Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting
Hospital Boardroom
Chair: Prof. Sir Christopher Edwards
Date: 15 September 2011 Time: 3pm

Agenda

'Starred' items will not be discussed unless an advance request is made to the Chairman.

	PLEASE NOTE THE EARLIER START AT 3PM	**Lead**	**Time**
1	**GENERAL BUSINESS**		
1.1	Welcome & Apologies	CE	3.00
1.2	Declaration of Interests	CE	
1.3	Minutes of Previous Meeting held on 14 July 2011 (attached)	CE	3.05
1.4	Matters Arising (attached)	CE	3.10
1.5	Chairman's Report (oral)	CE	3.15
2	**ITEMS FOR DISCUSSION/DECISION/APPROVAL**		
	GOVERNANCE		
2.1	Non-executive Directors Term of Office (attached)	CE	
2.2	Senior Independent Director (attached)	CE	
	COUNCIL OF GOVERNORS		
2.3	Council of Governors Funding Report* (attached)	CM	
2.4	Governors' Questions		
2.4.1	Private Patients Income – ACa	HL	
2.4.2	Salmonella Kentucky and Salmonella Heidelberg superbugs - ACl	HL	
2.4.3	Proportion of NHS spending on prevention and public health - ACl	HL	
2.4.4	Queens Jubilee, Olympics and Paralympics – ML	HL	
2.5	Governors' generic email account proposal (oral)	BG	
2.6	Governor/Senior Nurse Patient Rounds Update (attached)	TP	
2.7	FTGA/FTN Development Day 22 July 2011 – feedback (attached)	CBi/ACl	
2.7.1	'Fit for the Future Scenarios for low-carbon healthcare 2030' NHS Sustainable Development Unit (attached)		
	QUALITY		
2.8	Quality Sub-Committee report (draft minutes of 24 August 2011 meeting attached)	CM	
	MEMBERSHIP		
2.9	Membership Sub-Committee report (draft minutes of 26 July 2011 meeting attached)	CBi	
2.10	Membership Report (attached)	SN	
3	**ITEMS FOR INFORMATION**		
3.1	Finance Report – July 2011 (attached)	LB	
3.2	Performance Report – July 2011 (attached)	AP	
4	**ANY OTHER BUSINESS**		5.00
5	**DATE OF THE NEXT MEETING – 1 December 2011**		

PLEASE NOTE THAT THE ANNUAL MEMBERS' MEETING WILL FOLLOW AFTERWARDS AT 5.30pm

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 15 September 2011

AGENDA ITEM NO.	1.3/Sept/11
PAPER	Draft Minutes of Council of Governors Meeting – 14 July 2011
AUTHOR	Liz Revell, Interim Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper outlines a record of proceedings at the previous meeting.
DECISION/ ACTION	1. To agree the minutes as a correct record. 2. The Chairman to sign the minutes.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting Minutes, 14 July 2011
DRAFT

Present:

Prof. Sir Christopher	Edwards	Chairman		CE
Eddie	Adams	Public	Kensington and Chelsea 1	EA
Lucy	Ball	Staff	Allied Health Professionals, Scientific and Technical	LB
Chris	Birch	Patient		CBi
Christine	Blewett	Public	Hammersmith & Fulham 2	CBl
Fergus	Cass	Appointed	NHS Kensington & Chelsea	FC
Cass	Cass-Horne	Patient		NB
Alan	Cleary	Patient		ACl
Edward	Coolen	Patient		EC
Samantha	Culhane	Public	Hammersmith & Fulham 1	SC
Brian	Gazzard	Staff	Medical and Dental	BG
Melvyn	Jeremiah	Public	Westminster 2	MJ
Jacinto	Jesus	Staff	Contracted	JJ
Martin	Lewis	Public	Westminster 1	ML
Charlotte	Mackenzie Crooks	Staff	Support, Administrative & Clerical	CMC
Kathryn	Mangold	Staff	Nursing and Midwifery	KM
William	Marrash	Patient		WM
Susan	Maxwell	Patient		SM
Wendie	McWatters	Patient		WMW
Sandra	Smith-Gordon	Public	Kensington and Chelsea 2	SS-G
Frances	Taylor	Appointed	Royal Borough of Kensington and Chelsea	FT
Alison	While	Appointed	Kings College	AW
Taryn	Youngstein	Patient		TY

