20th March 2006

Dear Council Member,

MEMBERS’ COUNCIL MEETING – 30th March 2006

Please find attached the agenda for the meeting to be held on 30th March 2006 at 6.00pm. It will be held in the meeting room, Ground Floor Central Wing, 250 Euston Road. This is located at the top of the small stairway opposite the Security Guards’ desk, at the Euston Road (East wing) entrance to the building.

Yours sincerely,

Jocelyn Laws
Trust Administrator

AGENDA

1. Apologies for Absence

2. Minutes of the Meeting held on 5th December 2005

3. Matters Arising Report

4. Chairman’s Report

5. Chief Executive’s Report

6. Progress Report on Draft Annual Plan

7. Interim Reports from the Working Groups:
   • Communications & Membership (John Lee, Chair)
   • Chairman and Non Executive Director Recruitment & Remuneration (Graham Faulkner, Chair)
   • High Quality Patient Care (Veronica Beechey, Chair)
   • Working Group on Outcomes from the Joint Members’ Council/Board of Directors meeting, October 2005 (Amanda Gibbon, Convenor)
8. Report on Foundation Trust Network Governors’ Groups  
   *(Peter Davison)*  
   Attachment G

9. Declaration on Healthcare Standards  
   To follow

10. Register of Council Members’ Interests  
    Attachment H

11. Any Other Business

12. Dates of Next Meetings:  
   - Wednesday 21st June 2006  
   - Thursday 28th September 2006

13. Dates of Future Meetings  
   - Monday 4th December 2006  
   - Tuesday 27th March 2007
1. Apologies for Absence

Apologies were received from Peter Davison, Georgia Kaufmann, Liz Lowe, Sue McLellen, Jakki Mellor-Ellis and Mary Shelley.

2. Minutes of the Meeting held on 21st September 2005

The minutes were agreed to be a correct record.

3. Matters Arising

The report on matters arising from the previous meeting was noted.

3.1. Chief Executive’s Report – Terrorist Incidents in July (Minute 5.2. relates)

Graham Faulkner enquired if there had been any progress on discussions with the Department of Health regarding reimbursement of the income lost as a result of the terrorist attacks. Mike Foster said he was due to meet the NHS Finance Director but he was not optimistic that the Trust would receive reimbursement as incidents of this nature were not covered by
insurance. Graham Faulkner requested a further update at the next meeting.  

**Action:** Chief Executive

### 3.2. Foundation Trust Showcase Event, House of Commons (Minute 7.1. relates)

Two Council Members, Kevin Ryan and Alison Forbes, had attended the event. They felt it had provided a useful opportunity to network with Governors from other Foundation Trusts.

### 4. Chairman’ Report

#### 4.1. Non Executive Director Appointment

Following interviews held in October, Nigel Carrington had been appointed as a Non-Executive Director. Lucy Anderson said that, while she welcomed his appointment, she had concerns about gender inequality in the Board’s composition. Graham Faulkner said that the Chairman and Non Executive Director Recruitment and Remuneration Working Group had been aware that this was an issue and would give it further consideration.

#### 4.2. Constitution Review

An interim progress report from the Secretary to the Trust was attached to the Chairman’s report. A number of proposed amendments to the Constitution were listed and it was noted that further revisions may result from consideration of specific issues by the Chairman and Non Executive Director Recruitment and Remuneration Working Group. Council Members were requested to send comments on issues related to the election process, or any other section of the Constitution as set out in the report, to the Secretary to the Trust by 27th January 2006.

**Action:** All

Michael Lee said he had proposed an amendment to the Constitution which had been rejected and he wished to raise it with the full Members’ Council. He asked that the constitution be amended to permit carers of patients to become members, irrespective of whether the people they care for have chosen to be members. This change would remove the present ambiguity about whether patient carers should represent only the people they care for, or their own interests as carers too. It would also bring UCLH into line with those other Foundation Trusts that have carer members. Tonia Ramsden said she had referred to the original Constitution proposals which endorsed the current arrangement; however, if the majority supported Michael Lee’s proposal, the Constitution could be amended accordingly. Michael Lee confirmed he was not proposing that there should be two carer representatives on the Members’ Council. The Members’ Council agreed that Michael Lee’s proposal should be adopted.

**Action:** Secretary to the Trust
4.3. **Media Guidance**

A draft document providing guidance for Council Members when dealing with the Media was attached to the Chairman’s report for discussion. Amanda Gibbon believed that no restrictions should be placed on Council Members and that they should be able to speak to the Media without reference to the Trust. June Grun agreed that Council Members should be free to express their personal opinions. Veronica Beechey felt that an introductory paragraph was required stating that Council Members were independent of the Trust and had a right to express their views, although the requirement for confidentiality on certain issues must be recognised. However, John Carrier said it would be courteous to discuss issues with the Trust beforehand, and thought the document was satisfactory as it was.

The Chairman said it appeared that an introduction would be helpful and asked Veronica Beechey and Alison Cahn to revise the guidance and re-circulate it for comment and implementation.

**Action:** V.Beechey/Director of Communication

4.4. **Joint Meeting Between Members’ Council and Board of Directors**

The notes of discussions that had taken place at the meeting in October were attached to the report. Veronica Beechey felt it had been a very useful meeting and asked how the issues that had been identified would be taken forward. The Chairman outlined various initiatives involving individual or small groups of Council Members but said that this was work in progress. He did not support the proposal of a Council-Board ‘compact’ summarising the working relationship and reciprocal obligations. Amanda Gibbon suggested it may be more useful to convene a small, self-nominated group to look at the ideas that emerged from the meeting. Council Members were asked to contact Amanda Gibbon if they wished to become involved.

**Action:** A.Gibbon/All

5. **Chief Executive’s Report**

5.1. **Transfer of Clinical Services to the New Hospital/Financial Report**

The Chief Executive advised that significant progress on the transfer of services from the Middlesex Hospital had been made since his previous report. Lessons had been learnt from the move of services from Cecil Flemming House and it was felt that there had been less disruption this time. However, the reduction in clinical activity, both prior to and following the transfers, had been greater than anticipated and had resulted in a lower income level in the first half of the financial year. The Chief Executive emphasised the change that the Trust had experienced over the past year and said that these transfers had been accomplished without any serious incident occurring, which was a significant achievement. The Chairman said there had been some operational problems associated with the new hospital, but once these were addressed patients would benefit from the excellent facilities it provided.
The latest financial position was set out in the report. It was noted that at the end of Month 6 (September) the Trust was £8.7m overspent against the agreed budget plan. Since then the position had deteriorated further and the Chief Executive thought it would continue to do so for the remainder of the financial year. The Board of Directors had discussed the position at length, and strategies for addressing the issues and recovering the situation had been explained to Monitor.

The Chief Executive said the Trust was working hard on plans to return to a balanced income & expenditure position by the end of March, but would still have to address the non-recurrent financial situation, mainly caused by the disruption to services during the relocation. It had always been intended that the income from the disposal of the Middlesex Hospital site and other assets would be used to offset this. However, there was also an issue related to the Facilities Management contract, exacerbated by the fact that savings which should have resulted from the closure of Cecil Flemming House and the Middlesex Hospital had not materialised as quickly as anticipated. In addition, the turbulence across the NHS as a whole was likely to continue next year, with PCTs experiencing a shortfall in the funding required to commission appropriate levels of activity.

Kevin Ryan asked whether the terrorist incidents in July had contributed to the deficit. The Chief Executive said they had been a relatively small contributory factor. Scott Johnston asked if the loss of income was in part due to the launch of the Electronic Patient Record system and consequent reduction in the recording of patient activity. The Chief Executive said that, initially, it had appeared that the implementation of the new IT system had had a negative effect on the ability to maintain outpatient activity. However, further investigation had ascertained that some consultants had reduced outpatient activity and action was now being taken to return to previous activity levels.

John Lee asked whether pressure was being put on the PCTs to further increase activity. The Chief Executive stated that the Trust’s main commissioners were aware that activity would need to increase to meet Government performance targets.

In response to a question from Lucy Anderson the Chief Executive stated that no PCT had requested the Trust slow down activity to offset a lack of funding. Outpatient waiting times had increased but this was as a result of the move to UCH. It was anticipated that waiting times would reduce again but this could have a negative impact on inpatient waiting lists, as a proportion of outpatients would transfer to the waiting lists.

Virginia Beardshaw asked whether any other aspects of patient care would be affected by the current situation in the Trust and the NHS as a whole. The Chief Executive said he hoped they would not, but one issue that may have an impact was the possible reduction in tariff prices under the Payment by Results (PbR) system next year. Graham Faulkner said he understood that PbR disadvantaged trusts that provided specialist services and asked whether anything was being done to address this. The Chief Executive confirmed that there were instances where the cost of treatment was greater
than the tariff. The Trust was trying to persuade the Department of Health to remove specialist procedures from the tariff system.

Graham Faulkner also referred to an article in the tabloid press about the Trust’s marketing initiative. The Chief Executive said this was an example of poor media reporting. The Trust’s aim was to provide better information to patients, PCTs and GPs about our services. There was no intention to advertise on television.

5.2. **Performance Management Report**

The information on headline performance issues was noted. The Chief Executive proposed that the performance management report to the next meeting would be presented in a standard format so that Council Members could agree the type of information they wished to receive in future.

**Action: Chief Executive**

5.3. **Annual Plan 2006/7**

A project plan for the production of the Annual Plan had been developed and was attached to the Chief Executive’s report. The proposed arrangements had taken account of the Members’ Council’s wish to be engaged in the process. The three Medical Director-led seminars, which would provide an opportunity for them to outline their development plans to the Members’ Council, had been arranged for the 16th, 23rd and 30th January (venues to be confirmed.) Council Members welcomed the opportunity to become more fully involved.

5.4. **Improving Working Lives Practice Plus**

This item advised that the Trust had been awarded Practice Plus status under the Improving Working Lives initiative. A summary of the external assessors’ validation report was attached. The Chairman said that a great deal of effort had been put into achieving this position.

6. **Appointment of External Auditors**

A report updating the Members’ Council on progress with the appointment process was noted. A full report, containing a recommendation, would be considered in Part II. The Chairman thanked Amanda Gibbon and Clive Saville for their participation in the tender evaluation process.
7. Interim Report from the Working Groups

7.1. Communications and Membership Working Group (CMG)

A report of the meeting held on 8th November was received from the Chair, John Lee, which set out a proposed plan of action for the CMG, for agreement by the Members’ Council. John Lee said the CMG would like direction from the Council about priorities for the group. The Chairman said that the report contained evidence of some good work and Veronica Beechey felt the information on the composition of the current membership was useful. She asked whether there was a target for the size of the membership. The Chairman said that initial thinking was that 10,000 was a reasonable target. Wendy De Silva said that an active membership was more desirable than a large one. Kevin Ryan asked how data related to issues such as ethnicity and disability were recorded, and commented that we needed to be able to effect changes in the make-up of the membership if necessary, to create greater diversity. The Chairman said we must ensure the recording of data was comprehensive and accurate before we could begin to think about change. John Carrier advised that the Strategic Health Authority had undertaken a considerable amount of work in this area and it was agreed that the Trust should consult with them and ask the CMG to come back with some recommendations.

Action: John Lee

Veronica Beechey said that as part of the communications aspect, consideration had been given to what the Members' Council could offer to under-represented groups. Marisha Ray referred to a Pupils' Parliament that had been set up by Islington Local Authority and suggested that John Lee could discuss with them ways of engaging with younger people.

Action: John Lee

7.2. Chairman and Non Executive Director Recruitment and Retention Working Group

The Chairman left the meeting for this discussion and Veronica Beechey, as Presiding Council Member, took the Chair. The report was introduced by Graham Faulkner. The proposed Terms of Reference for the group were attached to the report.

The main focus of the first meeting had been the remuneration of the Chairman and Non Executive Directors, and the establishment of a process for appraising the Chairman. The group had also given consideration to issues of diversity among the Non Executive Directors and ways to ensure a satisfactory skills balance. Virginia Beardshaw said she was pleased to see the issues of gender balance and ethnicity had been considered and had some further comments that she would pass on outside the meeting.

The report contained recommendations relating to the remuneration of the Chairman, Chair of the Audit Committee and Non Executive Directors, based on a range of salaries proposed by the Foundation Trust Network recommended as a comparable remuneration. Specifically, it was recommended that, with effect from 1st July 2005, the remuneration of
Non Executive Directors should be increased to £12,000 p.a., to be reviewed in 12 months; that the remuneration of the Chair of the Audit Committee be increased to £17,000 p.a. to reflect the significance of the role, and that the remuneration of the Chairman should increase to £40,000 p.a., rising to £50,000 from 1st July 2006 and £60,000 from 1st July 2007. Comments were invited.

John Carrier felt it would be inappropriate for him to express a view or vote on the proposals. Alison Forbes asked whether the funding for the proposed increases was available in the budget. The Chief Executive said the funding had not been included in budgets because he could not have known what the recommendations from the working group would be. However, if the Members’ Council supported the recommendations, the money would have to be identified.

Kevin Ryan felt that the Chairman of a Trust such as UCLH warranted a salary at the higher end of the range (i.e. £60,000); however, Graham Faulkner said that consideration had been given to how such a decision would be viewed by staff. Scott Johnston agreed that the Members’ Council needed to be sensitive to the fact that staff were going through the Agenda for Change process. Paul Ostro said that, while he appreciated the nature of the work that the Non Executives undertook, he had concerns about a proposal to double the salaries. Graham Faulkner said the principles of Agenda for Change had featured strongly in the debate which was the reason that the benchmark ranges of remuneration had been used. It was also noted that there had been no effective increase in the remuneration of Chairmen and Non Executive Directors for several years. Furthermore, Council Members felt that the salary should reflect the requirement to attract a high calibre of applicants to the posts.

June Grun asked the Chief Executive if he had any comments. He said that while it was not appropriate for him to make a judgment on the specific proposal, he agreed that Non Executive Board Member salaries had not been increased for a number of years and did not match those offered in the commercial sector. He added that the role of Non-Executives and the Chairman, in particular, had changed significantly since the Trust had become a Foundation Trust and a considerable number of hours were worked.

Following the discussion, the Members’ Council voted on the recommendations by show of hands. John Carrier abstained from the vote; otherwise the proposals regarding remuneration, as set out in the report, and the Terms of Reference were agreed by all others present.

The Chairman returned to the meeting.

7.3. **High Quality Patient Care Working Group**

Alison Forbes had convened the first meeting and presented the report. It was noted that Veronica Beechey would chair future meetings. The Group had discussed methods of collecting data for the purpose of monitoring the patient experience. It would be different information from that collected for
Clinical Governance/Department of Health requirements. It had been agreed that the Foundation Trust Membership Office would start the information gathering process.

The Group had also agreed that it should act as a champion for carers, and the role of the Patient Forum had been discussed. The suggestion of a meeting between the Patient Forum and the Members’ Council would be followed up with Louise Boden.

**Action: Alison Forbes**

John Lee said that some of the proposed workstreams could involve significant resources and the Trust should be given the opportunity to indicate whether there was a requirement for the work. The Chairman said that this reporting was not part of the management process and he hoped that the outcomes would encourage the Trust to aim higher. Marisha Ray declared an interest as Chair of the Health Scrutiny Committee at Islington Local Authority. However, she felt that the Members’ Council would be able to add value to the process for determining how patients view their experience. John Carrier offered to share the outcome of a patient survey in Camden.

Veronica Beechey advised that the Group had agreed to hold three working seminars prior to the next full Members’ Council meeting. These would involve individuals from the Trust addressing the Group on particular issues. A work plan would then be developed that would be presented to the next Members’ Council meeting. The seminars would be open to all Council Members who wished to attend. Tonia Ramsden would circulate details.

**Action: Secretary to the Trust**

John Carrier said that the work plan should link to the presentation given by Una O’Brien at a previous meeting on Healthcare Commission standards. Veronica Beechey confirmed that would be the case.

8. **National Event for Foundation Trust Governors**

Eileen West presented a report of the event that had taken place on 3rd November. She said the event had been attended by a wide range of people and the speakers had been interesting. Group discussions had been held in the afternoon and there was a general level of consensus on most issues.

The afternoon session had been on the topic of working towards the establishment of a National Foundation Trust Governors’ Network. Tonia Ramsden advised that Peter Davison and Carol Hart had been put forward as volunteers to attend a Governors’ event to discuss this issue. Virginia Beardshaw said that she would like the Trust to consider changing the name of the Members’ Council to Board of Governors. It was agreed that this should be given consideration in a future review of the Constitution.

