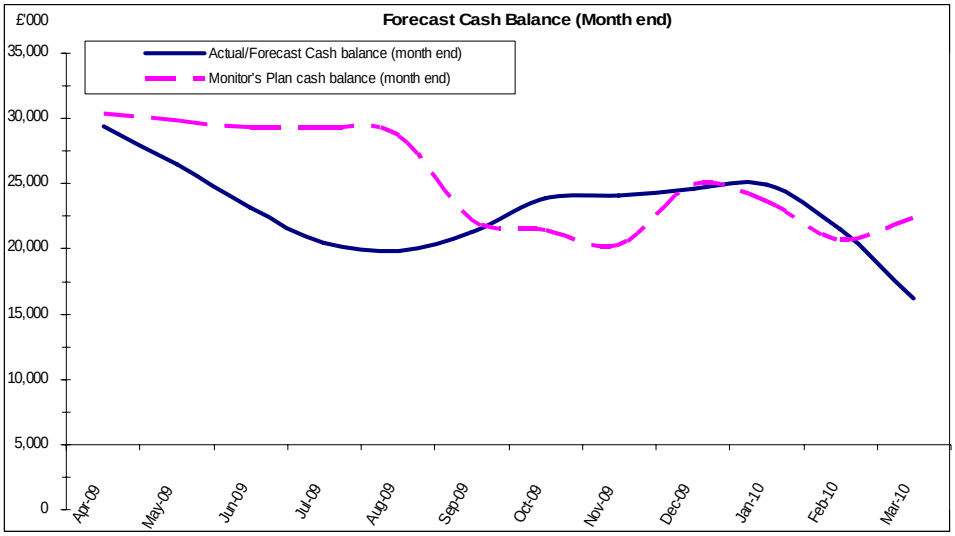
5 Cash Position

5.1 The cash position at the close of the month was £20.45m compared with the Monitor plan of £29.25m which is lower than plan by £8.80m. The table below shows the key variances from plan and the actions planned to ensure recovery of the cash position.

Cash Flow	YTD Plan	Explanation for variance and plan for recovery

	Variance(£m) (adverse)/ favourable	
Timing differences of PCT clinical and non-clinical acitivities income	(11.3)	Due to differences between plan of actual billing and collection of Q4 08-09 and Q1 09-10 over performance and non contracted activities: These account for £12m of NHS accrued income at end Month 4. However, this is forecast to fall in line with plan at the end of Q2 09-10.
Creditors and other financial liabilities	(3.0)	The increased creditor payments above plan are offset by planned release of deferred income at the start of the quarter which has not materialised, and further income has been deferred.
Capex under spend	3.0	Delay in approval of 2009/10 capital programme has led to late starts to new projects than planned.
Reduction in Stocks	2.4	£1.1m relates to a pharmacy stock write off; Balance of £1m is due to planning assumptions on increased pharmacy levels for increased activity not materialising. The planning assumption will be reviewed for next year.
Other	0.1	
Total Cash Flow Variance	(8.8)	

The graph below shows the actual/forecast cash balance for the financial year compared to the Monitor Plan:



5.1 In the above graph the increase in forecast cash compared to Monitor plan at end September is due to the expected collection of overperformance income, catching up on the monitor plan assumptions of prior months.

5.2 The year end forecast cash balance is £6m lower than Monitor plan. There is a small impact (£1.4m adverse) from not drawing down the £13m loan because the capital programme has similarly reduced in size (by £11.6m cash forecast). The remaining reduction is mostly (£4.2m) due to forecast increased activity over the year resulting in higher overperformance accruals at year end. In addition, in the latter part of the year the Trust is expecting to pay creditors ahead of plan in due to the introduction in 2009/10 of the CIP scheme to make early payment for a cash discount.

6 Capital Programme

6.1 The Capital Budget for the year advised to Monitor is £35.5m. However as at 31 July 2009 the budget has changed significantly. The revised budget for the year is £23.6m; within this is £8.0m of schemes carried forward from last financial year. The remaining budget of

£15.6m is for new projects, the largest of which is the Netherton Grove expansion and Paediatric development at £3.5m in 2009/10.

6.2 The Board has approved an expansion of paediatric facilities, the Netherton Grove Build project, for £36.28m. The majority of the expenditure will take place in 2010/11 and 2011/12.

7 Forecast

7.1 The forecast for the Trust is still that the financial plan will be achieved.

7.2 The key risks to achieving the planned surplus at year-end are the following:

- Directorates need to maintain control of expenditure on bank and agency staffing in order to achieve the planned surplus.

- The income forecast assumes that the activity plan is achieved for the remainder of the year with the exception of NICU and private patient activity. Further work is required to quantify if there are any changes in referral patterns to factor in, in relation to outpatients and elective work and to understand the strategic risks from any switch from elective to non-elective activity.

- The potential impact of a 'flu pandemic has not been factored into the forecast and this could have a significant adverse impact on agency spend and reduced elective and outpatient income. This will be modelled for next month.

Glossary of Terms

CIP: Cost Improvement Programme

Clinical Contract Income: Income from Primary Care Trusts (PCTs) for activity carried out by the Trust under agreed contracts.

Point of Delivery: Type of care, eg inpatient, outpatient or daycase.

Excess Bed Day Income: Income earned when patients stay in hospital longer than average for a particular procedure.

Elective: Planned Care (non emergency)

Non Elective: Emergency Care, e.g. ITU, Burns.

NICU: Neonatal Intensive Care Unit

SCBU: Special Care Baby Unit

Conversion Rate: The normal % of Outpatient or A&E attendances that become inpatient admissions.

Tariff: Nationally agreed price for a particular procedure.

PASA: NHS Purchasing and Supply Agency

Accrual: Accounting provision for liability where the goods or services have been received but the invoice has not yet been accounted for.

Acuity: Seriousness of a patient's condition

Locum: Temporary doctor covering vacancy or staff absence.