IN ATTENDANCE:

Heather Lawrence	Chief Executive	HL
Amanda Pritchard	Deputy Chief Executive	AP
Dr Mike Anderson	Medical Director	MA
Lorraine Bewes	Director of Finance	LB
Catherine Mooney	Director of Governance and Corporate Affairs	CM
Sir Geoff Mulcahy	Non-Executive Director	GM

Charles Wilson	Non-Executive Director	CW
Axel Heitmueller	Director of Strategy	AHe
Andrew Havery	Non Executive Director	AHa
Matt Akid	Head of Communications	MAk
Renae McBride	Communications Manager	RMB
Jane Tippett	Acting Assistant Director of Nursing	JT
Sian Nelson	Membership & Engagement Manager	SN
Liz Revell	Interim FT Secretary	LR
Rachel Arnold (in part)	Executive Producer, BBC	RA
Lucy Shepherd (in part)	Lucy Shepherd, BBC	LS
Samantha Vandervord (in part)	Assistant Producer, BBC	SV

1 GENERAL BUSINESS

1.1 Welcome & Apologies — CE

The Chairman opened the meeting by welcoming Fergus Cass who is representing NHS Kensington & Chelsea and congratulated Brian Gazzard on his CBE.

Apologies were received from: Carol Dale, Paul Baverstock, Nicky Browne, Rosie Glazebrook, David Finch, Professor Jenny Higham, Henry Morgan and Cyril Nemeth.

He also noted that Catherine Longworth was stepping down due to being no longer a Non-executive Director of NHS Westminster.

1.2 Declaration of Interests — CE

There were none.

1.3 Minutes of Previous Meeting held on 5 May 2011 — CE

The minutes were accepted as a true and accurate record of the previous meeting with the following changes:

- SS-G noted that she was present.
- CBi said that on page 3 he had not reported on the plasma screen and this should be deleted. What he had requested was that a notice should go above

the names of the Council of Governors saying who they were. He noted that this was now done.
- page 7: it was noted that the Chairman should have discretion regarding questions on the day and that "no" should be removed.
- Regarding the Governor/Senior Nurse Rounds on page 6 JT noted that Cass Cass-Horne had participated and WMW was still to do so.
- Dr Mike Anderson's correct title is Medical Director not Chief Medical Officer.

Action: LR to amend minutes in line with comments received. **LR**

1.4 Matters Arising

The update as described in the paper was noted.

1.4.1 Westfield Community Roadshow Project **MAk**

RMB outlined the progress to date. The company had produced four videos and carried out a recruitment drive at Westfield shopping centre. The videos were on: "Welcome to the Hospital"; "Maternity Services"; "Sexual Health" services and "Becoming a Foundation Trust". These are now on the website and the overall response had been positive with the videos having been viewed more than 2000 times. The bus had been very successful and the types of tests that were covered were outlined in the paper. The recruitment target was 300 but only 47 had been recruited so this had not worked as expected. The company guaranteed us 300 so they would do more work until we reach the target. It was confirmed that there would not be a further payment to the company for this. CBi noted that the target was probably unrealistic and HL agreed and said that this had previously been done in Oxford where there is only one hospital and Westfield attracts people from out of London and there are many hospitals. RMB thanked the Council for the funding.

1.5 Chairman's Report **CE**

The Chairman noted that Paul Baverstock has been unwell. According to our Constitution the Council of Governors can review membership of governors who fail to attend three meetings. Paul Baverstock has now missed five meetings. He suggested that if Paul Baverstock was unable to attend before the next elections his seat should be considered as being vacant. This was agreed.

He also would like to remind the governors that they can claim reasonable expenses and CM confirmed that these can be claimed via the Foundation Trust Secretary.

CE drew attention to two Monitor documents, 'Current practice in NHS foundation trust member recruitment and engagement' and 'Survey of NHS Foundation Trust Governors 2010/11' which had been circulated via email to the governors. CM will set up a small group to review 'Survey of NHS Foundation Trust Governors 2010/11' to see what we can learn from it.

The document 'Current practice in NHS foundation trust member recruitment and engagement' will be considered by the Membership Sub-Committee.