**Action: Secretary to the Trust**

9. **Any Other Business**

There was none.
10. Date of Next Meeting

The next meeting would be held on Thursday, 30th March 2006 at 6.00pm.
<table>
<thead>
<tr>
<th>Minute ref.no</th>
<th>Issue</th>
<th>Outcome</th>
</tr>
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<tbody>
<tr>
<td>3.1.</td>
<td>Chief Executive’s Report – Terrorist Incidents in July</td>
<td>The Finance Director has written to the NHS Finance Director concerning reimbursement of lost income. A response is awaited.</td>
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<td>4.2.</td>
<td>Constitution Review</td>
<td>The Secretary to the Trust sent a reminder to all Council Members about the deadline for comments. The agreed amendment concerning the status of carer members will be incorporated in the Constitution. The Secretary to the Trust will ensure that other agreed revisions will be made in the next review.</td>
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<td>4.3.</td>
<td>Media Guidance</td>
<td>The revisions were made and the guidance has been circulated. <strong>Action completed.</strong></td>
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<td>4.4.</td>
<td>Joint Meeting between Members’ Council and Board of Directors</td>
<td>Amanda Gibbon wrote to Council Members with a deadline for responding if they wished to be involved in the group. A meeting was held on 7th March. <strong>See Agenda Item 7, Appendix 4</strong></td>
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<td>5.2.</td>
<td>Performance Management Report</td>
<td>A standardised format will be included in the next Chief Executive’s Report. <strong>Action completed.</strong></td>
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<td>7.1.</td>
<td>Communications &amp; Membership Working Group – Consult with Strategic Health Authority on issue of ethnicity &amp; diversity recording.</td>
<td>Referred to the CMWG Meeting, 24th January 2006.</td>
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<td></td>
<td>Communications &amp; Membership Working Group – Contact Islington Pupils’ Parliament regarding ways of engaging with younger people</td>
<td>As above.</td>
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<td>7.3.</td>
<td>High Quality Patient Care Working Group – Proposed meeting between</td>
<td>The suggestion was followed up with the Chief Nurse. <strong>The Members'</strong></td>
</tr>
<tr>
<td><strong>7.3.</strong></td>
<td>High Quality Patient Care Working Group – circulate details of seminars to all Council Members.</td>
<td><strong>Action completed.</strong></td>
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<td><strong>8.</strong></td>
<td>National Event for Foundation Trust Governors – Proposed name change for Members’ Council</td>
<td>The proposal has been noted and will be considered as part of the Constitution review (refer to 4.2. above)</td>
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1. **RE-NAMING OF MEMBERS’ COUNCIL**

It has become increasingly obvious that we are out of step with most Foundation Trusts in using the term Members’ Council. I have therefore recommended to the Board that we should change the name as part of the forthcoming governance review and I would like agreement that we should rename the Members’ Council as either the Board of Governors or the Governing Body. My personal view is that there is some merit in using the term Governing Body in order to avoid any possible confusion with the Board of Directors. In either case, individual Council members would become Governors.

2. **CONSTITUTION AMENDMENT**

Tonia Ramsden has attached the papers for the amendment of our constitution. These have now been finalised and I am very grateful for the work which has been put into them and the comments from many of you. Singling out individuals is always invidious, but Clive Saville has given his expertise unstintingly and Veronica Beechey, Michael Lee and Amanda Gibbon have also been extremely helpful. The next stage of the process is for the amendments to be signed off by the Board of Directors and they will then be submitted to Monitor for approval.

3. **OPEN EVENT**

Many of you will have attended the open event which we held in 250 Euston Road and which was attended by more than 100 members of the public. The tours of the new building, which we offered, were particularly popular. There was also an opportunity for members of the public to engage with both management and members of the Board of Directors as well as to discuss the details of our planning for the coming year.

Based on the popularity of this event, we shall certainly be doing it at least once a year in the future. One of the lessons we have learnt from this particular occasion is that we need to find a way of making the discussion groups more accessible without turning them into formal seminars or lectures.

A particularly encouraging part of the evening was the way in which departments within the hospital, where staff may not always get the opportunity to meet each other, managed to get together and talk about issues of interest and very specifically how we can together, deliver better services to our patients.

4. **STRUCTURAL CHANGES IN LONDON**

Robert’s report has referred to the changes being made at a national level, so I will confine myself some of the issues concerning the London re-organisation. There will in future be one Health Authority for the whole of London and the present smaller Strategic Health Authorities are likely to be slimmed down very dramatically with everything that can be devolved to PCTs being handled at that level. The arrangements for commissioning in the future will mean that Camden PCT has an even greater importance as far as we are concerned, since the other London PCTs will in effect sub-contract their arrangements with us to Camden. This should have some advantages in avoiding unnecessary duplication and hopefully enabling us to deliver services more effectively. One of the big issues for next year is that because of the deficits in London as a whole, 3% is being top sliced from PCT budgets and they will therefore have less money to spend. Inevitably, this will have an impact on the volume of services which they are able to commission from us.
5. **BOARD-TO-BOARD MEETING WITH MONITOR**

We recently had a meeting of the Board of Directors with Monitor’s full Board. We spent some three hours discussing our plans for returning the Trust to balance and the work that is needed to achieve this. I am sure that Council members are well aware of much of the background to the issues we are dealing with but we are confident that our plans will produce the result we require, albeit over a timescale which is probably stretching at least two years ahead. I will not go into further detail since I know that these issues are being discussed in Robert’s report. We are now seeing activity levels recovering towards those we had planned at the start of the year but there are still very considerable issues around the application of the new tariff system and whether or not it rewards adequately many of the complex procedures which we carry out. There is also no doubt that we need to ensure that we are delivering our services in a way which is cost effective and we are using outside expertise in order to help us to achieve this. I will of course keep Council members in touch with any further developments between meetings of the Council.

6. **THE MIDDLESEX TOWER**

Some of you will be aware that we gave a commitment that the Tower of the new hospital would be named The Middlesex Tower. We have arranged that a naming ceremony will take place on 15 May which happens to be the 251\textsuperscript{st} anniversary of the laying of the foundation stone for the old Middlesex Hospital. Invitations to this event will be going out in due course. The plaque will be similar in style to the one which the Queen unveiled in October last year.

PETER DIXON  
CHAIRMAN  
MARCH 2006
Constitution Review
Final Report to the Members’ Council on 30th March 2006
A paper for information and consideration

1. Introduction

Since the Trust was issued with Terms of Authorisation on 1st July 2004 a review of Schedule 1 (The Constitution and Annexes) commenced and an interim report was presented to the Members’ Council on 5th December 2005.

The purpose of this report is to consult the Members’ Council on the final proposed amendments following which I will ask the Trust’s legal advisors to review the changes and produce a final draft of the revised Constitution. This draft will be presented to the Board of Directors for approval prior to submission to Monitor. Following the outcome of the assessment by Monitor the revised Constitution will be issued and Standing Orders for the Members’ Council will be revised as appropriate and presented for approval and adoption at the Members’ Council meeting on 21st June 2006.

2. Previous Proposals

The proposed amendments presented at the Members’ Council meeting on 5th December 2005 are attached for reference at Attachment A.

At that meeting Michael Lee, Patient Carer representative, proposed an amendment to the sections of the Constitution relating to the Patient Carer Class. He proposed that UCLH permit carers of patients to become members of the Foundation Trust irrespective of whether the person they care for is a member. The Members’ Council supported the recommendation and this will be incorporated as an amendment.

3. Issues for further consideration

The Members’ Council were also asked to consider sections of the election process (Annex 2).

i) The need for a candidate to have their nomination subscribed by two supporters from the same constituency.

ii) The use of Hustings. This is specified in the ‘proceedings at an election’ timetable only.

There was a significant level of support for the removal of the need for two supporters and this has been included as an amendment.
There is a difference of opinion amongst Council Members about how useful Hustings are. We have yet to test whether regional and national members will participate in or attend a Husting. Comments have been received about the formality of the process and many of the members who attended misunderstood the purpose of the event and used it as an opportunity to ask questions about specific issues related to individual care and services. On this basis it is proposed that Hustings should be optional and less formal and this has been included as an amendment.

In the meantime other ideas are being explored to support candidates in getting their message across to their constituents.

4. Proposed amendments.

The proposed amendments including those outlined above are attached at Attachment B.

5. The Chairman in his report to the Members’ Council has proposed that the Members’ Council should be renamed the Board of Governors or Governing Body. Subject to this proposal to change the name of the Members’ Council receiving the support of the Members’ Council, the Constitution will be amended.

6. Action

The Members’ Council are asked to:

• Note the deletion to the proposed amendments at Attachment A following the meeting of the 5th December 2005.

• Note, consider and comment on the proposed amendments at Attachment B.

• Consider the proposal submitted by the Chairman to rename the Members’ Council either:
  i) Board of Governors
  ii) Governing Body

• Note the process following the Members’ Council Meeting.

7. Finally the Trust has responded to the Monitor Consultation on the NHS Foundation Trust Code of Governance. The code is intended to be used as a voluntary, best practice code implemented on a comply or explain basis. Any implications for the Constitution will be taken into account when the final code is published and a subsequent review will be carried out as appropriate.

Tonia Ramsden
Secretary to the Trust
13th March 2006
## Constitution Review Proposed Amendments – For Information

<table>
<thead>
<tr>
<th>Section</th>
<th>Current</th>
<th>Proposed</th>
<th>Reason for change</th>
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<tbody>
<tr>
<td>Page 1</td>
<td>Definition “Independent Regulator”</td>
<td>Means the regulator for the purposes of Part I of the 2003 Act. Means the regulator for the purposes of Part I of the 2003 Act namely Monitor the Independent Regulator of NHS Foundation Trusts</td>
<td>Subsequent to Terms of Authorisation being issued The Independent Regulator chose the name Monitor</td>
</tr>
<tr>
<td>Page 10</td>
<td>7.4.6 Members of the Patient Carers Class are Members of the Patient Constituency who:- 7.4.6.2 …………</td>
<td>provide care on a regular basis for a Patient who is, by reason of physical or mental incapacity, unable to discharge the functions of a Member or is under 14 years of age; and</td>
<td>That Carers do not only represent Patients who are incapable of discharging the function of a Member but represent Patients who choose not to discharge that function</td>
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<tr>
<td>Page 10</td>
<td>7.4.6 Members of the Patient Carers Class are Members of the Patient Constituency who:- 7.4.6.5.1……..</td>
<td>nominated by that Patient as his Patient Carer for the time being for the purposes of this paragraph and have been accepted by the Trust as that Patient’s Carer for that purpose; or</td>
<td>Benefit from amendment to remove surplus wording</td>
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<td>nominated by that Patient as his Patient Carer for the time being and have been accepted by the Trust as that Patient’s Carer for that purpose; or</td>
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| Page 10/11 | 7.4.6 Members of the Patient Carers Class are Members of the Patient Constituency who:—
7.4.6.5.2…… … have been accepted by the Trust as a Patient Carer for the purposes of this paragraph where the Patient is under 14 years of age or lacks the mental capacity to nominate that person as his Patient Carer and the Trust has, to the extent that it is reasonably practicable to do so, consulted with that Patient as to his wishes and has then agreed to treat that person as the Patient’s Carer for the purposes of this paragraph
| have been accepted by the Trust as a Patient Carer for where the Patient is under 14 years of age or lacks the mental capacity to nominate that person as his Patient Carer and the Trust has, to the extent that it is reasonably practicable to do so, consulted with that Patient as to his wishes and has then agreed to treat that person as the Patient’s Carer.
| Benefit from amendment to remove surplus wording.

| Page 11 | 7.4.7 A person shall not be eligible to become a Member of the Patient Carer Class or to continue as a Patient Carer Class if:— 7.4.7.4………... the Patient on whose behalf he is a Patient is ineligible or disqualified from membership under paragraph 7.5; or
| the Patient on whose behalf he is a Patient Carer is ineligible or becomes ineligible or is disqualified from membership under paragraph 7.5; or
| Benefit from amendment to reflect that wording required correction and that the patient’s status could change.

| Page 11 | 7.4.7.5……… .. where paragraph 7.4.6.5.2 applies the Patient attains the age of 14 years or becomes capable of discharging the functions of a Member.
| where paragraph 7.4.6.5.2 applies the Patient attains the age of 14 years or becomes capable of discharging the functions of a Member and chooses to become a Member.
| Benefit from amendment to reflect the fact that the Patient is not automatically assigned Membership and must choose to become a Member.

| Page 22 | 8.15 Termination of Tenure
8.15.2…………… If a Council Member fails to attend any two meetings of the Members’ Council in any consecutive six month period a resolution to remove him from office shall be automatically considered at the next formal meeting of the Members’ Council and his tenure of office shall then be immediately terminated by the Members’ Council unless the Members’ Council is satisfied that:-
| If a Council Member fails to attend any two meetings of the Members’ Council in any consecutive six month period a resolution to remove him may be proposed by the Chairman and considered at the next formal meeting of the Members’ Council and his tenure of office shall then be immediately terminated by the Members’ Council unless the Members’ Council is satisfied that:-
| The existing paragraph is considered draconian. This provides the Chairman with the discretion to deal with the issue in the first instance.
<table>
<thead>
<tr>
<th>Page 23 8.15.3</th>
<th>The resolution under paragraph 8.15.2 may be put by any Council Member.</th>
<th>Delete 8.15.3</th>
<th>Benefit from amendment to reflect the above change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Page 23 – 24 8.15.4. – 8.15.11</td>
<td>General paragraph references to be amended to reflect removal of 8.15.3</td>
<td>Benefit from amendment to reflect the above change</td>
<td></td>
</tr>
<tr>
<td>Page 23 8.15.4</td>
<td>The Members’ Council may terminate a Council Member’s tenure of office as a Council Member if for reasonable cause it considers that he:</td>
<td>The Members’ Council may by a resolution terminate a Council Member’s tenure of office as a Council Member if for reasonable cause it considers that he:</td>
<td>Indicates what action must to be taken to terminate a Council Member’s tenure</td>
</tr>
<tr>
<td>Page 24 8.15.11</td>
<td>Where a decision to terminate a Member’s term of office is referred to the Dispute Resolution Procedure and the outcome of that reference is a recommendation that the Council Member should be restored to his office as a Council Member and the Members’ Council then resolves to reverse its earlier decision and restore that Council Member to his said office then he shall thereupon be restored to that office and to the Register of Council Members.</td>
<td>Where a decision to terminate a Member’s term of office is referred to the Dispute Resolution Procedure and the outcome of that reference is a recommendation that the Council Member should be restored to his office as a Council Member the recommendation shall require the approval of at least two-thirds of Council Members’ present at a properly constituted meeting of the Members’ Council to reverse its earlier decision and restore that Council Member to his said office. Thereupon the Council Member shall be restored to that office and to the Register of Council Members.</td>
<td>Amendment will bring the procedure for restoration to office of a Council Member in line with that of the removal procedure (current 8.15.5) requiring the Council to give both processes equal weight</td>
</tr>
<tr>
<td>Page 29/30 8.21 Meetings 8.21.7</td>
<td>A Council Member elected to the Members’ Council by the Public Constituency, the Patient Constituency or a Staff Class of the Staff Constituency may not vote at a meeting of the Members’ Council unless within the period of 6 months prior to the date upon which he exercises that vote he has made a declaration in the form specified at paragraph 8.21.8 stating which constituency or Class of a constituency (as the case may be) he is a Member of and that he is not prevented from being a Member of the Members’</td>
<td>A Council Member elected to the Members’ Council by the Public Constituency or the Patient Constituency may not vote at a meeting of the Members’ Council unless within the previous 12 months he has made a declaration in the form specified at paragraph 8.21.8 stating the constituency of which he is a Member and that he is not prevented from being a Member of the Members’ Council by paragraph 7 of Schedule 1 to the 2003 Act, or otherwise under this Constitution.</td>
<td>The amendment is to ensure that if the Council were required to vote on an issue circa the months of December and May in any annual period that Public and Patient Council Members could exercise that right to vote. The declaration referred to is contained in the election process. The requirement for Staff to sign the declaration annually is withdrawn. Elections for Staff are held every 3 years.</td>
</tr>
<tr>
<td>Page</td>
<td>Section</td>
<td>Text</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>8.23 Conflict of Interests of Council Members</td>
<td>It is the obligation of the Council Member to inform the Membership Administrator in writing within 7 days of becoming aware of the existence of a relevant or material interest and the Membership Administrator shall thereupon amend the Register of Council Members’ Interests within three working days of having received the said written notification from the Council Member.</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>8.23 Conflict of Interests of Council Members</td>
<td>The Register of Council Members’ Interests shall be kept up to date by means of a monthly review of the Register by the Membership Administrator during which any changes of interest declared during the preceding month shall be incorporated subject always to the provisions of paragraph 8.23.7.</td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>11. Conflicts of Interest of Directors</td>
<td>It is the obligation of the Director to inform the Membership Administrator in writing within 7 days of becoming aware of the existence of a relevant or material interest and the Membership Administrator shall thereupon amend the Register within</td>
<td></td>
</tr>
</tbody>
</table>

All Interests should be declared and recorded in the Register of Interests. Only Conflicts of Interest should be recorded in the minutes. The latter is covered in paragraph 8.23.9.
following the change occurring. It is the obligation of the Director to inform the Membership Administrator in writing within 7 days of becoming aware of the existence of a relevant or material interest and the Membership Administrator shall thereupon amend the Register within three working days of having received the said written notification from the Director.

The Register of Directors Interests shall be kept up to date by means of a monthly review of the Register, by the Membership Administrator during which, any changes of interest declared during the preceding month shall be incorporated, subject always to the provisions of paragraph 11.2.5.

The Register of Directors Interests shall be kept up to date by means of an annual review of the Register, by the Membership Administrator during which, any changes of interest declared during the preceding month shall be incorporated, subject always to the provisions of paragraph 11.2.5.

The ward changed name in 2002

Incorrect spelling

A tidy up of spelling and removal of surplus wording will be carried out when all the amendments have been agreed.
Constitution Review Proposed Amendments

<table>
<thead>
<tr>
<th>Section</th>
<th>Current</th>
<th>Proposed</th>
<th>Reason for change</th>
</tr>
</thead>
</table>
| Page 10 - 11 7.4.6 – 7.6.9 References to Patient Carer Class and Constituency | This section will be redrafted after a discussion with the Trust legal advisors to meet the revised requirements including:  
• that both the Patient and the Patient Carer can be a Member  
• that the Carer provides care on a regular basis  
• that the Carer does not provide care by contract or as a volunteer  
• that the Carer has been nominated by the Patient or has been accepted by the Trust where the patient is under 14 or lacks mental capacity  
• that when the Patient ceases to be a Patient Member the Patient Carer ceases to be a Patient Carer Member  
• that the Patient Carer may not belong to more than one class. | | |
<p>| Page 23 8.15.6 A Council Member whose tenure of office ..... | is terminated under this paragraph shall not be eligible to stand for re-election to the Members' Council for a period of three years from the date of termination of his office or the date upon which any appeal against his removal from office is disposed of, and .... | is terminated under this paragraph shall not be eligible to stand for re-election to the Members' Council for a period of up to three years from the date of termination of his office or the date upon which any appeal against his removal from office is disposed of, and .... | The existing paragraph is considered draconian. This provides the Members' Council with an opportunity to consider the circumstances of the termination in particular where this relates to a health or personal issue. |</p>
<table>
<thead>
<tr>
<th>ANNEX 1</th>
<th>Constituencies of the Trust</th>
<th>ANNEX 2</th>
<th>Election scheme</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The following wards in the City of London:</td>
<td>List of proposed amendments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Bread Street</td>
<td>1. <strong>Remove references to ERS.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The following wards in the City of London:</td>
<td>ERS may not necessarily be engaged as the election returning officer every year.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Bread Street</td>
<td>2. <strong>Part 2 Timetable for Election</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Broad Street</td>
<td>2. Timetable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reinstated Bread Street. All Bread Street and a small number of addresses in Broad Street are included in the Public Constituency.</td>
<td>2.1 The timetable will be revised to improve understanding. For example:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Current: Deadline for ERS to receive completed nomination form 01/07</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Future: Final day for delivery of nomination papers to returning officer 01/07</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.2 Hustings</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>It is proposed that Hustings are removed from the ‘proceeding at an election’ as a requirement. It is proposed this requirement be replaced with a new paragraph to confirm that Hustings are optional and may be held as required.</td>
<td></td>
</tr>
</tbody>
</table>
3. **11. Subscription of candidate**

   11.1 The nomination paper must be subscribed by at least two supporters.

   It is proposed that the requirement for nomination papers to be subscribed by at least two supporters is removed.