Working Capital: Assets available for use in the production of further assets, e.g. stock.

BPPC: Better Payment Practice Code

Deferred Income: Income received relating to a future period which is carried forward on the balance sheet.

IM&T: Information Management and Technology

Monitor: Regulatory body for NHS Foundation Trusts.

CHELSEA & WESTMINSTER HOSPITAL NHS FOUNDATION TRUST

FINANCE REPORTS

#REF!

CHELSEA & WESTMINSTER HOSPITAL NHS FOUNDATION TRUST

CONSOLIDATED INCOME & EXPENDITURE SUMMARY

TRUST WIDE

FORM F1
July 09

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										
NHS Clinical Contract Income	(22,079)	(22,018)	(61)	(85,000)	(86,784)	1,783	(253,571)	(253,023)	(257,758)	4,735
Other NHS non tariff	(52)	(31)	(21)	(281)	(311)	30	0	(904)	(1,067)	163
Other non-NHS Clinical revenue	(83)	(162)	80	(331)	(499)	168	(993)	(993)	(1,475)	482
Private Patient Income	(687)	(578)	(110)	(3,062)	(2,600)	(462)	(9,236)	(9,446)	(8,293)	(1,153)
Education & Training Income	(1,988)	(2,106)	118	(7,953)	(8,081)	127	(22,778)	(23,860)	(24,043)	183
Research & Development Income	(259)	(293)	34	(1,020)	(1,092)	71	(4,041)	(4,041)	(4,049)	8
Misc other operating income	(854)	(951)	97	(3,306)	(4,187)	881	(17,247)	(11,125)	(12,146)	1,021
TOTAL INCOME	**(26,003)**	**(26,139)**	**136**	**(100,954)**	**(103,553)**	**2,599**	**(307,866)**	**(303,392)**	**(308,831)**	**5,439**
EXPENDITURE										
Medical Pay - Bank & Agency	6	247	(240)	48	1,053	(1,005)		144	3,256	(3,112)
Medical Pay - Contracted	4,130	4,036	94	16,301	15,769	532		49,316	46,506	2,810
Nursing Pay - Bank & Agency	103	1,895	(1,791)	460	6,620	(6,160)		872	17,748	(16,876)
Nursing Pay - Contracted	4,988	3,887	1,101	20,071	15,523	4,548		61,136	47,924	13,212
Other Pay - Bank & Agency	73	696	(623)	141	2,511	(2,370)		286	5,434	(5,148)
Other Pay - Contracted	3,635	3,084	551	14,725	12,355	2,370		47,460	43,453	4,007
Sub-total Pay	**12,936**	**13,844**	**(908)**	**51,745**	**53,830**	**(2,085)**	**160,026**	**159,214**	**164,321**	**(5,107)**
Clinical supplies	2,588	2,360	228	10,356	10,662	(306)	32,126	30,599	32,122	(1,523)
Non-clinical supplies	3,186	3,230	(44)	12,592	12,083	510	40,289	37,874	38,073	(199)
Drug Costs - Tariff	2,747	2,699	47	12,995	13,891	(896)	46,967	37,177	40,762	(3,585)
Drug Costs - Exclusions	1,598	1,557	41	2,830	3,096	(266)		8,490	5,262	3,228
Education and training expense	72	55	17	293	176	117	869	874	828	46
Research & Development expense	298	72	226	1,010	516	494	1,019	2,848	1,087	1,761
Sub-Total Non Pay	**10,488**	**9,974**	**514**	**40,076**	**40,424**	**(348)**	**121,270**	**117,862**	**118,134**	**(272)**
TOTAL COSTS	**23,424**	**23,817**	**(393)**	**91,821**	**94,254**	**(2,433)**	**281,296**	**277,077**	**282,455**	**(5,378)**
EBITDA	**2,579**	**2,321**	**(257)**	**9,133**	**9,299**	**166**	**26,570**	**26,315**	**26,376**	**61**
EBITDA %	9.9%	8.9%		9.0%	9.0%		8.6%	8.7%	8.5%	1.1%
Depreciation	821	853	(32)	3,214	3,302	(88)	10,277	10,022	10,022	0
Interest Payable	56	53	3	224	221	3	741	742	742	0
Interest Receivable	(0)	(8)	8	(0)	(38)	37	0	(0)	(73)	73
PDC Dividend expense	763	763	0	3,051	3,051	0	9,152	9,152	9,152	0
Profit/Loss on Asset Disposal	0	0	0	0	135	(135)	0	0	135	(135)
SURPLUS / (DEFICIT)	**939**	**661**	**(279)**	**2,644**	**2,626**	**(17)**	**6,400**	**6,400**	**6,400**	**(0)**

