GOVERNING BODY

30th MARCH 2011
21st March 2011

Dear Governor,

GOVERNING BODY MEETING – 30th MARCH 2011

Please find attached the agenda for the meeting to be held on Wednesday 30th March. The meeting will take place in the Education Centre, 1st Floor West Wing, 250 Euston Road, London NW1 2PG, commencing at 6.00pm.

Yours sincerely,

Jocelyn Laws

Jocelyn Laws
Trust Administrator

1. Apologies for Absence
2. Minutes of the Meeting held on November 25th 2010 Attachment A
3. Matters Arising Report Attachment B
4. Chairman’s Report Attachment C
5. Chief Executive’s Report Attachment D
6. Presentation: National Patient Experience Surveys 2010 Sandra Hallett, Director of Quality & Safety
8. Report from the High Quality Patient Care Group Attachment E
10. Reports from Governor Representatives on Trust Committees:
   10.1. Quality & Safety Committee Attachment G.i
   10.2. Older People’s Strategic Steering Group Attachment G.ii
11. Annual Report from the Chair of the Audit Committee Attachment H
12. Any Other Urgent Business

13. Dates of Next Meetings:

Monday 4th July 2011
Tuesday 20th September 2011 – Annual Public Meeting (AGM)
Thursday 24th November 2011

Meetings for Governors only (not public meetings):

Thursday 16th June – Joint GB/Board meeting
Monday 10th October – Informal GB meeting

All meetings commence at 6.00pm.

Please send apologies to: Ros Waring, FT Membership Manager. By email to: foundation.trust@uclh.nhs.uk or by telephone: 020 7380 9290.
Agenda Item 2

Minutes of the Meeting held on
25th November 2010
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST

Minutes of the Governing Body Meeting held on 25th November 2010

Present: Richard Murley, Chairman

Patient & Public Constituency:

Anthony Baylord           Carol Hart
Veronica Beechey          Christine Mackenzie
Joan Bell                 Fiona McKenzie
Peter Brayshaw            Patricia Orwell
Dee Carter                Stuart Shurlock
Amanda Gibbon             Diane Wales
John Green                Bonnie Wallace

Staff & Stakeholder Constituency:

Malcolm Barnicoat        Kate Groucutt
Fion Bremner              Tom Hughes
Caroline Dux              David Taylor
Judith Ellis              Andrew Whitley
Graham Faulkner

In Attendance: Sue Atkinson, Non-Executive Director
Geoff Bellingan, Medical Director, Surgery and Cancer Board
Richard Delbridge, Non-Executive Director
David Fish, Managing Director, UCLP (for item 4)
Mike Foster, Deputy Chief Executive
Nick Monck, Non-Executive Director
Robert Naylor, Chief Executive
Jane Ramsey, Non-Executive Director
Sheila Adam, Head of Nursing (on behalf of Louise Boden)
Tonia Ramsden, Director of Corporate Services
Jocelyn Laws, Trust Administrator (Minutes)
Ros Waring, Membership Development Manager

1. Apologies for Absence

Apologies were received from Sheela Bonarjee, Maureen-Rose Brown, Wendy De Silva, Adam Harrison, Maureen Holas and Marcia Persaud. Apologies were also received from Richard Alexander, Louise Boden, Gill Gaskin, Paul Glynne, Tony Mundy, John Tooke and David Wherrett

2. Minutes of the Meeting held on July 6th 2010

The minutes were agreed to be a correct record.

3. Matters Arising Report

The report was noted.
4. Presentation: UCL Partners – Highlights of First Year

David Fish gave a presentation which provided information about UCL Partners and a wider overview of Academic Health Science Centres (AHSCs). AHSCs were partnerships between major universities and leading hospitals, the aim of which was to bring about excellence in health research translation. Key issues from the presentation were:

- There were approximately 30 AHSCs globally, the majority of which were in the USA. Of the five AHSCs in the UK, three were in London.
- Harvard University and its hospitals was the role model for UCLP.
- AHSCs enabled improvements in patient care and economic gain to be achieved; the key aim was to help speed up the process of translating research developments into health-related benefits for patients and the community, a process which currently averaged 17 years.
- The Secretary of State for Health was very supportive of AHSCs and Academic Health Science Systems which embraced health in the community.
- UCLP’s approach was outlined:- all 12 programmes were goal-orientated and addressed specific health challenges. Individuals with good leadership skills had been appointed as Programme Directors who had a responsibility across the whole partnership to address major health challenges.
- External grants had been obtained, enabling world-class individuals to be recruited.
- All Programme Directors had drawn up targets and milestones for the delivery of their objectives and excellent progress was being made.
- Partnerships were being developed with GPs, district general hospitals and mental health trusts in North Central London and North East London/Essex, with other London AHSCs and internationally with Yale and Yale New Haven Hospital. Partnerships were also being developed with industry, pharmaceutical companies and with the charitable sector.
- Examples of successes in the first year included enhanced entry into early phase clinical trials; enabling the delivery of the London stroke service reconfiguration; development of new models of care and new treatments for long-term health conditions; becoming an accredited lead provider for medical and dental education and co-hosting with Monitor a forthcoming conference on quality and value.
- UCLP had supported UCLH’s joint bid with Christie Hospital in Manchester to provide proton beam therapy, demonstrating the combined activity and turnover of the partnership’s member organisations.
- Potential future methods of communicating and interacting with patients were outlined; in partnership with Microsoft UCLP had been developing an on-line booking system, similar to systems used by airlines.
- Potential advantages for partners included improved quality of patient care and value for money, support for major initiatives, increased throughput for clinical trials and the potential to increase supra-regional/national patient flows for specialist treatments, potential for cost savings through rationalisation of corporate and clinical support functions, enhanced staff recruitment, reputational gain and greater influence through scale and pace of combined developments. There was also the potential to bring on board new partners.
- Priorities for next year would be delivery of the new London plans for cancer care, enhanced education and development of a staff college at UCH, and driving research into new treatments in tandem with industry.

The Chairman invited questions.

Peter Brayshaw referred to plans to build a medical research institute – the UK Centre for Medical Research and Innovation – at St. Pancras. David Fish welcomed
the plan and said UCLP would work closely with the UKCMRI to speed up translational research.

Amanda Gibbon asked how basic research in fields outside the major areas was taken forward. David Fish said it was a competitive process and it was not possible to do everything, although he was open to new initiatives.

In response to a question from Veronica Beechey, David Fish explained the governance arrangements. UCLP was a company limited by guarantee and the Board comprised the Chairs and Chief Executives of the partner organisations, plus himself. Other organisations could join the executive group without becoming full partners but it was not possible to keep changing the shareholders. Patients and the public were very involved in the programmes; there were focus groups both on the research side and the clinical side, but no patient or public representatives on the Board. The Chief Executive explained that all partners had one vote each but so far there had not been a requirement to vote on any issue as the benefits of working collaboratively were recognised.

The Chairman thanked David Fish for his presentation.

5. **Chairman’s Report**

5.1. **Sir Robert Naylor**

The Governing Body was advised that November marked the 10th anniversary of the Chief Executive’s appointment. The Chairman’s report paid tribute to Sir Robert’s leadership which had contributed significantly to the Trust’s considerable achievements.

5.2. **Governors**

The Chairman welcomed the 11 new Governors who had recently been elected. He was also pleased to welcome Kate Groucutt who had taken over from Janet Burgess as the representative from Islington Council.

5.3. **Disabled Parking at Queen Square**

The report advised that the Chairman had written to Camden Council about disabled parking in Queen Square, following which it had been agreed to hold a site meeting with the Council. The Chairman advised that Jackie Sullivan, Divisional Manager at Queen Square, had met with representatives from Camden that afternoon. He understood that the Council had agreed to install two dropped kerbs outside the NHNN and Royal London Hospital for Integrated Medicine, and Jackie Sullivan would write to them to set out our requirements for disabled parking. It was hoped they would give us parity with the arrangements in place for GOSH. Veronica Beechey said that, while dropped kerbs would allow easier wheelchair access, they did not resolve the issue of allowing parking to drop off patients.

The Chairman thanked Adam Harrison and Peter Brayshaw for their input in this issue.

5.4. **White Paper**

The Trust’s response to the consultation had been submitted by the deadline. The Chief Executive advised that the bill was expected in the new year but it
would probably not become legislation before the summer.

5.5. **Constitution**

The report proposed a review of the Trust’s Constitution should be undertaken to ensure it continued to meet our needs. Tonia Ramsden would establish a working group of governors and a Non-Executive Director to carry out the review and produce proposals for the March meeting.

**Action: Director of Corporate Services**

The remaining items in the report were noted.

The Chairman advised that, together with Paul Glynne, he had commenced a programme of visits to local GP surgeries. There had been one meeting to date and a number of issues had been raised which the Trust would be addressing.

6. **Chief Executive’s Report**

6.1. **Financial Position**

The report advised that at the end of Month 6 the Trust had a surplus of £4.7m which was £1.2m behind plan. The Chief Executive said the Trust held some reserves to deal with issues such as winter pressures and it was expected that we would meet out financial target at the end of the year and achieve the planned financial risk rating of 4. The Trust was also on course to achieve the QEP target of £26.5m.

The Chief Executive advised that the Trust was beginning to come under pressure from PCTs to reduce activity and it may become more difficult to get PCT agreement to continuing the current activity levels. As a result it was likely that waiting times would start to increase again.

6.2. **Performance Report**

At the end of Q2 activity was above plan. With regard to performance on national targets, at Month 6 there had been 7 recorded cases of MRSA against an annual threshold of 8. However, two further cases had occurred since then and the Trust was certain to breach the target for the year. The Chief Executive thought it could take a further year for the Trust to manage the number of cases down to this extremely low threshold.

The excellent performance on A&E waiting times was noted and the Chief Executive was confident that we would achieve the national target of 95% of patients treated within 4 hours and our own internal target of 98%. However, there was enormous pressure on the department at times and the Chairman said this was likely to increase with the forthcoming cold weather.

With regard to the issue of cancer waiting times, the Chief Executive said that the Trust had very few patients referred from a screening service which meant that a small number of individual breaches resulted in the target being missed. The breaches were mostly due to patient choice and he had that morning written to Professor Mike Richards, the National Cancer Director at the Department of Health, to complain about this standard which could have an unfair impact on the Trust’s governance rating under Monitor’s compliance framework.
In response to a question from Amanda Gibbon about the MRSA threshold next year, the Chief Executive anticipated it would remain at 8. He said the Trust had invested a huge amount of time and effort into achieving the target and had made enormous progress over the past few years in significantly reducing the incidence of MRSA. The Chairman said that some areas of the Trust had had no cases for 6 months and it should be possible to achieve zero cases in the Trust.

Graham Faulkner raised the issue of penalties for emergency readmissions within 28 days. The Chief Executive said that while some patients required readmission, many readmissions were justifiable and unrelated to the original condition. These figures needed to be separated. Graham Faulkner requested some statistics and the Chief Executive agreed to include this information in his next report.

**Action:** Chief Executive

### 6.3 Quality, Efficiency and Productivity (QEP) Programme

This issue was noted. Governors had received an excellent presentation on QEP at the informal meeting in October. The Chief Executive emphasised that the future would be more challenging, with a potential requirement for c.5% savings to be made each year for the next four years.

### 6.4 North Central London Financial Position and Future Contracts

The report advised that the Trust had received correspondence from NCL stating that it was facing severe financial problems which were unlikely to improve in the foreseeable future. The Chief Executive advised that the deficit was £140m across the sector, although hospital trusts were in balance. It was recognised that we would have to assist the commissioners to reach their target but no conclusion yet as to how the situation could be resolved. The report outlined the potential impact of the financial challenge, including the possibility of growing waiting lists, cessation of low priority procedures and increased pressure for service rationalisation.

### 6.5 Tripartite Discussions

The report updated on the ongoing discussions between the Royal Free Hospital, the Whittington Hospital and UCLH. The Chief Executive said that the changes in political emphasis meant that both the RFH and the Whittington were likely to pursue applications for Foundation Trust status.

We had already completed service reconfiguration in respect of stroke and hepatobiliary services and were in discussion with the RFH on ENT services. During December the Boards of the three trusts would be considering a report commissioned from KPMG exploring the potential for greater partnership working and centralisation of services. The Chief Executive emphasised that this was being done primarily to improve services to patients, not for financial reasons.

### 6.6 Partnerships with GPs

The Governing Body was advised that the Board of Directors had discussed options for responding to the implementation of GP commissioning and had agreed a strategy and action plan which were attached to the report. The Chief Executive suggested that Paul Glynne give a presentation on progress
at a future meeting of the Governing Body and felt that March might be appropriate.

Action: Medical Director, Medicine

Veronica Beechey referred to an annex of the appendix which listed the key issues identified in the GP survey. She noted that the survey response rate was very low and the number of individual GPs raising issues was small. The Chairman said the purpose of his programme of visits was to improve communication with GPs and address their concerns.

Peter Brayshaw welcomed the Trust's plans to engage with GP consortia although he felt the move to GP commissioning would present difficulties as many GPs did not support the initiative. It was therefore essential to bring them on board. David Taylor felt that the Trust was pursuing the right course of action although it was difficult to achieve change with limited resources. The Chief Executive said that demand on the NHS was growing and funding was not keeping up with the increasing costs of providing services. He felt there was a huge risk in making such radical changes to the NHS structure at a time of economic downturn.

Fiona McKenzie requested an update on the GP action plan for the next meeting.

Action: Chief Executive

6.7. Current Developments:

Cancer Centre

Good progress was being made and the project remained on time and on budget. The Charitable Trustees had agreed to underwrite the estimated costs of installing a PET/MRI scanner in the facility, although the Trust had also submitted a bid to the Wolfson Foundation. A redesign of the lower ground floor would be required to accommodate the installation and therefore if the Board approved the scheme, there would be a slight delay in completion of the building.

Proton Beam Therapy (PBT)

Governors were advised that the Trust had won a national bidding process to become the first PBT service in the NHS, in collaboration with the Christie Hospital in Manchester. A business case was being prepared for submission to the Treasury.

John Green asked whether the Trust had plans for a cyberknife. The Chief Executive said it was hoped to install a gamma knife at the NHNN but this required agreement from the PCT. We were continuing negotiations with them.

6.8. Centre for Nurse and Midwife Led Research

This issue was noted. Sheila Adam advised that the Centre would be launched on 9th December. A second phase of the research project had also been funded.
6.9. **Chief Executive Roadshows**

The report advised that the latest round of Chief Executive roadshows had recently been completed and approximately 800 staff had attended.

6.10. **Appointment of New Chief Nurse**

Governors were advised that Katherine Fenton had been appointed as the new Chief Nurse, replacing Louise Boden who would shortly be retiring. Katherine Fenton would take up her post from 1st January.

Governors joined Board members in wishing Louise Boden well for the future and in thanking her for her tremendous contribution and commitment to the Trust over the past 17 years.

7. **Reports from Governor Representatives on Trust Committees**

7.1. **Nursing & Midwifery Advisory Board**

The report was presented by Christine Mackenzie and noted. Christine Mackenzie said she wished to thank Louise Boden for encouraging Governor representatives on committees that she chaired. Amanda Gibbon endorsed this in relation to the Patient Issues Committee and said that Louise had been a great advocate of Governor Involvement.

7.2. **Arts Committee**

Bonnie Wallace presented the report in Wendy De Silva’s absence. The Committee was working hard and the focus now was on the incorporation of artwork in the Cancer Centre. She also paid tribute to Louise Boden who had established the Arts Committee.

In response to a question from Veronica Beechey, the Chief Executive said the Trust had sold the Cayley Robinson paintings, previously in the Middlesex Hospital, to the Wellcome Foundation on the condition that at any time we could have two of them back. It was intended to install them in the Cancer Centre.