ACl drew attention to a paper called 'Quality Oversight in England - Findings,

Observations, and Recommendations for a New Model' which had been published on 30 January 2008 noting that he had asked several times for this paper to be considered. CBl noted that there was a process for items to be approved to go on the Council of Governors agenda and this was via the Agenda Sub Committee. The request for this paper to be considered has been raised before and the Agenda Sub-Committee has decided not to include it. This is the system and valuable time is being taken up as this item keeps coming back. SS-G wondered whether a small library for the governors to access paper documents would be of benefit. CE said that this would be considered. BG said that he takes his role on the Agenda Sub-Committee very seriously. This paper was read by them and the Agenda Sub-Committee did not think it was valuable. He believed that it was more valuable for an ongoing debate on the current NHS. It was agreed to circulate this document electronically.

ACl also noted that governors can no longer raise matters under AOB unless raised with the Chairman in advance. CE said this was not correct and he was happy to take matters arising at the meetings.

CE noted that the Chelsea and Westminster Health Charity are looking for a new Chief Executive.

Action: CM to consider a small library for the governors to access paper documents. **CM**

Action: The document 'Current practice in NHS foundation trust member recruitment and engagement' to be considered by the Membership Sub-Committee. **TD**

Action: CM to set up a small group to review 'Survey of NHS Foundation Trust Governors 2010/11' to see what we can learn from it. **CM**

1.6 BBC Documentary "Young Doctors; Your Life in their Hands" **MAk**

The Chairman introduced this item and gave a background to the documentary. MAk outlined further details. The programme will be filmed from 1 August and will involve seven to eight new doctors. The primary reason we are doing this is because we are a teaching hospital and this will raise our profile. Newcastle's experience was that their reputation was maintained and improved. There are always risks but we have mitigated these by putting stringent processes in place particularly around consent.

The three representatives from the BBC introduced themselves: Rachel Arnold (Executive Producer), Lucy Shepherd (Series Producer) and Samantha Vandervord (Assistant Producer). Rachel said that this documentary had been shown on BBC3 and was the highest rating they had ever had. The young doctors will live together in a house.

A three minute clip from the documentary was shown to the Council and CE invited governors to note and raise any concerns.

ML asked whether the BBC can guarantee that they will protect the privacy, dignity and confidentiality of patients. Rachel replied that there is a very comprehensive consent procedure. This is currently with MAk for review and

agreement. It will be signed off by the hospital. Techniques which can be used to protect patients include blurring or hiding them. This will be dealt with on a case by case basis.

ML asked about the reputation of the Trust and how this will be protected. Rachel replied that a Steering Committee will be set up with representatives from the hospital and they will meet once or twice a week to discuss problems. The Steering Group will also view the documentary prior to broadcasting.

ML also asked about any derogatory comments and if those will be removed. Rachel said that the Steering Committee will view all episodes in advance but will not have editorial control. However, the BBC is committed to listening and editing accordingly. She would like to emphasise that it was a collaborative venture. She noted that in the Newcastle experience the CEO was very supportive and this had been a key part of the success.

ACl asked how we would prevent a similar incident as was filmed during the Prime Minister's visit to Guys Hospital. Rachel said that this would not happen. We will be spending time with the departments and understanding the way they work so that when filming starts in August this would not be a problem. All the areas where filming will take place are aware of the filming and the crew are aware of practices to be followed. HL emphasised that we have been very careful in planning this. The ward sister is responsible for the ward environment not the consultants, and we have been involving them and taking great care to do so.

TY asked whether filming would be done out of hours. This was confirmed. HL also noted that the Deanery has been involved. There was a contract with each doctor which MAk was looking at with the Trust lawyers. The most important elements were consent and reputation of the Trust.

MAk said that the crew would be undertaking a half-day induction which would involve Health and Safety, Security and Infection Control. The junior doctors will receive specific training regarding infection control as this would be a key reputational issue.

CBl said she has concerns as she thinks that this is risky but she assumes that the Steering Group will ensure that we are not at a disadvantage. She asked about the financial implications and MAk confirmed that there would be a fee to include the staff time but the junior doctors were not being paid. He noted that documentaries had been filmed previously at the hospital and the hospital had not been paid.

CE asked whether there was an opportunity for junior doctors to shadow their educational supervisors (consultants) before starting work for real in the hospital on 1 August. It was confirmed that shadowing had taken place for half of the doctors and the plans for the remaining had been set up.