Chelsea & Westminster Hospital NHS Foundation Trust

BALANCE SHEET

Responsibility: Finance Director

FORM F6
July 09

	Mar 09	Jun 09	Jul 09	Mar 10	
	Opening Balance	Prior Month Actual	Current Month Actual	Forecast	Monitor Plan
	£'000	£'000	£'000	£'000	£'000
NON-CURRENT ASSETS					
Property	257,395	256,422	255,964	264,922	277,718
Plant & Equipment	26,589	27,214	26,820	32,192	30,295
Assets under construction	5,256	7,490	9,144	5,763	6,732
	289,240	291,127	291,928	302,876	314,746
CURRENT ASSETS					
Inventories	6,588	5,755	5,157	7,134	7,684
NHS Trade Receivables	6,565	17,610	18,364	9,679	5,971
Non NHS Trade Receivables	3,587	2,936	2,655	2,936	5,233
Allowances for Receivables Impairments	(2,574)	(2,302)	(2,252)	(1,755)	(2,690)
Other Receivables	3,069	3,513	3,738	3,858	2,510
Accrued income	312	345	591	682	559
Prepayments	458	1,073	983	872	761
Cash and Cash Equivalents	32,053	23,141	20,450	16,201	22,287
	50,058	52,070	49,686	39,607	42,313
CURRENT LIABILITIES					
Borrowings	(1,470)	(1,470)	(1,470)	(1,470)	(2,402)
Finance Leases	(47)	(154)	(155)	(163)	(164)
NHS Trade Creditors	(7,798)	(7,912)	(4,691)	(7,411)	(7,922)
Non NHS Trade Creditors - revenue	(3,187)	(5,141)	(4,260)	(4,012)	(4,356)
Other creditors	(7,250)	(6,586)	(6,696)	(6,485)	(7,501)
Capital Creditors	(1,076)	(981)	(1,303)	(2,362)	(2,728)
PDC Dividend creditor	-	(2,288)	(3,051)	-	-
Interest Payable Creditor	-	(135)	(180)	-	-
Accruals	(10,036)	(7,706)	(8,258)	(7,776)	(8,130)
Deferred income	(5,660)	(2,186)	(2,437)	(1,700)	(280)
Provisions	-	(89)	(96)	(22)	(22)
	(36,524)	(34,649)	(32,597)	(31,401)	(33,503)
Net Current Assets/(Liabilities)	13,534	17,421	17,089	8,205	8,810
Total Assets less Current Liabilities	302,774	308,548	309,016	311,081	323,555
NON-CURRENT LIABILITIES					
Borrowings: FTFF - £12.5m facility	(9,560)	(9,560)	(9,560)	(8,090)	(8,090)
Borrowings: FTFF - £27m facility	-	-	-	-	(12,069)
Finance Leases	(2,145)	(2,621)	(2,455)	(2,463)	(2,463)
Deferred income	-	(3,400)	(3,400)	(3,400)	(3,822)
Provisions	(440)	(420)	(406)	(390)	(390)
	(12,145)	(16,001)	(15,821)	(14,343)	(26,834)
Total Assets Employed	290,629	292,548	293,195	296,738	296,722
TAXPAYERS EQUITY					
Public Dividend Capital	162,549	162,549	162,549	162,549	162,549
Revaluation Reserve	91,320	91,320	91,320	91,320	91,320
Donated Asset Reserve	7,472	7,426	7,412	7,180	7,164
Retained Earnings	29,289	31,254	31,915	35,689	35,688
Total Taxpayers' Equity	290,629	292,548	293,195	296,738	296,722
Committed Working Capital Facility	20,000	20,000	20,000	20,000	20,000

KPIs

Stock days	33	25	22	33	35
NHS Trade Debtor days	7	24	24	13	8
Non-NHS Trade Debtor days	13	9	7	12	21
Trade Creditor days	15	17	11	15	16
Liquid Ratio (days)	53	40	41	29	27
Return on Assets Employed	6.4%	5.7%	5.8%	5.2%	5.0%

Council of Governors meeting 17 September 2009

AGENDA ITEM NO.	3.2/Sep/09
PAPER	Performance Report
LEAD EXECUTIVE	Lorraine Bewes – Director of Finance and Information
AUTHOR	Mohammad Wasim – Interim Information Manager Contact Number: 020 8237 2426
SUMMARY	The purpose of this report is to update the Board on the Trust's service performance for the period ending 31st July 2009. We are on track to meet all Monitor targets and submitted the first quarter's performance return to Monitor at the end of July. This return did not highlight any issues and the trust expects to fully meet all Monitor targets. The ratification for the Care Quality Commission (CQC) 2008/09 annual health check: financial management is now complete; from this initial ratification the trust should receive an 'excellent' rating for the financial management of the trust. The CQC made a further release of guidance on the 12th July 2009 for measuring performance targets in the financial year 2009/10. Much of this release reinforced the targets already in place; however the CQC has reinstated three targets that will be discussed in section 3. In terms of the CQC targets for 09/10 we are currently on track for an "Almost Met" rating for the existing indicators and a "Fully Met" for the national priorities. The Almost Met in the existing indicators is due to data quality on ethnic coding being below the target, the six outpatient 13 weeks breaches in May and two 28 day cancelled operations breaches. We expect the outpatient 13 weeks indicators to be fully met by the end of August, the 28 day cancelled ops also to be fully met by the end of August and patients are being contacted for us to record data on their ethnicity retrospectively. We have until the 22 January 2010 to update the data warehouse with correct ethnic codes. 79% of discharge summaries are completed within 24 hours. From July 2010 the target is 100% discharge summaries being completed and sent within 24 hours. Recent performance has been closer to 84% over the last few months. IT are looking into the usability of the discharge summary screens on LastWord and the Directorates are being asked to provide an updated plan on meeting the 24hour targets for next year.
BOARD ACTION	The Trust Board is asked to note the report.

DISTRIBUTION	Board only ☐	Directors ☐	Trust Exec ☒	General ☐

LEGAL REVIEW EQUIRED?	No

PERFORMANCE REPORT FOR THE PERIOD July 2009

1. PURPOSE

1.1 The purpose of this report is to provide information about the Trust's performance for April to July 2009/10. The Trust Board is asked to note the report and conclusions.

2. CONTENT OF PERFORMANCE REPORT

2.1. The attached performance report comprises of the following components

- **Monitor Indicators**
- **Care Quality Commission Indicators**

3. SUMMARY OF PERFORMANCE REPORT

MONITOR

In July the Trust met all Monitor targets that can currently be measured.

3.1 The MRSA screening target is new this year, it measures the number of elective admissions we have in a month and the number of MRSA swabs we do. If the ratio for swabs against admissions is greater than 1 then the target is met. The MRSA screening ratio was 1.33.

3.2 There were 3 cases of MRSA bacteraemia up to the end of July against a threshold of no more than 6.3 cases in that time. There were 2 occurrences in July. The first occurred in the AMU; the patient was admitted on the 7th July and had various IV drips. The patient was tested for MRSA on the 9th July and proved positive, this was a hospital acquired case. The second patient came in on the 15th July form St Georges nursing home he had been unwell for a number of days. The test for MRSA was done in the Emergency department on the15th; this is a community acquired case.