8. **Nomination & Remuneration Committee Report**

Graham Faulkner presented the report and drew attention to changes in the membership of the committee. Amanda Gibbon had been elected as the new Chair of the committee. Graham Faulkner also highlighted the issue of the Chairman’s appraisal and advised that Richard Murley had agreed to undertake a 360° appraisal.

The 12 month work plan was noted.

9. **Audit Issues**

The report was presented by Amanda Gibbon who referred to a meeting in October with Nick Monck, Chairman of the Audit Committee, and Peter Anthony, Deputy Finance Director, to discuss the performance of PwC, the Trust’s auditors. It was recommended that PwC be reappointed for a 5th and final year and that the audit contract from 2011/12 be tendered for. A tender panel would be set up and would include Governor representation. Tonia Ramsden asked Governors to let her know if they were interested in being on the panel, otherwise she advised that Amanda Gibbon and Peter Brayshaw were willing to act as the representatives.
Governors **approved** the reappointment of PwC for a further year to conduct the 2010/11 audit. Governors also **endorsed** the proposals to nominate two Governors to the tender panel.

10. **Progress on Delivery of the Membership Development Strategy**

The report on membership, engagement and involvement was noted. Peter Brayshaw spoke about community engagement activities including a recent visit to a local Bengali Community Centre which had been welcomed and had resulted in a number of new members. Approaches to other sections of the local community were planned and the Chairman said this would help to promote the DGH services provided by the Trust for the local population, as well as the more specialist tertiary services.

Fiona McKenzie referred to the data on disability and asked what the Trust was doing to build relationships with disabled patients and encourage them to join the Trust. Tonia Ramsden said we had only recently begun to gather data on disability and it was therefore difficult to judge whether the membership was representative. However, this work was part of the membership strategy.

Fiona McKenzie volunteered to become the Governor membership ‘champion’ and support Ros Waring with the delivery of the strategy, including participating in community visits. Kate Groucutt would provide information on groups for the disabled in Islington.

11. **Register of Governors’ Interests**

The revised Register of Governors’ Interests was noted. It had been updated to include the declarations of new Governors and two additional declarations from Graham Faulkner.

12. **Matters Arising from the Informal Meeting held on 14th October**

The report was noted. Veronica Beechey asked that the presentations from the PPI event on 12th November be circulated to all Governors.

**Action: Director of Corporate Services**

Veronica Beechey also referred to the work on the clinical administration workstream of the QEP that had been presented to the HQPC and said that Governors were welcome to attend the next meeting to be held on 10th January.

13. **Any Other Business**

There was none.

14. **Dates of Next Meetings:**

- Wednesday 30th March
- Monday 4th July
- Thursday 29th September – Annual Public Meeting
- Thursday 24th November.
Agenda Item 3

Matters Arising Report
UNIVERSITY COLLEGE LONDON HOSPITALS
NHS FOUNDATION TRUST

GOVERNING BODY

REPORT ON MATTERS ARISING FROM THE MEETING
HELD ON 25th NOVEMBER 2010

<table>
<thead>
<tr>
<th>Minute no.</th>
<th>Issue</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.5.</td>
<td>Establish a working group to undertake a review of the Constitution and submit proposals to the Governing Body</td>
<td>The review has been conducted and a report containing proposed revisions is appended to the Chairman’s report. Action completed.</td>
</tr>
<tr>
<td>6.2.</td>
<td>CEO’s report on Performance: provide statistics on proportion of readmissions within 28 days both related and unrelated to the original condition</td>
<td>The Trust is currently exploring the introduction of a database that will track all readmissions, together with reasons. The information is not yet available for inclusion in performance reports.</td>
</tr>
<tr>
<td>6.6.</td>
<td>CEO’s report: Update on progress with GP engagement strategy and action plan</td>
<td>This issue is referred to in the Chief Executive’s report. Action completed.</td>
</tr>
<tr>
<td>12.</td>
<td>Circulate feedback from the PPI event to all Governors</td>
<td>The information has been circulated. Action completed.</td>
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</tbody>
</table>

Actions from Previous Meetings

<table>
<thead>
<tr>
<th>Date of meeting</th>
<th>Minute no.</th>
<th>Issue</th>
<th>Action</th>
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<tbody>
<tr>
<td>July 2010</td>
<td>5.7.</td>
<td>Keep Governors advised of progress on tripartite discussions with RFH and WH and proposals for collaboration with Barts on cardiac and cancer services</td>
<td>Discussions on potential collaboration in clinical services are continuing but there is nothing specific to report at this time.</td>
</tr>
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Agenda Item 4

Chairman’s Report
1. REVIEW OF THE TRUST CONSTITUTION

Governors will recall that at the meeting in November it was agreed to establish a small working group to review the Trust Constitution. The group consisted of Veronica Beechey, Graham Faulkner, Amanda Gibbon, Tom Hughes and Fiona Mackenzie, representing the Governors, and Nick Monck representing the Trust Board. The results of the review were, with minor amendments, considered and approved by the Trust Board on 9th March, always subject to the endorsement of the Governing Body. The amended conclusions and recommendations of the group are attached in a paper at Appendix A and Governors are invited to support the proposals. If Governors do so, the revisions will be submitted for a final review to our legal advisors and the amended Constitution will subsequently be submitted to Monitor. I would like to thank Tonia Ramsden and those who sat on the working group for all their help with this piece of work.

2. UCL STAKEHOLDER GOVERNOR

The UCL Stakeholder Governor position has been vacant for some time. I am very pleased to be able to inform Governors that Professor Lord Kakkar, the distinguished surgeon and expert on thrombosis, has agreed to take up the post. Ajay Kakkar is also a Director of UCL Partners. I am sure that the Governing Body will greatly profit from his contribution.

3. TRUST BOARD PAPERS

I am keen to ensure that Governors have the best possible access to publicly available Trust Board papers. The papers are available on the website and a number of Governors already receive hard copies. I think that all Governors might find it useful to receive hard copies of the monthly Performance Report, which summarises the Trust’s financial and clinical performance in a readily digestible format. If any Governor who does not receive hard copies of the full papers would like to do so please contact Tonia Ramsden. Tonia, I and Executive Board members are always available to answer any questions that Governors may have arising out of the Board papers.

4. DISABLED PARKING AT NHNN

There has been some progress on this issue since the last meeting when I advised that Jackie Sullivan, Divisional Manager at Queen Square, had met with representatives from Camden to discuss parking at the NHNN. Two additional dropped kerbs have been installed outside the NHNN and RLHIM and the NHNN have been awarded five ‘yellow tickets’ (the system in place at GOSH) allowing patients attending the NHNN to be dropped off in Guildford Street. Camden also suggested that Jackie Sullivan discuss a more equitable arrangement with GOSH to allow parking in the vicinity of both hospitals. In addition, to assist patients who need help accessing the NHNN buzzers are being installed at each entrance to the hospital.

5. VISITS TO GPS

Since the last Governors’ meeting, I have been to visit a number of local GP practices, accompanied by Paul Glynne, Medical Director, and on one occasion by Daniel Wallis, Clinical Director Emergency Division. These meetings have been very useful since they provided an opportunity for GPs to tell us face to face how the Trust can improve the service that it offers. The meetings also allowed us to talk about our plans for improving co-operation with the GPs. In addition, we have had two broader meetings hosted by the
North Central London Sector where we have met with a wider group of GPs and discussed some of the commercial issues which they and we face. Again I think that out of these will come more efficient working relationships which should improve the quality of care which our patients receive.

6. MEETINGS WITH STAFF

As pressures on the Trust mount, it is clearly important that Trust Board members remain very visible to, and in close contact with, members of staff at all levels. I am arranging a number of informal meetings with groups of staff from all different areas of the Trust to understand their perspective on the issues that they face. I expect to continue to with these meetings on a regular basis.

7. CHRISTMAS “WALKABOUT”

On Christmas Eve I went round most of the Specialist Hospitals Board sites with Gill Gaskin, Medical Director, and Duncan Burton, Head of Nursing for the Board. On Christmas Day I visited most of the units in the Tower with Sheila Adam, acting Chief Nurse. It was good to have the opportunity to meet with members of staff who were working over the Christmas break and to have a chance to talk to patients who had to remain in the hospital. It was particularly striking to see the pleasure given by the Christmas presents from the UCLH Charities to the patients. I would like again to thank the Trustees for this much appreciated gesture and all those that took the time to wrap the presents up!

8. LONG SERVICE AWARDS

On 22nd February, I was very pleased to be able to present the Long Service Awards to members of staff who have worked for the Trust or its predecessors for over 25 years. It was particularly striking to see the range of NHS professionals who have shown such loyalty. As ever, we are very grateful to the UCLH Charities for sponsoring the awards.

The following were the recipients:
Beverley Astley, EDH Consultant Anaesthetist
Rina Bonaventura, Diabetes and Endocrine support administrator
Siew-Peng Crevel, EGA Senior Staff Midwife
Libby David, UCH site manager
Sharon Davis, Ophthalmology Clinic Coordinator
Nenita Enriquez, NHNN Staff Nurse
Norma Facey, Outpatients Sister
Aurea Fenty, Rosenheim Department Administrator
Ellen Gregory, A&E
Angela Hawkins, Heart Hospital Senior Chief Cardiac Physiologist
Kamlu Jeswani, EGA
Alison Johns, EGA Transitional Care Sister
Steven Jones, EDH Consultant in Orthodontics
Marios Karseras, UCH Mortuary Service Manager
Marcellous Lewis, NHNN Porter
Lesley Morton, NHNN Senior Nurse
Chandra Mubaiwa, UCH Acute Medical Ward
Christopher North, UCH Clinical Nurse Specialist
Been Teen Ooi, UCH Clinical Site coordinator
Damiantee Ramdoo, EGA Healthcare Assistant
Rebecca Ridge, Rosenheim Rheumatology Infusion Clinic
Cheryl Roberts, Workforce Information Advisor
Pete Robbins, Surgical Admissions Officer
Christopher Tims, Chief Biomedical Scientist
Amanda Todd, EDH Office Manager
Kate Welford, UCH Clinical Nurse specialist
9. **WARD SAFETY CHECKLIST**

I have been on a number of visits to differing parts of the Trust and have attended a range of functions which I have described in my reports to the Trust Board. One of particular interest was on 7th January when I attended a morning’s training with Dr Yogi Amin, consultant anaesthetist at NHNN, and a team of clinicians to learn about the Ward Safety Checklist. As Governors will be aware, this is an important element of our programme to improve patient care. I followed this up on 11th March by joining one of Dr Amin’s ward rounds at the National Hospital to see the checklist being applied on the ground.

10. **INFECTION CONTROL**

On 30th March Annette Jeanes, the Trust's Director of Infection Prevention and Control, and I are due to spend the morning at the Royal Free Hospital to learn more about their infection control procedures. Governors may be aware that RFH has recently scored very well in this area and they have kindly offered to share some of their practices with us. Reducing the incidence of infection remains one of our highest priorities at UCLH and I hope that this event will help us to make further progress.

**RICHARD MURLEY**  
CHAIRMAN
1. **Introduction**

Since the Trust was authorised as a Foundation Trust in 2004 it has revised its Constitution (Schedule 1 of the Trust’s Terms of Authorisation) on two occasions.

The Chairman established a small review group to consider changes to the Constitution. The group met on two occasions between January and February. It considered a report on aspects of the Constitution that might benefit from review and concluded that a number of areas warranted revision; the issues under consideration were also circulated to governors for comment. As a group a degree of consensus was achieved; no fundamental concerns or issues were raised by governors.

The Trust may amend its Constitution following a process outlined at paragraph 22.2 of the Constitution which states;

> No proposal for the amendment of [UCLH’s] Constitution shall be submitted to the Independent Regulator unless it has first been approved by the Board of Directors who shall have consulted with the Governing Body before doing so.

However, to meet the 2011 governors election timetable a revised Constitution needs to be submitted to Monitor in early April. The Chairman therefore agreed that the Board would approve the revisions at its meeting on 9th March 2011 subject to consultation with the Governing Body.

The purpose of this report (and Attachment 1) is to consult the Governing Body on the following proposed amendments to the Constitution which the review group has considered and the Board of Directors have approved.

2. **Specific Amendments**

The group reviewed the overall composition of the Governing Body; it looked at membership constituencies and the stakeholder positions. In reviewing the allocation of seats the group did not consider changing the overall balance of the Governing Body.

2.1 **Membership Constituencies**

In 2008 changes were made to the staff classes. It was agreed the Governing Body would return to the membership constituencies at a later date.

The group considered the composition of the membership constituencies (public, patient and staff) and the distribution of governor seats and concluded that;

- the public geographical area should be expanded; and
- the number of patient classes reduced.

Proposals to amend the staff constituency were considered; it was agreed there should be no further changes at this time.

**New public constituency**

It was recognised that there was greater public interest in the Trust than when it was first authorised in 2004. It is a leading London Trust; part of the largest AHSC in Europe conducting research that delivers benefit to both patients and the wider population; and has developed partnerships with other health organisations e.g. the Christie for PBT. The group supported a proposal to extend the public area.

**Proposal** – the public area be extended to include all Boroughs in London.
Revised patient constituency
The group reviewed the patient constituency and agreed the number of classes should be reduced from four to three; this could be achieved through the merger of the local and regional groups into one class. Governors elected to patient seats would all be referred to as patient governors in the same way as staff are called staff governors. For the purpose of providing a definition in the Constitution the new combined class would be called Patients – London and the current National class would be renamed. There would be no change to the Patient Carer class.

Proposal - the patient constituency will be revised and divided into three classes

To support the change it is proposed the seats are distributed as outlined in the table below. Transition arrangements will be incorporated in the Constitution to ensure that all current elected governors retain a position on the Governing Body for the remainder of their tenure. See Attachment 1 for new paragraph.

<table>
<thead>
<tr>
<th>Constituency / Class</th>
<th>Number of seats</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public –London</td>
<td>4</td>
</tr>
<tr>
<td>Patient – London</td>
<td>9</td>
</tr>
<tr>
<td>Patient – Non-London</td>
<td>3</td>
</tr>
<tr>
<td>Patient - Carer</td>
<td>1</td>
</tr>
<tr>
<td>Staff (no change)</td>
<td>6 seats in total</td>
</tr>
</tbody>
</table>

Table1 – Distribution of 23 elected seats

2.2 Patient Constituency
Specific changes were proposed to the Membership Paragraphs – Attachment 1

(i) Although parents of young patients can join the Trust as Carers it was agreed that this should be made explicit in the relevant section. However, it was noted that this could only be given to the parent of a patient under 14 as at age 14 a patient could become a member in their own right

(ii) To avoid the cost of a by-election if an elected governor leaves office mid-term it was agreed to introduce a reserve governor position. This provision already exists for staff. However in the case of patient governors this will be limited to two reserve positions only. This new reserve clause would also apply to public candidates.

To ensure public and patient governors are in the majority the paragraph will include a provision to hold an election if one is required.

2.3 Staff Constituency
The position of the Trust’s volunteers has been clarified. Generally the volunteers do not consider themselves staff and many have applied to join the Trust as patient or public members. The act states staff employed by a voluntary organisation qualify under the staff rule. A voluntary organisation in this context means for example the Red Cross. On this basis it was agreed Trust volunteers should not be considered staff.

2.4 Stakeholder Governors
The Chairman had suggested that the Trust should strengthen its engagement with GPs to recognise the emerging health reforms; the group also agreed UCL Partners were a key stakeholder and any review should take that into account.

A Trust is only required to have one PCT governor; it was therefore agreed to support the Chairman’s proposal and suggest that a GP governor replace the Westminster PCT representative. The WPCT position is due for review at the end
of March 2011. The group noted that when the new Health Bill is passed all PCT positions will need to be reviewed.

It was proposed that the seat assigned to the UCLP Research Group transfer to UCL Partners. UCL Partners is a leading AHSC; through this seat the Trust can ensure it has a partner with a research interest. The distribution of stakeholder seats is outlined below.