   All subsequent sections relating to supporters will be removed.

4. **16. Publication of statement of nominated candidate**

   16.2 The statement must show:

   16.2.1 the name, contact address and constituency or class........

   It is proposed the contact address is removed from the requirement to show the address as part of the statement.

   For the 2005 election the contact address was given as the Electoral Reform Service.

5. **Part 6 Counting the Votes**

   The UCLH FT election process is carried out under Single Transferable Voting (STV) rules which was agreed at time of Authorisation. At the time UCLH was granted its Terms of Authorisation ‘model election rules’ were being developed. The election rules would benefit from redrafting to clearly explain STV interpretation.

   It is proposed the ‘model election rules’ now available are used for this purpose. The impact of the ‘STV model election rules’ will be applied throughout Annex 2.
### 6. Declaration of results for Contested Elections

41.1.2.1 where the election ....... on the Guy’s and St Thomas’ NHS Trust....

All references to Guy’s and St Thomas’ NHS Trust will be removed.

<table>
<thead>
<tr>
<th>ANNEX 3</th>
<th>Identity Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Identity is confirmed as part of the nomination process.</td>
</tr>
<tr>
<td></td>
<td>It is proposed that the Identity Guidelines are removed.</td>
</tr>
</tbody>
</table>

Typographical errors, spelling mistakes and removal of surplus working will be corrected in the final draft.

The Constitution definitions will be amended to reflect the agreed amendments for example the change of name adopted by the Members’ Council.

The Constitution will be amended to incorporate the change of name adopted by the Members’ Council.
1. THE NEW UNIVERSITY COLLEGE HOSPITAL – PROGRESS WITH SERVICE TRANSFERS

At the last Members’ Council meeting in December 2005, I reported that all inpatient services had transferred from the Middlesex Hospital, leaving outpatients and some support service departments on that site. The outpatient services transferred over the Christmas period into the new outpatients department which now operates on a three-session day basis. This has resulted in a significant increase in outpatient capacity which should allow us to reduce outpatient waiting times, subject to funding provided from PCTs, in line with the NHS Plan over the next two years.

The support service departments remaining in the Middlesex Hospital are Sterile Services, Medical Physics and academic departments associated with UCL. The UCL academic departments are due to move out by 19 October 2006 at which time we shall have full vacant position of the whole of the Middlesex island site. However, there are indications from the University that a delay in one of their capital developments may result in a request to stay on the Middlesex Hospital site slightly longer, but this is being resisted and is subject to further discussions between the Trust and the University.

The Trust has engaged CBRE as managing agents for the sale of the Middlesex site. This company is currently finalising a marketing brochure which is due to be launched within the next two months. It is hoped that a sale of the site can be secured during the course of this calendar year so that the sale receipt can be received by the end of the financial year.

The PFI contractors have progressed rapidly with the demolition of Cecil Fleming House – the site for Phase 2 (the new Elizabeth Garrett Anderson & Obstetric Hospital). This scheme is due for completion in the autumn of 2008. We are now well advanced with the detailed planning for Phase 2, although we shall be reviewing the functional content to consider whether the commission of Phase 2 might present an opportunity to relocate the Heart Hospital back on to the main hospital campus. This option will be considered against the current strategic intention of building a new Heart Hospital on the Obstetric Hospital site in the strategic period following 2008.

2. FINANCIAL POSITION

The income and expenditure variance from the plan at 31 January 2006 was £28.7M. The main component factors are as follows:

- Income shortfall £18.5m
- FM additional costs of £10.8m

A table which sets out the position in summary form by clinical board is detailed overleaf.
Corporate Financial Assessment – for the period ending 31 January 2006

<table>
<thead>
<tr>
<th>Line Ref</th>
<th>Business Unit</th>
<th>Annual Budget (A)</th>
<th>Budget (B)</th>
<th>Actual (C)</th>
<th>Variance (D = B - C)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>1</td>
<td>Central Income</td>
<td>-413.887</td>
<td>-345.192</td>
<td>-326.726</td>
<td>-18.466</td>
</tr>
<tr>
<td>2</td>
<td>Sub-Total Financing Sources</td>
<td>-413.887</td>
<td>-345.192</td>
<td>-326.726</td>
<td>-18.466</td>
</tr>
<tr>
<td>3</td>
<td>Clinical Services</td>
<td>60.601</td>
<td>49.467</td>
<td>50.003</td>
<td>-0.536</td>
</tr>
<tr>
<td>4</td>
<td>Specialist Hospitals</td>
<td>135.979</td>
<td>112.956</td>
<td>115.462</td>
<td>-2.506</td>
</tr>
<tr>
<td>5</td>
<td>Medicine &amp; Surgery</td>
<td>105.015</td>
<td>87.170</td>
<td>87.391</td>
<td>-0.221</td>
</tr>
<tr>
<td>6</td>
<td>Corporate Directorates</td>
<td>35.566</td>
<td>29.679</td>
<td>29.003</td>
<td>0.676</td>
</tr>
<tr>
<td>7</td>
<td>Corporate Services (incl. Interim FM)</td>
<td>13.290</td>
<td>12.301</td>
<td>23.105</td>
<td>-10.805</td>
</tr>
<tr>
<td>8</td>
<td>New Hospital unitary charge</td>
<td>32.021</td>
<td>25.999</td>
<td>25.900</td>
<td>0.099</td>
</tr>
<tr>
<td>9</td>
<td>Central Budgets (incl. Reserves)</td>
<td>37.377</td>
<td>31.417</td>
<td>28.314</td>
<td>3.103</td>
</tr>
<tr>
<td>10</td>
<td>Sub-Total Financing Applications</td>
<td>419.849</td>
<td>348.988</td>
<td>359.178</td>
<td>-10.190</td>
</tr>
<tr>
<td>11</td>
<td>Total - performance-related</td>
<td>5.962</td>
<td>3.796</td>
<td>32.452</td>
<td>-28.656</td>
</tr>
</tbody>
</table>

The current position is in line with the forecast income and expenditure position as presented to Monitor in November 2006 and we remain on track to deliver the forecast year end position.

A series of management actions have been put into place to ensure that the year end forecast is achieved and to deliver the financial plan for 2006/07. These measures include:

- Strengthening the monthly Clinical Board Financial Review process.
- Additional initiatives such a contract for private patient services and control of the FM contract.
- Strengthening of the financial and other managerial processes and the Financial Control Review Project.

The cash position of the Trust is under some pressure and we are currently not able to manage our invoice payments in line with the timescales that we would wish, however, dialogue is being established with our creditors and any difficulties being experienced are being satisfactorily negotiated through.
Turning to 2006/07, progress has been inhibited through the withdrawal of the Department of Health Tariff for 2006/07. The Tariff has subsequently been re-issued but the impact is not yet clear.

3. PERFORMANCE MANAGEMENT REPORT

As reported previously, the Trust has been experiencing a number of challenges in maintaining activity levels during the transition from the old buildings into the new hospital. There has been a significant reduction in patient activity during this transition period which will not be recovered during this year. This reduced in patient activity is the major contributory factor to the Trust’s current poor financial performance. The following is a summary of the patient activity position as at end January.

Inpatient Activity

On inpatient activity overall (emergencies, electives and day cases) the Trust is now slightly over-performing on a monthly basis. The number of elective admissions is lower than planned but the number of day-cases is higher. To some degree this represents a change from inpatient to day-case activity which was always planned to occur in the new hospital facilities. As anticipated, emergency admissions have increased during the winter period, which in turn has resulted in an increased in the cancellation of elective procedures.

Outpatient Activity

The Trust continues to under-perform on outpatient activity, although performance has slightly improved since the last meeting. As reported previously, this under-performance is caused by a number of factors including difficulties in operating the new outpatient department at an optimal level, problems associated with booking arrangements and the availability of medical records. There is every indication that we are likely to experience a reduction in the number of GP referrals in the future, due to arrangements being put in place by PCTs to screen GP referrals prior to them being received at the hospital. An example of this is the screening of orthopaedic referrals by physiotherapists and subsequent treatment in primary/community care, rather than in the hospital.

The number of A&E attendances continues to increase, but despite this we have maintained 99% of patients treated within 4 hours of attendance, one of the best performances in the NHS.

Healthcare Standards

I am pleased to report that the Trust is meeting the target to achieve the key waiting list standards for outpatients (less than 13 weeks) and inpatients (less than 6 months). However, it is disappointing to report that due to a number of very late cancer referrals from our neighbouring Trusts, it is unlikely that we will be able to achieve the 62-day target from GP referral to commencing treatment. It should be stressed that this is entirely as a consequence of late referrals from several Trusts in other parts of North London. We are currently in discussions with these Trusts to improve the timeliness of these referrals.
Workforce

Vacancy rates have reduced over the last quarter, as has the use of bank and agency staff. This is as a result of HR changes associated with the move into the new hospital. These changes are expected to be concluded by the end of March.

I attach as Appendix ‘A’, some key graphs which illustrate performance so far this year.

4. **ANNUAL PLAN 2006/07**

I am pleased to report that the Members’ Council seminars given by the Medical Directors appear to be very well received overall. These have been of considerable help in developing thoughts about the Annual Plan for next year. The plan will also have to take into account the Trust’s current and perspective financial position, as well as a wide range of other issues that could have a major impact on the Trust in the next three years.

The first draft of the Annual Plan for 2006/07 is attached separately to this pack. This first draft draws upon the discussions in the Members’ Council seminars and is presented here for discussion and comment prior to a subsequent draft being presented to the Board of Directors. It is proposed to circulate a third draft to members of the Members’ Council for individual comment prior to completion and submission to Monitor at the end of April.

5. **EXTERNAL AUDITS ANNUAL MANAGEMENT LETTER**

I am pleased to confirm that the Trust has received a positive annual Management Letter from the Audit Commission. This Management Letter was considered by the Audit Committee and the Board of Directors at their December meetings. The Management Letter is largely positive but there are three issues raised that I should like to bring to the attention of the Members’ Council. I attach these issues as Appendix ‘B’.

ROBERT NAYLOR  
CHIEF EXECUTIVE  
MARCH 2006
External Audit’s Annual Management Letter
for the Year Ended 31 March 2005

Introduction

The Annual Management Letter on the audits of the two part year accounts for the financial year 2004/05 was produced by the auditor, the Audit Commission, in December 2005. It was considered by the Audit Committee and the Board of Directors at the December meetings.

Key issues raised and actions taken

1. Delays were noted in relation to the completion of the accounts for the nine months ended 31st March 2005, the accounts were not submitted in accordance with the timetable set by Monitor.

The December Board of Director’s meeting received a report on the work to deal with the ongoing issues through the Financial Control Review which is concentrating initially on the general ledger work stream. A project management approach for the 2005/06 final accounts has been introduced to ensure Monitor’s timetable is achieved.

2. Concerns on the level of investment in the finance function, including Internal Audit and a recommendation that resourcing and investment is reviewed by the Trust.

This is one of the objectives for the Financial Control Review to review investment in the finance function and to ensure that the objectives of the review are achieved and maintained over the longer term. As part of the Internal Audit work stream an audit needs assessment has been undertaken by external consultants – Parkhill Audit Agency who will issue their report this month.

3. It was noted that the accounts and the audit opinion are based on the principal of going concern and it is therefore essential that adequate arrangements are in place to satisfy the Board that the financial position of the Trust is sustainable.

Under the Foundation Trust regime as Monitor has powers through the Health and Social Care Act to dissolve a Foundation Trust the accounting principal of ‘going concern’ is a relevant and important consideration for the audit of the annual accounts. In producing the annual accounts an assessment of the Trusts ability to continue as a going concern will be undertaken with a judgement made on the financial position for future years.
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST

DRAFT ANNUAL PLAN 2006/2007

March 2006
CONTENTS

Introduction ..........................................................................................................................................

Section 1
- Background & Vision .....................................................................................................................

Section 2
- Past Year Performance ..................................................................................................................
  2.1 Chief Executive’s summary of the year ....................................................................................
  2.2 Summary of Financial Performance .......................................................................................).
  2.3 Other Major Issues ...................................................................................................................

Section 3
- Changes to Business plan and Governance ..................................................................................
  3.1 Strategic Overview – The Changing Healthcare Context .........................................................
  3.2 Trust Objectives ....................................................................................................................
  3.3 Service Development Plans ....................................................................................................
  3.4 Operating Resources required to deliver service development ..............................................
  3.5 Investment & Disposal strategy ..............................................................................................
  3.6 Financing and Working Capital Strategy ................................................................................

Section 4
- Risk Analysis ................................................................................................................................
  4.1 Governance Risk ....................................................................................................................
  4.2 Mandatory Services Risk ........................................................................................................
  4.3 Financial Risk ........................................................................................................................
  4.4 Risk of other non-compliance with Terms of Authorisation ...................................................

Section 5
- Declaration and Self-Certification ...............................................................................................
  5.1 Board Statements ....................................................................................................................
  5.2 Membership Report ................................................................................................................

Section 6
- Financial Projections ....................................................................................................................

Appendices
  Appendix A
  Appendix B
  Appendix C
  Appendix D
Introduction

In July 2004, University College London Hospitals NHS Trust was one of the first NHS Trusts to be granted Foundation Trust status. This document sets out the Annual Plan for 2006/07, supported by the five year service development strategy that was agreed by the Trust and its stakeholders. It identifies new national and local initiatives that the Trust will need to take account of in planning for its future, and builds on achievements and progress to date.

The Annual Plan for 2006/07 has been developed in close collaboration with the Members’ Council who have been involved in a series of seminars to set out plans for 2006/07, as well as contributing to the overall content of the plan. This feedback, combined with other external stakeholder views, has been extremely influential and helpful in developing the plan.

Section 1

Background

University College London Hospitals NHS Foundation Trust is a major university teaching hospital located in central London. It is one of the largest and most complex Trusts in the NHS, with an annual income of approximately £500 million, serving one of the largest and most diverse populations in the country. The Trust comprises eight separate hospitals as follows:

- Eastman Dental Hospital
- Elizabeth Garrett Anderson & Obstetric Hospital
- Hospital for Tropical Diseases
- National Hospital for Neurology and Neurosurgery
- The Heart Hospital
- The Middlesex Hospital
- The Royal London Homoeopathic Hospital
- University College Hospital

The Trust has a reputation for innovation, delivery of NHS targets and translating leading-edge teaching and research into high quality care for patients. It has consistently scored highly in performance management systems and has demonstrated outstanding achievements by:

- Retaining three star status;
- 1st and 2nd position in the national Dr Foster clinical league tables;

In addition the Trust took delivery of the £422 million new University College Hospital in April 2005, currently the largest PFI in the country, and the refurbished Royal London Homoeopathic Hospital. These will provide a fantastic opportunity to modernise and improve the facilities in which the Trust delivers healthcare.
Our vision

“UCLH is committed to delivering top quality patient care, excellent education and world class research.”

This is underpinned by a set of values that states:

“We will:

- Take pride in caring for our patients as individuals;
- Provide equal access to all our patients;
- Be open and approachable to all;
- Deliver high quality outcomes in partnership with others;
- Value the contribution and develop the potential of all our staff;
- Be responsible and accountable for all we do.”

The Trust is committed to developing strong relationships with stakeholders and partners locally and nationally. Our commitment to deliver top quality patient care, especially services to local residents, must remain a prime focus for our activities.

The Trust’s eight specialist hospitals provide treatment for local people, commuters and visitors to London, as well as highly specialised services for patients referred from all over the country. Its links with the Royal Free and University College London Medical School make it one of the UK’s leading centres for medical education. The Trust, together with the University Medical School, has the largest research and development budget in the NHS which is reflected in the excellence of its programmes. These were major factors in the Medical Research Council deciding, in principle, to relocate the National Institute for Medical Research on the university/hospital campus in the future.
Section 2

Past year performance

2.1 Chief executive’s summary of the year

Last year proved to be extremely challenging, as the Trust undertook one of the most complex hospital moves ever experienced, transferring services into the new state-of-the-art University College Hospital. The move to the new hospital involved moving more than 4,000 staff and hundreds of thousands of patient appointments over a period of more than six months. During the move, this disruption led to a fall in the number of patients treated with a consequent loss of income, impacting upon the ability of the Trust to present a breakeven financial position. It is reassuring to note that the levels of patients being treated has returned to plan now, and that a substantial part of the problem would not repeat in 2006/07.