2 ITEMS FOR DISCUSSION/DECISION/APPROVAL

GOVERNANCE

2.1 Findings and Recommendations from the 2011/11 NHS Quality Report HB

Heather Bygraves presented the report. She said that there is a requirement by Monitor for external audit to review the Quality Account for the required content and consistency with other information. There are two mandated indicators. The Trust chose *C-Difficile* and 62-day cancer indicator. In addition, a local indicator had to be chosen by the governors. The conclusion was that the Quality Account did meet Monitor's requirements and was consistent with other information.

This year's report was a private report although it did go to the Board, Council of Governors and Monitor. Next year there will be a public report on the external indicators audit but the local indicator results will remain private.

She drew attention to page 18 which demonstrates that the overall outcome for *C-Difficile* was 'green'. The outcome for the 62-day cancer indicator was 'amber'. This was because they were not able to track through all the information for each patient and in some cases a number that was different from what was recorded was found. This indicator will be repeated next year and the auditors will start to do some work in October. She noted that our results are not unusual compared with other Trusts although there are some areas for improvement.

CE asked about materiality and how this was defined. CE drew attention to the discrepancies identified such as 1 out of 193 or 1 out of 402 incorrect and noted that in financial accounts this would not be material and we would not want a risk rating to reflect this level of error. HB said that this was not defined but will be next year. She said that if errors did not cause a breach, this would not be considered material but, if an error did cause a breach, the auditors would extend the sample to the number that was required to give assurance. HB said as a result of the audit the Quality Account report on indicators had been changed from a percentage to "achieved".

ACl noted that the second paragraph on page 2 says that this is a confidential report so he questioned why it was going to the Council. HB said that this was a routine statement that Deloitte make in their reports. BG asked what happens with missing data. HB replied that they do not conclude on it. She said that some problems arose because patients were referred from another hospital and therefore their notes were not available. This meant that the data was missing. We should, however, keep a copy on our files of important data. She did note however, that had there been more time for the audit there would have been time to obtain some of this data.

The report was noted by the Council of Governors.

2.2 Presentation of Annual Accounts & Auditors Report 2010/2011 HB

LB drew the Council of Governors' attention to page 73 onwards of the Annual

Report and Accounts. She said that there were four statements which comprised the accounts. The first one, the Annual Governance Statement was previously known as the Statement on Internal Control. She also noted the External Auditor's Report. She said there is no discretion as to how we present them as it is outlined by Monitor. The reporting was done to International Account Reporting Standards. She noted that these were the best results we have posted as a Foundation Trust. Monitor assign a rating and we have achieved the highest financial rating of 5. She is unclear about what this will be replaced with in the near future.

The achievement was underpinned by successful implementation of Cost Improvement Plans (CIPs) as we are expecting a reduction in income. There is a 9% CIP this year and almost 100% of this has been identified. We are at the cap regarding the private patient income. It is likely that the Health & Social Services Act will increase or remove this so this will be an opportunity for us. She confirmed that the cap is based on historical private patient income based on 2002 and 2003. We have less than 4% private patient income and the Marsden has 30%. She reminded the Council that we need to make a surplus in order to invest and some of the investments we have made include £25m on Netherton Grove and also a significant amount on the plant infrastructure which is important for our extended facilities and for decrease utility costs. She also noted the new adult outpatient department on the lower ground floor. Other capital costs include medical equipment and IT.

ML asked whether we can set our own private charges. LB said it depends on the market but for patients who fund themselves we can. WM noted that this was a very commendable performance and in particular p78 -79 which he said in this environment of uncertainty was an exemplary result. He would like to pass on his congratulations.

CE thanked CBi for noting some errors on pages 60 and 61 which were relatively minor. However CBi noted that the errata were also incorrect and the Council meet normally four times per year. Sam Culhane noted that her name was missing on page 60 and the Chairman apologised.

The Chairman asked that the Council of Governors formally adopt the Accounts. **This was agreed.**

2.3 Auditors Report 2010/2011

HB said that this is the report that went to the Audit Committee and to the Board and the auditors had issued an unqualified opinion. AHa commented that the external audit report was as good as you can get so the Trust should be commended for that.