<table>
<thead>
<tr>
<th>Governor</th>
<th>Number of Seats</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCT – Camden and Islington</td>
<td>2</td>
</tr>
<tr>
<td>Local Authority – Camden and Islington</td>
<td>2</td>
</tr>
<tr>
<td>University – UCL</td>
<td>1</td>
</tr>
<tr>
<td>Friends of UCLH</td>
<td>1</td>
</tr>
<tr>
<td>UCL Partners</td>
<td>1</td>
</tr>
<tr>
<td>UCLH Charities Committee</td>
<td>1</td>
</tr>
<tr>
<td>London South Bank</td>
<td>1</td>
</tr>
<tr>
<td>GP representative</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 2 - Distribution of 10 appointed seats

Legal advice confirmed that the Trust can future proof its Constitution in the unlikely event that either Camden or Islington Local Authority fail to nominate a representative. The provision exists to approach an alternate organisation without referral to Monitor subject to the organisations being named. It is therefore proposed to name the City of Westminster and the City of London as alternate qualifying local authorities. All areas of both authorities are fully covered in the new public area.

2.4 Board of Directors

The Chairman wants the option to appoint a further non-executive director increasing the number to six. The group agreed that an additional NED on the Board would enable the Trust to better comply with the Monitor FT Code of Governance by increasing the number of independent non-executive directors and creating a more suitable balance on the Board. In addition the Chairman indicated that an additional NED would help to cover the increasing workload.

The group also discussed the appointment process for non-executive directors (including the Chairman). It is clear that the power to make the decisions about these matters sits with the Governing Body (and this will be reflected in the Constitution) however, it was agreed that the detailed processes currently described in section 9.6 and 9.7 of the Constitution should be transferred into the Governing Body Standing Orders. The Constitution would refer to the role of the Nomination and Remuneration Committee and the statutory responsibilities of the Governing Body regarding appointments, remuneration and Chairman’s appraisal.

3. Other Amendments

A number of other amendments were discussed which would assist with procedure; correct errors in the current Constitution; or simplify process making it easier to understand and interpret the Constitution. These are listed below:-

3.1 Staff Membership

The requirement to be at least age 14 before you can qualify as a Staff member will be removed.

3.2 Disputes Procedure

The current procedure requires the Governing Body to resolve all issues; a clear disputes resolution procedure has been drafted - Attachment 1.

3.3 Code of Conduct

The group noted that Board members were asked to comply with a Code of Conduct which included the Nolan Principles. Monitor’s reference guide for governors advises that these principles should also apply to governors. Having a code would also assist the Governing Body should it need to consider terminating a
governor’s position. It was agreed a succinct Code of Conduct should be included as an Annex to the Constitution. A draft code is attached as Attachment 2.

3.4 Declaration of Interests
The Constitution currently lists the interest governors and board members are required to declare. The requirement will be referred to in the Constitution and the detail transferred into the relevant Standing Orders.

3.5 Eligibility Certificate
Governors are required to annually declare that they are eligible to be a governor. An eligibility certificate has been developed for this purpose and will be included as an Annex to the Constitution.

4. Recommendation
The review group has considered all the proposed changes and the Board of Directors approved the changes at its meeting on 9th March 2011. The Trust’s Legal Advisors have reviewed the proposed changes; they have been asked to flag up any typographical or other minor corrections and to make the Constitution an easier read. A final review will be undertaken following the Governing Body meeting and a revised Constitution produced for submission to Monitor.

The Governing Body is asked to consider the following amendments:

(a) The revisions set out in Attachment 1 to the report;
(b) The specific amendments outlined in section 2 of the report including:
   - The extension of the Public Area to include all Boroughs in London;
   - The proposal to reduce the patient constituency to three classes;
   - The redistribution of seats outlined in table 1 and table 2;
   - That volunteers are no longer classified as staff members;
   - That the City of Westminster and the City of London are named as alternate Local Authorities;
   - That the number of non-executive directors may be increased to six;
   - That the detailed NED appointment process is incorporated into the Governing Body Standing Orders; and
(c) The other amendments set out in section 3 of the report, including a Code of Conduct.

Tonia Ramsden  
Trust Secretary  
17th March 2011
### Amendmends to the Constitution

#### Public Area

<table>
<thead>
<tr>
<th>Section</th>
<th>Current provision</th>
<th>Revised draft provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annex A - Area of qualification</td>
<td>London Borough of Camden, London Borough of Islington, The following wards in the City of Westminster: Marylebone High Street; West End; St James. The following wards in the City of London: Farringdon Without; Farringdon Within; Aldersgate; Cripplegate; Bassishaw; Cheap; Cordwainer; Walbrook; Vintry; Queenhithe; Castle Baynard; Bread Street; Coleman Street; Dowgate.</td>
<td>Greater London is the City of London, the City of Westminster, and 31 other London Boroughs.</td>
</tr>
</tbody>
</table>

#### Reason for change

Increase public engagement and involvement; reduce incidence of membership disqualification by postcode within specific streets of Westminster and city of London.

#### Transition arrangements

<table>
<thead>
<tr>
<th>Section</th>
<th>New section</th>
<th>Current provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>No provision</td>
<td>No amendments to this Constitution shall affect the validity of appointments made, action taken or processes followed prior to the adoption of the amendment. Upon the adoption of amendments to this Constitution, the posts within the Trust and procedures to be followed shall be reorganised accordingly to give effect to the amendments and, to the greatest extent possible, such persons appointed prior to the amendment shall be deemed to be appointed to positions stipulated in the Constitution, as amended.</td>
<td>No provision</td>
</tr>
</tbody>
</table>

#### Reason for change

To provide a clause to accommodate changes to the Governing Body from time to time.

#### Patient Carers

<table>
<thead>
<tr>
<th>Section</th>
<th>Current provision</th>
<th>Revised draft provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Constituency paragraphs 7.4.6.1</td>
<td>provide care on a regular basis for a Patient who has not attained the age of 14 years or who lacks capacity within the meaning of mental Capacity Act 2005; and</td>
<td>To make more explicit that parents of patients under 14 can join as members. Governors should note that the carer and the patient cannot both be members this is unconstitutional – the patient constituency is one constituency; if both the parent and patient are members they are considered as having two votes.</td>
</tr>
</tbody>
</table>

#### Reserve list

<table>
<thead>
<tr>
<th>Section</th>
<th>New section</th>
</tr>
</thead>
<tbody>
<tr>
<td>No provision</td>
<td>Where a Public Governor or Patient Governor ceases to hold office during his term of office the trust shall offer the candidate who secured the second highest number of votes in the last election for the constituency (or Class of constituency, as the case may be) in which the vacancy has arisen the opportunity to assume the vacant office for the unexpired balance of the retiring Governor’s term of office. If that candidate does not agree to fill the vacancy it will then be offered to that candidate who secured the third highest number of votes. If no reserve candidate is available or willing to fill the vacancy, an election will then be held in accordance with the Election Scheme at Annex (X) save that, if an election is due to be held within twelve months of the vacancy</td>
</tr>
</tbody>
</table>

| New draft provision | No provision | Where a Public Governor or Patient Governor ceases to hold office during his term of office the trust shall offer the candidate who secured the second highest number of votes in the last election for the constituency (or Class of constituency, as the case may be) in which the vacancy has arisen the opportunity to assume the vacant office for the unexpired balance of the retiring Governor’s term of office. If that candidate does not agree to fill the vacancy it will then be offered to that candidate who secured the third highest number of votes. If no reserve candidate is available or willing to fill the vacancy, an election will then be held in accordance with the Election Scheme at Annex (X) save that, if an election is due to be held within twelve months of the vacancy |
having arisen, the office will stand vacant until the next scheduled election unless by so doing this causes the aggregate number of Governors who are Public Governors or Patient Governors to be less than half the total membership of the Governing Body. In that event an election will be held in accordance with the Election Scheme as soon as reasonably practicable.

| Reason for change | To avoid the unnecessary expense of a by-election should a governor no longer qualify as a governor or choose to resign from their position. The position would be filled for the unexpired term of office.
A similar clause was successfully used to fill a staff vacancy when a governor left UCLH to take up a new post. |

### Disputes Procedure

<table>
<thead>
<tr>
<th>Section</th>
<th>Current provision</th>
<th>New draft provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dispute resolution procedures – paragraph 22</td>
<td>for disputes involving Members in relation to matters of eligibility and disqualifications, the dispute shall be referred to a committee of the Governing Body composition of which is determined by the Chairman. for disputes with Governors in relation to matters of eligibility, disqualifications and termination of tenure, the dispute shall be referred to the Governing Body; and for other disputes, such as between the Governors and the Board of Directors, the parties may resolve the same by agreement or by such other means as are appropriate and available.</td>
<td>Dispute resolution procedures shall operate in the following circumstance: In the event of any dispute about entitlement to membership a member or applicant shall be invited to an informal meeting with the Secretary to discuss the matter in dispute. If not resolved, the individual may refer the dispute in writing within 14 days of the decision of the Secretary to a panel of the Chairman and Lead Governor or another elected governor if lead governor has an interest or is not able to attend. The decision of the panel shall be final. In the event of any dispute relating to eligibility, disqualification or termination a governor or prospective governor it shall be referred to the Chairman who shall make a determination on the point at issue. If the dispute is not resolved, the individual may appeal in writing within 14 days of the decision to a panel of the Chairman and lead governor or another elected governor if lead governor has an interest or is not able to attend. The decision of the panel shall be final. If through informal efforts the Chairman is unable to resolve a dispute between the Governing Body and the Board of Directors the Chairman shall set up a special ad hoc committee (a resolution committee) comprising no more than eight members of which three will be board directors including the Chairman and Chief Executive and five will be governors including the Lead Governor to consider the circumstances and make a recommendation to the Governing Body and the Board of Directors with a view to resolving the dispute. Directors or governors who have or may be perceived to have a conflict of interest in respect of the matter in dispute may not be members of the resolution committee. The aim of the meeting will be to achieve resolution. The Chairman will have the right to appoint an independent facilitator to assist the process. If the recommendations (if any) of the resolution committee are unsuccessful in resolving the dispute the Chairman may refer the dispute back to the Board of Directors to decide on the matter.</td>
</tr>
<tr>
<td>Reason for change</td>
<td>To ensure a written process is agreed and can be enacted should it be required.</td>
<td></td>
</tr>
</tbody>
</table>
Governors at UCLH Foundation Trust are required to:

1. Uphold the Nolan principles* of public life;
2. Attend Governing Body meetings;
3. Attend induction, seminars and training events as required;
4. Declare political affiliations;
5. Comply with the Trust’s Constitution and Governing Body Standing Orders;
6. Comply with the confidentiality requirements of the Trust;
7. Follow the Trust’s Guidelines for Governors in dealing with the media;
8. Treat colleagues, staff and patients equally and comply with equality legislation^.

* The Seven Principles of Public Life (Nolan)

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

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

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

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

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

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

Leadership: Holders of public office should promote and support these principles by leadership and example. These principles apply to all aspects of public life. The Nolan Committee has set them out here for the benefit of all who serve the public in any way.

^Equality legislation covers age, disability, gender, race, religion and belief and sexual orientation.
Agenda Item 5

Chief Executive’s Report
1. **FINANCIAL POSITION**

EBITDA (earnings before interest, depreciation and amortisation) £49.6 million at month 9 is £0.5 million ahead of plan. This translates into an overall income and expenditure position for the nine month period up to the end of December 2010 showing a surplus of £7.6 million (£0.1 million behind plan).

**Table 1** below shows the overall income and expenditure position, by Board, at month 9:

<table>
<thead>
<tr>
<th>Area of Review</th>
<th>Plan £m</th>
<th>Actual £m</th>
<th>Variance £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine</td>
<td>2.6</td>
<td>4.2</td>
<td>1.5</td>
</tr>
<tr>
<td>Specialist Hospitals</td>
<td>20.6</td>
<td>21.0</td>
<td>0.4</td>
</tr>
<tr>
<td>Surgery &amp; Cancer</td>
<td>12.2</td>
<td>8.0</td>
<td>(4.2)</td>
</tr>
<tr>
<td>Research &amp; Development</td>
<td>0.0</td>
<td>0.0</td>
<td>0.1</td>
</tr>
<tr>
<td>Education</td>
<td>(2.4)</td>
<td>(2.4)</td>
<td>0.0</td>
</tr>
<tr>
<td>Corporate Budgets</td>
<td>16.1</td>
<td>18.8</td>
<td>2.7</td>
</tr>
<tr>
<td><strong>EBITDA</strong></td>
<td>49.1</td>
<td>49.6</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>ITDA (excl. exceptional items)</strong></td>
<td>(41.5)</td>
<td>(42.1)</td>
<td>(0.6)</td>
</tr>
<tr>
<td><strong>Net Surplus/(Deficit)</strong></td>
<td>7.7</td>
<td>7.6</td>
<td>(0.1)</td>
</tr>
</tbody>
</table>

**Table 1 – Month 9 year-to-date financial position**

The Trust’s financial performance and financial risk are assessed in line with the Monitor framework – this assessment is summarised in **table 2**, below. Ratings in this table are scored from 5 (indicating low risk) to 1 (indicating high risk). Our financial risk rating of 4 is on plan.

<table>
<thead>
<tr>
<th>Area of Review</th>
<th>Financial Risk Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Year to Date</td>
</tr>
<tr>
<td>Operational Performance</td>
<td>4</td>
</tr>
<tr>
<td>Liquidity</td>
<td>3</td>
</tr>
<tr>
<td>Use of Assets</td>
<td>4</td>
</tr>
<tr>
<td>Income &amp; Expenditure</td>
<td>3</td>
</tr>
<tr>
<td><strong>Trust Financial Summary</strong></td>
<td>4</td>
</tr>
</tbody>
</table>

**Table 2 – Month 9 year-to-date financial performance summary**

Although the Quality, Efficiency and Productivity (QEP) programme is slightly behind plan at month 9, it is forecasting full achievement of the £26.5m for the current financial year.

The Trust is on course to deliver a year-end income & expenditure surplus (excluding exceptional items) of around £10m, which will mean we achieve a financial risk rating of 4 (as planned). However, this will remain dependent on the delivery of a satisfactory operational performance over the remaining three months of the financial year, full achievement of the Trust's QEP, and a satisfactory outcome to current discussions with commissioners regarding payment for activity.
2. PERFORMANCE REPORT

Activity and referrals

Operational performance to the end of Q3 was above plan, as set out below and at Appendix 1.

Table 1 – activity for 2010/11:

<table>
<thead>
<tr>
<th>Activity Type</th>
<th>2010/11 activity to end of Q3</th>
<th>% Variance vs. 2010/11 plan to end of Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient (new + follow up)</td>
<td>558,876</td>
<td>1.9%</td>
</tr>
<tr>
<td>Elective (day-case + inpatient)</td>
<td>59,488</td>
<td>0.3%</td>
</tr>
<tr>
<td>Non-Elective</td>
<td>36,241</td>
<td>5.1%</td>
</tr>
</tbody>
</table>

Performance against national targets

Infection – MRSA and Clostridium *difficile*

At the end of quarter 3 we were above our threshold for MRSA, with 10 recorded cases against an annual threshold of 8. As outlined in previous reports, the new MRSA standard is based on a national median but we were clear that to deliver this was extremely challenging.

Compared to the same period in 2009/10, we recorded 4 fewer cases of MRSA. Our improvement is the result of an action plan focussing on improvements in intravenous line care, hand hygiene and wound care.

To the end of quarter 3, we were within our threshold for Clostridium *difficile*, with 51 cases against a threshold of 90.

Early indications are that our MRSA threshold for 2011/12 will be 5 cases. There is also likely to be a stretching Clostridium *difficile* threshold, possibly 59 (compared with our current average of 5.7 per month which equates to 69 per annum).

18 week referral to treat target

The Trust achieved the 18 week referral to treatment targets (95% for the non-admitted pathways and 90% for admitted pathways) and agreed thresholds for date completeness.