In addition to the new Hospital move, there were a number of other important developments across the Trust through out the year;

Delivering top quality patient care – delivering top quality patient care continues to be at the core of clinical services across UCLH. The Trust once again achieved a number of improvements to patient care across a broad spectrum of clinical indicators and national targets. These were supported by a continued focus on supporting and developing our staff. A summary of the main improvements is set out below:

- Further reductions in waiting times – The Trust has once again delivered a step improvement in the length of time patients are required to wait for a GP out-patient appointment or operation. By December 2005, no patient waited more than 13 weeks for an out-patient appointment and no more than 6 months for an operation.
- Delivering the emergency care target – The Trust has continued its excellent performance in this area, ensuring that over 99% of patients are now seen and treated within four hours of coming to the emergency department.
- Reduction in infection rates – UCLH now has one of the lowest infection rates of any specialist Trust in the country, and has already delivered the national targets for 2008.
- Delivering workforce improvements – In conjunction with the physical moves that have taken place, a major series of change programmes and specialist training has delivered the staffing levels and new ways of working for the new hospital. These changes have been achieved in partnership with Staffside and the Unions.

Developing relationships with our external stakeholders – The development of the Members’ Council with elected representatives of all communities has continued to be one of the focal points for UCLH in 2005/06, in addition to increasing the level of engagement with PCTs and GPs. The main areas of development over the past year have been to:

- Deliver membership seminars, based upon areas of interest identified by the Members’ Council. This has included much greater involvement in the development of the Annual plan and information regarding service developments in future years;
- Establish a Trust “Open Evening” with a number of information stands for members of the public to meet and question key staff. This event was attended by substantial numbers of the public and as a result of the feedback received, a further event will be organised again for 2006/07;
- Appoint a new Director with the specific remit of developing and managing external relationships. This process has already led to the re-focus of the GP Liaison Committee to ensure that GPs directly interact with senior clinicians and managers in the Trust to develop services in line with PCT requirements;

The progress made in 2005/06 has strengthened the Trust’s desire to establish improved relationships with local GPs and Primary Care Trusts (PCTs.) The change in the focus of commissioning moving into 2006/07 will once again inform a key element in the Trust’s top 10 objectives for 2006/07.

**Renewing the estate** – 2005/06 has been a watershed in the development of the UCLH estate. Set out below are the key events

- The new hospital – As most observers will be aware, the Trust took ownership of the new UCH “on time and on budget” on 19 April 2005. Clinical services were transferred from Cecil Flemming House and the Rosenheim Building into the new hospital by the end of June 2005, with services from the Middlesex Hospital transferred in by the end of September. In July Cecil Flemming House was handed over to the builders for demolition and an immediate start on the building of the second phase of the new hospital was made;
- Sale of the National Temperance Hospital -
- Refurbishment of the Rosenheim - [DN - PB to complete]
- Other major developments included:
  - [DN - PB to complete]

As set out above, UCLH has had an extremely busy and turbulent year. 2006/07 is expected to be even busier, with the prospect of treating more patients than ever before. This Annual Plan highlights the main objectives that the Trust will be focussing on throughout 2006/07, in the context of delivering our strategic objectives and mission statement.

**2.2 Summary of financial performance**

**2.2.1 Key financial events during 2005/06**

**2.2.2 Outturn 2005/06 as compared to original plan**

**2.2.4 Exceptional in year items**

**2.2.5 Forward look – 2006/07**

**2.3 Other major issues**

**2.3.1 Appointments to the board – 2006/07**
Chairman – Peter Dixon was re-appointed by the Members’ Council on the recommendation of the Chairman Appointment Sub-Committee (a sub-committee of the Members’ Council) for a period of three years from 1 July 2005.

Non Executive Director – Nigel Carrington was appointed by Members’ Council on the recommendation of the Non Executive Director Appointment Panel (a panel of the Members’ Council) and took up post on 1 November 2005. He will chair the Trust Investment Committee. He was a corporate and commercial lawyer for Baker McKenzie and is currently a trustee and treasurer of Crisis, the homelessness charity.

The terms of office of two Non Executive Directors come to an end in the coming year and arrangements are in place to appoint to these positions.

2.3.2 Changes to the Members’ Council – 2006/07

There have been a number of changes to the Members’ Council.

Partner Organisations
Sue Payne replaced Deian Hopkins as the London South Bank University representative on 1st July 2005.

Professor Stephen Spiro replaced Professor Peter Ell as the University College London representative on 1st January 2006.

Staff Constituency
Paul Ostro was elected unopposed as the staff representative in the Health Care Assistant, Support, Scientific, Therapeutic and Technical Staff. He replaced Charlotte Cole who resigned in July 2005, taking up his position on 1 September 2005.

Public Constituency
Wendy De Silva was re-elected to the public seat.

Patient Constituencies
Christine McKenzie was re-elected to the Local Patient seat.

Pal Luthra and Jakki Mellor-Ellis were elected unopposed to the Regional Patient seat. The latter replacing Vivian Biriotti who chose not to stand for re-election.

Carol Hart was elected unopposed to the National Patient seat replacing Gwen Tighe who resigned in June 2005.

2.3.2 Significant changes to clinical delivery – 2006/07

All planned changes to service delivery that took place in 2005/06 are outlined under section 3 of this Annual Plan and are in line with the five year Service Development Strategy of the Trust. During 2005/06 there were no unplanned, significant changes to clinical delivery at UCLH.
Section 3
The changing healthcare context

3.1 Strategic overview
UCLH has to ensure that going forward into 2006/07 it is focused on delivering the mission statement in the context of a number of external strategic influences. An assessment of some of the major influences, their potential impact on the financial position of the Trust and their likelihood of occurrence are set out below:

Key External Strategic Influences

<table>
<thead>
<tr>
<th>Negative impact</th>
<th>Positive impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute rationalisation</td>
<td>Income generation</td>
</tr>
<tr>
<td>Public health</td>
<td>Specialist tariff</td>
</tr>
<tr>
<td>Less likely</td>
<td>More likely</td>
</tr>
</tbody>
</table>

A summary of the potential risks and mitigations associated with these more likely strategic influences is set out below:

<table>
<thead>
<tr>
<th>PCT/GP Demand management</th>
<th>Risks</th>
<th>Mitigations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Loss of referrals</td>
<td>Active marketing collaboration with PCTs</td>
</tr>
<tr>
<td></td>
<td>Waiting list reduction</td>
<td>Enforce contractual obligations</td>
</tr>
<tr>
<td></td>
<td>Return to primary care</td>
<td></td>
</tr>
</tbody>
</table>

| R&D income loss          | Fail to become an academic medical centre   | Prepare excellent case with UCL                    |
|                          | Fail to retain Culyer funding              | Thorough financial analysis of R&D costs           |

| Shift to Primary Care    | Potential loss of referrals                | Identification of key risk areas for detailed capacity planning with PCTs |
|                          | Excess capacity                            |                                                     |
In order to continue to deliver the essential components of the vision and deliver the objectives for 2006/07 in the context of the above strategic influences, the Board of Directors identified the strategic drivers that impact on UCLH;

- The drive to continually improve clinical quality and “customer care”;
- The need for increasing flexibility and capacity to be able to respond to changes quickly;
- The requirement to deliver patient-centric care, focused around the whole patient experience;
- The need for financial viability to ensure the long-term development of UCLH;
- The desire to be the employer of choice, recruiting and retaining the best staff.

In light of these, the Trust has set out below the overall objectives for next year.

### 3.2. Draft Objectives for UCLH 2006/2007

**1. Achieve financial balance by end of 2007/08**
- Approve and agree budgets and activity targets for all budget holders in 2006/07
- Achieve income and expenditure targets agreed by the Board throughout the year
- Maintain cash balance and liquidity throughout the year.

**2. Implement projects in 2006/07 to support recovery plan**
- Implement Clinical Efficiency Project plans for 2006/07
- Implement other projects to achieve 2006/7 financial targets
- Develop and implement plans to enhance management capacity.

**3. Complete the opening of the new hospital**
- Finalise the transfer of services into the new hospital
- Prepare marketing materials and dispose of the Middlesex Hospital in 2006/07
• Finalise plans for Phase 2.

4. Maintain high performing status

• Maintain and develop the performance management reporting structure
• Ensure key performance targets are achieved
• Deliver compliance with the Healthcare Commission standards.

5. Develop marketing strategy and maximise patient income

• Agree PCT and other contracts for 2006/07
• Prepare and implement a new marketing strategy for 2006/07
• Develop strategy for improved coding and influence the DH on the specialist tariff.

6. Delivering the workforce

• Achieve staffing reductions associated with the new hospital and financial targets
• Complete the implementation of Agenda for Change
• Develop a new process to benchmark staffing levels against other Trusts.

7. Develop the Foundation Trust model

• Prepare the Strategic and Operational Plans for 2006/07, including updating the service development strategy
• Assist the Members’ Council in role development and relationships with the Trust
• Strengthen the management structure to deliver the complex agenda.

8. Continue the implementation of the EPR Project

• Complete the implementation of Phase 1 of EPR
• Renegotiate the contract structure for EPR with GE Healthcare
• Agree the process for compatibility with the national Connecting for Health project.

9. Progress other developments

• Develop plans for the relocation of EDH and Heart Hospital onto the main campus
• Increase the extent of day surgery by 50% and prepare a strategy for ambulatory care
• Progress Queen Square developments – MRI and 33 Queen Square.

10. Other Priorities

• Continue to improve arrangement to minimise cross infection and improve cleanliness
• Work with the new R&D Director to develop the Research Governance Committee, and prepare for the “Best Health, Best Research” changes.

• Assist UCL/MRC in developing the National Institute for Medical Research.

Against each one of these objectives there is a nominated director lead who has a detailed operational plan underpinning all elements within the objective. These detailed plans form part of the assurance framework process outlined in section 4 of this plan, and are reported to the Board of Directors each quarter.

In the context of these objectives, and as part of delivering the original Service Development Strategy, the following section highlights progress made against the 5 year plans, indicating where there will be further work throughout 2006/07:

3.3. Service development plans – Progress against key topics

As part of the Trust Service Development Strategy, 18 key themes for development over a five year period. An assessment of progress to date and next steps is set out below:

- **Reducing waiting times** - The Trust continued to reduce overall waiting times for patients during 2005/06, meeting the national waiting times targets of ensuring that no patient waited more than 13 weeks for a new GP out-patient appointment, and no more than 6 months for a routine elective operation. UCLH is now well-placed to move towards the national 18 week maximum waiting time to be delivered by 2008.

- **A&E performance** – The Trust continues to have one of the best performing emergency departments in the country, ensuring that more than 99% of patients are treated and either admitted or discharged within 4 hours. The focus throughout 2006/07 will be to develop the clinical pathways for urgent and emergency patients coming to UCLH in partnership with our PCTs, including making the best use of the Commuter Centre, Walk-in Centre and Primary Care Centres. This work is essential in preparing the Trust for managing increasing emergency pressures and the potential impact of the Kings Cross development due to open in 2007/08.

- **Better hospital environment** – With the successful completion and handover of the new hospital at the start of April, the Trust completed phase one of improving the hospital environment. The building of phase two has now started, and further plans to consolidate the estate within the overall campus are being developed.

- **An internationally renowned centre for teaching and research** - Developing and sustaining world class medical research is central to the Trust’s mission statement and core values, particularly in light of the planned re-structuring of R&D funding across the NHS (“Best Research Best Health”). Although we have received interim funding for R&D of £43m in 06/07 in line with our historic allocation, this will be phased down over the next 3 years – to be replaced by a series of competitive bids for major programmes. It is likely that there will be some redistribution out of London affecting our income stream. We have set up a joint UCLH-UCL team to maximise our strength in this process. The criteria developed against which to assess further opportunities across specialist work include the following key headings:
  - Well functioning team with first class clinical leadership
- Evidence that centralisation of services at UCLH improves patient outcomes
- Evidence of excellence in teaching
- Programme grant support/UCL commitment
- External strategic support
- Efficient use of resources

- **Care for people with cancer** – Further progress has been made during 2005/06 to develop the UCLH strategy for cancer services: improving quality of care and access for all patients with cancer, while focusing additional resources to secure supra-regional/national referral patterns in six major cancers. This is now in place for gynaecological cancer which has expanded to support the whole sector, haematological, and neurosurgical cancers, and Head & Neck Cancer services which were transferred into the Trust in July 2005. Plans are well advanced to similarly secure sustainable supra-regional cancer referral bases in adolescent and urological cancers in 2006/07. These developments are in line with PCTs expectations and meet the overall sector-wide strategy for all Cancer services. We are continuing our drive to shift patient care to an ambulatory centre when ever possible and have received very encouraging feedback from patients who have benefited from this option.

- **Care for mothers-to-be and the new born** – UCLH provides a high quality, patient focused service for local families and acts as the designated specialist perinatal centre for north central London, taking care of women with high risk pregnancies and the smallest and sickest babies.

  2005/06 saw a consolidation of the progress made under the umbrella heading of “Healthy Starts, Healthy Futures” which sets out a model of care for the whole of north central London. Whilst the formal stakeholder consensus meeting confirmed UCLH as the perinatal centre for the sector, discussions have been ongoing as to how services will develop over the next few years in the other key sites in the sector. The expert panel elected to review this process is due to report shortly, and is expected to endorse the model of care proposed. This will lead to a continued strengthening of these services throughout 2006/07. This would be an important step – although the number of deliveries at UCLH is showing a sharp increase compared to historic levels. [DN – quantify changes in 2005/06]

- **Care for children** – UCLH offers an acute paediatric service to the local population and is one of only 22 paediatric cancer centres in the UK. UCLH, with the support of Great Ormond Street hospital, developed this service throughout 2005/06 and now provides the largest international cancer service for 0-19 year old patients. 2006/07 will see the further development of a paediatric A&E service for the local community as part of the overall drive to meet the National Service Framework and Healthcare Commission standards for paediatric care.

- **Care for teenagers** – The new self-contained floor for teenagers (T12) in the tower which opened in 2005/06 is a national icon supporting age appropriate environment for this age group. There are both dedicated facilities for cancer (supported by the Teenage Cancer Trust) as well as resources for all teenagers requiring inpatient care. During 2006/07 the main focus will be on ensuring that Consultants across the Trust make best use of this facility.

- **Care for women** – UCLH continues to be at the forefront of developing women’s health services. The gynaecology services moved into Tower during 2005/6 and
provides a women’s health only environment, in keeping with the traditions and ethos of the Elizabeth Garrett Anderson Hospital. The Institute of Women’s Health, developed jointly by UCLH and UCL is now well established and already showing major gains for women’s health across all aspects of our vision statement – clinical care, teaching and R&D.

- **Care for people with neurological disabling conditions** - The National Hospital for Neurology and Neurosurgery achieved the reconfiguration of inpatient services to minimise length of stay, and maximise day case and outpatient services during 2005/06. Throughout 2006/07 the NHNN will strengthen its London-wide base for neurosurgery and consolidate its place as the sector lead for neurological cancer. In addition, the joint UCLH/UCL project to develop 33 Queen’s Square will continue now that building permission has been obtained.

- **Dental care** – The Eastman Dental Hospital remains a leading European dental facility for teaching, research and specialist dental care. The main focus of 2006/07 will be to plan for future NHS needs, including improving the availability of special needs dentistry. This will be done in conjunction with the agreed strategy to relocate the NHS service to the main campus as soon as possible. It is likely that there will be changes on the academic side with a greater alignment with King’s College London which has a major undergraduate dental school.

- **Care of the elderly** – [DN – T Mundy to complete]

- **Better care for the critically ill** – [DN – A Webb to complete]

- **Care for people with heart disease** – [DN – T Mundy to complete]

- **Homoeopathic and alternative therapies** – Following the opening of the refurbished RLHH facilities, the focus in 2006/07 will be to work with Trust partners to integrate alternative health care options for NHS patients. Working with our commissioners, a substantial programme of education and training will be undertaken to ensure that this strategy of assimilation is recognised and commissioned appropriately.

- **Cutting hospital-acquired infection and improving the treatment of infectious diseases** – [DN – A Webb to complete]

- **Improved communication and stronger local partnerships** – [DN – S Johnston to complete]

- **Electronic patient record and picture archiving system** – [DN – C Jervis to complete]

### 3.4 Operating Resources required to deliver service developments

### 3.5 Investment and disposal strategy

### 3.6 Financing and working capital strategy

**Handling Strategies**
Section 4

Risk analysis
Set out within this section are the key areas of risk identified by the Trust for 2006/07, and the methodology used to both manage and mitigate these risks. In addition, it demonstrates the steps that are being taken by UCLH to strengthen the management of risk across the whole organisation.

4.1 Governance risk

4.1.1 Legality of the Constitution – 2006/07
The Constitution meets the terms of authorisation for 2006/07 and has not changed throughout 2005/06.

[DN – T Ramsden to confirm]

4.1.2 Growing a representative membership
This is set out in detail as part of the future membership strategy in the next section, (5.2)
[DN – T Ramsden to confirm]

4.1.3 Effective risk and performance management
As part of the on-going strengthening of Trust performance management and the management of risk during 2005/06, an increasing focus will be placed on the Assurance Framework (AF). This approach will be used by UCLH to assess performance against the Trust objectives. This framework is described in detail below and attached as Appendix C.

4.1.1 The assurance framework
[DN – A Glover to up-date]

4.1.2 Breadth & depth of assurance framework

4.1.3 Assurance framework reporting

4.1.4 Assurance framework review cycle

4.2 Mandatory services risk
Clause 14 of the Health and Social Care (Community Health and Standards Bill) allows the regulator of NHS Foundation Trusts to prevent Trusts from unilaterally withdrawing from provision of currently provided NHS services deemed as “protected”. The same applies to the facilities and staff used for the purposes of NHS-related education, research, and training carried on by others.

This power is there in order to protect the public from a decision by a NHS Foundation Trust (NHSFT) to unilaterally withdraw from provision of
services/facilities, where the Regulator deems there is not a viable alternative supplier. This is intended to ensure continuity and access to services for NHS patients.