3.3 The number of C Diff cases was below the target in July. There have been 12 cases so far this year against a maximum target of 36 in that time.

3.4 Monitor have confirmed that the target for the new 2 week wait for urgent referral cancer standard is 93%. Our performance in July was 94.33%. There have been 8 breaches of this target in July, six skin, one Urology and one Colorectal. All of

these breaches occurred because of patient choice; four of the patients were booked to go on holiday and couldn't come to their appointments. July's position is lower than previous months as it is the first major holiday period since the change in rules. The quarter one position was 97.88%.

3.5 The Department of Health announced details of the operational standards for existing and new commitments to cancer waiting times. Alongside the introduction of the new commitments from the Cancer Reform Strategy, a decision was taken to align the monitoring of cancer waiting times with the existing 18 weeks data collection methodology, with the consequence that the previous thresholds required to assess performance against 31- and 62-day commitments are no longer valid

The new thresholds, and our approach, are outlined below.

Targets – weighted 1.0 (national requirements)	**Threshold**	**Weighting**	**Monitoring period**
62-day wait for first treatment from urgent GP referral to treatment: all cancers	85%	1.0	Quarterly
62-day wait for first treatment from consultant screening service referral: all cancers	90%	1.0	Quarterly
31-day wait for second or subsequent treatment: surgery	94%	1.0	Quarterly
31-day wait for second or subsequent treatment: anti cancer drug treatments	98%	1.0	Quarterly
Targets – weighted 0.5			
31-day wait from diagnosis to first treatment: all cancers	96%	0.5	Quarterly
Two week wait from referral to date first seen: all cancers	93%	0.5	Quarterly

Table 1: New Cancer targets

Implications for Monitor's regulatory framework are as follows:

- These targets come into effect with immediate effect and NHS foundation trusts will be required to declare and will be scored against them at Q2;
- The two national requirements – the 62-day referral to treatment target and the 31-day wait for second or subsequent treatment target – include two thresholds. Failure of either or both thresholds will represent a single failure of the target, and this failure will be scored 1.0 under our service performance scoring framework

3.6 In quarter two we are at 100% for 62 day wait for first treatment for all cancers and 97.44% for the 31 day diagnosis to treatment standard, the trust has had one Skin breach. Processes are being put into place to measure the new cancer targets and these will be reported on in the next report. Our A&E performance year to date is 98.47% (98% target).

3.7 18 week Trust level performance was met in July with 99.20% in non-admitted and 95.59% in admitted. In quarter 2 we have had no breaches of this target at speciality level. The 18 weeks target remains unchanged for Monitor. Section 4

sets out the prediction of performance for next month. Specialty level performance will be measured by Monitor next year.

3.8 Care Quality Commission

The Care Quality Commission has published the first and second phases of the 2009/10 periodic review indicator constructions, which have now been formally approved. The remaining indicator constructions will be published as soon as they are approved.

Existing commitments indicators

3.9 We are on track to receive an 'Almost Met' rating for the Existing Commitment indicator group. This is mainly due to the Data quality on ethnic coding remaining below the target, six breaches in the outpatient 13 week standard and the two 28 day cancelled operations breaches. Despite these issues, we forecast a rating of 'Fully Met' for year end.

3.10 The Trust's performance for data quality for ethnicity for July is 93.8% against a target of 95%. A 'mail shot' is being sent out by the medicine directorate to update as many records as possible. Medicine account for 781 of the 1564 missing records; the majority being on George Watts and Kilmartin wards. Day surgery and Saturn ward account for another 280 between them. Anne Stewart ward had 1771 patients passing through their doors and they managed to record ethnicity for 98.25% of their patients. Similarly for the Medical Day Unit 2461 admissions with 98.09% recording. This indicator is now being discussed at the Data Quality meeting and new methods of updating the records in real time are being sought.

3.11 We have no further breaches of the 13 week standard in July and we are only 0.003% over the target at 0.033%; if we do not have any breaches in August we will again be meeting this target by the end of August.

3.12 We have had no further 28 day cancelled operation breaches in July and performance YTD is 94.59% compared to a target of 95%; if we do not have any further breaches in August we will be back within target by the end of August.

3.13 The performance to date for cancelled operations by the hospital for non-clinical reasons is 0.39% (against a target of no more than 0.8%).

3.14 Our Performance for the Rapid Access Chest Pain Clinics in July was 100%, compared with an expected threshold of 98%.

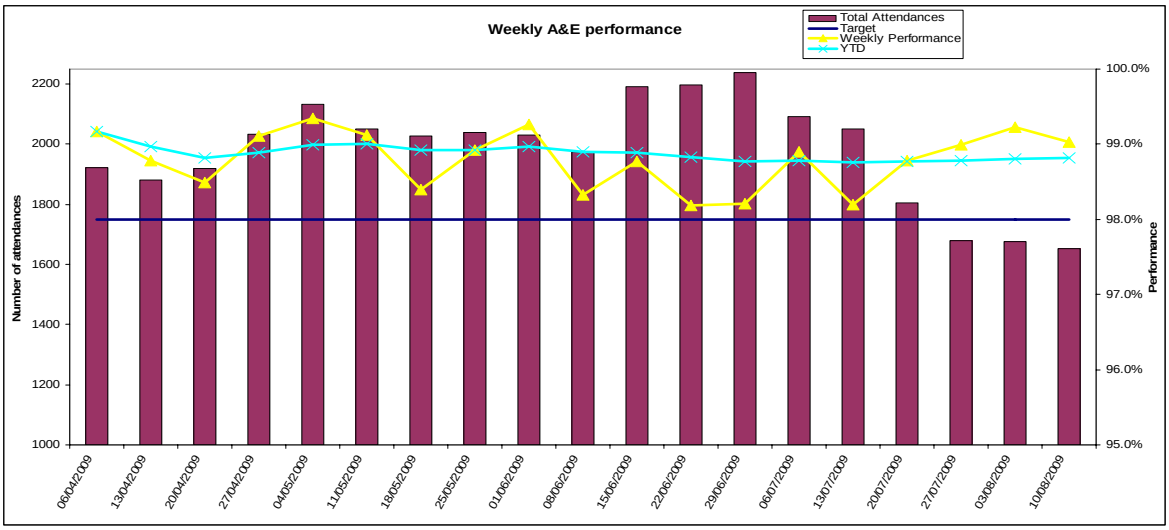
RACPC REFERRALS			
	Total number of patients	**% Complete**	**Patients seen within the target**
April	39	100.00%	39
May	28	100.00%	28
June	25	100.00%	25
July	25	100.00%	25
Total	92	100.00%	92