A&E – 4 hour wait target

To the end of Q3, we had the best A&E waiting times of any acute trust in London. Our performance in Q3 was 98.5%, which was above the external target of 95%. We have retained an internal target of 98% to demonstrate our continuing commitment to patient experience in A&E.

Cancer waiting times

During quarter 3 we were compliant with the majority of cancer wait targets with the exception of the 62 day wait for first treatment from urgent GP referral and the 62-day wait for first treatment following referral from a screening service. This is partially due to late referrals from other hospitals to our specialist services.

During quarter 3, five patients referred from the screening programme breached the 62 day screening target. These breaches are largely driven by patient choice, and therefore are outside of our control. There are however parts of the patient pathway under our control that we can improve, and we have an action plan to deliver improvements in these areas.
Monitor governance rating

As a result of missing the 62 cancer screening target and exceeding the annual MRSA target we have been rated amber-red for governance risk under Monitor’s compliance framework for quarter 3 (see Appendix 2).

The proposed introduction of new A&E quality indicators has been identified as a high risk next year. The Operating Framework has classified A&E quality as a key issue and five new measures are proposed for inclusion in the Compliance Framework as follows:

- 95% of patients waits less than 4 hours
- 5% reattendances within 7 days
- 95% ambulance assessments within 15 minutes
- Median waiting time less than 60 minutes
- 5% patients left without being seen

Recent analysis suggests that performance against these new indicators will be challenging and they pose a significant risk to the Trust. We are concerned that we don’t have full control over the re-attendance indicator. Although we will work with our commissioners on reducing attendance in general at A&E, the DH guidance on this indicator makes clear that “a high re-attendance rate does not only reflect the standard of care in the A&E. It may also reflect a lack of accessible community services”.

2. HEALTH & SOCIAL CARE BILL – SECOND READING

The second reading of the Health & Social Care Bill has commenced in the House of Commons. The draft legislation builds upon major themes presented in the White Paper ‘Equity and Excellent: Liberating the NHS’. Discussions in the House have been widely reported in the national media and there are various summaries and parliamentary briefings available from a wide range of sources. The Bill itself is extremely lengthy and is likely to receive substantial amendments during its passage through Parliament. I attach, as Appendix 3, a briefing provided by Nuffield Trust, an independent health think tank, which highlights controversial aspects of the legislation.

I attach, as Appendix 4, a letter from David Bennett, recently appointed as Chairman of Monitor. This letter sets out his priorities. An early task will be to recruit a permanent Chief Executive - he will continue as interim Chief Executive in the meantime. He states that the Government has said that it had no intention of asking Monitor to lower its assessment bar and this is something that he is equally clear about. He expresses the intention for Monitor to become an exemplary economic regulator, promoting competition where appropriate and regulating effectively where necessary. His main duty is ‘to protect and promote the interests of people who use healthcare services’.

3. CO-OPERATION AND COMPETITION PANEL (CCP) – ‘ANY WILLING PROVIDER’

I should like to bring to the Governor’s attention an interim assessment of the CCPs review of the operation of ‘any willing provider’ for the provision of routine elective care.

The report deals with two main issues, the problems in transferring independent sector providers of NHS funded care to PCT-based contracts and broader concerns that a significant number of PCTs are engaging in behaviours that could raise issues of consistency with the principles and rules for co-operation and competition. It is this latter aspect which is of particular concern to the Trust. The report expresses concern about a pattern of behaviour by PCTs (and SHAs acting on behalf of PCTs) that could breach the principles and rules, as well as obligations arising under the NHS constitution. In particular the alleged behaviour includes:

- Restricting Patient Choice of provider for routine elective care through directions to GPs, waiting list requirements and referral processes which direct patients to particular providers.
• Inserting provisions into contracts with providers that restrict Patient Choice including, for example, activity caps and reductions in the type of procedures that providers can offer.

• Creating incentives that undermine Patient Choice, for example, setting different prices for different providers, local price negotiations and block contracts.

Lord Carter of Coles, the Chairman of the CCP, comments ‘our interim report highlights that some parts of the NHS have yet to fully embrace the role of choice and competition. Both NHS and independent sector providers are being hampered in their efforts to deliver the kind of choice that is expected by patients. Through our review, we aim to better understand the motivation for this restrictive behaviour and how it might be addressed’.

The Secretary of State now says that he will amend the Health Bill to ensure his policy of tariff as ‘a maximum’ price will not introduce competition on price. He is quoted as saying that the Government wants the tariff to be a nationally regulated price, not a starting point for price competition.

4. FOUNDATION TRUST NETWORK AND ITS SUBMISSION TO THE DEPARTMENT OF HEALTH

The Board will recollect, from previous reports, that members of the NHS Confederation, including the Foundation Trust Network, were balloted on the issue of FTN independence from the NHS Confederation. The ballot concluded that 77% were in favour of independence for the FTN. This matter is now being taken forward with the NHS Confederation Trustees who will want to ensure that independence for the FTN is closely tied in to solving the ‘going concern’ issue for the NHS Confederation.

In its role as representing the interests of Foundation Trusts, the FTN has written to the Deputy Chief Executive of the NHS on a number of issues of significant importance to UCLH. It provides evidence that the mean average cost improvement programme (CIP) that Foundation Trusts are facing is 6.33%. The FTN suggests that for many organisations this means serious financial stress that will lead to the loss of many thousands of jobs and will endanger waiting times and services for vulnerable patients, as well as threatening organisational survival. The FTN comments that it does not believe that this is the policy intention.

A second issue concerns the policy on emergency readmissions and argues that they are largely caused by patients with conditions unrelated to the original treatment, or are entirely justifiable in the interests of patients.

A third issue, which was particularly raised by UCLH, concerns the timescales in which providers are expected to agree contracts this year. The failure to agree contracts by 31st March may result in Trusts being reimbursed on a ‘pay as you go’ basis which could result in a delay in payments (perhaps up to three months) with severe liquidity implications.

The letter concludes that there is a growing sense of frustration that whilst there is money in the system, it is just not getting to the front line of patient services and even the most efficient Foundation Trusts will be pushed into failure.

5. COMMISSIONING UPDATE

The commissioning process across North Central London is in transition with GP consortia replacing the five PCTs. For 2011/12 commissioning is being focused on a single sector (cluster) approach to reduce the management costs associated with this function.

The financial position of NCL commissioners remains very challenging with the position being presented as a potential deficit of over £730m by 2014/15 on a “do nothing” basis. There are however a number of queries which have been raised, not least of which is the very substantial forecast of acute growth over this period that will need further explanation and substantiation.
The 2011/12 updated PbR tariff was issued in February 2011. The key points are as follows:

- A net tariff uplift of 1.5% (uplift for pay of 2.5% and efficiency of 4%).
- Changes to the “specialist top ups”.
- The continuation of a 30% marginal rate for emergency admissions.
- CQCIN payments of up to 1.5% of income.
- No reimbursed for emergency admissions within 30 days from an elective stay, other readmissions within 30 days paid at a reduced rate.

Currently there is a difference of £42.7m between the financial offer made by NCL plus a £15m gap associated with the NCL plan to restrict access to UCLH for DGH services for residents of Barnet, Enfield and Haringey. There are a number of apparent discrepancies which need to be investigated.

The most significant issues being handled as part of this contracting round relate to:

- The planned implementation of performance metrics and the implications of the Quality Intervention Prevention and Productivity (QIPP) schemes devised by commissioners covering acute productivity, low priority treatments, decommissioning activities, medicines management, local price review, consultant to consultant referrals, non-payment for emergency readmissions and first to follow up ratios etc.
- The proposal to establish 2 contracts with UCLH for 2011/12 (one for tertiary services and one or DGH services) as referred to above.

Governors may be interested to know that I have written to Sir David Nicholson regarding the distorting impact that incorporating the Market Forces Factor (MFF) in standard unit prices potentially has on commissioning decisions. I await a reply to this letter and I will update the Governing Body when further information is received on this.

6. **QUALITY, EFFICIENCY & PRODUCTIVITY PROGRAMME (QEP)**

   **UCLH approach**

   The prime objective is to maintain quality whilst improving productivity and efficiency as we address the economic downturn. The intention is to involve everyone in the Trust, on a scale that has not been achieved previously. As part of this, four large-scale QEP Events have now been held; open to staff of all disciplines. We have attracted high-profile external speakers and these events have been a great opportunity to share good practice from across the Trust and beyond.

   **Structure**

   The vast majority of QEP schemes are delivered at the Clinical Divisional or Corporate Departmental level. To support this there are five pan-Trust strands, each of which is led by a Director:

   - Workforce
   - Productive clinical services
   - Procurement
   - Clinical and corporate support services
   - Asset utilisation

   **QEP Performance at Month 10 – January 2011**

   The overall Trust requirement for 2010/11 is £26.5m QEP target plus local management of incremental drift of £5.1m. We are now confident that we will broadly meet this year’s target.
Quality Performance

The overall measures for quality for the Trust are Hospitalised Standard Mortality Ratios (HSMR) and patient experience. There are agreed quality as well as efficiency measures for clinical work streams to ensure that there are quality as well as efficiency benefits. The HSMR at the Trust is still jointly the lowest in the country and was 69% of the NHS average.

Standard quality measures such as readmission data have been reviewed – readmissions have stayed within the target of 7% since March 2010. The monthly patient experience will now be referenced in this report as one of the balancing measures used to assess how productivity and efficiency impact on Trust services. The overall indicator on patient experience has not been affected and is at 82% within our normal range patient experience.

2011/12 onwards

Although we are now confident about achieving this year’s QEP target, the outlook for future years is challenging. While the NHS has been given a degree of protection, compared to other parts of the public sector, in view of the ageing population, new technology and rising public expectations, this is generally considered to be a real terms reduction of 20% over the next 4/5 years.

Our target for 2011/12 is currently £45m and there are plans defined for over half of this. During this year, our workforce reductions have focused on reductions to our agency staff bill. However our permanent staff numbers have continued to grow. Next year we will need to reduce the overall size of our workforce, despite rising levels of activity. We need to do this as carefully and sensibly as possible, using existing vacancies and natural turnover as far as we can.

7. PARTNERSHIP WITH GPs

You will recall at the last meeting I advised that the Board had discussed the latest proposals for GP commissioning and I attached to my report the Trust’s GP engagement strategy and action plan. As well as the GP visits to local practices referred to in the Chairman’s report work has taken place to improve the service offered to GPs. A GP Partnership Board chaired by Paul Glynne, was set up to co-ordinate the action plan. The Partnership Board has already delivered improvements for example in pathology where the Trust is now able to view GP pathology results thus avoiding duplication of tests. There has also been an improvement in the timeliness and quality of discharge summaries to GPs, and the use of the UCLH GP Portal has enabled some GPs to access information about their patients including results for treatment undertaken at UCLH.

A second area of work was to improve relationships and communication. We have created a GP section on our website providing information to support the referral process and make it easier for GPs to contact Trust staff, and in collaboration with local GPs we will be to developing an integrated care strategy. This will be designed to improve overall clinical outcomes, improve patient satisfaction and reduce duplication across acute and community services.

At the last meeting I suggested that Paul Glynne give a presentation about partnership working with GPs. I propose that this should be organised when we are clearer about the future shape of GP commissioning, and to give the topic an appropriate amount of time for discussion it might be better dealt with at a governor seminar.

8. PATIENT SURVEYS

Several sets of national patient survey results have recently been published which cover in-patient, maternity and cancer services. The Quality & Safety Committee and the Board of Directors have received reports on all of these surveys.

In-patient Survey - results at this stage only compare the outcome of surveys undertaken by Picker and although they represent a reasonable cross-section they are incomplete. However in previous years they have provided the Trust with a good indication of its overall national results.
Taken overall, the interim results show a good performance. We scored significantly better than average on 26 of the survey questions and worse in seven. Patients want improvements in: being admitted sooner, availability of hand gel, quality of food and the quality of clinical information given by nurses. The full results will be published later this year.

Maternity Survey - A CQC survey into maternity services showed better performance (than in the previous survey) in a number of areas such as: facilities, antenatal screening and birth planning. However it suggested we have more to do in terms of postnatal care and the provision of helpful information to women during their pregnancy. A detailed action plan is has been put together and many of the actions are already being implemented.

Cancer Survey - the results of a DH survey into cancer services were disappointing particularly in relation to explanation and information about the patient's condition and support given. The Trust has set up a Cancer Steering Group under the leadership of Geoff Bellingan who is working in close collaboration with Macmillan Cancer Support to help us improve our services in advance of the new cancer centre opening next year.

Sandra Hallett, Director of Quality and Safety, has been invited to the Governing Body meeting to present the key outcomes and issues arising from the three surveys for UCLH.

9. **STAFF SURVEY**

We have had a preview of the results both from the CQC and for our survey provider Picker. Some UCLH headlines are:

- The Trust’s response rate has improved from 43% in 2009 to 57% in 2010.

- In 2010 there were 38 key findings and a separate score for staff engagement.
  - The Trust scored in the top 20% of all acute trusts in England for the key composite result on “staff engagement”.
  - Of the 38 key findings, we scored in the top 20% of acute trusts for 8. We were in the bottom 20% of acute trusts for 8 key findings. This is an improved position from 2009, when 15 key findings were in the bottom 20%.
  - Our results have not deteriorated in any areas.
  - The Trust is in the top 20% of all acute trusts for recommendation as a place to work or receive treatment; that staff believe that their role makes a difference to patients; that staff believe that there are fair and effective incident reporting procedures.
  - The number of staff experiencing physical abuse from patients, relatives and the public is much lower than average and there are significantly improved perceptions that the Trust takes effective action with regards to violence and harassment.
  - More work needs to be done to improve equal opportunities, reduce discrimination, reduce harassment, bullying and improve working relationships between work colleagues.

10. **UCH MACMILLAN CANCER CENTRE**

The cancer centre building remains on time and on budget. Andrew Lansley, Secretary of State for Health visited last autumn to announce the £10 million commitment from Macmillan Cancer Support. A “topping out” ceremony will be held at the end of March.

The UCLH Art Committee, Macmillan, and patient representatives have been brought together to ensure that the building provides a restful and welcoming environment to patients to enhance their experience of cancer care and treatment at all stages.
We have purchased the first PET-MRI machine in the UK which will arrive in September. This and other new imaging equipment will support improved diagnosis and monitoring and research in cancer in the new centre.

The building will be formally handed over to the Trust in January 2012, and will open to patients in April 2012.

We acknowledge that cancer patients at UCLH do not always receive fully joined up pathways of care and the new cancer centre will improve this in several important ways. New ICT developments will mean that patients receive one letter with all of their appointments details and a single phone number to contact about any changes. The cancer division are putting a major effort into ensuring that all clinics and other appointments in the cancer centre will take place on time. Many chemotherapy pathways are being planned in advance to reduce waiting times. More and more patients are benefiting from ambulatory care treatments, which will be delivered in the cancer centre without the need for staying in hospital. This approach is being extended to teenagers in the next month.

Macmillan are helping us to develop a new cancer patient support service which will bring together different patient support services provided by many different groups of staff: clinical nurse specialists, information officers, welfare and benefit advisors, counsellors, psychologist, complementary therapy, lymphoedema treatment, dieticians – with links throughout the building to volunteers, spiritual care, palliative care, art, yoga, nutrition, rehabilitation and more. This service will be available to all cancer patients throughout their pathway of care. They are also helping us with many other aspects of the project: introducing a new volunteer service, bringing their expertise to the design of the building, and helping us to develop models of care which allow patients to take more control over their follow-up, which research has shown improves quality of life.

11. **TOP 10 PRIORITIES**

I attach, as Appendix 5 the latest version of the proposed top 10 objectives for next year. The final version will be included in the Annual Plan which should be completed when we have agreed the contract with the commissioners next month.