Clause 16 of the Bill allows the Regulator to designate property owned by a NHSFT as protected. The Regulator may only designate property as protected if he or she considers it is needed to provide NHS goods and services that are “protected”. The Trust envisages that decisions on the protection of specific services and assets will follow the commissioning arrangements established by the Trust and their Commissioners. This will mean that all current NHS services provided, and the estate utilised to deliver such services will be designated as protected. It is further envisaged that this may change over time in accordance with the Service Strategy across the sector, led by the Strategic Health Authority, which will be reflected in PCTs’ commissioning intentions and in contract arrangements.

Within the Trust, however, a significant programme of service change is taking place largely driven by the opening of the new hospital on the Euston Road, commencing April 2005 (phase one) and then in 2008 which will see the opening of phase two.

4.2.1 Changes to mandatory service provision – 2006/07

Following sector-wide consultation and approval with all key stakeholders, the Trust recently transferred all renal and Nephrology services to the Royal Free Hospital. This planned service change reflects sector strategy and is consistent with the Trust plan. UCLH followed due process in formally actioning this change in mandatory service provision. There are no formal service changes planned in 2006/07. [DN – M Foster to advise]

4.2.2 Disposal of protected assets

4.3 Financial risk

4.3.1 Commentary on Financial risk rating

4.4 Other risks

As set out above, the Trust has a substantial risk management process in place to support the assurance framework. Within the overall objectives of the Trust, risks associated with delivery are identified and plans for mitigation set out.
Section 5

Declarations and self-certification

5.1. Board statements
Appendix XX sets out the self-certification statements for the Trust. [DN – Not clear if these are required in 2006/07 as no guidance currently available.]

5.1.1 Risk and performance management
Set out below is the work that UCLH has undertaken to provide greater assurance in key areas. In addition, areas that are being strengthened throughout 2006/07 to further improve standards are also highlighted:

- **External audit**
  All external audit reports are routinely reported to the Hospital Management Board and the Audit Committee, with regular reporting through to the Board of Directors. Combined with each external audit report is a detailed action plan setting out what steps are required to be met within specific timescales. This process is managed by the director of finance.

- **NHS Litigation Authority – RPST standards**
  [DN – A Glover to complete]

- **NHS Litigation Authority CNST standards**
  [DN – A Glover to complete]

- **Health and Safety Executive**
  [DN – A Glover to complete]

- **Audit Committee**
  [DN – M Foster to complete]

- **Planning and risk management processes**
The Board of Directors adopted the Service Development Strategy as part of the Foundation Trust application process, outlining the key service developments and five year financial and business modelling plan for the Trust. Key components of this strategy, including the business financial and business modelling elements have been revised and up-dated, and underpin the Annual Plan. In addition, the Trust has identified the known risks to compliance and incorporated these within the assurance framework, supported by the risk register. This assurance framework will form the basis of checking each planned development against the current environment, clinical priority and financial viability through the Hospital Management Board and the Board of Directors.

- **Internal control system**
  [DN – M Foster to complete]

- **Meeting core national health care targets and standards**
  Each month the Board of Directors receives a performance report on the progress against all core targets. This is supplemented by a quarterly presentation to the Board, focused on the demand and capacity of the Trust to meet changing patient flows. This process is supported by the self-certification process that is routinely reported through to HMB and the Board of Directors.
5.1.2 Board roles, structures and capacity – 2006/07

The Board of Directors can confirm the following statements:

- **Register of interest**
  The Board maintains a register of interests, available for public scrutiny. There are no material conflicts of interest in the Board.

- **Qualifications of directors**
  The Board is satisfied that all directors are appropriately qualified to discharge their functions effectively. This includes:
  1. Setting strategy
  2. Monitoring and managing performance
  3. Ensuring management capacity and capability

- **Skills and experience of non-executive directors**
  The selection process in place ensures that the non-executive directors have appropriate experience and skills. This is supported by the planned implementation of a Board-wide development programme in 2006/07.

- **Delivery of the forward plan**
  The Board recognises that the management team is required to deliver the national targets and local priorities. There are plans in place to deliver these targets during 2006/07. [DN – J Harrison to check]

- **Management structure**
  The clinically-led management structure at UCLH has supported the Trust in consistently delivering its objectives over several years. This structure has been further strengthened in 2005/06 and the Board believes that it is the most suitable to deliver the forward plan objectives in the future.

5.1.3 Compliance with authorisation – 2006/07

- **Authorisation**
  The Board is satisfied that UCLH has systems and processes in place to ensure the Trust is working with Monitor to deliver compliance with its authorisation and relevant legislation. This process of compliance is being strengthened by an internal audit review of the terms of authorisation process.

- **Risks and evidence to compliance**
  The Board considers known future risks to compliance with the terms of authorisation as part of the on-going assurance framework and risk management strategy. The level of severity of these risks and the likelihood of a breach occurring is assessed and plans for mitigation put in place as appropriate.

  In addition, the Board recognises the need for, and considers appropriate evidence to review these risks and implements action plans to address them where required to ensure continued compliance with the authorisation.

5.2 Membership report – 2006/07

Table A shows an up-dated position of the membership position, including an estimate for planned foundation trust membership:
<table>
<thead>
<tr>
<th>Public Constituency</th>
<th>Last Year</th>
<th>Next Year (Estimate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start of Year</td>
<td>287</td>
<td>500</td>
</tr>
<tr>
<td>New Members</td>
<td>216</td>
<td>-</td>
</tr>
<tr>
<td>Members Leaving</td>
<td>7</td>
<td>-</td>
</tr>
<tr>
<td>Year End</td>
<td>496</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff Constituency</th>
<th>Last Year</th>
<th>Next Year (Estimate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start of Year</td>
<td>6,465</td>
<td>6,465</td>
</tr>
<tr>
<td>New Members</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Members Leaving</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Year End</td>
<td><em>no significant change</em></td>
<td><em>no significant change</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Constituency</th>
<th>Last Year</th>
<th>Next Year (Estimate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start of Year</td>
<td>1,440</td>
<td>3,000</td>
</tr>
<tr>
<td>New Members</td>
<td>1,164</td>
<td>-</td>
</tr>
<tr>
<td>Members Leaving</td>
<td>42</td>
<td>-</td>
</tr>
<tr>
<td>Year End</td>
<td>2,562</td>
<td></td>
</tr>
</tbody>
</table>

**Total** 9,523

*Staff automatically become members when they join the Trust. Staff are offered the option to ‘opt out’ of the membership. Only 12 staff have opted out to date. (Verification of membership class and membership numbers will be carried out pre-election.)*

[DN – Numbers will be up-dated at year-end by T Ramsden]

### 5.2.1 Constituencies – 2006/07

The Members’ Council comprises three Public, 14 Patient and five Staff Council Members elected from three membership constituencies together with 11 appointed representatives from partner organisations. The three constituencies which make up the membership are:

**The public constituency** is defined as those residents who live in Camden, Islington, Westminster [the wards of Cavendish, West End or St James] and the City of London; [the wards of Farringdon Without, Farringdon Within, Aldersgate, Cripplegate, Bassishaw, Cheap, Cordwainer, Walbrook, Vintry, Queenhithe, Castle Baynard, Bread Street, Coleman Street, Dowgate].

**The patient constituency** is divided into four classes: local patients, regional patients, national patients and patient carers. Patients are defined as having attended the hospital during the last three years.

**The staff constituency** is divided into four classes: medical and dental practitioners class, nursing and midwives class, health care assistant (HCA) support, scientific, therapeutic and technical class and finally administration and clerical (including senior managers), estates and auxiliary class. This constituency includes staff who are employees of the Trust and who provide a service for the Trust through a contract of employment with the Trust. This right is explained on appointment and on the staff Intranet.

### 5.2.2 Future membership Strategy – 2006/07

A group of the Members’ Council, the Communications and Membership group has been set up to plan initiatives for recruitment, membership engagement and
communication with constituencies of the Foundation Trust membership and it has produced a work programme for 2006/07.

Recruitment Initiatives will include:
- recruitment drives through our membership newsletter
- recruitment adverts in the local press
- posters and leaflets displayed around the Trust
- initiatives to attract local student population and younger members
- strategies to engage with black and ethnic minority groups.

A focus group of Council Members will be set up to discuss recruitment ideas for improving membership.

5.2.3 Membership Seminars and Events – 2006/07

Membership seminars were held for the first time in 2005 and these will continue in 2006/07. A survey was undertaken to determine what topic areas would be of interest to membership and these ‘Members Meets’ are planned for the coming year:

- MRSA,
- Neurology services
- Healthy Heart

An event will also be planned providing members with an opportunity to meet Council Members and the Trust will hold an open event at which the Members’ Council will have a stand and use this as an opportunity to recruit members.

5.2.4 Election of Governors – 2006/07

There will be six seats available for election to the Members’ Council in the following constituencies:

- Public
- Local Patient
- Regional Patient
- National Patient
- Patient Carer

Elections will be held in accordance with the election rules as stated in the Constitution

Section 6 Financial Projections
COMMUNICATIONS AND MEMBERSHIP GROUP

1. Terms of Reference for the Communications and Membership Group
A draft Terms of Reference (which follows) has been agreed by the CMG and is presented for the Members' Council's approval. It will be adopted following any necessary amendments.

Action – please would the Members’ Council approve the Terms of Reference

2. Analysis of the membership
a. SHA advice – action point from last Council meeting
Robert Mitchell, from the North Central London Strategic Health Authority, has been contacted and asked for advice about how we record ethnicity, disability and diversity. He has been working on the national ‘knowledge and skills framework’ which contains details about staff ethnicity in relation to the training they receive. As far as patients are concerned, the SHA advocates that we should collect the same information as does the Census which is in many cases is contracted to 16 categories + 1 (the latter being ‘not stated’) from the 99 available Census groupings. However, this is not very sensitive to London diversity where a Turkish Cypriot may classify themselves as ‘Any other white background’. 16+1 can be modified to allow a self-identifying box, and then the Trust would need to undertake the categorisation into one of the 99 groups. Ethnic monitoring should be undertaken as accurately as possible as only then can this be correlated with equity, access, needs and so on. As far as how the Trust progresses this, Language Line may be able to give a better idea of the practical diversity than patient information systems.

With respect to other issues of diversity, should disability be monitored? Should sexual orientation or HIV status be monitored? This is more a local issue at the moment. Monitoring sensory impairment may assist the patient experience (e.g. would sign language help an interaction), but issues of HIV or sexual orientation are very problematic and Mr Mitchell suggests expert advice is taken from, for example, Stonewall (a professional lobbying group that tries to prevent attacks on lesbians, gay men and bisexuals occurring and acts to promote their equality).

Action – please would the Members’ Council advise on how this information should be used
b. **GIS software**
The CMG has investigated the use of Geographic Information System software to compare the demographic information of our membership with (1) our patient population and (2) Census data. Information such as ethnicity, or age, or social group can be used to see how our membership reflects the larger groups. The CMG is undertaking this work to see if the constitution of the membership should be able to make a balanced contribution to the work of the Trust. There are inherent problems with this: are the Trust’s ethnicity records of 16+1 really comparable to the more complex census data? Has an audit been undertaken of the reliability of the Trust’s records? To what extent do we want the membership to reflect either Census data or our patient population? How do we reflect the national patients and carers in these comparisons? This work is on going and the CMG will report on it periodically.

3. **Communication**
The CMG has agreed that questions can be asked of the membership through the Newsletter (UCLH News) and the Trust’s website. The CMG has agreed that developing communication between different staff groups is not Members’ Council business.

a. **Young people and children – action point from last Council meeting**
A number of different initiatives have and are being explored. UCLH NHS FT Council Member Marisha Ray has suggested a contact about the Pupils’ Parliament, and Gabriella Di-Sciullo, Head of the Social Inclusions Unit of Camden Education Authority, has provided a collection of web links to different resources. These will be discussed at the next CMG meeting. UCLH NHS FT Council Member Tricia Pank is actively pursuing meeting with local schoolchildren, probably through their Citizenship classes.

b. **Ethnic diversity**
Nasim Ali, Councillor for Regent’s Park Ward and Executive Director of King’s Cross-Brunswick Neighbourhood Association, has been contacted and has passed on the details of the CMG to a number of different groups and associations. Plans are in hand to arrange community meetings with Council Members through this route. Depending on the experiences, the CMG also has the contact details of Somali community leader and will pursue a similar exchange.

c. **Forthcoming focus group**
Following invitations sent out with the last edition of UCLH News, the CMG plans to hold a focus group meeting with members of the public to see if there are further suggestions for improving our membership recruitment. The date for this meeting is Wednesday 17th May 2006.

4. **Trust open day**
With the excellent help of Julian Draper, Membership Office Manager of UCLH NHS FT, the CMG ran a stand at the Trust’s open day on 20th February. A number of new members were recruited at this event, and it was a chance for Council
Members to talk in a relaxed fashion with potential members, staff members, and each other.

5. Communication received from private individuals
A significant number of communications have been received by both the Membership Office and the chair of the CMG from one individual. The communications have asked a lot of questions, many of which have been answered and which have produced more questions. Unfortunately, it was felt beyond the resources of the Chair to continue to provide a personal response to any single individual as the Council Members have a responsibility to the whole membership.

Action – please would the Members’ Council consider the limitations to the resources available for contact with Members and the Public and suggest a course of action.

6. Date of the next CMG meeting
Tuesday 23rd May 2006 at 17.30h.

Dr John Lee
Chair, Communications and Membership Group
UCLH NHS FT
March 2006
UNIVERSITY COLLEGE LONDON HOSPITALS
NHS FOUNDATION TRUST
COMMUNICATIONS AND MEMBERSHIP GROUP
TERMS OF REFERENCE (draft 2)

OBJECTIVES
1. To promote improved communication as it relates to all the member constituencies of UCL Hospitals NHS Foundation Trust
2. To encourage and stimulate a productive membership of UCL Hospitals NHS Foundation Trust

RESPONSIBILITIES
1. To develop and oversee the implementation of a communications and membership work plan
2. To ensure that plans take into account ethnicity, diversity and deprivation issues relevant to the current and future membership
3. To monitor membership recruitment at regular intervals
4. To provide regular activity reports to the Members’ Council, UCL Hospitals NHS Foundation Trust

PROCEDURAL NOTES
1. The Communications and Membership Group will meet as required to achieve its objectives
2. The Working Group will seek advice from external advisors or other bodies as necessary

CURRENT MEMBERSHIP

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Lee</td>
<td>Chair and Staff Council Member</td>
</tr>
<tr>
<td>Jakki Mellor-Ellis</td>
<td>Joint Deputy Chair and Regional Patient Council Member</td>
</tr>
<tr>
<td>Eileen West</td>
<td>Joint Deputy Chair and Stakeholder Council Member</td>
</tr>
<tr>
<td>Janet Clarke</td>
<td>Staff Council Member</td>
</tr>
<tr>
<td>Peter Davison</td>
<td>National Patient Council Member</td>
</tr>
<tr>
<td>Wendy De Silva</td>
<td>Public Council Member</td>
</tr>
<tr>
<td>Carol Hart</td>
<td>National Patient Council Member</td>
</tr>
<tr>
<td>Christine Mackenzie</td>
<td>Local Patient Council Member</td>
</tr>
<tr>
<td>Paul Ostro</td>
<td>Staff Council Member</td>
</tr>
<tr>
<td>Patricia Pank</td>
<td>Local Patient Council Member</td>
</tr>
<tr>
<td>Mary Shelley</td>
<td>Regional Patient Council Member</td>
</tr>
<tr>
<td>Veronica Beechey</td>
<td>Regional Patient Council Member</td>
</tr>
<tr>
<td>Marisha Ray</td>
<td>Stakeholder Council Member</td>
</tr>
</tbody>
</table>
University College London Hospitals NHS Foundation Trust Members’ Council

Chairman and Non Executive Director (NED) Recruitment and Remuneration Working Group

Final Report to the Members’ Council
30th March 2006

1. This group was set up by the Members’ Council at its meeting on 21st September 2005. While the membership of the group changed during its deliberations the following people have contributed as full members of the group: -

   Graham Faulkner  - Stakeholder & Chair
   Peter Davison  - National Patient Council Member
   Amanda Gibbon  - Public Council Member
   June Grun  - Public Council Member
   Scott Johnston - Staff Council Member
   Clive Saville  - Local Patient Council Member

2. In addition we had the benefit of input from 3 corresponding members: -

   John Lee  - Staff Council Member
   Virginia Beardshaw - Local Patient Council Member
   Veronica Beechey - Regional Patient Council Member

3. We also had immeasurable help and assistance from Tonia Ramsden, Director of Corporate Services, and Selina Cheung and I would want to place on record my thanks and appreciation to them.

4. The Terms of Reference of the group were approved by the Members’ Council at its meeting on 5th December 2005 and are attached as Appendix 1 to this report.

5. The group presents the following recommendations to the Council.

**Remuneration of Chairman and Non Executive Directors**

6. The Members’ Council meeting on 5th December 2005 received an interim report from this working group and endorsed its recommendations on the remuneration of the Chairman and the NEDs. These recommendations were as follows: -

   Non Executive Directors  £12,000
   Chair of the Audit committee  £17,000
   Chair  £40,000 to be increased progressively over two years to £60,000

7. The increases were back-dated to 1st July 2005 and it was agreed that they should be reviewed annually on 1st July.
Remuneration Committee

8. The Group agreed that a Remuneration Committee should be established to deal with matters relating to remuneration and appraisal and that it should also receive the appraisals of the Non Executive Directors. This Committee should be drawn from the members of the Recruitment Pool (see paragraph 12 below)

Process for the appointment of the Chairman and Non Executive Directors

9. The Constitution refers to an Appointments Panel for the appointment of NEDs and a Sub-Committee of the Board for the appointment of the Chairman. For ease of reference in this report we have referred to each of these bodies as the “appointment panel”.

10. Detailed programmes for the recruitment and selection of the Chairman and the NEDs are presented as Appendices 2 and 3. It will be noted that we believe that both processes need to be started well in advance to give sufficient time for the full participation of the Members’ Council following the initial work which will be undertaken by an appointment panel. Therefore we have suggested an 8-month period for the NEDs and a full 12 months for the Chairman. This would also enable an induction programme to be organised and undertaken and in the case of the Chairman, for a smooth handover from one Chairman to the next.