***Table 2**. RAPC analysis*

3.15 The Trust's performance for Access to Genito-Urinary Medicine (GUM) clinics within 2 days year to date is 100%.

3.16 The Trust's performance against the delayed transfer of care target continues to be good. In July the cumulative performance was 1.58% against an expected threshold of 3.5%.

3.17 Our performance for waiting times in A&E in less than 4 hours is 98.63% for April to July. The number of A&E attendances has returned to normal at the end of July and in the beginning of August which has meant performance has improved. This rise was attributed to the swine flu situation and the very hot weather.



Graph 1 A&E attendances and performance

New National Priority indicators

3.18 For the new national priority targets (we can track) we are on course to receive a "Fully Met" rating. There have been some changes to the guidance in the last month and the CQC have reinstated three targets that they had previously omitted. The three targets are: Engagements in clinical audits, Participation in heart disease audits and Time to reperfusion for patients who have had a heart attack. The CQC have not published the construct of these indicators yet but we do not expect them to change from last year. Last year the Trust submitted information on the Engagement in clinical audits and participation in heart disease audits, we expect to submit the same audits this year.

3.19 Our performance to date on data completeness for breastfeeding initiation to date is 100% (against a target of 95%) and data completeness for smoking during pregnancy to date is 99.01% (against a target of 95%). Failure to meet data completeness would mean the two standards below would not be assessed.

3.20 We have 0.73% less mothers smoking than last year and the target is to have less than last year. Last year, we had 4.81%, this year (YTD) we have 4.08%

3.21 3.1% more mothers are known to initiate breastfeeding at delivery than last year. Performance is not allowed to worsen against last year by more than 5%.

3.22 Access to healthcare for people with a learning disability is the new target. The Trust's position is not yet confirmed. Assessment is being undertaken by the equality and diversity group and should be complete by the end of September. This indicator will not be included in the scored assessment for 2009/10. However, the Trust will be expected to collect the requisite information and report on it separately and the CQC will publish this along side the results of the review to ensure visibility.
The Trust will be assessed on the responses to the six questions, based on the recommendations set out in 'Healthcare for all' (2008) – the Independent Inquiry into Access to Healthcare for People with learning Disabilities.

The scoring guide for all questions (except question 2) is as follows:

(1) = Protocols/mechanisms are not in place.
(2) = Protocols/mechanisms are in place but have not yet been implemented.
(3) = Protocols/mechanisms are in place but are only partially implemented.
(4) = Protocols/mechanisms are in place and are fully implemented.

1. Does the trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients? (1-4)

2. In accordance with the Disability Equality Duty of the Disability Discrimination Act (2005), does the trust provide readily available and comprehensible information (jointly designed and agreed with people with learning disabilities, representative local bodies and/or local advocacy organisations) to patients with learning disabilities about the following criteria:

- treatment options (including health promotion)
- complaints procedures, and
- appointments

Scoring:
1. Accessible information not provided
2. Accessible information provided for one of the criteria
3. Accessible information provided for two of the criteria
4. Accessible information provided for all three of the criteria.

3. Does the trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities, including the provision of information regarding learning disabilities, relevant legislation and carers' rights? (1-4)

4. Does the trust have protocols in place to routinely include training on learning disability awareness, relevant legislation, human rights, communication techniques for working with people with learning disabilities and person centred approaches in their staff development and/or induction programmes for all staff? (1-4)

5. Does the trust have protocols in place to encourage representation of people with learning disabilities and their family carers within Trust Boards, local groups

and other relevant forums, which seek to incorporate their views and interests in the planning and development of health services? (1-4)

6. Does the trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports? (1-4)

The Trust's Nursing director has asked a working group to do a gap analysis on which of these indictors we are currently meeting and which we are missing. This work has just begun and there will be more detail about the action plan and the level of assurance offered to the Board in next months report.

3.23 The Stroke indictor has been simplified; there are now only two parts to the indicator. The first looks at the percentage of stroke patients who are treated in the stroke unit. The trust performance year to date for this indicator is 97.01% against a target of 70% as set in the Vital Sign's framework for PCTs.
The second is the percentage of Transient ischaemic attack (TIA) cases with a higher risk of stroke who are treated within 24 hours, the trust's year to date performance is 40% against an expected target of 45%; there were no cases that could be included in July. These targets are set by the Department of Health and are expected to rise each year to push up performance throughout the NHS

3.24 Our performance against patients first seen by a specialist within two weeks when urgently referred by their GP or dentist with suspected cancer, April 2009 to March 2010, year-to-date (until July) is 96.82% against a target of 93% (subject to target publication).

Our Performance for the two 31 day cancer targets, patients receiving their first definitive treatment within one month (31 days) of a decision to treat (as a proxy for diagnosis) for cancer and patients receiving subsequent treatment (surgery and drug treatment only) within one month (31 days) of a decision to treat for July was 100% and 97.44% respectively. The year to date position for these two targets was 98.22% and 97.97%.