2.4 Audit Committee Annual Report **AHa**

AHa presented the Annual Report from the Audit Committee. He noted that the Audit Committee covers external audit including the accounts, internal audit and fraud and certain specific governance issues such as waivers. We have reappointed Deloitte as our external auditors and have appointed KPMG jointly with the Brompton Hospital. He drew attention to 2.2 which was the opinion. He

congratulated LB on the performance of the Finance Team. He also noted his gratitude to Cathy Mooney, Director of Governance and Corporate Affairs for her oversight role. The Audit Committee work in conjunction with the Assurance Committee who considers quality.

CE noted the opinion from Internal Audit that additional costs associated with CIPs are not always taken into account and he would like reassurance that the 9% CIP is not affected by this. LB said there was one scheme where savings were identified but when the scheme began to be implemented it was clear that investment was needed. A recommendation is that more time is spent on the planning stage.

CE thanked AHa and the Audit Committee.

2.5 Council of Governors Quality Sub-Committee Terms of Reference **CM**

This item was starred.

2.6 Council of Governors Name Badges **ML**

ML proposed that proper name badges were available for the Council of Governors. The Quality sub-committee had recently reviewed badges for staff and it was suggested that the same size and quality were used for the Governors. He requested that the funding came from the Council fund.

This was agreed.

2.7 Governors' generic email account proposal (oral) **ML**

ML said that there had been a poor uptake in obtaining Chelwest email accounts and asked whether we should continue to pursue this or have a system where emails are sent through the FT Secretary.

MJ said he thought that email was a good idea but he had not got one despite requesting it. SM said that getting the daily bulletin was very helpful and a plus to enable her to know more about the hospital. SS-G said she had had an email account for two years but had only received one email. It was noted that the governors do not have constituents' email addresses.

CBi suggested governors@chelwest as an email address although this might add work for the FT Secretary. He found the document from IT unhelpful.

It was suggested that email addresses should be available on the website for the relevant governors. AW asked that nominated governors could be considered differently as they have a different role and CE agreed.

CE requested that IT are invited to come along to the next meeting of the Council of Governors to explore the best option for communication.

Action: Invite IT to attend the next meeting of the Council of Governors and to explore the best option for communication. **LR**

2.8 Chair Appraisal Process **CW (BG)**

BG introduced the paper. He said that both ways of the governors undertaking an appraisal of the Chairman had been tried, both meetings and email. Regarding the email only four commented and one was unrelated. SS-G proposed a meeting and it was agreed that a meeting would be convened for that purpose and that that would take place prior to the next Council of Governors meeting. CM confirmed that this would be timely as the appraisal is due in October.

ACl said that he objected to the procedure and identified the risk of judicial review. CBl said that the role of the governors was to assess the chairmanship of the Council and this was described in section 1.2. The meeting would be very clearly set up to address this and therefore she could not see the relevance of suggesting a judicial review might be possible.

Action: BG to organise a meeting prior to the Council of Governors meeting in September to discuss the Chairman's performance. **BG**

2.9 Annual Members Meeting Proposal **MAk**

MAk outlined the paper and informed the Council there were certain things that had to be covered which were outlined in the paper. He proposed themes around older people.

ML agreed with care of elderly people as a theme and said there was a lot in the press at the moment. He asked if we would consider using a larger room. CE agreed with the themes and asked for an elected governor to volunteer. CBi suggested that as it was a short meeting that we would go for one theme only which was the care of the older people. HL pointed out that 50% of patients were not elderly. CE said we would take the comments away and note them.

CE confirmed that the meeting was on 15 September.

QUALITY

2.10 Quality Awards **CM**

CM introduced the paper and said that the governors and Mike Anderson, in the absence of Carol Dale would report on each award.

MJ reported on the SWISH award and said that this team was very impressive. It was about taking hospital services into the community to a group that were vulnerable and at risk. It also contributes to avoiding spread of infections. They are a small team of three people who have been working with the Terence Higgins Trust with whom they have a very good relationship. It was a carefully designed project and well taken forward.

SM outlined the award to the Tissue Viability Nurse. She said that Susan Masterton educates and inspires people regarding tissue care. She asked that the governors on their visits should ask about pressure sores and how they are managed on the wards, ask to see the turning charts and sit on the new chairs. If

any governors want to inform themselves she has the presentation.