11. The group considered a number of issues concerning how the process should proceed and submits its recommendations on these, as follows: -

12. Recruitment Pool - We propose that a Recruitment Pool be established from among the members of the Members’ Council which would include representatives from all the constituencies represented on the Council. It would need to be of sufficient size and composition to enable appointment panels to be created for both NED and Chairman appointments, in accordance with the requirements of the Constitution. Individual appointment panels could then be selected by correspondence, identifying those from the pool who were willing and able to participate. The final membership of any appointment panel should be endorsed by the full Members’ Council.

13. The members of the Pool should be appointed by the Members’ Council for 3 years, with membership being reviewed on an annual basis.

14. Establishing such a pool would have the following advantages: -

- All members of the Recruitment Pool would receive recruitment and selection training, including diversity training, giving the Trust and the Council greater flexibility to act at short notice when setting up panels.

- The need for recruitment training would be removed from any specific appointment process thus shortening the timetable.

- Members of the Pool would acquire a depth of knowledge about a range of issues adding value to the Council.
15. We propose that the Members’ Council should establish the Remuneration Committee, referred to in paragraph 8 above from among the members of the Recruitment Pool.

16. If this recommendation is supported by the Members’ Council, consideration should be given to establishing the Pool immediately so that it can begin work on the recruitment of NEDs in 2006.

17. Requirements of the Constitution - The Constitution defines the membership of the appointment panels for the appointment of the Chairman and NEDs. Some concern was expressed to the group about the potential size of the panel, but it was agreed that the composition as specified in the Constitution, is appropriate given the importance of the roles. However, candidates would be better prepared if they were advised prior to interview about the composition of the panel.

18. We agreed that the appointments panels should aim to reach a unanimous decision. However, the Constitution allows for the recommendation of not more than two candidates being put to the Members’ Council.

19. Advisors and assessors – The Constitution allows for the use of assessors and advisors by appointment panels.

   • The role of advisors is to provide reassurance on the process for the appointment panel but they are not party to the final decision.

   • The role of assessors is to advise whether candidates are suitably qualified to fulfil the basic requirements of the role, but again they are not party to the final decision.

20. It should be for each appointment panel to decide whether to involve advisors and assessors although some form of external input to the process is desirable. However external support must not dilute the responsibility of the panel. It must be the panel members that make the final decision about which candidate(s) to recommend to the Members’ Council.

21. Job Description and Person Specification – One of the first tasks of an appointments panel is to agree the job description and the person specification. In finalising these documents, the panel should take account of the needs of the Board as specified by the Chairman, Chief Executive and Non-Executive Directors and as evidenced by the skills evaluation mentioned below.

22. Skills required of NEDs - Peter Dixon confirmed that he has a good understanding of the skills of the current NEDs and can therefore identify the skills needed when recruiting new NEDs. We understand that the Chairman and Chief Executive are currently undertaking a “knowledge and skills evaluation” of the Board. The outcome of this process should enable them to identify any shortfall in the collective skills of the Board and inform the appointment panel about the specific expertise, skills or knowledge required of a future NED candidate.

23. An understanding of the expertise, skills and knowledge needed by the Chair should evolve from the appraisal and objective setting process as outlined below (see paragraphs 41 to 46). This should be complemented by input from the Chief Executive outlining any specific requirements from his perspective.
24. **Diversity** – Although the primary concern must be to create a Board that has the skills and qualities to meet the needs of the organisation, we agreed that a more diverse Board was desirable in terms of its gender/ethnic/age/disability balance, and that diversity itself was relevant to the capacity of the Board to address the needs of the organisation. It was agreed that the need for diversity should be considered alongside the skills and qualities of Board members.

25. We recommend that we should wherever possible aim for greater diversity on appointments panels.

26. We suggest that the Trust should also investigate more imaginative ways of encouraging greater diversity in those engaging directly with the Trust and willing to consider participating in its governance. In this context, we welcome the work of the Communications and Membership working group to promote more active engagement with local communities.

27. **Practical arrangements for the recruitment process** - It is proposed that the Director of Corporate Services should manage the recruitment process with the Human Resources Department (HR) providing administrative support. This would ensure that one person had overall responsibility for ensuring the process is managed efficiently and effectively. It was suggested that the Director of Corporate Services should develop a ‘good practice protocol’ to include a checklist (with sample letters as part of the guidance) for HR to follow. The administrative protocol would sit alongside the process timetables attached as Appendices 2 and 3 to this report.

28. **Interview date and time** - We agreed that the interview date should be specified in the advertisement and consideration should only be given to changing the date or time in exceptional circumstances. We suggest that a ‘faith calendar’ be used to avoid clashes with religious festivals.

29. The timing of interviews should wherever possible be negotiated with candidates.

30. **Presentation** - After some discussion the group concluded that a presentation to the appointment panel would give the opportunity to gain a wider insight into the applicant’s skills and experience.

31. Consideration was given to whether a presentation should be given by all candidates to the full Members’ Council. It was concluded that this is not practical although some members took a different view. The decision on this must rest with the full Council.

32. **References** - It was acknowledged that a reference is an important part of the appointment process and that the decision to appoint a candidate should never be made without references being considered by the appointment panel.

33. The Trust’s policy is that references should not be viewed until the interview has been concluded when they are used to confirm a decision or to help make a choice between two candidates where the panel is undecided.

34. One member of the working group felt strongly that references should be requested and reviewed prior to interview in case they threw up concerns about any of the candidates.

35. On balance, we agreed that the Members’ Council should follow the Trust policy and that the following should be incorporated into the ‘good practice protocol’;
• References will be taken up on all candidates invited for interview
• Referees will be checked to establish that they are appropriate people to be providing a reference
• Written/emailed references will be available on the day of interview
• References will be provided to the Panel when the interviews have been concluded and used to confirm a decision or help to make a choice between candidates.

36. Report from Appointments Panel to the Members’ Council – The date of the Members’ Council meeting at which the appointment panel’s recommendation is to be presented should be set well in advance and the meeting should be held not more than 5 working days after the interview date. A progress report should be presented at any regular meeting of the Members’ Council that occurred during the recruitment process.

37. If possible, the timetable for the appointment should be set so as to enable the recommendation for appointment to be made to a regular programmed meeting of the Members’ Council rather than organising an extraordinary meeting.

38. We agreed that, where possible, a written report and a CV of the successful candidate should be sent out in advance of the meeting of the full Council with the recommendation to appoint. On occasions, circumstances may make this inappropriate, e.g. reappointment of a Chair. A decision on what to send out in advance should be taken on each occasion taking into account the circumstances at the time.

39. We agreed that, if the Council rejected a recommendation made by the appointment panel, a new panel would need to be appointed. The new panel could make a decision to restart the whole process or review the previous process and opt in at any particular point, e.g. calling one of the other applicants in for interview etc.

40. Feedback to unsuccessful candidates - If requested, feedback should be provided by the Chair of the appointment panel or by a panel member with delegated responsibility from the Chair to unsuccessful candidates.

**Appraisal of the Chairman**

41. The group felt strongly that the appraisal of the Chairman was a key task for the Members’ Council rather than for the Non-Executive Directors on the Board, and that this should be a responsibility of the Remuneration Committee.

42. We propose that the Chair should set personal objectives each year, which should be endorsed by the Council. We recommend that (s)he should carry out a self-assessment of his/her performance against these objectives as a part of the appraisal process.

43. These personal objectives might be different, although related to, the objectives of the organisation. For example they might emphasise the difference in role between the Chair and the Chief Executive. They would essentially form the agenda for an appraisal meeting with the Remuneration Committee to be held 12 months hence.

44. It was further agreed that in addition to an appraisal against stated objectives, a 360° appraisal among colleagues, managed by an external facilitator, should be
undertaken. This would enable the chair’s style, behaviour and qualities as well as his skills and achievements to be assessed.

45. We suggest that the appraisal should be undertaken in July each year and the outcome should be reported to the Members’ Council.

46. Discussions were held with the current Chairman who confirmed that he would be happy to participate in such a process. A letter setting out his proposed objectives for 2006 is attached as Appendix 4.

**Consultation on the Foundation Trust Code of Governance**

47. While the group has been meeting, Monitor has published a consultation document on the Code of Governance of Foundation Trusts. It contains much relevant material related to the tasks set for the group and we gave it consideration.

48. It was noted that it is still only a consultation document and in any case the proposal is to make it voluntary on a "comply or explain" basis, rather than mandatory. It was agreed that the group’s task was to put forward procedures that were appropriate for the UCLH NHS Foundation Trust even if they differed from the advice in the consultation document, and this is what we have done.

**Appointment of Non Executive Directors in 2006**

49. We understand that the terms of office of two NEDs come to an end in November 2006, although only one of these is for appointment by the Members’ Council. Therefore, if we are to adhere to the proposed timetable, it is necessary to begin the recruitment process at the March Members’ Council meeting.

50. Ideally it would be helpful if the Recruitment Pool could be established at the March Council meeting with the appointment panel being selected and confirmed at the same time.

51. I present this report on behalf of the working group and I **RECOMMEND** its approval by the Council.

Graham Faulkner  
13 March 2006
Chairman and Non Executive Director
Recruitment and Remuneration Working Group

TERMS OF REFERENCE

The Constitution of UCLH NHS Foundation Trust provides that the rights and duties of the Members’ Council include the appointment of Non Executive Directors and deciding on their remuneration, allowances and other terms of office.

OBJECTIVES

1. To advise the Members’ Council about appropriate remuneration, allowances and other terms and conditions of office of the Non Executive Directors.
2. To review the procedure for appointment of the Chairman and Non Executive Directors.
3. To consider a procedure for appraising the Chairman.

RESPONSIBILITIES

1. To make recommendations to the Members’ Council:
   i) on the remuneration, allowances and other terms and conditions of office of:
      a) the Chairman
      b) the Non Executive Director – Chair of the Audit Committee
      c) other Non Executive Directors;
   ii) on an implementation date for remuneration;
   iii) that remuneration levels, when set, are reviewed at an agreed interval;
   iv) to consider if a remuneration committee should be established for this purpose.
2. To recommend a revised procedure for the appointment of both the Chairman and Non Executive Directors having given due consideration to constitutional implications.
3. To recommend a procedure for appraising the Chairman.

PROCEDURAL NOTES

• The Recruitment and Remuneration Working Group will meet as required to achieve the objectives.
• The Working Group will submit a report to the Members’ Council each time it meets.
• The Working Group will seek advice from external advisors or other bodies as required.

MEMBERSHIP

Working Group Members:
Graham Faulkner  - Chair and Stakeholder Council Member
Peter Davison   - National Patient Council Member
Amanda Gibbon   - Public Council Member
June Grun       - Public Council Member
Scott Johnston  - Staff Council Member
Clive Saville   - Local Patient Council Member

Corresponding Member:
Virginia Beardshaw - Local Patient Council Member
Veronica Beechey  - Regional Patient Council Member
John Lee          - Staff Council Member

The group was supported in its work by Tonia Ramsden, Director of Corporate Services

December 2005
### Process for the appointment of the Chairman (draft 5)

Process to commence at least 12 months prior to end of Chairman’s term of office.

<table>
<thead>
<tr>
<th>Action</th>
<th>Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of Corporate Services to contact members of the Recruitment Pool to ascertain who would be willing and able to serve on the selection sub-committee.</td>
<td>2 weeks prior to Council meeting</td>
</tr>
<tr>
<td>Members’ Council meeting to set up selection sub-committee in accordance with Constitution and in accordance with terms of reference agreed for the Recruitment Pool.</td>
<td>1/54 June Council meeting</td>
</tr>
<tr>
<td><strong>First</strong> meeting of Sub-committee to agree;</td>
<td>8/54</td>
</tr>
<tr>
<td>• Chair of Sub-committee</td>
<td></td>
</tr>
<tr>
<td>• Job description and person specification</td>
<td></td>
</tr>
<tr>
<td>• Recruitment pack etc.</td>
<td></td>
</tr>
<tr>
<td>• Timetable including Members’ Council involvement, advert, shortlisting process, interview date, date of Members’ Council meeting to make recommendation (if possible the process should be arranged so that the report recommending an appointment can go to a programmed meeting of the Council to avoid convening a special meeting)</td>
<td></td>
</tr>
<tr>
<td>• Process for appointment (presentation etc)</td>
<td></td>
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<tr>
<td>• Use of external advisors, assessor and headhunters if thought appropriate</td>
<td></td>
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<tr>
<td>• Budget.</td>
<td></td>
</tr>
<tr>
<td>Sub-committee Chair to approach and select external Advisor/Assessor/Head-hunters as required.</td>
<td>9-10/54</td>
</tr>
<tr>
<td>Director of Corporate Services to draft recruitment documents and circulate to the Members’ Council for comment.</td>
<td>13-15/54</td>
</tr>
<tr>
<td>(Meeting of Sub-committee to be arranged if required to agree documentation before circulation to Members’ Council).</td>
<td></td>
</tr>
<tr>
<td>Sub-committee meeting to consider Members’ Council comments and amend documentation as appropriate.</td>
<td>18/54</td>
</tr>
<tr>
<td>Chair of Sub-Committee to ask Chairman to call an Extraordinary Members’ Council, if necessary, the meeting to be held not more than 5 working days after interview and the date of meeting to be included in the pack to be sent to candidates.</td>
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<tr>
<td>Activity</td>
<td>Date</td>
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<td>-------------------------------------------------------------------------</td>
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<tr>
<td>Sub-committee to agree shortlisting process including scoresheet, final advert, and media to be used.</td>
<td>18/54</td>
</tr>
<tr>
<td>Advertise post with a three-week closing date &amp; include interview date in advert or information sent to candidates (6 week timetable required to meet key journals/newspaper deadlines for publication).</td>
<td>20-26/54</td>
</tr>
<tr>
<td>Short-listing scores collated and appropriateness of the referees checked.</td>
<td>27/54</td>
</tr>
<tr>
<td>Sub-committee meeting to discuss and agree shortlist and agree interview arrangements, e.g. allocation of questions.</td>
<td>28-29/54</td>
</tr>
<tr>
<td>Interviews followed by Sub-committee meeting</td>
<td>33-34/54</td>
</tr>
<tr>
<td>• If there is an agreed decision – check references</td>
<td></td>
</tr>
<tr>
<td>• If there is a split decision between candidates – check references in an attempt to reach an agreed decision. If agreement cannot be reached then agree the process for presentation of 2 candidates to Members’ Council for decision.</td>
<td></td>
</tr>
<tr>
<td>Chair of Sub-Committee to produce report for the Members’ Council meeting.</td>
<td></td>
</tr>
<tr>
<td>Members’ Council Meeting.</td>
<td>5 working days following interview</td>
</tr>
<tr>
<td>Chair of sub-committee to inform successful candidate</td>
<td>Immediately after meeting</td>
</tr>
<tr>
<td>The Director of Corporate Services will arrange for unsuccessful candidates to be notified of the decision and confirm which member of the interview panel will provide feedback if requested.</td>
<td></td>
</tr>
<tr>
<td>Chief Executive or Director of Workforce to send a letter of appointment to the successful candidate on behalf of the Members’ Council.</td>
<td>36/54</td>
</tr>
</tbody>
</table>
Appendix 3

Process for the appointment of Non Executive Directors (draft 5)

Process to commence at least 8 months prior to end of Non Executive Directors term of office.