SIR ROBERT NAYLOR
CHIEF EXECUTIVE
### Table 1: Monitor Indicators – Compliance Framework

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Thresholds</th>
<th>Weighting</th>
<th>Q1 Performance</th>
<th>Q2 Performance</th>
<th>Q3 Performance</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidence of MRSA</td>
<td>Refer to comments</td>
<td>1.0</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>Refer to comments 1.0. MRSA is red for the YTD up to quarter 3 against a threshold of 8. The full year threshold of 8 is phased in the early part of the year (from April to July) with a zero tolerance from August to March.</td>
</tr>
<tr>
<td>Incidence of Clostridium difficile</td>
<td>Refer to comments</td>
<td>1.0</td>
<td>17</td>
<td>19</td>
<td>15</td>
<td>Refer to comments 1.0. Clostridium difficile is green for the YTD position up to quarter 3 against a threshold of 90. Our full year threshold is 119. The monthly threshold is 10 for every month except March 11 where it is 9.</td>
</tr>
<tr>
<td>62 day wait for first treatment from urgent GP referral</td>
<td>88%</td>
<td>1.0</td>
<td>88.7%</td>
<td>81.6%</td>
<td>79.1%</td>
<td>To note, our submission to Monitor includes breach sharing for this indicator.</td>
</tr>
<tr>
<td>62 day wait for first treatment from consultant screening-service referral</td>
<td>90%</td>
<td>1.0</td>
<td>100.0%</td>
<td>88.7%</td>
<td>88.7%</td>
<td></td>
</tr>
<tr>
<td>31 day wait for second or subsequent treatment: Surgery</td>
<td>94%</td>
<td>1.0</td>
<td>96.4%</td>
<td>100.0%</td>
<td>98.5%</td>
<td></td>
</tr>
<tr>
<td>31 day wait for second or subsequent treatment: anti cancer drug treatments</td>
<td>96%</td>
<td>1.0</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>31 day wait for second or subsequent treatment: Radiotherapy (from 1 Jan 2011)</td>
<td>94%</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>31-day wait from diagnosis to first treatment (all cancers)</td>
<td>96%</td>
<td>0.5</td>
<td>97.5%</td>
<td>98.0%</td>
<td>98.5%</td>
<td></td>
</tr>
<tr>
<td>Two week wait from referral to date first seen: all cancers</td>
<td>93%</td>
<td>0.5</td>
<td>93.1%</td>
<td>93.7%</td>
<td>94.3%</td>
<td></td>
</tr>
<tr>
<td>Two week wait from referral to date first seen: symptomatic breast patients</td>
<td>96%</td>
<td>0.5</td>
<td>96.1%</td>
<td>96.5%</td>
<td>94.2%</td>
<td></td>
</tr>
<tr>
<td>Screening all admissions for MRSA</td>
<td>100%</td>
<td>0.5</td>
<td>100%+</td>
<td>100%+</td>
<td>100%+</td>
<td></td>
</tr>
<tr>
<td>Maximum waiting time of four hours in A&amp;E from arrival to admission, transfer or discharge</td>
<td>98%</td>
<td>0.5</td>
<td>98.5%</td>
<td>99.0%</td>
<td>98.5%</td>
<td></td>
</tr>
<tr>
<td>Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability</td>
<td>N/A</td>
<td>0.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall governance rating</td>
<td></td>
<td></td>
<td>Green</td>
<td>Amber/Green</td>
<td>Amber/Red</td>
<td></td>
</tr>
</tbody>
</table>

Green: <1.0, Amber-green: 1.0-2.0, Amber-red: 2.0-4.0, Red: >4.0

Note: Thrombolysis is a Monitor Indicator but we do not provide this service in the Trust therefore we are not measured on this.
Health and Social Care Bill

Second reading

The Government’s Health and Social Care Bill makes provisions for major changes to the NHS in England. The plans build on previous NHS reforms to devolve more responsibility to the front line and, we believe, are broadly in the right direction. However, they will be judged on the extent to which they deliver sustained improvements to patient care during a period of major financial challenge for the NHS. Implementation therefore needs to be managed very carefully. This briefing by the Nuffield Trust, an independent health think tank, highlights aspects of the legislation that we believe merit greater scrutiny.

GP-led commissioning consortia (Clauses 1, 5–6, 9–10, 13, 16, 22, 24)

Under the proposals, groups of GPs will be given real budgets to buy care on behalf of their local communities. They will be responsible for handling about £70 to 80bn of the NHS budget. GP practices will continue to offer community-based services as independent businesses contracted into the NHS, but will also form new, legally separate organisations – commissioning consortia – that will be statutory NHS organisations. All GP practices will have to be part of a commissioning consortium, although they will have a degree of choice over which one they join.

- The principle of giving doctors more responsibility for how services are planned is a logical one, since they are in effect responsible for most NHS spending through prescribing, patient referrals to hospital, and other clinical decisions. However, evidence from similar but less radical policies in the past – GP fundholding, total purchasing, primary care groups and practice-based commissioning – shows they will take several years to develop properly. GP practices are used to acting as small businesses, not large conglomerates, handling millions of pounds.

- In their early years, GP commissioning consortia will be underdeveloped as commissioners and subject to the same pressures as primary care trusts (PCTs) but with significantly reduced management resources. The Government needs to consider carefully how GP consortia can be provided with high-calibre management and analytical support, and how to address both the risks of loss of financial control by GP consortia in the early years and the handling of financial risk. In addition, the systems for assessing independently whether GP consortia are sufficiently prepared to assume budget responsibility and achieve value for money are as yet unclear. With the large sums of money involved, it is crucial that these arrangements are robust.

- Substantial investment in leadership, management and IT will be vital if GP consortia are going to be able to manage public funds on such a large scale effectively, to reduce inappropriate hospital admissions and succeed in moving care into the community. There are clear risks of introducing GP commissioning in England when the Government has placed such a strong emphasis on reducing management costs.

- GP consortia should have an explicit authorisation regime similar to the one NHS hospital and mental health trusts undergo before achieving autonomous foundation trust status. This would enable them to demonstrate that they can commission good-quality care across a wide range of services, as well as handle increasing amounts of NHS funds effectively before assuming full responsibility. It would also allow the ‘first wave’ (the enthusiasts) to demonstrate success and encourage subsequent development.

- If the high level of public trust in general practice is to be maintained it will be important that patients do not perceive a conflict of interest over their GP’s role as both a commissioner and provider of services. A particularly sensitive issue will be the extent to which the personal remuneration of GPs is affected by commissioning decisions.

- If they are to succeed, GP consortia will need to work with hospital consultants, patients and social care organisations to expand their own and other community based services, to ensure that patients can access a range of care in hospitals and in their local communities. The US experience of doctor-led commissioning shows that integration of primary and secondary care is vital to the delivery of efficient high-quality care.
The NHS Commissioning Board (Clauses 1, 5, 11, 13, 16, 19, 21, 23, 38, 41)

Although *Equity and Excellence: Liberating the NHS* stated clearly that the NHS Commissioning Board is not meant to be the ‘headquarters’ of the NHS, the Board will play a pivotal role as the overall funder of NHS commissioners by undertaking resource allocation, designing service standards, and holding GP consortia to account against the NHS Outcomes Framework.

- **In a tense financial climate, the role of the centre will need to be thought through carefully.** The Bill gives considerable powers to the Board to intervene in the activities of GP consortia. While this might arguably be necessary to guard against management failures that seriously affect patients’ access to services, such provisions are in tension with the localism that the legislation is seeking to embed.

- **A key challenge will be to make sure there is clarity about how hard choices will be made, and who will be held responsible for them.** A forthcoming Nuffield Trust report on the experiences of the new national health board in New Zealand suggests there is a need for formal restrictions on the Government’s ability to intervene in the work of the Board, and equally limits on the ability of the Board to interfere in the activities of GP consortia. One major test will be if the Secretary of State can stand aside from contentious political decisions, such as about local hospital closures.

- **Notably, the Board will also hold all individual general practice contracts on behalf of the NHS.** This poses the question of as to whether and how these two principal areas of general practice activity (commissioning and provision) can be jointly and effectively overseen at the national level. Under the present system PCTs have made significant progress modifying the contracts they held with GPs locally in order to develop extended and improved general practice services in the community to meet complex patient needs. Thought needs to be given as to how this progress can be sustained and built upon with the new national focus given to general practice contracts.

Abolition of strategic health authorities and primary care trusts (Clauses 28–29)

The NHS, in particular commissioners, have been subject to numerous reorganisations over the past two decades. Despite pledges not to subject the NHS to a further structural reorganisation, the Government is planning radical changes that will see all 150 PCTs in England abolished from 2013, together with all ten strategic health authorities (SHAs).

- **This is a huge undertaking and will distract management attention at a period when the NHS needs to make rapid and extensive efficiency savings.** Research evidence on restructuring and mergers suggests that there are inevitable costs to organisations of such change, including the loss of organisational memory, time and resources taken up by the process of implementing change, and distraction of organisations from their core activity. Furthermore, evidence on high-performing health organisations points to the importance of long-term, sustained clinical and general managerial leadership with senior teams among whom there is trust and expertise developed over many years.

- **Reinforcing the recommendation by the House of Commons’ Health Committee, we have suggested that the formation of the PCT ‘clusters’ (which will help manage the transition) needs to be speeded up to ensure there is appropriate oversight during the challenging interim period before GP consortia take up their new powers.**

- **Assurances about the longer-term existence of clusters should also be given so that they can attract and retain the best managerial and analytical talent.** If allowed to, such clusters could perform a valuable long-term role by helping to manage financial risk, assure the quality of patient services during a time of transition, provide commissioning support to GP consortia and oversee the contracts for local primary care providers on behalf of the Board.
The proposed role of Monitor as an economic regulator, price based competition and the universal creation of FTs (Clauses 51–59, 103–112, 164–165)

Under the Bill, all NHS trusts will become foundation trusts within three years. The foundation trust regulator Monitor will also be developed into an economic regulator of ‘providers of NHS care’. Its main functions will be to promote competition between providers where appropriate, set maximum prices and help the Board ensure that all populations have access to care should a hospital fail in their local area. The legislation makes it clear that in performing its role around competition, Monitor will be required to do so in accordance with the Secretary of State’s wider duties to deliver a comprehensive health service, improve the quality of services, reduce inequalities and promote autonomy.

• The Nuffield Trust supports the aim of using competition and choice to help improve quality and efficiency. However, if patient care is to improve and taxpayers are to get better value for money, Monitor will need to decide on the most appropriate units of competition. Promoting competition simply between the GP practices or hospitals may prevent GPs and hospital consultants from cooperating to provide new forms of care, despite this approach holding more promise for achieving efficiency and quality gains through, for example, reducing inappropriate emergency hospital admissions. Vertically integrated providers – practices and hospitals – may be the more appropriate unit of competition.

• We support the proposal for Monitor to focus on economic regulation, leaving the Care Quality Commission (CQC) to regulate quality, for these require different and specialist skills. However both organisations will need to work together effectively. Concerns that the Bill allows for Monitor to pursue untrammelled competition at the expense of other considerations may be unfounded under the legislation as presently phrased. However, practice will to a large extent depend on the wider political consensus and policy framework. A key consideration will be the extent to which it is understood that the Competition Commission, in its seven yearly review of Monitor’s performance does so with due regard to the specific context of health care and Monitor’s wider obligation to support the Secretary of State’s duties (as laid out above).

• The economic literature on competition between hospitals suggests that competition with fixed prices increases quality of care, provided that the price is above the marginal cost of providing it. Competition on price is however associated with decreases in quality, since quality is less measurable and observable than price. The evidence does not support moving to a maximum tariff (something that is allowed under this Bill).

• The creation of foundation trust status (which brought greater independence) for high-performing hospitals was a key reform of the previous Labour Government. There are now 160 foundation trusts (over half of all NHS trusts). We are concerned that the fixed deadline for making all NHS Trusts foundation trusts will, within three years, either require Monitor to lower the bar for attaining foundation status, or mean that some individual hospitals will concentrate on achieving and maintaining this status at the expense of other priorities, as the case of Mid Staffordshire NHS Foundation Trust appears to demonstrate.

Public involvement and local government (Clauses 166–184)

It has proved very difficult in the past to achieve local legitimacy and accountability in the NHS as strong lines of accountability reach upwards to the Secretary of State and to Parliament. The further development of community services, the expansion of foundation trusts and the increased use of independent sector providers all underline the need to have an impartial body to ‘hold the ring’ of local involvement and represent the views and concerns of patients and the public.

• The proposals to create health and well-being boards go some way towards creating a representative local body to help shape local commissioning decisions. However, while the Bill is clear about the importance of needs assessment, the power these boards may have to challenge or intervene in commissioning decisions seem less certain.

• Governance arrangements for GP consortia, with respect to the accountability to the enrolled population served, are weak and need to be developed. The Government has chosen not to mandate public involvement in the governance of GP consortia, so the Board will need to develop an understanding of what effective public engagement should look like and ensure that local GP consortia do not neglect this aspect of their work. It is particularly relevant in relation to decisions about scarce resources, which will appear to be illegitimate if GP consortia have not adequately involved and consulted with local people, directly and in conjunction with local government.
Possible questions to raise in the debate

Reform of commissioning
1. What methods will be used to assess the readiness of GP consortia to take on and manage NHS budgets?
2. How will it be established that GP consortia are delivering value for money for taxpayers?
3. How will the remuneration of GPs for commissioning performance be kept separate from their clinical decisions about individual patient care, in a transparent manner?
4. How will the Board manage the performance of consortia that appear to be failing, and what will it do if they are unable to improve?
5. Will the Board’s control of general practice contracts undermine local commissioners’ ability to improve local primary care services in a timely and flexible manner?
6. What will be the longer-term function of PCT clusters in relation to GP consortia and the Board?
7. How exactly will GP consortia be accountable for commissioning to the population enrolled in their constituent practices?
8. How will the Board be able to manage 8,200 practice contracts?

Economic regulation
1. On what basis will Monitor measure the extent of competition in local health services?
2. How will the well-known risks of price competition within health services be mitigated?
3. Through what process will Monitor and the CQC (and indeed the Board) resolve conflicts when their objectives clash?

Public involvement
1. How will Healthwatch relate to the Care Quality Commission at a national level?
2. What assurances will be put into place to ensure that local Healthwatch organisations are representative?
3. How will the Board ensure that GP consortia involve and consult local people in relation to commissioning decisions?
4. How will Health and Well Being Boards hold commissioners to account?

About the Nuffield Trust
The Nuffield Trust is charitable trust carrying out research and policy analysis on health services. Our focus is on the reform of health services to improve the efficiency, equity and responsiveness of care. We have recently published a number of briefings and reports dealing with several of the key themes underpinning the Bill:
1. GP Commissioning: Insights from medical groups in the United States
2. NHS Resources and Reform: Response to the White Paper Equity and Excellence: Liberating the NHS, and the 2010 Spending Review
4. Giving GPs Budgets for Commissioning: What needs to be done?
5. Making Progress on Efficiency in the NHS in England: Options for system reform

To download free copies of these publications visit www.nuffieldtrust.org.uk/publications

For more information on any of the points raised in this briefing, or to speak to one of our policy leads, please contact Frank Soodeen on 020 7462 0555 or write to frank.soodeen@nuffieldtrust.org.uk

To sign up to receive our regular e-newsletter, visit www.nuffieldtrust.org.uk/newsletter/login.aspx
2 March 2011

By email

Dear colleague

I am pleased to let you know that as from 1 March I have taken up my new role as non-executive Chair of Monitor.

Over the next few months I hope to meet many of you face-to-face to get your views on how we can build on the success so far of the foundation trust sector as we move into a new stage of NHS reform. To start that process I thought it would be helpful if I set out how I see my immediate priorities here as Chair.

An early and critical task for me will be to recruit a permanent Chief Executive. As this could take a number of months I will continue as interim Chief Executive in the meantime.