There are three 62 day cancer targets: Patients receiving their first definitive treatment for cancer within two months (62 days) of GP or dentist urgent referral for suspected cancer, secondly patients receiving their first definitive treatment for cancer within two months (62 days) of urgent referral from a consultant (consultant upgrade) for suspected cancer and thirdly patients receiving their first definitive treatment for cancer within two months (62 days) of urgent referral from the national screening service. Performance for the first two targets during July was 100% for both targets and the Trust did not have any direct referrals for the 62 day national screening target.

4. 18 WEEK ACTIVITY (awaiting update)

4.1. 18 week performance for Quarter

	July	August	September	Q1 Total
Admitted performance	**95.59%**			**95.59%**
Non-Admitted performance	**99.20%**			**99.20%**
Admitted speciality breaches	**0**			**0 (calculated average score)**
Non-Admitted speciality breaches	**0**			

4.2. 18 week performance for July 2009

	Treated within 18 weeks		Not treated within 18 weeks		Total volume	Unknown clock start date volume	Data Completeness
	%	Volume	%	Volume			
Admitted	**95.59**	1148	4.41	47	1201	2	**91.89 %**
Non-admitted	**99.20**	11018	0.80	86	11107	0	**92.55 %**

4.3. Predicted 18 week performance for August 2009

	Treated within 18 weeks		Not treated within 18 weeks		Total volume	Unknown clock start date volume
	%	Volume	%	Volume		
Admitted						
Best Case	**94.10**	1021	5.9	64	1085	
Worst Case	**93.18**	1011	6.82	74	1085	

4.4. The Access policy has been signed off by the PCT and Trust Executive and is currently being rolled out in admissions, with outpatients the next phase in September

4.5. The central validation team in now in place and achieved the validation of all admitted patients in mid August. Non-admitted validation has not been completed on schedule, mainly due to the number of 'pop-ups' that are occurring on a weekly basis. A revised plan has been put in place to achieve the outstanding validations by the end of September and the implementation of the pathway based PTL will reduce the number of weekly 'pop-ups' in future. Service Level Agreements between the Validation Team and the Directorates are being signed off to ensure appropriate response and escalation at operational level

4.6. Whilst we have very good performance from quarter one at specialty level (2 specialties out of 36), there has been no further details published on thresholds for the specialty level indicator at the end of the year. The Directorates are working to ensure no specialties breach in further quarters but this presents a challenge where capacity or volumes are outlying or inconsistent.

4.7. The Trust has implemented the pathway based PTL at the beginning of September and is running it in parallel with the current PTL. This will help ensure that we are able to pro-actively manage patients through their pathway from referral to treatment. It is also necessary to enable the Trust achieve the 5 day reporting standard that will be required from January 2010.

4.8. The central implementation plan for 18 weeks is being overseen by an Executive level steering group to ensure continued progress

5. DISCHARGE SUMMARY TARGET

5.1. The July 2009 Monthly Discharge Summary target performance dropped to 79.96% from 84.35% the previous month.

5.2. Performance on discharge summary completion 100% within 48 hours for the month of July was 84.62% for inpatients and 81.96% for daycases.

5.3. From July 2010 the target is 100% discharge summaries being completed and sent within 24 hours. We are currently at 79.64% within 24 hours. Daily discharge summary reports continue to be circulated to the directorates and this percentage is expected to increase as managers ask clinicians to 'step up' the efforts to record all discharges within 24 hours.

6. CHOOSE AND BOOK

6.1. Slot availability is measured by the proportion of bookings where there were no slot issues and the appointment was made successfully. In 2008/09 the target was 80%. Average performance for the year to date is 69.43% and July was 66.3%. This is being investigated as part of demand and capacity analysis led by the Director of Operations.

6.2. The number of services that are on C&B as directly bookable was 87% at the end of July. (The target for this indicator in 2008/09 was 60%).

7. EFFICIENCY (AND OTHER TARGETS)

7.1. At the end of July 98.26% of clinical coding was being completed within the 7 day target. The internal target for the year is 98%.

7.2. Efficiency and Use of Resources –

- The Trust's daycase rate is 75.2% in July 2009. The target for the year is 73%. Benchmark data shows that for October to December 2008 the national average was 73.34% with the top 25% of Trusts scoring over 79.45%.
- Elective average length of stay year to date is 3.05 (against a target of 3.00) and non-elective average length of stay year to date is 3.18 (against a target of 4.00).

- The percentage of outcomes recorded in outpatients is at 91.1% compared with 94.5% for the previous year. The outcomes performance is now circulated both daily and weekly and discussed at the general managers meetings and data quality meetings weekly and monthly respectively.
- The theatre improvement project is now in progress and updates of the project and improvements in performance are expected soon and will be reported to the Board through this report.

8 HUMAN RESOURCES PERFORMANCE

8.1 Key HR Metric targets have been proposed for this financial year are outlined below:

HR Metric	Target	2008/2009	Year to Date
Turnover rates	14%	16.71%	**14.49%** (rolling 12mths : Aug 08 – Jul 09)
Stability rates	97%	95.9% (excluding Jnr Drs)	**96.9%** (excl Jnr Drs : rolling 12mths : Aug 08 – Jul 09)
Vacancies:			
total	10%	12.28%	**15.54% avg**
active	4%	n/a	**3.19% avg**
Sickness absence rates	3.75%	3.70%	**2.96% avg**

8.2 .For the financial year 2008/09 the Trust achieved the following rates:

Sickness: Total Trust sickness was **3.70%;** this is the lowest annual rate of the last 3 years.

Turnover: Total Trust turnover for the 08/09 was **16.71%**, this is up 1.56% from last year.

Vacancies: The average Trust vacancy rate for 08/09 was **12.28%,** this is an increase of 0.96% on the previous year

Average Inpost: The average number of substantive staff in post over the year was 2552.60 wte, this is the highest number of staff the Trust has employed

8.3 In July, the Trust staff inpost increased by 6.73 wte in comparison to the previous month. This is the largest number of staff the Trust has ever employed for the ninth consecutive month and represents a total increase in the overall workforce of 103.60 wte on the July 2008 position.