<table>
<thead>
<tr>
<th>Action</th>
<th>Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Director of Corporate Services to contact members of the</td>
<td>2 weeks prior to Council meeting</td>
</tr>
<tr>
<td>Recruitment Pool to ascertain who would be willing and able to serve</td>
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<tr>
<td>on the Appointments Panel.</td>
<td></td>
</tr>
<tr>
<td>Chairman of the Trust and Chief Executive to draw up a schedule of</td>
<td>1/32</td>
</tr>
<tr>
<td>the skills required of the Non- Executive Director.</td>
<td></td>
</tr>
<tr>
<td>Members’ Council meeting to agree process to set up a Non Executive</td>
<td>1/32</td>
</tr>
<tr>
<td>Director Appointments Panel in accordance with the Constitution and</td>
<td></td>
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<tr>
<td>the terms of reference agreed for the Recruitment Pool.</td>
<td></td>
</tr>
<tr>
<td>Meeting of Appointments Panel to agree;</td>
<td>8/32</td>
</tr>
<tr>
<td>• Job description and person specification taking account of the</td>
<td></td>
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<tr>
<td>skills required as notified by the Chairman and the Chief Executive</td>
<td></td>
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<tr>
<td>• Recruitment pack etc.</td>
<td></td>
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<tr>
<td>• Timetable including Members’ Council involvement, advert, short</td>
<td></td>
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<tr>
<td>listing process, interview date, date of Members’ Council meeting</td>
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<tr>
<td>to make recommendation (if possible the process should be</td>
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<tr>
<td>arranged so that the report recommending an appointment can go</td>
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<td>to a programmed meeting of the Council to avoid convening a</td>
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<td>special meeting)</td>
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<td>• Process for appointment (Presentation etc.)</td>
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<td>• Use of external advisors, assessor and head-hunters if thought</td>
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<tr>
<td>appropriate</td>
<td></td>
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<tr>
<td>• Budget</td>
<td></td>
</tr>
<tr>
<td>Chair of the Appointments Panel to approach and select external</td>
<td>9-10/32</td>
</tr>
<tr>
<td>Advisor/Assessor/Head-hunters if required.</td>
<td></td>
</tr>
<tr>
<td>The Director of Corporate Services to produce draft recruitment</td>
<td>11/32</td>
</tr>
<tr>
<td>documents and circulate to the Members’ Council for comment.</td>
<td></td>
</tr>
<tr>
<td>(Meeting of Appointments Panel to be arranged if required to agree</td>
<td></td>
</tr>
<tr>
<td>documentation before circulation to Members’ Council).</td>
<td></td>
</tr>
<tr>
<td>Meeting of Appointments Panel to consider Members’ Council</td>
<td>13/32</td>
</tr>
<tr>
<td>comments and amend documentation as appropriate.</td>
<td></td>
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<tr>
<td>Chair of the Appointments Panel to ask the Chairman of the Trust to</td>
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<tr>
<td>call an extraordinary Members’ Council meeting (if necessary), this</td>
<td></td>
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<tr>
<td>meeting to be no more than 5 working days after interview date, the</td>
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<tr>
<td>date to be included with the information to be sent to candidates.</td>
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<tr>
<td>Event</td>
<td>Date</td>
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</tr>
<tr>
<td>Appointments Panel to agree short listing process including scoresheet, final advert and media to be used.</td>
<td>13/32</td>
</tr>
<tr>
<td>Advertise post with a three-week closing date &amp; include interview date in advert (6 week timetable required to meet key journals/newspaper deadlines for publication).</td>
<td>16-22/32</td>
</tr>
<tr>
<td>Short-listing scores collated and appropriateness of referees checked.</td>
<td>23/32</td>
</tr>
<tr>
<td>Appointments Panel meeting to discuss and agree shortlist and agree interview process including allocation of questions.</td>
<td>25/32</td>
</tr>
<tr>
<td>Interviews followed by Appointments Panel meeting</td>
<td>27/32</td>
</tr>
<tr>
<td>• If agreed decision – check references</td>
<td></td>
</tr>
<tr>
<td>• If split decision between candidates – check references in an attempt to reach an agreed decision. If agreement cannot be reached then agree the process for presentation of 2 candidates to Members’ Council for decision.</td>
<td></td>
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<tr>
<td>Chair to produce report for the Members’ Council meeting.</td>
<td></td>
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<tr>
<td>Members’ Council meeting.</td>
<td>5 working days after interview</td>
</tr>
<tr>
<td>Chairman to inform successful candidate</td>
<td>Immediately after meeting</td>
</tr>
<tr>
<td>The Director of Corporate Services will arrange for unsuccessful candidates to be notified of the decision and confirm which member of the interview panel will provide feedback if requested.</td>
<td></td>
</tr>
<tr>
<td>Chairman to send a letter of appointment to the successful candidate on behalf of the Members’ Council.</td>
<td>29/32</td>
</tr>
</tbody>
</table>
Dear Graham

My apologies for the delay in coming back to you with further thoughts around objectives for myself. Tonia and I did have a very useful conversation before she went on holiday and some of the ideas we discussed were as follows:

1. Responsibility for ensuring that Board and Members' Council work together as effectively as possible.

2. Facilitating the contribution of Non-Executive Directors and ensuring constructive relationships between Non-Executive and Executive Directors.

3. Appraisal and performance management of Non-Executive Directors and the Chief Executive.

4. Leadership of both the Board and the Members' Council as appropriate.

5. Performance assessment of the contribution of the Members' Council as a whole.

I would be quite happy with something based around these plus the achievement of the Trust's mainstream Top 10 objectives. What I think is perhaps more difficult is how we assess them in anything other than a fairly informal way but I am open to further suggestions.

I am very grateful to you for having taken on what I suspect is going to be a rather onerous role but one which I hope will enable us to be more effective over the long-term.

With best wishes

Yours sincerely

PETER DIXON
CHAIRMAN

Copy to: Tonia Ramsden
Progress Report from the High Quality Patient Care (HQPC) Group
March 2006

1. Introduction

1.1 The HQPC group is a working group of the Members’ Council which meets to consider issues relating to High Quality Patient Care, carers’ issues and improvement of the patient experience.

1.2 The group has met four times since the December Members’ Council meeting. Three of these meetings were working seminars designed to help the group understand what UCLH is currently doing concerning high quality patient care, the quality issues which the Trust will have to address over the next year, and the issues which are important if UCLH is to continue to improve patient care and fully embrace the ‘quality’ agenda.

2. Working Seminars

2.1 The group had presentations on the following topics:

- The Essence of Care, a DoH initiated programme to ‘get the basics right’ which establishes benchmarks across a range of areas. Presentation by Paul Reeves, Head of Nursing, Specialist Hospitals Board.

- Standards for Better Health (on the Healthcare Commission’s Core and Developmental Standards). Presentation by Alison Glover, Head of Clinical Governance and Risk.

- Taking the ‘Quality ‘ Agenda Forward within UCLH: Ideas, Suggestions and Opportunities. Presentation by Professor Paul Bate, Chair of Health Services Management.

All three presentations were well attended and enthusiastically received. In addition to Council Members, Louise Boden, Jane Hawdon, Sarah Johnston and Tonia Ramsden attended and contributed to some of the seminars.

3. Reports from Council Representatives

3.1 At its fourth meeting the group received written reports from Council representatives on the Clinical Governance, Patient Issues and Arts Committees and from Council Members who took part in the PEAT inspections (copies attached).

3.2 It also received an oral report of a meeting between the Members’ Council representatives on the Patient Issues Committee, representatives from the Patient and Public Involvement Forum and Louise Boden.
4. The Case for the ‘Quality’ Agenda

4.1 The HQPC group has concluded, on the basis of the seminars, work which Council Members are doing in a number of areas in the Trust, perusal of a variety of forms of evidence and informal feedback from our members that we have identified an area of work, High Quality Patient Care, which is of crucial importance to the Trust and where the skills and experience of Council Members can play a significant role in adding value to the Trust.

4.2 The group recognises that the Trust already collects and acts upon a huge amount of information about the patient experience and that a considerable amount of work designed to improve the experience of patients is already taking place in many parts of the Trust. We very much appreciate this work and do not wish to replicate it. However, our collective experience and feedback from our members suggests that there are a number of ways in which patients’ relationships with the Trust’s hospitals need to improve and we have concluded that adopting a High Quality Patient Care agenda which has input from Council Members would focus attention on these questions.

4.3 We would expect a programme of work in this area to result in improved services, better patient and carer experiences, increased public and patient loyalty to the Trust, and possibly service innovations.

4.4 Lastly, and perhaps most importantly, we believe there is a strong business case for the Trust to embrace this area of work. As the NHS moves further into a world of choice, contestability and payment by results, quality issues will become increasingly important. If UCLH can provide high quality care across the whole range of its services, patients and the public will increasingly choose to come to its hospitals, and money will follow. Providing ‘the best care in town’, and gaining a reputation for doing so, should, we believe, be part of the Trust’s strategies for financial recovery and long term financial stability.

5. Programme of Work

5.1 The group has considered a wide range of proposals in order to produce a programme of work for the next year. Broadly speaking, there are 3 kinds of project which the group wishes to concentrate on. All would add value to the Trust.

5.2 Engaging in activities initiated by the Trust

From time to time the Trust invites Council Members to assist in projects initiated internally and the group believes that, where possible, cooperating with these requests should form one strand of its work. We propose initially:

- To contribute to the Essence of Care Benchmarking exercise by working on the Privacy and Dignity benchmark along side Trust staff.
- To participate in a project in the Outpatient Contact Centre in order to make suggestions about ways of improving the service.
- Anticipating that the Trust will want to involve Council Members in other short term projects, the group proposes that Council Members are invited to add their names to a list of volunteers who Trust executives can approach for assistance.
5.3 Initiating short term projects which can be carried out by group members or the Membership Office, broadly within existing resources

The Group believes that systematising feedback from patients and the public and consulting the Trust membership are high priorities and proposes that:

- The Membership Office is asked to draw up a form which Council Members can complete when patients and members of the public make comments or suggestions about the Trust’s services. Completed forms will be passed on to the relevant manager by the Trust office, with a request for a response to the Council Member as well as to the initiator of the comment.

- The group should produce a simple questionnaire for patients and public members of the Trust in order to elicit feedback about their experiences of the Trust’s services and invite suggestions about how these can be improved. We propose that the questionnaires should be sent out with the next issue of UCLH News.

5.4 Influencing strategic thinking

Following on from the joint meeting of the Board and the Members’ Council last Autumn, the group believes that it is important for the Members’ Council to continue a dialogue with the Board about High Quality Patient Care issues. The aim of this dialogue would be to give Council Members an opportunity to influence strategic thinking about the quality of patient care within the Trust.

- With this aim in mind, there is one area of HQPC work which members of the group are particularly keen to see the Trust embrace. This is experience mapping and involves capturing patients’ experiences of care by undertaking narrative-based research. It is different from collecting data on outcomes, undertaking consultation exercises, conducting surveys of patient/carer experiences or doing market research. This kind of research attempts to answer the following questions:
  - What is a ‘good experience’?
  - How far is the Trust living up to patients’ expectations and what is the potential for exceeding these?
  - How and what can the Trust learn from its patients?

- The HQPC group believes that undertaking some work in this area would help the Trust develop its goals of delivering high quality outcomes in partnership with others, ensuring that the patient remains at the centre of all care and working in partnership with patients and the public to deliver the Trust’s services (cf A World Class Future: Our strategic direction and Patient and Public Involvement Strategy 2005-2007). It would also be advantageous to patients whose experience of care at UCLH would improve.

- Obviously this is not work which the HQPC group could undertake on its own. Nor would we want to. It is also work which would require funding, probably from external sources. The group does however have several members who have considerable experience of designing and carrying out
social research projects, as well as staff and stakeholder members who are interested in this kind of project, especially if it involves tracking patient journeys between primary and hospital based care.

- Our collective professional and personal experience has led us to conclude that this is an area which the Trust could profitably pay more attention to.

6. **Terms of Reference**

   The group has established terms of reference for its work, a copy of which is attached to this report.

7. **Volunteers required**

   7.1 Council Members are invited to work with members of the HQPC group on particular projects which interest them.

   7.2 There is an opportunity for a second Council Member to join June Grun and work on the Privacy and Dignity benchmarking exercise.

   7.3 Council Members who are willing to be approached by Trust executives to work alongside Trust staff on specific short term projects are asked to let Tonia Ramsden know.

8. **Recommendations**

   The Members’ Council is asked to consider the HQPC group’s report and to endorse the approach adopted for its future programme of work. In particular it is asked to:

   9.1 Endorse the 3 broad areas of activity identified in sections 5.2, 5.3 and 5.4.

   9.2 Commend the proposal for experience mapping for consideration by the Board of Directors.

   9.3 Accept the Terms of Reference.

   9.4 Note the Reports from the Members’ Council representatives on the Clinical Governance, Patient Issues and Arts Committees and from Council Members involved in the PEAT Inspections.

**Veronica Beechey**  
HQPC Chair

**Attachments**

- Report on Clinical Governance Committee
- Report on Patient Issues Committee
- Report on Arts Committee
- Report on PEAT Inspections
- Terms of Reference
Members’ Council

High Quality Patient Care Working Group
Terms of Reference

Aims

The High Quality Patient Care Group (HQPC) is a working group of the Members’ Council that meets to consider issues relating to high quality patient care, improvement of the patient experience and carers issues.

It works in co-operation with the Communications and Membership Group.

Responsibilities

Within its area of interest, the group may:
- make recommendations to the Members' Council
- initiate and oversee studies and projects relevant to the aims of the group including projects which engage the Trust membership
- respond to requests for co-operation with initiatives launched within the Trust or by outside agencies
- receive reports from Council Members who represent the Council on Trust committees, PEAT inspections and other activities
- seek advice from external advisors and other bodies as appropriate.
- raise issues for discussion at the Patient Issues Committee.

Procedural Notes

- The group will elect its own chair and deputy chairs.
- The group will determine the frequency of its meetings and its own procedures for the conduct of business
- The group will submit a report to each meeting of the Members' Council following an HQPC meeting
- Council Members wishing to attend meetings or receive papers should notify Selina Cheung
- Membership of the group is open to all Members of the Members' Council.

Membership

<table>
<thead>
<tr>
<th>Group Members</th>
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<tbody>
<tr>
<td>Veronica Beechey - Chair</td>
<td>Georgia Kaufmann</td>
</tr>
<tr>
<td>Carol Hart – Deputy Chair</td>
<td>John Carrier</td>
</tr>
<tr>
<td>Christine MacKenzie – Deputy Chair</td>
<td>June Grun</td>
</tr>
<tr>
<td>Andrew Whitley</td>
<td>Kevin Ryan</td>
</tr>
<tr>
<td>Bernadette Porter</td>
<td>Marisha Ray</td>
</tr>
<tr>
<td>Clive Saville</td>
<td>Michael Lee</td>
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<tr>
<th>Corresponding Members</th>
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<tbody>
<tr>
<td>Alison Forbes</td>
<td>Mary Shelley</td>
</tr>
<tr>
<td>Amanda Gibbon</td>
<td>Paul Ostro</td>
</tr>
<tr>
<td>Greg Battle</td>
<td>Sue Payne</td>
</tr>
<tr>
<td>Liz Lowe</td>
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Clinical Governance Committee

Note for the High Quality Patient Care Working Group

1. The terms of reference of the Clinical Governance Committee (CGC) are attached. Briefly, the CGC is responsible for setting clinical and patient care standards for the Trust, monitoring compliance with externally imposed standards - most notably those of the Healthcare Commission, clinical risk management, including the Trust's response to serious untoward incidents, and overseeing the work of the Clinical Governance Directorate, which includes, for example, the production of the monthly Clinical Governance bulletin and the Clinical Governance development and action plan and annual report. The CGC meets monthly. It receives reports from three sub-committees (Clinical Standards, Risk Management and Patient Issues) and in turn reports to the Board of Directors. Its reports are publicly available, either on the internet or from the Clinical Governance Directorate.

2. Following interviews held last spring, Alison Forbes and Clive Saville were invited to join the CGC in June 2005. Alison is a regional patient member and Clive is a local patient member. Since then the work of the CGC has been dominated by two main areas.

3. First of these is the self assessment exercise in relation to the core standards of the Healthcare Commission (The Annual Health Check). The Board of Directors will have to make an annual declaration of compliance with the standards in much the same way as it has to make annual declarations of compliance with accounting standards. Rather than a centrally managed top-down exercise the Trust decided to require each of the 22 clinical directorates to conduct its own check for compliance with the Commission's 24 core standards. The CGC oversaw this process and was rigorous in rejecting reports it felt were superficial or otherwise inadequate.

4. Second is the on-going work of monitoring the Trust's response to what are called "serious untoward incidents". Examples of such incidents include the treatment in A&E of a baby who later died from meningitis, viral infection at the Heart Hospital, patient injury from falling out of bed because of lack of bed rails, systemic failures in communication with a GP practice, delays in repairs to lifts compromising patient safety, and delays in medical staff attending a patient which led to a review of the balance of resources for the Hospital at Night scheme. The Trust treats all such incidents with the seriousness they deserve. It is open in its dealings with affected patients and relatives, ready, for example, to commission independent reports and to discuss them with family members. The CGC is particularly concerned to ensure that lessons for the whole Trust are learned from such incidents. It agrees and supervises the implementation of an action plan leading for example to revised protocols and training for all concerned in revised clinical practices.

5. Examples of other aspects of the CGC's work have included a review of patient consent procedures, the continuing review of MRSA and infection control, child protection procedures, and the introduction of new safety controls for clinicians planning to undertake intervention procedures either new to the Trust or new to them personally.
CLA**INAL GOVERNANCE COMMITTEE**

**TERMS OF REFERENCE**

The overall purpose of the Committee is to ensure the development, implementation and monitoring of Clinical Governance standards/strategy.

**OBJECTIVES**

To ensure that systems are in place across the Trust to support clinical governance, including:

1. **Clinical Standards, incorporating:**
   - Specialty and corporate Clinical Audit Programmes
   - Trustwide clinical protocols and patient pathways
   - Education and Development relating to Clinical Governance

2. **Risk Management, incorporating:**
   - Adverse incident monitoring and clinical claims
   - Incident investigation procedures and risk reduction strategies
   - Health & Safety and associated activities

3. **Patient Quality & Environment, incorporating:**
   - User Involvement, incorporating the Patient Advice & Liaison Service and Patient Forum development
   - Complaints management
   - Hospital environment, including cleanliness.

4. Take action to resolve issues of ongoing or intractable concern raised by Chairs of the sub committee reporting to the Clinical Governance Committee.

5. Monitor the Trust performance against national standards and indicators (access & waiting times, outcome indicators, Patients Charter Standards, Controls assurance, Clinical Negligence Scheme for Trusts).

6. Ensure the decisions of NICE and other national groups (e.g. NCEPOD, Royal College guidelines) are implemented.

7. Assist in the arrangements for CHI and other formal visits.

8. Co-ordinate clinical governance with the Trust research & development and professional education agenda.

9. Ensure and support the development of local mechanisms for the development of care pathways, which will provide a vehicle for routine audit and outcome measurement.

10. Develop arrangements for the benchmarking of clinical governance reporting, in comparison with other similar Trusts.

**SUB-COMMITTEES OF THE CLINICAL GOVERNANCE COMMITTEE**

Clinical Standards
Risk Management
Patient Issues
PROCEDUAL NOTES

- The Committee will submit a written report to the Trust Board each time it meets.
- The Committee may request the presence of any senior executive or Clinical Director to interpret data being presented.
- The Committee will receive routine reports and information from its standing sub-committees.
- Committee papers will be available 4 days prior to meetings.
- The Committee will meet every month.
- To receive regular reports from the 3 sub-committees, including quantifiable and written reports.

MEMBERSHIP
(up-dated Feb 06)
Prof Richard Frackowiak  Chair
Prof Tony Mundy  Medical Director
Prof David Fish  Medical Director
Dr. Andy Webb  Medical Director
Louise Boden  Chief Nurse
Susan Kerrison  Assistant Director R&D
Tonia Ramsden  Corporate Services Director
Joe Harrison  Director of Performance
Clive Saville  Patient Representative
Alison Forbes  Patient Representative
Alison Glover  Head of Clinical Governance & Risk
Colin Jervis  Interim IT Director
Bruce Macrae  Consultant, Clinical Microbiology
UCLH ARTS COMMITTEE

The Arts committee was set up in September 2005. It is a small committee with around 8 members who represent different disciplines. I was invited to join it as a public representative in October and have been attending monthly meeting since.