My first business priority will be to ensure that we remain strongly focused on our compliance and assessment activities. Our core task remains to ensure, on behalf of patients and taxpayers, that foundation trusts are well run and financially strong. We know that the financial pressure on foundation trusts will be increasing over this coming year, although I believe most of you should be well placed to face the challenges ahead. We will continue to encourage foundation trusts to develop detailed, integrated plans that identify how operational changes can be made whilst maintaining a strong focus on the quality of care delivered. I firmly believe that the foundation trust sector should be capable over the next few years of improving quality and controlling costs at the same time. Increasingly this will mean leading efforts in the local health economy to redesign fundamentally clinical pathways and patterns of service.

At the same time we will continue to set high standards in our assessment process as we play our part in meeting the April 2014 deadline for all remaining trusts to become foundation trusts. Our view is that having this deadline set in legislation should usefully force the difficult but necessary decisions that will put all NHS providers on a sounder footing as they face the challenges ahead. The Government has said that it has no intention of asking Monitor to lower its assessment bar and this is something that I am equally clear about. It is not in the interests of patients and the public for trusts that are not well run and financially strong to be granted the independence and autonomy that comes with foundation trust status.
Next month we will publish our *Business Plan 2011-12* which will set out what we aim to achieve in the year ahead for our “business as usual” activities. I would welcome any comments or thoughts you want to share with me on these plans either by email or by letter.

As you will know, provided that the Health and Social Care Bill passes through Parliament successfully, Monitor will become the economic regulator for health from April 2012. The second of my key business priorities will be to make sure we are prepared for this new role. Over the coming months we will begin to design and build the new organisation. I will need to think through how to shape and recruit to my new board, and how to get my new top team working effectively. Finalising the new organisation will need to wait until the new Chief Executive is in place, but I plan to start making transitional arrangements as soon as possible.

My goal is to ensure that the economic regulator continues the Monitor tradition of outstanding professionalism, rigour and independence. I want Monitor to become an exemplary economic regulator, building on lessons from other sectors and making sound decisions in an open and transparent way based on dialogue, widespread consultation and rigorous, fact-based analysis. The measure of our success will be whether, by promoting competition where appropriate and regulating effectively where necessary, we have made a material and beneficial difference to the quality and value for money of the care that is provided to users. In order to do this, there will be many policy decisions to be made and they will need to be made carefully. The thing I am absolutely clear about is that we will always make decisions in the light of the economic regulator’s main duty, which is “to protect and promote the interests of people who use healthcare services”.

We will be open about our aims and will set out our thinking as carefully and as clearly as possible so that all stakeholders can contribute to the design of the new regulatory regime. For example, you can expect to see consultation documents emerge over the next few months on some of the key features of the regime, such as the provider licence, as we prepare for the April 2012 start date.

Another priority will be playing our part in making sure that the new arrangements for regulation and oversight of the healthcare system are effective. This means building strong and collaborative relationships with the Department of Health, the NHS Commissioning Board and the Health and Social Care Information Centre (as they come into existence), the Care Quality Commission and NICE. Strong and effective relationships will be key to the success of this next phase of health service reform. Also important for me will be the framework for our own accountability, and as part of that I will actively seek a regular dialogue with Parliament.

Together we are facing a period of significant challenges. Although I do not underestimate the size of the task, I am convinced that there are real opportunities here to put the NHS on a sound basis for the long term, for the benefit of patients and taxpayers. I am looking forward to working with you, as well as with the Government and other partners, to make this a reality. I will keep you informed and seek your input as we develop our proposed new role and our thinking on the many critical policy issues that we will need to address. With this in mind I have started to discuss with the team
here how I can meet with as many of you as possible over the next few months. I will let you have details as soon as plans have been made.

I feel honoured to be taking over leadership of an organisation as successful as Monitor, and to be given the chance to make a real and positive difference for the NHS. I would like to thank Steve Bundred for his stewardship of the organisation as Chair over the last year and I look forward to working with you as we move into an exciting new phase in the development of both Monitor and the NHS.

Yours sincerely

[Signature]

David Bennett
Chair and Interim Chief Executive
DRAFT TRUST CORPORATE OBJECTIVES 2011/2012

1. Deliver excellent clinical outcomes
   - Improve performance on hospital mortality
   - Reduce avoidable emergency readmissions
   - Review divisional clinical audit arrangements

2. Improve patient safety
   - Reduce MRSA, Clostridium difficile and other key infections
   - Reduce numbers of blood clots, central venous line and surgical site infections
   - Achieve zero pressure ulcers and reduce falls with harm.

3. Deliver high quality patient experience
   - Enable patients to manage their appointments easily and with confidence
   - Achieve patient experience to the upper quartile in the national inpatient survey
   - Improve patient experience for cancer, maternity and outpatient services.

4. Build strong relationships with GPs
   - Improve the patient pathways of ten key conditions, as agreed with GPs.
   - Improve the timeliness and quality of GP discharge letters
   - Make it easier for patients and GPs to contact hospital staff.

5. Achieve sustainable financial health
   - Achieve agreed income, expenditure and cash targets
   - Deliver service line management and patient level costing
   - Replace the existing financial management system.

6. Deliver cost savings through the Quality & Efficiency Productivity Programme
   - Deliver QEP savings in 2011/12 and a 3-year strategy
   - Develop and implement a plan for long-term productivity and efficiency savings
   - Rationalise clinical and support services across UCL Partners.

7. Develop R&D and education through UCLP
   - Achieve full utilisation of the UCLH clinical research facility
   - Achieve re-designation as a comprehensive biomedical research centre
   - Implement a leadership staff college.

8. Develop and enable staff to maximise their potential
   - Reduce stress in the workplace and set a zero tolerance towards violence against staff
   - 90% staff appraised and mandatory training compliance doubled by the end of the year.
   - Ensure that all staff roles are fit for purpose and affordable

9. Deliver wait times in line with contract
   - Deliver patient waiting times agreed with commissioners
   - Deliver standards for timeliness of care in A&E
   - Meet the cancer waiting time targets

10. Strategic development of clinical services
    - Be successful in our bid for proton beam therapy
    - Commission the Cancer Centre, redesigning pathways to deliver improved care
    - Progress plans for RNTNE and EDH replacements.
UCLH Hospitals
National In Patient Survey
Picker Results 2010
Priorities for 2010

• Maintaining performance
• Retaining position relative to London peers
• 4 low scoring areas
• Quality Account priorities:
  □ Overall satisfaction
  □ Would recommend
• CQUIN priorities
Historical Performance 2009 vs 2010

Improved in 4 areas
- Bathroom gender separation
- Anaesthetist explanation
- Explanation of results of surgery
- Told side effects of medication on discharge

Worsened in 3 areas
- Storage of personal belongings
- Hand gels not available
- Privacy when being examined or treated.
2010 Performance vs Picker Average

2009 results
- Significantly better on 18
- Significantly worse on 1
- Scores were average 69

2010 results
- Significantly better on 26
- Significantly worse on 7
- Scores average on 55
UCLH IP Survey vs Peer Group (Acute Teaching London)

Significantly better than London peer average on 40 questions

- all Dr questions
- 3 of 6 nurse questions
- discharge information
- overall rating of care
- would you recommend

Worse than London peer average on one question

- should have been admitted sooner.
Low scoring questions in 2009

- A&E: did you get the right amount of information about your condition
- Did you see posters or leaflets on ward asking patients/visitors to wash their hands — **new question**
- Explanation of anaesthetic & pain control
- Discharge delay

Have all improved in 2010
Key areas where results are better than Picker average

- All Dr questions
- Explanations about condition; surgery; anaesthetic; results
- Discharge involvement & medications
- Overall rating
- Would you recommend

University College London Hospitals
NHS Foundation Trust
Low scoring Picker questions in 2010

- Should have been admitted sooner
- Printed information about condition
- Hand gel not available or empty
- Noise from other patients visitors
- Food was fair or poor
- Trust & confidence in nurses
- Nurses not knowing enough about condition or treatment
Next Steps

- Communication strategy
- Specialty analysis
- IPSG assess improvement priorities & actions for this year
- Continue to keep focus on improvement actions using “Frequent Feedback” surveys
- Utilise national benchmark results when available (April 21st)
UCLH Hospitals
National Cancer Survey Results
2010
Methodology

- Commissioned by DoH & 158 Trusts providing cancer services took part

- Survey included all adult patients admitted as in patient or day case between Jan – March

- 1290 patients from UCLH were eligible & our response rate was 59% (722 patients)

- All tumour groups included: Breast, Lung, Colorectal, Prostate, Brain/CNS, Gynae, Head & Neck, Urology, Haematology, Sarcoma, Upper GI
Key National Findings

“Cancer inpatients are significantly more satisfied with their care and treatment than hospital inpatients generally.”

“Variations between the best and the worst Trusts can be very wide.” (13% - 92% for written information)

“Important differences between different cancer groups: rarer cancer patients have less positive views (e.g. sarcoma, brain/central nervous system and urology)”

Impact of CNS profound: significant variation by Trust

“Significant differences between London & non London Trusts with patients in London being more critical of aspects of cancer services”

17 of the lowest performing Trusts are in London.
## UCLH vs London Peers

<table>
<thead>
<tr>
<th>Trust</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guys and St Thomas NHS Foundation Trust</td>
<td>32%</td>
</tr>
<tr>
<td>St George’s Healthcare NHS Trust</td>
<td>34%</td>
</tr>
<tr>
<td>King’s College Hospital NHS Foundation Trust</td>
<td>47%</td>
</tr>
<tr>
<td>University College London Hospitals NHS FT</td>
<td>56%</td>
</tr>
<tr>
<td>Barts and the London NHS Trust</td>
<td>66%</td>
</tr>
<tr>
<td>Royal Free Hospital NHS Trust</td>
<td>73%</td>
</tr>
<tr>
<td>Imperial College Healthcare NHS Trust</td>
<td>80%</td>
</tr>
</tbody>
</table>
Tumour Group Analysis

- Not all tumour group scores are negative in relation to same tumour nationwide
- Breast tumour, Urology & Haematology patients for example rate UCLH better than that tumour group nationally
- CNS support rated positively in Haematology & Breast tumour groups
- Common to all – speed of access; communication & information
Overall Themes from Survey

- Information (verbally & written) not understandable or complete
- Explanation at all parts of pathway not adequate or understandable
- Involvement in decision making
- Emotional support
Positive comments

“My breast care nurse was excellent. I could not have got thro my treatment without her. My surgeon was extremely good & caring.”

“My cancer nurse was wonderful. Always available, clear & helpful & gave me huge confidence. Sadly she has left & not been replaced. She is hugely missed.”

“I think I am lucky & that good people were caring for me, I am in love with all of them”

“ the medical care was excellent.”
What could be improved

“Delays between diagnosis and tests to treatment were too long.”

“The day clinics seem to work on the chaos theory with overruns of 2 hours + being the norm.”

“Communication between medical & surgical teams when care is shared could have alleviated a few moments of upset for me”

“...failure to focus on holistic care.”
Next Steps

• Presentations to clinical forums across the Trust
• Analysis by tumour group circulated to MDTs
• Cancer MDTs examining their own results & planning improvement strategy.
• Cancer Steering Group coordinating
• CNS & nursing improvement plan via Chief Nurse
• Real time patient feedback
UCLH Hospitals
Maternity Survey Results 2010
National Maternity Survey

• Done in 2007 and repeated in 2010
• 360 women included from February admissions
• 162 women responded (45% return rate)
• 53 questions in 5 care categories: antenatal, labour & birth, staff during labour & birth, care following birth, feeding baby during first few days
Picker Results: Peer Comparison

**Significantly Better than Peers**
- Women are given a choice of where to have baby
- Women are encouraged to make a birth plan.
- Fewer feel care during pregnancy is fair or poor
- Cleanliness of facilities
- Food choice: postnatal
- Mothers have postnatal health check at 6 weeks

**Significantly Worse than Peers**
- Not treated with respect and dignity during labour
- Not always a staff member available in postnatal
- Postnatal information
- Partner/companion not made to feel welcome
- Infant feeding information during pregnancy
### Picker Results: Historical Comparison

#### Significantly Better than 2007

<table>
<thead>
<tr>
<th>Service</th>
<th>2007</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall: care during pregnancy fair or poor</td>
<td>19 %</td>
<td>6 %</td>
</tr>
<tr>
<td>Labour &amp; birth: toilets and bathrooms not clean</td>
<td>31 %</td>
<td>3 %</td>
</tr>
<tr>
<td>Postnatal care: hospital or ward not clean</td>
<td>18 %</td>
<td>7 %</td>
</tr>
<tr>
<td>Postnatal care: toilets and bathrooms not clean</td>
<td>39 %</td>
<td>11 %</td>
</tr>
<tr>
<td>Overall: after birth care fair or poor</td>
<td>34 %</td>
<td>19 %</td>
</tr>
</tbody>
</table>

#### Significantly Worse than 2007

<table>
<thead>
<tr>
<th>Service</th>
<th>2007</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal care: information /explanations</td>
<td>35 %</td>
<td>49 %</td>
</tr>
<tr>
<td>Postnatal Care at Home: did not receive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>enough about baby’s sleeping position</td>
<td>35 %</td>
<td>51 %</td>
</tr>
<tr>
<td>did not receive enough advice on baby crying</td>
<td>50 %</td>
<td>70 %</td>
</tr>
<tr>
<td>Executive Themes</td>
<td>CQC 19 Questions/5 Category View</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Antenatal care</strong></td>
<td>• 7.3/10 Expected range 7.5 – 9.2</td>
<td></td>
</tr>
<tr>
<td><strong>Labour and birth</strong></td>
<td>• 7.3/10 Expected range 6.8 – 8.1</td>
<td></td>
</tr>
<tr>
<td><strong>Staff during labour and birth</strong></td>
<td>• 7.9/10 Expected range 7.7 – 9.3</td>
<td></td>
</tr>
<tr>
<td><strong>Care in hospital following birth</strong></td>
<td>• 6.3/10 Expected range 6.5 – 8.3</td>
<td></td>
</tr>
<tr>
<td><strong>Feeding the baby during first few days</strong></td>
<td>• 5.2/10 Expected range 5.3 – 7</td>
<td></td>
</tr>
</tbody>
</table>

**Overall Antenatal Care improved since 2007:**
+ Choice of birth offered and having birth plans, access to screening.
- Choice of home birth – 70% out of area women & cannot offer them a choice of home birth.

**Overall Labour and Delivery similar results to 2007 & peers:**
+ Environment/Cleanliness, Choice of pain relief, Movement encouraged during labour, use of birth pools.
- Access to pain relief, continuity of care, involvement in decisions,
  - Confidence in staff.