8.4 Unplanned turnover (i.e.: resignations) increased slightly in July now standing at 0.98%, this is 0.74% lower than the same period last year. Turnover for the twelve month period ending July 2009 was 14.49%

8.5 The Trust's vacancy rates are calculated using the budgeted wte (based on reconciliations with the Finance department), and the wte staff inpost at the end of the month. This represents the 'total vacancy' position. The full Trust vacancy rate for July 2009 increased to 15.50%. This represents a 2.8% increase on the same period in the previous year. This increase is due to new posts being introduced in Management Executive Directorate (Governance, Finance, Operations). Some of these are as a result of department restructures, and therefore the vacancy rate will decrease once the jobs are advertised and appointed to. All monies for these additional posts have been found from within the department's annual budgets.

A truer measure of vacancies is those being actively recruited to, based on job currently being advertised through NHS jobs at the end of June. We have an 'active' vacancy rate of 2.13%. The average vacancy rate this financial year is 15.54%, with and average active vacancy rate of 3.19%
The staff groups with the highest number of vacancies were non-clinical Senior Managers at 21.94%, Nursing and Midwifery (registered) at 21.74%, and Administrative and Clerical at 20.48%

8.6 The Trust's sickness rate showed an increase in June, now at 3.14%. This is up 0.27% on last month and down 0.01% on the same period last year. The average sickness rate for Quarter 1 is 2.95%. The number of sickness days by department (cost centre) and short/long-term absence is available in the 'Monthly Sickness by Department' report. More detailed sickness information by employee in the form of sickness trigger reports are sent via the HR Administrators to department/ward managers on a monthly basis to progress absence management. The HR team review every case of long term absence or high levels of intermittent short term absence, and support managers with their action plans to address each individual case.

8.7 Overall Bank & Agency usage in July increased, up 44.91 wte in comparison to the previous month. Bank usage of 304.21 wte showed an increase of 5.64 wte on the previous month, Agency usage increased by 39.26 wte on the previous month now at 217.96 wte. This is an increase in Agency usage of 79.64 wte (58%) on the same period last year. While a reasonable level of Bank usage is expected to cover the peaks and troughs in activity/staffing levels, the large increase in agency usage over recent months and the increased costs associated with agency staff is an area of concern and one which the HR team are working with managers to address.

8.8 The introduction of a specialist nurse bank rate from March for particular specialties where there are national shortages – theatres, ICU, paediatrics, midwifery and NICU – supports the Trust's approach to reducing the number of agency staff employed. The Executive Team have published guidelines on managing Agency spend within Budget which took effect from the 15th June. In addition, the Trust cascaded a Trust agency authorisation protocol and code to all managers on 20th July 2009.

	May 2009	June 2009	July 2009
Vacancy	472.67 wte	502.18 wte	482.21 wte
B&A usage	506.21 wte	477.26 wte	522.17 wte
Vacancies – B&A usage	**-33.54 wte**	**24.92 wte**	**-39.96 wte**

9 SLA PERFORMANCE AND ACTIVITY

9.1 The NHS Clinical Contract Income cumulative position for the four months in 2009/10 is £0.624m which is an in-month deterioration of £0.052m. There is a further deterioration of £0.01m in the prior year benefit of income. This has moved from £1.169m to £1.158m. The cumulative position is therefore £1.783m above the phased plan to July which is a total deterioration in the month of £0.06m.

The performance against planned contract income by point of delivery is shown in the following table and shows that activity at 546,880 is only 0.05% above plan. The £0.624m surplus which is 0.73% better than plan is due to higher than planned burns critical care bed days, recognition of additional excess bed day income, continued high A&E attendances, higher case mix in some areas and reclassification of single professional attendances to Multi professional attendances

Activity Type	Currency	Activity Actual	Activity Variance Over/(Under) %	Surplus / (Deficit) July 2009 £000's
Elective (incls RDA, PSD)*	Spells/FCE's	12,023	(2.5)	(46.5)
Non Elective	Spells/FCE's	11,776	12.69	1,027.7
Critical Care – Adult	Bed days	928	0.06	61.6
Critical Care – Burns	Bed days	232	551.6	339.7
Critical Care - NICU/SCBU	Cot days	3,842	4.53	(55.5)
A&E attendances	Attendances	35,370	5.14	134.0
Outpatients(incls procedures and virtual clinics)	Attendances	142,779	(1.22)	(334.9)
Excess Bed Days	Excess bed days	6,255	1.21	208.8
Other	Tests , Tele calls and Provisions	332,675	(0.0)	(711.1)
Total for 2009/10		**545,880**	**0.05**	**623.9**
Prior Year		3,387		1,158.6
Grand Total		**549,267**		**1,782.5**

9.2 Elective activity to maintain the 18-week target is broadly on plan. With respect to speciality performance against the capacity plan, activity is below plan by 2.5%, of which the significant underperformances are against HIV, Obstetrics, and Plastics but the elective shortfall is more than compensated for by emergency over-performance. However for Trauma & Orthopaedic, HIV, Medical Oncology, Respiratory and Urology both elective and emergency work is below plan which is under investigation by the General Managers. The other significant variance is against General Surgery which is showing a 15%/15% activity/income over-performance which may be impacting on the other specialties. Paediatric surgical and medical specialities are significantly over performing in activity terms by 10.8% which is generating a surplus of £301k.

9.3 Non-elective with a positive variance of £1.028m is 12.69% above plan and General Medicine continues to be the main contributor with a 32.2% increase over the cumulative plan to month 4. The A&E activity (as shown in section f below) is continuing to be significantly higher than planned and this is resulting in the increased inpatient activity. The General Medicine over-performance is still off-setting the significant under-performance in Elderly Medicine (down by 43% on plan) and the two specialties need to be looked at together because of how the grouper works. Obstetrics continues to show a significant over-performance but at a lower rate than the month 3 positions.