The committee’s role is to:

- Support the new Arts Curator, Guy Noble
- Agree the Arts Strategy
- Provide a network of contacts
- Identify opportunities for potential arts projects.

All funding for arts projects has to be raised from charitable sources, and a charities fund for the Arts Project has been set up. An extract from the draft strategy is included at the end of this report. There are several arts projects underway already, e.g. The ‘Street Gallery’, which faces the Euston Road, has been fitted with a hanging system and an exhibition programme is being drawn up for it. The Arts curator is organising a series of musical events for staff, visitors and patients.

PATIENT AND STAFF ENVIRONMENT

The Arts Committee also considers the patient and staff environment as well as the integration of artwork in new developments. It is currently reviewing and commenting on the interior design strategy for the Elizabeth Garrett Anderson (EGA) wing of the new hospital.

EGA Roof Garden

The possibility of adding a roof garden on the top of the 4th floor of the EGA wing is currently the subject of a feasibility study. The chairman’s support facilitated charitable funds being raised to commission the study, and should this prove to be feasible, significant charitable funds will have to be raised to build this.

On this and future capital projects at UCLH, the extent to which it is important to provide external “recuperative” space, and the degree to which the Foundation Trust should fund this (or not), is something the Members Council should debate.

Wendy de Silva
Members Councillor
**UCLH Arts mission**  
To provide a welcoming, uplifting environment for patients, visitors and staff through the use of a varied and stimulating arts programme and in so doing improve patient well-being, boost staff morale and widen access to the arts across the trust.

A programme of arts events across the Trust can celebrate the individuality of each hospital, highlighting their history and specialities whilst uniting them under the common aim of improving their environment through the use of the arts.

This strategy outlines the way in which this will be achieved.

**Key messages**
- An uplifting and engaging hospital environment improves the well-being of patients, visitors and staff.
- The provision of the Arts within a hospital environment is integral to providing a high quality, modern patient-centred NHS.
- The Arts project is funded entirely by charitable donation and no money is diverted from patient care.

**Audience**
- Patients, Local Community
- Staff
- Art Public Bodies (National Network for Arts in Health, hospital art projects, Arts Council, England)
- Opinion formers (Special Trustees, Trust Board, Members Council, Art community within London)

**Objectives**
1. Map existing art practice and resources within the trust and identify potential areas for arts activity.
2. Widen access to the arts by engaging patients, staff and visitors and encouraging participation and ownership of the art project.
3. Provide a variety of arts activity within the trust.
4. Fundraise and develop resources for UCLH Arts.
5. Work closely with the communications team to provide up-to-date information and news about the art project and its events, both internally and externally.
6. evaluate and respond to the arts project  
   - across the Hospital  
   - within departments  
   - within patient areas

Keep the arts project on the Hospital agenda.
PEAT Inspections – January 2006

In December we attended a training session which familiarised us with the rationale and process for the Patient Environment Action Team inspections. There have been inspections since 2000 and they are altered annually to reflect the changing expectations of patients. Cleanliness is the most over-riding concern. However the state of décor and the quality of the food, menus, privacy and dignity, infection control and safety also feature significantly. Ratings are awarded ranging from unacceptable, through poor, acceptable and good to excellent. The Trust previously achieving an overall “good” self-assess with possibility of a random validation check from an external team.

The team was led by Karin Roberts, Corporate Projects manager and included, Louise Boden, Chris Kavanagh, Facilities Manager, an Infection Control Nurse, a Modern Matron and three patient representatives from the Members Council and Patients Forum. This was a minimum. The hospitals visited were UCH, EGA & Obstetrics, NHNN and the HH.

What impressed us the most was how thoroughly the inspections were conducted. Nothing or nowhere was held back from scrutiny and great care was taken to examine in detail all aspects of the patient environment from bed frames and curtains to windows and electrical sockets. The forms are pretty exhaustive including just about every component of the environment from many different angles. Not only did the approach and scrutiny impress us but also the weight given to the patient representatives role. When we entered sensitive areas the patient representatives would be sent in without the rest of team.

In general the hospitals were clean, there were some depressingly worn bits waiting for repair in the older buildings and sad design mistakes in UCH such as the flooring especially in bathrooms and the new waste bins which had caused unsightly marks on the new walls. We saw some shoddy cleaning practices in action in UCH but overall the level of cleaning was better than anticipated. Yet even in UCH there was already a build up of lime scale on taps, loos and basins and the sides and corners of the floor were dirty because the floor polishers do not reach to the edges.

It was depressing to see how the shortfall in funds translates immediately into cost-cutting in the wards. Environmental money, the matrons discretionary budgets £5000 per ward has been withheld so that all kind of small improvements can’t be made (this was mentioned several times). Disposable bed curtains were being kept too long because of the replacement cost.

The overarching presence of Interserve at UCH was disquieting, from the explanation of why they wouldn’t buy machines that actually cleaned the floors properly (too costly) to the fact that the food at UCH was not as good as the Medirest food at the NHNN and the HH.

The scoring was for the most part fair and accurate. Different people attended different hospitals for the PEAT visit and this led to slight inconsistencies. Our questions and concerns were voiced to Interserve, Medirest and Sodexho. The OH with its old premises impressed us particularly with its efforts especially in cleanliness.

Georgia Kaufmann and Christine Mackenzie
Follow-up to joint meeting of the Members’ Council and Board of Directors,
October 2005

At the December 2005 meeting of the Members’ Council it was agreed that the issues raised at the joint meeting of the Board and the Members’ Council on 20th October and summarised in the paper produced by Paul Bate needed to be kept under review in order to ensure that decisions made were implemented and ideas raised were followed up. As a result of this a small, self-nominated group consisting of Paul Ostro, Tricia Pank and Amanda Gibbon and assisted by Tonia Ramsden met on 7th March to review Paul Bate’s paper and to consider what progress had been made in the intervening period in the area of joint working of the Members’ Council (“MC”) and Board of Directors.

The paper summarised three key areas for improvement:

1. **Communications**

   (a) Supply of information

   In many ways information flows have improved considerably over the last few months. It was agreed that the MC needed a “no surprises” policy such that information about important developments is given to Council members in good time and that Council members are frequently updated on matters of serious concern such as the budget deficit. In practice, the day to day decision about what information should be distributed to Council members was likely to be made by Tonia. However executive directors should be encouraged to be proactive in considering what information arising from their individual areas of responsibility was of such significance that it justified distribution to the MC.

   (b) Contact between the Board and the MC

   The increased attendance by non-executive directors at Council meetings was welcomed and the series of seminars on the annual plan presented by the medical directors had been very useful in strengthening the interface between the Board and the MC. It was considered that it would be helpful for executive directors to attend Council meetings wherever possible.

   (c) Communications with the membership

   The subject of communications with the membership was being addressed by the Communications working group and so was not discussed in any detail although it was agreed that the Trust should be urged to implement the plan to make the website interactive as soon as possible so that members could post comments on it.
2. The Members’ Council as the Patient Voice or Champion

This work is largely being pursued through the High Quality Patient Care Group (HQPC) and through MC participation on bodies such as the Patient Issues Committee. In particular the HQPC group is keen to promote the MC’s ability to influence strategic thinking about the quality of patient care within the Trust and has identified some key areas in which this work might begin. Championing patient care is generally accepted as central to the role of the MC. We agreed that there is further thinking to be done on how projects relating to patient care that the MC might wish to initiate are best planned and executed in co-operation with the Board and so as to avoid, for example, duplication of effort or the MC adopting an overly executive stance.

3. Contributing to and influencing strategy

This area of work probably remains the most difficult to define and to set out ways in which the MC can contribute and work with the Board. While acknowledging that they cannot and should not have a managerial role within the Trust, nevertheless MC members would like to take a more active part in the debate and have some say in the formation of Trust strategy. We recognise that defining the parameters of what constitutes “strategy” remains a difficult area. In particular, many members of the MC considered that they had insufficient opportunity and time to comment on the 2005 Annual Plan. In an effort to address that concern, the Trust organised a series of three seminars in January 2006 presented by each of the medical directors, covering strategic developments within their individual areas of operation. These appear to have been welcomed by those who attended them. We understand that the MC will receive and be invited to comment on the draft annual plan for 2006 in due course. Our group would like to take time to reflect on the MC’s involvement in the 2006 planning process once the Annual Plan has been finalised.

June MC meeting

It is proposed that the June MC meeting should be a joint meeting with the Board, in accordance with one of the conclusions of the October 2005 joint meeting, and that at least part of this meeting should involve a closed session. We suggest that the agenda for this meeting should include a revisiting of the theme of how the Board and Council should be working together and probably covering the areas noted above. We suggest that this working group might assist in producing ideas for the agenda for this meeting and to that end would welcome Board input to the agenda through one or more non-executive directors joining the group. We would also be delighted if other members of the MC would join us.

Amanda Gibbon
March 2006
1. **Introduction**

   In accordance with the Constitution, the Trust is required to maintain a Register of Interests to record formally declarations of interest of Council Members. The Register is kept up to date by means of an annual review and Council Members are required to complete and return a declaration form even if there are no interests to be declared.

2. **Annual Review 2006**

   Late in 2005 declaration forms were sent to all Council Members with a request that they complete and return them by mid February in order that the Register could be amended.

   Thirty one Council Members (including the Chairman) returned the completed forms, of which 17 Members had no interests to declare. One stakeholder representative will be standing down at the end of March and did not complete a declaration form. Despite several reminders a further two Council Members failed to return their forms.

3. **The Register of Interests 2006**

   The updated Register is attached.

Tonia Ramsden

**Secretary to the Trust**
## REGISTER OF COUNCIL MEMBERS' INTERESTS

**March 2006**

<table>
<thead>
<tr>
<th>Interest Declared</th>
<th>Council Member</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Directorships (including non-executive directorships) held in private companies or PLCs:</strong></td>
<td></td>
</tr>
<tr>
<td>Dunfermline Heritage Trust</td>
<td>Peter Davison</td>
</tr>
<tr>
<td>Dransfield Owens de Silva Ltd. (Architects)</td>
<td>Wendy de Silva</td>
</tr>
<tr>
<td>The Pyramid Building Ltd.</td>
<td>Wendy de Silva</td>
</tr>
<tr>
<td>Garthgwynion Estate Ltd.</td>
<td>Amanda Gibbon</td>
</tr>
<tr>
<td>The Children’s House School Ltd.</td>
<td>Amanda Gibbon</td>
</tr>
<tr>
<td>Shadwell Estates</td>
<td>Pal Luthra</td>
</tr>
<tr>
<td>Birchwood Properties</td>
<td>Pal Luthra</td>
</tr>
<tr>
<td>Fortismere Housing</td>
<td>Pal Luthra</td>
</tr>
<tr>
<td>Director, Freehold Company for the Residents’ Association (unpaid)</td>
<td>Eileen West</td>
</tr>
<tr>
<td>Vice-Chair, Threshold Housing Ltd</td>
<td>Andrew Whitley</td>
</tr>
<tr>
<td>Co Vice-Chair, CityWest Homes Ltd</td>
<td>Andrew Whitley</td>
</tr>
<tr>
<td>Member, Threshold Key Homes Ltd</td>
<td>Andrew Whitley</td>
</tr>
<tr>
<td>Non-Executive Director, Westminster Primary Care Trust</td>
<td>Andrew Whitley</td>
</tr>
<tr>
<td><strong>Ownership or part-ownership of private companies, businesses or consultancies likely to do business with the NHS:</strong></td>
<td></td>
</tr>
<tr>
<td>Secretary/Chief Executive Officer, Scientific Documentation Centre (SDC) Ltd.</td>
<td>Peter Davison</td>
</tr>
<tr>
<td>Part-owner, Dransfield Owens de Silva Ltd.</td>
<td>Wendy de Silva</td>
</tr>
<tr>
<td>Chief Executive, National Society for Epilepsy</td>
<td>Graham Faulkner</td>
</tr>
<tr>
<td><strong>Majority or controlling share holdings in organisations likely or seeking to do business with the NHS:</strong></td>
<td></td>
</tr>
<tr>
<td>Control of SDC Ltd. (though no shareholding)</td>
<td>Peter Davison</td>
</tr>
<tr>
<td>Shareholder, DAVAL (pharmaceutical research company)</td>
<td>Susan Payne</td>
</tr>
<tr>
<td>Threshold Housing Ltd (parent company of Threshold Support Ltd which provides a number of contracted services to NHS Trusts)</td>
<td>Andrew Whitley</td>
</tr>
<tr>
<td><strong>Position of authority in a charity or voluntary body in the field of health and social care:</strong></td>
<td></td>
</tr>
<tr>
<td>Chief Executive ‘I CAN’</td>
<td>Virginia Beardshaw</td>
</tr>
<tr>
<td>Trustee, ‘Start Here’</td>
<td>Virginia Beardshaw</td>
</tr>
<tr>
<td>Trustee, Margaret Pyke Memorial Trust</td>
<td>John Carrier</td>
</tr>
<tr>
<td>Member, External Advisory Panel, Royal College of Physicians</td>
<td>John Carrier</td>
</tr>
<tr>
<td>Trustee, Royal Free Charitable Trust</td>
<td>John Carrier</td>
</tr>
<tr>
<td>Role</td>
<td>Name</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>Chairman, The Housing Corporation</td>
<td>Peter Davison</td>
</tr>
<tr>
<td>Trustee, NHS Confederation</td>
<td>Peter Dixon</td>
</tr>
<tr>
<td>National Society for Epilepsy</td>
<td>Peter Dixon</td>
</tr>
<tr>
<td>Member of Finance &amp; Management Committee, The Social Care Association</td>
<td>Graham Faulkner</td>
</tr>
<tr>
<td>Chair, Corporation of London Access Group</td>
<td>Graham Faulkner</td>
</tr>
<tr>
<td>Youth Offender panelist</td>
<td>Jakkı Mellor-Ellis</td>
</tr>
<tr>
<td>Trustee/Clinical Adviser, Helen Bamber Foundation</td>
<td>Patricia Pank</td>
</tr>
<tr>
<td>Trustee, British Lung Foundation</td>
<td>Stephen Spiro</td>
</tr>
<tr>
<td>Vice-Chairman, Friends of UCLH</td>
<td>Eileen West</td>
</tr>
<tr>
<td>Trustee, Dolphin Square Charitable Trust</td>
<td>Andrew Whitley</td>
</tr>
<tr>
<td>Margaret Pyke Centre</td>
<td>John Carrier</td>
</tr>
<tr>
<td>SDC Ltd.</td>
<td>Peter Davison</td>
</tr>
<tr>
<td>Dransfield Owens de Silva Ltd.</td>
<td>Wendy de Silva</td>
</tr>
<tr>
<td>Head of Specialised Commissioning, London Specialised Commissioning Group</td>
<td>Sue McLellen</td>
</tr>
<tr>
<td>Council Member, Royal Society of Medicine</td>
<td>Patricia Pank</td>
</tr>
<tr>
<td>Lay Member, Ethics Committee, British Association of Psychotherapists</td>
<td>Patricia Pank</td>
</tr>
<tr>
<td>London Specialised Commissioning Group</td>
<td>Sue McLellen</td>
</tr>
<tr>
<td>Member, Royal Institute of British Architects</td>
<td>Wendy de Silva</td>
</tr>
<tr>
<td>Member, Architects for Health</td>
<td>Wendy de Silva</td>
</tr>
<tr>
<td>Accredited Steward and Member, Royal College of Midwives</td>
<td>Scott Johnston</td>
</tr>
<tr>
<td>Secretary, Rochester Terrace Gardens Residents' Association</td>
<td>Georgia Kaufmann</td>
</tr>
<tr>
<td>Complaints reviewer, Healthcare Commission</td>
<td>John Lee</td>
</tr>
<tr>
<td>Member, Royal College of Nursing</td>
<td>Susan Payne</td>
</tr>
<tr>
<td>Election Agent for Karen Buck, MP (2001 and 2005)</td>
<td>Andrew Whitley</td>
</tr>
<tr>
<td>Election Agent for all sitting Councillors in Westbourne, Queen’s Park, Church Street and Harrow Road wards of Westminster City Council (2002)</td>
<td>Andrew Whitley</td>
</tr>
<tr>
<td>Treasurer, Regent’s Park and Kensington North Labour Party</td>
<td>Andrew Whitley</td>
</tr>
<tr>
<td>Islington GP, member of Islington PCT Professional Executive Committee and Commissioning Lead for South Islington</td>
<td>Dr. J. Dixon (Mrs. Peter Dixon)</td>
</tr>
<tr>
<td>Member, Royal College of Nursing</td>
<td>Mrs. Graham Faulkner</td>
</tr>
<tr>
<td>Chief Executive Officer, Trace Group plc</td>
<td>Husband of Georgia</td>
</tr>
<tr>
<td>Director, 15/27 Gee Street Residential Management Co.Ltd</td>
<td>Pal Luthra</td>
</tr>
<tr>
<td>Chief Executive, The Princess Royal Trust for Carers</td>
<td>Partner of John Lee</td>
</tr>
</tbody>
</table>
### Any other interests that should be declared

<table>
<thead>
<tr>
<th>Interest</th>
<th>Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member of Advisory Committee on Clinical Excellence Awards (Consultant Awards Panel)</td>
<td>John Carrier</td>
</tr>
<tr>
<td>Bar Standards Board (Camden)</td>
<td>John Carrier</td>
</tr>
<tr>
<td>Shareholder, Retirement Security Ltd (private sector provider of very sheltered housing)</td>
<td>Graham Faulkner</td>
</tr>
<tr>
<td>Justice of the Peace, Camden &amp; Islington Petty Sessional Division</td>
<td>Patricia Pank</td>
</tr>
</tbody>
</table>