**Postnatal care improved over 2007, but still much to do:**
+ High rates at early success with breastfeeding, low length of stay.
- Information and support in postnatal period including infant feeding, lack of kindness and support.
Actions & Progress

- 12 months since survey period
- Comprehensive improvement action plans have since been implemented
- Postnatal ward has joined “Transforming Care at the Bedside” (TCAB) since July
- Attended Picker Maternity Survey Quality Improvement workshop in November
- Repeating the survey in 2011
Draft Annual Plan  2011/12

Governing Body
March 2011
The forecast position for NCL is a run rate deficit of £59.2m going into 2011/12. The impact of activity growth, inflation, planning requirements and local cost pressures sees this rise to a cumulative gap of £730.8m by 2014/15. This comprises a £682.6m gap in the outer PCTs, Barnet, Enfield and Haringey and a £48.3m gap in Camden and Islington. The cumulative QIPP target of £824.4m is required to deliver NCL to surplus in 2012/13 as a cluster and by PCT in 2013/14. Delivery of this programme will result in an overall NCL surplus of £48.3m by 2014/15.
2011/12 Financial Plan update
Worked Example of Commissioner Purchasing from UCLH

- Recurrent PCT budgets are increasing in 2011/12 by about 2%
- Tariff down despite inflation high (4% efficiency assumed)
- BUT PCTs are required to pay 2% to NHS London and generate a surplus
- No money left to fund growth
- Initial contract offer to UCLH from local PCTs is more than £50m lower than 2010/11 actual income

<table>
<thead>
<tr>
<th></th>
<th>Funding</th>
<th>Price per procedure</th>
<th>Buys how many?</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11</td>
<td>£100,000</td>
<td>£1,000</td>
<td>100</td>
</tr>
<tr>
<td>PCT recurrent allocation growth (2%)</td>
<td>£2,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduction in tariff (0.8% average for UCLH)</td>
<td></td>
<td>-£8</td>
<td></td>
</tr>
<tr>
<td>NHS London top-slicing of PCT budgets by 2%</td>
<td>-£2,040</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Requirement for PCTs to generate 1% surplus</td>
<td>-£1,020</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011/12</td>
<td>£98,940</td>
<td>£992</td>
<td>100</td>
</tr>
</tbody>
</table>
2011/12 Financial Plan update
Income growth vs. activity growth

![Graph showing income growth vs. activity growth](image-url)
Income waterfall to 2011/12 Plan
Expenditure waterfall to 11/12

- 10/11 FOT
- Infl (Pay & Non Pay)
- Net Incr Drift
- Marg Cost of Growth
- Cost Savings from Comm int
- ITDA
- Other
- QEP
- 11/12 Plan
2011/12 Financial Plan update

Cash

- Cash outflow (before loan) of £64m includes £36m cancer centre and maintenance of essential ongoing equipment and property
- Phase 4, RNTNE, Proton Beam etc. are not included in this cash plan

<table>
<thead>
<tr>
<th></th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening cash</td>
<td>77.5</td>
<td>77.3</td>
<td>85.9</td>
</tr>
<tr>
<td>EBITDA</td>
<td>60.9</td>
<td>66.7</td>
<td>67.5</td>
</tr>
<tr>
<td>ITDA Cash Items</td>
<td>(43.7)</td>
<td>(53.9)</td>
<td>(53.5)</td>
</tr>
<tr>
<td>Operating Cash flow before Capex and Financing</td>
<td>17.2</td>
<td>12.9</td>
<td>14.0</td>
</tr>
<tr>
<td>Property/Charity Receipts</td>
<td>0.9</td>
<td>33.4</td>
<td>8.0</td>
</tr>
<tr>
<td>Capital Programme - Phase III</td>
<td>(35.5)</td>
<td>0.9</td>
<td>0.0</td>
</tr>
<tr>
<td>Capital Programme - Other</td>
<td>(46.3)</td>
<td>(33.2)</td>
<td>(34.8)</td>
</tr>
<tr>
<td>Cash flow before loan financing</td>
<td>(63.7)</td>
<td>13.9</td>
<td>(12.8)</td>
</tr>
<tr>
<td>Financing Activities (Loan)</td>
<td>63.5</td>
<td>(5.3)</td>
<td>(5.3)</td>
</tr>
<tr>
<td>Closing Cash</td>
<td>77.3</td>
<td>85.9</td>
<td>67.8</td>
</tr>
</tbody>
</table>
## 2011/12 Financial Plan update

### Risks and Opportunities

<table>
<thead>
<tr>
<th>Description</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educ. &amp; R&amp;D CLRN Income higher than plan</td>
<td>£1-£3m</td>
</tr>
<tr>
<td>Activity growth higher than internal plan &amp; paid</td>
<td>?</td>
</tr>
<tr>
<td>Sale of Middlesex Annexe in 11/12 with planning permission</td>
<td>cash</td>
</tr>
<tr>
<td>Commissioning Intentions risk worse than estimated</td>
<td>(£1m)-(£10m)</td>
</tr>
<tr>
<td>Marginal cost of commissioning intentions not removed</td>
<td>(£10m)</td>
</tr>
<tr>
<td>Non-pay Inflation higher than plan</td>
<td>(£3m)</td>
</tr>
<tr>
<td>Project Diamond</td>
<td>?</td>
</tr>
<tr>
<td>Contracts not signed by 31st March</td>
<td>Cash flow</td>
</tr>
<tr>
<td>Revenue costs of initiating strategic projects</td>
<td>(£4m+)</td>
</tr>
<tr>
<td>Inclusion of RNTNE in plan</td>
<td>?</td>
</tr>
<tr>
<td>QEP delivery and cost of delivery</td>
<td>?</td>
</tr>
<tr>
<td>Surgery and cancer performance risk</td>
<td>?</td>
</tr>
<tr>
<td>A&amp;E / pathology disruption</td>
<td>?</td>
</tr>
</tbody>
</table>
## 2011/12 Financial Plan update

### Other Issues

**Operational performance** Has been strong – based upon growth

<table>
<thead>
<tr>
<th>Activity Growth and Commissioner Risk</th>
<th>Demand lower, commissioner affordability very unclear Challenging negotiations, lack of clarity at start of year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Price Reductions</td>
<td>UCLH hit by MFF reduction in addition to universal tariff reduction</td>
</tr>
<tr>
<td>QEP Programme</td>
<td>Continuing shift from efficient growth to cost cuts</td>
</tr>
<tr>
<td>Service Line Management</td>
<td>Continuing movement to devolved decision-making</td>
</tr>
</tbody>
</table>
Q&A
Agenda Item 8

High Quality Patient Care
Group Report
The HQPC group has been very busy since our last report to the governing body, taking forward projects outlined in our work programme for 2010/11. The group meets five times a year and a subgroup comprising Dee Carter, Amanda Gibbon, Christine Mackenzie and myself also meet with Sandra Hallett, director of quality and safety, four times a year to discuss quality issues. The HQPC group has evolved a slightly different way of working over the past year, with fewer presentations, more work being undertaken in time-limited subgroups and individual members of the group taking responsibility for liaising with trust staff about issues which the group has been involved in and wants to keep an eye on. This has worked well.

The purpose of this report is to inform the governing body about what we have achieved between April 2010 and March of this year and what we propose to do during 2011/12. The programme is fairly flexible to allow time for new issues which arise during the year to be addressed.

**Major activities undertaken during 2010/11:**

1. **Experience mapping projects**

   These have formed a major part of the group’s work since 2007 and have been particularly productive in identifying areas which other forms of auditing do not always capture.

   - **EGA project follow-up.** The first project in which we interviewed women about their experiences of maternity services took place in 2007 before the move to the new hospital. We also undertook a follow-up project in 2009. In November 2010 we checked with Kara Gelb, divisional general manager, on what progress Women’s Health had made in improving care in response to our proposals. Improvements were found in some areas, e.g. endocrinology waiting times, fewer women left alone in labour and in post-natal care which appeared to have improved since 2007. However concerns remain about care on the observation ward, lack of breastfeeding advice and post-natal care (again). Amanda Gibbon, who conducted the review, concluded that “it has been very heartening to see how hard the EGA has worked to put our recommendations into practice. The subsequent problems on the post-natal ward, however, demonstrate how important it is to maintain standards across the board, and shows how easily, when management focus is distracted by a problem elsewhere, these can slip.”

   - **Hip and knee surgical patients project follow up.** We had been somewhat despondent after finishing the hip and knee project in 2008/9 because there seemed to be little interest from the divisional management in following up our recommendations. We therefore decided to have a further follow up meeting with Geoff Bellingan, medical director for surgery and cancer and Daniel York, the new general manager of surgical specialties, in September 2010 to discuss outstanding issues and were encouraged by the improvements which have been made. We are particularly pleased that most of our recommendations have been included in the new pre-admission presentation and booklet, that physiotherapy forms a key part of the orthopaedic enhanced recovery programme and that a
nurse or physiotherapist now calls patients 48 hours after discharge. Work is in progress to improve post-operative feedback, information and x-ray appointments.

- **New project with cancer patients.** We have interviewed 17 patients, 8 women with gynaecological cancers and 9 men with prostrate or urological cancers. This is the first project where the administration has been managed by the division. We will review how well this has worked and any lessons learnt when we compile experience mapping dossier. The evidence is now being analysed and we are due to discuss a draft report at the April HQPC group meeting.

### 2. Improving patient information

- Several members of the group have contributed to trustwide leaflets for outpatients and inpatients, and specific leaflets on complaints, leaving hospital and patient transport services in order to ensure that they are clearly written and user friendly.
- **Revising the patient registration form.** Two group members worked with Alison Bond, head of operations & performance, medicine board, to produce a new patient registration form which is now in trustwide use for new patients. It is not clear whether this information is being collected for existing patients. The form is due to be audited this spring with input from the HQPC group.
- Ensuring that information on complementary therapies is included in local patient information leaflets.

### 3. Environment and access issues

The group discussed a wide range of access and disability issues, e.g. portering, wheelchairs, access doors at UCH, disabled parking and patient transport over the past year. We had to press quite hard for these to be recognised as important quality issues within the trust but a number of recent initiatives have helped to focus attention on these and secure improvements. These include:

- Holding a governor walkabout in UCH atrium and outpatients to see how far things have improved since a members' focus group was held in 2007. The walkabout identified a number of areas where improvements were needed.
- The appointment of Debra Glastonbury, operational manager, UCH, to take charge of atrium issues. She also chairs the ground floor services group which a member of the HQPC group sits on.
- Trustwide attempts to improve disabled parking and drop-off facilities at Queen Square (NHNN and RLHIM).
- Establishment of a group to work with Trevor Payne, director of estates & facilities, and colleagues on proposals for a managed patient transport service across UCLP hospitals. This work had a rocky start and it is still unclear how effective governor input has been despite a lot of work.

### 4. Nursing issues

We have been fortunate in that Louise Boden or one of her deputies has attend every meeting and look forward to welcoming Katherine Fenton, the new chief nurse, to our April meeting. We have invited her to speak about how she sees the
future of nursing and her role at UCLH and how governors might be involved in nursing issues.

- The group had an interesting presentation by Guy Young, head of quality improvement, called releasing time to care at its September 2010 meeting. This covered the transforming care at the bedside and productive ward initiatives.
- **Benchmarking.** A significant number of governors and members took part in the nursing benchmarking audits, although yet again a few were not included in the audit which they had signed up for. A meeting has been organised with Jane Champion, senior nurse, practice development, to see how governors can become more actively involved in the benchmarking process. This will take place in March.

5. **Clinical administrative processes workstream**

The HQPC group is extremely keen to make a contribution to this part of the QEP programme, and has already done some preliminary work in the area.

- One member of the group drew together a lot of information from governors and members to illustrate problems with the trust’s appointment systems. This was fed into the QEP workstream on outpatient services. Another group member was invited to review some draft new letter templates.
- Following the presentation on the QEP by Tara Donnelly, project director, and colleagues at the informal governing body meeting, Lisa Hollins, who is leading the QEP patient administration processes workstream, spoke at a HQPC meeting about governor involvement. She and a colleague also attended a subgroup meeting.
- Members of a subgroup discussed the pilot survey on outpatients which James Anderson, head of operations and performance, specialist hospitals, oversaw, and made several suggestions on how this could be improved before rolling it out more widely.

We have found it rather difficult to mesh our patient-centred approach with some of the QEP’s more technical initiatives but hope that a further meeting with Tara Donnelly and colleagues to be held in March will help to take things forward.

6. **A&E triage arrangements**

Question were raised about changes which were introduced in A&E about 18 months ago and in particular about the fact that patients now see a receptionist before going through triage. Some members of the HQPC group met Nicola Ranger, head of nursing, medicine board who explained why these changes had been implemented. The group is planning to meet again on 30th March and will discuss both the new A&E performance indicators and measures to improve patient care and experience.

7. **The future of the RLHIM**

- The right of existing and future patients to exercise choice and attend the RLHIM has been strongly asserted at a number of HQPC meetings and the group is alarmed by the commissioning proposals currently under discussion with North Central London NHS. Mike Foster, deputy CEO, produced some helpful
suggestions on how the HQPC group or individual governors might influence decisions about this and has shared Islington PCT’s consultation document with governors. We are pleased that Mike organised a seminar for governors on commissioning. This was widely felt to be both useful and extremely informative and useful.

8. Quality accounts

The HQPC group has also had several discussions of the quality accounts.

- It contributed to the formulation of the trust priorities for 2011/12. We think that governor involvement in this process should be more formalised in future.
- The subgroup was asked to decide which of the trust’s local priorities for 2010/11 should be formally audited by PwC, the trust’s external auditors, as part of the assurance process. We drew up a shortlist of three areas out of a possible 21:
  1. Incidence of falls per annum
  2. Medication errors
  3. Involvement in decisions.

After some discussion the subgroup decided to select ‘medication errors’. Sandra Hallett has assured us that she will ask the trust’s internal auditors to scrutinise the evidence on the other two areas.

9. Proposals for 2011/12 work programme

Major projects

Patient experience projects

- Since three of the four governors with expertise of experience mapping projects are leaving this summer, we propose to produce a dossier so that our experience of running these projects is made available to future governors.
- The HQPC group’s patient experience work has focused almost exclusively on the UCH campus. We have therefore decided to approach Queen Square (NHNN and RLHIM) to see if they are interested in any HQPC group input.
- Revisit the possibility of initiating an “In Your Shoes” project.
- Consider HQPC group input into trust surveys including frequent feedback.

QEP issues: The group is keen to work with the trust on clinical administrative systems as it believes these are extremely important and that a patient focus is crucial.

Quality watch: The group would like to monitor how the quality of patient care is being affected by the need to make efficiency savings. One possibility is to conduct a survey of patient members fairly soon and repeat this annually. Another is to initiate some governor quality walkabouts.

New PPI strategy: The HQPC group will scrutinise the draft new PPI Strategy when it becomes available to see how well it is linked to the membership strategy and how governors might be involved.
Maintenance projects

Atrium and access issues Further EGA follow up
Patient information Physiotherapy and x-ray for orthopaedic patients
Portering and patient transport RLHIM developments
Patient registration form TCAB and productive ward initiatives

The group has benefited greatly from the presence of some enthusiastic new governors since the autumn. It will need to elect a new chair to replace me and its ability to develop this programme of work will depend upon individual members of the group taking responsibility for particular areas. As always, we would welcome new members.

10. The governing body is invited

- To ratify the HQPC subgroup’s decision to ask PwC to focus on medication errors as part of the assurance process for 2010/11;
- To agree the HQPC group’s proposed work programme for 2011/12.

Veronica Beechey
Chair
Early March 2011
Agenda Item 9

Membership Development Strategy
Progress Report
1. Membership Review

This is an interim report on the membership development strategy and key developments since the last report to the Governing Body in November 2010.

With the current recruitment campaigns in place we expect to meet the public and patient targets set at the beginning of the year (10% and 5% respectively) by 31 March 2011.

2. Membership strategy – progress update

Recruitment, engagement and involvement have been the main focus of work during the year - the following actions have been delivered against the agreed plan.

2.1 Membership engagement and involvement

The objective to encourage membership and engagement with local and hard to reach communities has been successful. The programme of work has included events at Full of life in Camden; the Bloomsbury Clinic; a stall at Camden Volunteering; and a specific diabetes seminar at the Bengali Workers Association. Through this route we have increased the number of interested members from the local Asian community.

We have other meeting planned during March including with the Islington Bangladesh Association and the Somers Town Youth Centre. Next year we will continue this programme and plan to engage with disability groups and people from the local Black and Turkish community.

Engagement with existing members has increased. Members were invited to participate in a survey in November 2010. Analysis of the survey showed 823 members responded and approximately 50 were interested in standing for governor. Members ranked in order of importance to them, what priorities they would like the Trust to focus on in 2011/12, and selected topics for the 2011 MembersMeet programme.