9.4 Critical Care bed days for the Burns Unit show a 552% increase over plan. This is due to the plan being set on Intensive Care (ICU) activity only using month 6 in 2008/09 data to extrapolate the activity to inform the plan for 2009/10) as noted last month. However, the Commissioners know that the plan is understated and have accepted that they will have to pay for the significant over performance that is expected by the year end, however they may wish to revisit the increased price agreed last year to reflect the under-recovery of our costs because the gap may have reduced as we capture more activity. A meeting is to be scheduled for September with the Specialist Commissioners to discuss this issue.

9.5 The NICU/SCBU cot days are ahead of plan by 167 cot days plan despite the delay in the opening of the planned additional 11 cots, this over-performance is being delivered by very high occupancy levels in the cots open.

As reported last month, the Directorate had informed the Trust that the opening of the 11 additional cots that were expected to come on stream from the 1st June would not now happen until October. This delay would result in a potential net loss of £0.5m and this has been provided for in the forecast. However, the Directorate has been asked to bring the capacity back on line earlier than the current plan.

9.6 The cumulative A&E attendances of 35,472, as at month 4, are significantly above planned activity at 5.2% and have generated a favourable variance of £0.134m. The conversion rate of A&E attendances has not significantly changed so this has resulted in an increase in emergency admissions which partly accounts for the increased activity in Non-Elective for General Medicine as reported above.

9.7 Outpatients have seen an adverse movement in the month of £0.244m, which is due to a correction to the Burns tariffs against overseas patients that has resulted in a reduction of £0.141m; removal of £0.153m previously recorded for the 21 new HIV patients as noted below and a drop in Obstetric attendances being recorded

and a continued shortfall in Genito-Urinary Medicine (GUM) attendances. However, this is being partially mitigated by Multi-professional attendances and Neonatal Ward Attenders' activity being captured for the first time in Month 4. Year to date outpatients is showing an adverse variance of £0.345m. The main areas of under achievement for outpatient income are following the trend as previously reported:

- GUM attendances and outpatients' procedures are 8.3% below plan to the end of month 4 which is an improvement against the June position, but the Service is still and only partially meeting the activity growth expectation for Dean Street. The total number of attendances including Dean Street within the plan to month 4 was 34,559 against an actual of 31,677. In the month of July the actual attendances were 8,027 against a plan of 8,273. The plan assumed that Dean Street would be fully operational from January 2009. However, as the clinic did not open until early March, there has been a delay in the build up to the full plan. The Directorate July advertising campaign which targeted a 5% increase in the other clinics should start to come on stream in the coming months. In addition, the benefit of the 21 new HIV positive patients identified in the three month period has been removed because 21 existing patients have left the Service. Staffing costs at the Dean Street clinic are also being managed closely to ensure that the variable costs of running the service are kept to a minimum.

- All the surgical specialties are under performing against the plan. This is the fourth consecutive month and most of the surgical specialties are showing an increased adverse movement from plan, with Trauma & Orthopaedics (T&O) and Plastic Surgery, being the most significant. T&O's month 4 position is showing a higher rate of over performance but the Plastic Surgery's rate of under performance improved in month. The Directorate has conducted a review of the capacity model assumptions, and for Plastics the capacity model assumed continuation of the extra clinics to deliver the 18 weeks target , the extra clinics were removed in April 2009. The Service is reviewing the possibility of reinstating the extra clinics. For T&O, the team has been restricting follow ups in order to meet the ratio cap but the rate has fallen below the cap so the service will increase its follow ups in the coming months. For Urology the recruitment of the fellow in October will enable the Service to provide more clinics and for Ophthalmology the change in staffing has resulted in less throughput which is being taken forward with the Service.

9.8 Excess Bed days continue to over-perform although at a slightly lower rate than in Month 3. Significant improvements made in the level of coded activity has enabled timely reflection of excess bed day income, as only coded activity can be used to calculate the excess bed day income.

9.9 The of £0.711m under this category is due to a provision of £0.3m being made against income and a correction to the NICU Critical care tariffs of £0.4m, which was required to correct a budget error where the ITU tariff price was overstated.

10 CONCLUSION

10.1 In month four the Trust's performance on all targets we can currently as assessed by Monitor is positive with all targets being met.

10.2 Our performance as assessed by the CQC has areas of risk around data completeness for ethnic coding, 13 week breaches and cancelled operations within 28 days. All these areas are being addressed.

10.3 There have been a number of changes in the construct of Monitor Cancer targets and the CQC have reinstated the audit targets from last year but have not yet published constructs.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting
17 September 2009

AGENDA ITEM NO.	3.3/Sep/09
PAPER	Membership Report for period ended 26 August 2009
AUTHOR	Sian Nelson, Membership & Engagement Manager
LEAD	Sian Nelson, Membership & Engagement Manager
EXECUTIVE SUMMARY	This report provides details of membership statistics.
DECISION / ACTION	The meeting is asked note the report.

Membership Report for Chelsea & Westminster Hospital from 01/04/2009 26/08/2009

Public constituency	Last year (2009/2009)
As at start (April 1)	6,372
New Members	31
Members leaving	185
At year end (August 26)	6,218

Patient constituency	Last year (2009/2009)
As at start (April 1)	6,136
New Members	21
Members leaving	211
At year end (August 26)	5,946

Public constituency	Number of members
Age(years):	
0 - 16	0
17 - 21	64
22+	5,334
Ethnicity:	
White	4,451
Mixed	240
Asian	337
Black	272
Other	303

Socio-economic groupings:

ABC1	5,393
C2	2
D	0
E	809

Gender analysis:

Male	2,488
Female	3,686

Patient constituency	Number of members
Age(years):	
0 - 16	0
17 - 21	61
22+	2,917