The three issues considered to be most important to members’ were:

- Infection prevention strategy – including reducing levels of MRSA and Clostridium difficile in line with national objectives
- Reducing the average waiting times for treatment following referral to UCLH
- Meeting the cancer waiting times targets
The top three topics for MembersMeets were:

- Improving care for the elderly
- Transforming care at the bedside – how to make the ward more efficient
- Stroke – the hyper acute stroke unit

Members are linked to all the nursing benchmark programmes, have been involved in service improvement projects and focus groups and helped with the members’ area on the website.

MembersMeets seminars with a good balance of new and longstanding members provide a regular mechanism for involvement. Generally chaired by a governor they continue to be well attended – with 60+ members attending a March seminar on putting the older person at the centre of acute care. The 2011 programme has been planned using topics selected by members in the recent survey. New technology has allowed us to improve communication about events. We now post invitations to MembersMeets on the website, on the new UCLH twitter page and in the Camden LINKs calendar. We are also inviting members to contribute to UCLH News, the membership magazine.

A staff intranet forum is being established to make staff governors more visible – the objective is to improve the interface between staff governors and their members so that staff understand what their governors do and why it matters.

2.2 Membership Recruitment

Our programme of recruitment campaigns across the Trust’s hospital sites is supported by a governor membership champion who assisted by members and other governors will recruit patient members and answer questions about membership and how members can make a difference. All those involved in recruitment receive training.

Other recruitment initiatives include sessions at local GP surgeries – this will be extended in 2011. A membership letter from Chairman, Richard Murley to patients is proving to be very successful as has a local mail shot campaign.

We are also placing membership forms in local community facilities within Camden and Islington such as libraries.

3. Action Plan

The action plan will be made available to governors at the end of April when after the membership has been collated for the Annual Plan and Annual Report.

Ros Waring
Membership Development Manager
March 2011
Agenda Item 10.1

Quality & Safety Committee
1. **Introduction**

The period since my last report to the Governing Body has been a very busy one for the QSC which gets through a huge volume of work. The QSC is a sub-committee of the Board of Directors and reports to it on a monthly basis. Since governors can access these reports in the Board papers I do not intend to provide a summary of the committee’s work. Instead I shall identify some issues which I hope will interest governors and highlight areas of concern. Two governors are appointed to sit on the QSC. I have been a member for three years and Patricia Pank, who was a member for two years, resigned when her term of office as governor ended last summer. Fiona McKenzie joined the committee in January of this year.

2. **Objectives**

The QSC oversees all clinical governance activity at UCLH, monitors implementation of strategic priorities, and ensures compliance with regulatory requirements and aims to establish best practice within the patient safety and quality improvement areas.

3. **Organisation of the committee**

The QSC is very large, usually comprising forty to fifty people. It is deftly chaired by Professor Sir John Tooke. Richard Murley, its previous chair, continues to participate actively in meetings. Professor Tony Mundy and Sandra Hallett are executive leads and continue to make a huge contribution to the committee’s work and development of the quality and safety agendas. The three operational medical directors are members of the committee and all divisional clinical directors and divisional general managers are required to attend every meeting. Meetings are divided into two main parts. The first part covers general issues such as the trustwide infection scorecard, VTE prevention updates, CQC compliance monitoring reports, unexpected clinical event reports and divisional scorecards/quality indicators. The contents of the second part rotate quarterly between issues relating to patient experience, patient safety/risk, and outcomes and effectiveness. There have been some changes in the kinds of issues which the QSC discusses over the part year. Details of individual serious incidents are no longer scrutinised by the committee. Neither are the trustwide comparative divisional scorecards. For a while the individual divisional scorecards/quality indicators were not discussed either, but this has changed over the past few meetings.

4. **Participation in meetings**

As several of the governors who sat in on one meeting noted, participation is sometimes patchy and can be minimal. There is certainly less widespread participation in meetings than there was a year ago. This decline may be due to the sheer volume of work which the committee has to get through or the fact that more work is carried on outside the committee – by the divisions, at the clinical boards and at the recently convened a QSC sub-group. As a governor I believe that scrutiny of evidence and assuring compliance with regulatory requirements have both improved over the past year but that opportunities for organisational learning appear to have declined. Discussions are currently taking place outside
the meetings to establish whether there is a better way of organising the committee’s work.

Summary of issues which may be of interest to governors

5. **Divisional scorecards/quality indicators**

Each month the QSC receives a report in the form of a scorecard which summarises the performance of divisions on fifty-one key performance indicators. These fall into five categories: clinical outcomes, patient safety, patient experience, infection and mortality. The committee also receives reports from five or six divisions at each meeting. The quality of reporting has greatly improved over the past year, with divisions identifying successes, exception issues (i.e. where there are problems) and trends and themes arising from complaints, incidents and claims, among other things. Governors often raise issues on these reports. The committee very occasionally focuses on problems within a specific division when there are serious issues and the division can be required to report to the committee on a monthly basis until improvements are evident.

6. **Infection control**

Data on MRSA and *C. difficile* trends are presented to the QSC every month. Governors will know that UCLH breached its MRSA threshold for 2010/11. The trust also has to collect data on cases of MSSA starting in January 2011, and in the summer the number of e-coli bacteraemia will also have to be reported on. Annette Jeanes, director of infection prevention & control presents very clear accounts of infections which occur and appears to leave no stone unturned in her attempts to find out why they happened and what lessons can be learned. Infection control has always been taken seriously by the committee, but Richard Murley’s championing of it as one of his objectives has given it greater prominence. Governors have taken a very close interest in infection control and divisional handwashing data. The results of handwashing audits, although better, are still somewhat patchy. We are very pleased that new targets and tolerances for hand hygiene and hand hygiene reporting are being introduced.

7. **Falls**

Governors on the QSC first drew attention to the significant number of falls within the trust several years ago and have pressed hard for improvements. A series of measures have been introduced trustwide to mitigate the risk of falls, and each area now has a falls champion. The number of falls, particularly falls with harm, has declined as a result of these measures. However the trust still has further to go in reducing the number of falls. UCLH currently has 2 - 3 falls per 1000 patient days, and the aim is to reduce this to 2:1000. It needs to ensure that so called falls without harm do not become sidelined as managerial attention focuses on falls with harm. The HQPC subgroup included “incidence of falls per annum” on its shortlist of 2010/11 quality account local priority areas to be audited and is pleased that Sandra Hallett has agreed to ask internal auditors to audit the data in this area.

8. **Consent**

The QSC discussed UCLH’s current process for establishing consent at its March 2010 meeting. This is because the CQC and NHSLA have asked NHS organisations to review their processes for medico-legal reasons. There was
considerable disagreement at the QSC meeting and a policy review was established. Discussions have since been taking place outside the committee’s meetings. The reviews proposal have not yet been finalised but Professor Mundy reported recently that it is expected to recommend that consent must be a sequential process which starts at the patient’s first out-patient visit. Letters including an explanation of risks and benefits will be written directly to the patient and copied to the GP, treatment options must be thoroughly discussed with the patient, and consent forms must be signed before a patient is admitted to hospital. While we broadly support the process of consent being a process in which a patient is fully involved all three governors who have sat on the QSC over the past year have had serious concerns about any proposal that consent must be completed before admission as we do not believe that this is in the best interest of patients.

9. Complaints

These are discussed at the PIC and the QSC and there seems to be some duplication of reporting between the two committees. The QSC has kept a close eye on how the new complaints system has developed and it receives quarterly reports on the numbers or complaints in each division, whether reporting targets have been met, cases which have been referred to the Ombudsmen, and actions taken and lessons learned (based on the PIC reports). The QSC also discusses an annual report on complaints management. It appears that complaints are being dealt with better overall although there is some evidence of variation in the quality of letters to patients. A new more clinically focused approach to complaints is being piloted in paediatrics and surgical specialties in 2011.

10. National surveys and frequent feedback

The QSC receives presentations on the national in-patient surveys by Sandra Hallett each year and on other national surveys when these are conducted. Most of the detailed analysis and development of action plans takes place in the national survey steering group and relevant divisions and clinical boards. We were pleased that the results of the 2010 national inpatient survey were good and broadly in line with those from 2009. We were however disappointed by the results from the recently published maternity services and cancer surveys. Looking back at evidence presented to the QSC for the past year it is clear how beneficial the introduction of frequent feedback on a set of specific trustwide questions has been in helping to detect when the quality of care is poor or starting to dip. We wonder if the cancer survey results would have been better if the cancer division had used handheld devices to obtain regular feedback from its patients. An analysis of the frequent feedback data presented to the QSC has identified an interesting phenomenon. The feedback from the single question which has been used trustwide to assess patients’ satisfaction with their care and to compare UCLH with other trusts (the overall rating of care) is often worse than the answers to a composite list of twelve patient experience questions which have also been used by UCLH for the past sixteen months. More work is being done to establish whether the single or the composite score is a more reliable indicator of patient experience.

11. Patient reported outcome measures (PROMs)

PROMs, a mandatory national programme for evaluating the effectiveness of surgical interventions as perceived by patients, has been running since 2009 and governors have taken a close interest in this. The programme currently covers
hip replacement, knee replacement, groin hernias and varicose vein surgery and provisional figures for 2009/10 have recently become available. These show that, apart from groin hernias, UCLH had the highest participation rate in comparison with five other London trusts. PROMs measure general health improvement resulting from an operation and condition specific improvements using a variety of forms of data. These include a questionnaire which the patient completes before their operation and three to six months afterwards. The detailed data is used to compare the performance of hospitals and is unfortunately not made available to specific trusts. This tool, which could be incredibly useful thus has limited possibilities for helping UCLH improve its care.

12. Quality accounts

The QSC has discussed the quality accounts for the past three years and has established mechanisms to ensure that data on the priority areas are collected. Governors can find details of the quality accounts for 2010/11 on the website. The DH currently requires three areas from the quality account to be audited by PwC, the trust’s external auditors. These are compliance with the 62 day cancer waiting times (required by the DH), MRSA or C difficile (chosen by the trust – UCLH chose MRSA) and a local priority chosen by the governors (medication errors - see HQPC group report to this meeting for details).

13. Reports

The committee discusses a large number of reports. Among the internal reports which might interest governors are the annual clinical audit report which provides a very interesting overview of the trust’s clinical work, safeguarding reports for vulnerable adults and children, and the annual infection control report. We also discussed the findings of the Francis enquiry into the catastrophic decline in patient care at the Mid Staffordshire NHS Foundation Trust. The purpose of the QSC discussion was to ensure that UCLH has systems in place to deal with the report’s recommendations. Among the presentations which governors have found particularly interesting are one on the WHO ward safety checklist and one on the Global trigger tool. This is used to measure the rate of harm to patients over a period time by retrospectively reviewing a random sample of patient notes each month as well as records covering fifty consecutive deaths. Governors can obtain copies of reports from Ros Waring.

14. Conclusion

The trust will want to appoint a new governor to the QSC when my term ends in the summer. Sitting on the committee involves a lot of work (there are sometime over a 100 pages to read for one meeting) but I have found it incredibly interesting. Everyone on the committee is friendly and supportive and it has been a privilege to contribute as a governor to the trust’s work in the quality and safety areas.

Veronica Beechey
Patient Governor
Agenda Item 10.2

Older People’s Steering Group
Older Peoples Strategic Steering Group

The OPSSG aims to improve the patient experience for older patients within UCLH. It also recognises, that for this group of people in particular, the interfaces that UCLH patients have with PCT’s, local authorities and local voluntary groups are important. Good integrated care pathways between hospital, primary and social care mean that older people are able to be treated and/or cared for in the most appropriate place for them.

In the 6 years that I have been a governor at UCLH there has been a gradually increasing recognition that older people, as a group, warrant special attention. The redesign of their care pathways to include an assessment ward in 2010 has significantly improved the quality of care for older people who are now assessed by a specialist team. This has also resulted in significant efficiency savings. All those involved in this initiative are to be congratulated on this outcome.

The clinical team, which has been increased in size in the last year, are also making very tangible improvements to the inpatient experience, most recently by making special provisions for patients with dementia.

There are still day-to-day issues that need to be addressed, the current one is a shortage of mental health nurses, and I hope that the Trust will review this provision as a matter of urgency.

Overall I am heartened by the attention given to older people’s services over the last year. In my March 2010 report to the GB, I noted that it had been a difficult year and said I hoped ‘to be able to report better news next year’. Given the Ombudsman’s damning report on the treatment of older people in the NHS, it is a relief to know that UCLH has indeed stepped up to the mark and focussed on improved care for this group of patients.

Unfortunately there is a serious challenge ahead for the OPSSG. Whereas in the early years of its formation, the PCTs and local authorities were ahead of UCLH in funding specialist posts for older peoples services, the imminent demise of the PCTs and budget cuts at local authorities have already resulted in gaps in this provision. Designing care pathways which cross institutional boundaries is difficult for all concerned but essential for the older person who moves between hospital, primary, and local authority care. A loss of focus on this issue will adversely affect patients and may result in ‘bed blocking’.

The reorganisations within the NHS will mean that next few years are going to be difficult times as new relationships will need to be forged. I very much hope that the UCLH board will recognise the threat to its newly developed integrated care pathway and will do what it can to step into the breach. The governing body will be one of the fora in which GP Commissioners, Local Authorities and Trust Board Members share information. I very much hope services to older people stays high on its agenda.

This will be my last report to the governing body, I would like to thank the board, and in particular the past chairman Sir Peter Dixon, NED Dr Sue Atkinson and the CEO Sir Robert Naylor for their support in improving older peoples care at UCLH.

Wendy de Silva
Public Governor
13. 03.2011
Agenda Item 11

Annual Report from the Audit Committee Chair
Work of the Audit Committee March 2010 – February 2011

This report covers meetings in 2010 on 20th April, 3rd June, 22nd July, 16th August, 23rd September, and 25th November; and in 2011 on 27th January.

The membership of the Audit Committee (AC) remains stable, with three members, who are familiar with the work of the Committees on Quality and safety, HR and Communications, and Finance and Contracting. This broad coverage strengthens the Audit Committee.

Risk Management

The Committee discussed the risk reports at the November AC. It was agreed that in future the covering note to the Board should confirm that the reports are a fair reflection of the risks and mitigating actions and give the Executives’ opinion on one or two of the major risks.

Information for the Board on progress with top objectives

The objectives are of course the basis of the Assurance Framework. In addition most of them are covered in the high quality monthly information pack for the Board. Any objectives not suitable for this treatment are covered in the Chief Executive’s report.

Accounting & Audit

The preparation and delivery of the Annual Accounts for 2009/10 were dealt with at the April and June meetings.

The Trust is now reporting under IFRS instead of UK GAAP; the accounting treatment of a number of items has consequently changed. In particular the Trust’s PFI scheme is shown as on-balance sheet under IFRS accounting.

PwC noted at the November AC that the Trust has been successful in providing the required deliverables and supporting papers to support the programme of Q1 and Q2 audit work. This is part of the Trust’s move to quarterly closure and also deals with some points raised in last year’s audit.

The Governors agreed that PwC’s contract should be extended to cover the accounts for 2010/11 and that there should be a tender in the New Year to select the auditors for 2011/12 and beyond. The Governing Body will be considering elsewhere the recommendation for the new contract.

Internal Audit work & action on recommendations

The Committee approves the Internal Audit (IA) programme, taking account of the Trust’s objectives and the risks it faces, considers its reports and recommendations, and monitors implementation. The follow up on overdue
recommendations has been strengthened during the year, as the action tracker shows. The November Committee discussed the latest IA reports and noted that none had scored the lowest rating of red.

The AC initiated an internal audit report on clinical audit last year. We will be considering proposals for action resulting from this and from a wider review at our March meeting.

Other

The Audit Committee received a note on the terms of reference and governance of the new Paying Patients Management Group which will report through the Finance Director and the Corporate Medical Director. It will oversee the handling of issues common to the management of patients who pay for their own care. Internal Audit will revisit these arrangements as part of its work programme for 2011/12.

The AC has acted on an internal audit report on its effectiveness and held private meetings with both internal and external auditors.

Nick Monck
Chairman of the Audit Committee
18th March 11