MA said that the Communications Team won the award as they do a great job re communication and, in particular, regarding vaccination. He said that the vaccines tend to come in late so we always have a challenge and we were lagging this winter until the Communications Team got on board and it then worked through lots of different messages.

COUNCIL OF GOVERNORS

2.11 Council of Governors Funding Report **CM**

CM noted Section A which outlined funding to date.

RMB requested funding for the Annual members meeting. The meeting itself costs about £1.5k but she was also asking for extra £3.5k to fund the events which were described earlier on in the meeting. It was at the early planning stages but they were looking at setting up focus groups and promoting the benefits of natural birth. CE said this fits in very well with what was discussed earlier and noted that the Royal College of Obstetricians had highlighted the need to decrease medicalisation of pregnancy. **The Council of Governors agreed to support funding of Maternity and Children's Services Events for £5,000.**

ML asked about the two touch screens that had been funded by the Council of Governors. It was noted that the Health Screen had been moved to the Lower Ground Floor where it was being used quite a lot and the other one was still in the Information Zone and it was working.

SN presented the bid for an additional recruitment campaign. She noted that this was important because of the high drop-out rate. **The Council of Governors agreed to support extra funding of Members Recruitment Campaign 2011 for £2,340.**

SN requested funding for a table and chairs in the Information Zone. **The Council of Governors agreed to support funding for a table and chairs in the Information Zone for £580.80.**

2.12 Governors' Questions **HL**

HL reported that the question was whether it was true that waiting times for appointments had increased. HL said that this was not correct. The Trust had not relaxed on the 18 week referral to treat target and there was a slight reduction of 0.1 weeks compared with last year. There is some variation within specialities with 15 showing an increase and 19 showing a decrease.

2.13 The Friends Patient Support Project **SS-G**

SS-G introduced the paper and said that it had been a very successful project.

The Friends had funded the salary for the organisation of this for 18 months with the hope that this would be successful and the hospital will continue the funding.

The initiative involves a team of volunteers on the wards helping patients particularly with feeding. There are approximately thirty volunteers a day, supervised by Serena Venticonti, the Friends Patient Support Co-ordinator.

CMC described the referral system and the button on the website which can be used to request a volunteer visit. This was launched In March/April and has been a success with ten to twelve referrals so far. She distributed leaflets describing the initiative to the Council and asked that governors would help disseminate these e.g. in libraries and GP surgeries. She said continued recruitment is a challenge and she asked governors to help promote this.

CBi said this was very interesting and he would formally like to thank the Friends for the funding and thank and congratulate CMC for organising it. WMW asked how often volunteers visit patients? CMC said that patients come in and out so quickly so it is usually done and planned on a daily basis. ACl commented on an article in a newspaper outlining the increase in the number of patients with dementia. CE commented that the aging population is changing in the UK and life expectancy is increasing by five hours per day. He noted the need to think about this in the context of the community.

HL outlined the integrated care organisation (ICO) involving Kensington, Chelsea, Westminster, Fulham and Hammersmith PCTs. The pilot was covering diabetes and frail elderly. The aim was to improve continuity between GPs and hospital doctors. She also noted that we have a hospital group looking at dementia. As part of the ICO, multi-disciplinary groups were meeting to improve care and reduce readmissions.

CE said that this was a very interesting first step and wondered how we could learn from volunteers. He commented that the situation at Mid-Staffordshire Hospital would not have happened if there had been an army of volunteers out there observing and feeding back. CMC confirmed that she is looking to develop social groups. In the meantime she does get informal feedback which she follows up and perhaps this needs to be more formalised.

CE asked for a report to come back to the Council in six months time on progress with this initiative.

Action: To provide a report to the Council in six months time on progress with this initiative. **TBC**

Action: Governors to assist with distribution of leaflets. **All**

2.14 Governors/Senior managers Patient Round Update **JT**

CBi reported on a four hour tour at St Stephens. He said he was very impressed with the enthusiasm of the staff. CE said it was a very useful report and he thanked the governors for participating in these visits. He noted the next dates. The Council agreed that this was a very useful way of governors to see what was going on.

2.15 Membership Development and Engagement Strategy **SN**

SN noted the focus on recruitment and engagement in areas with low representation. CBi congratulated SN on this strategy which was a big improvement to previous ones as it was much more focused. He noted that on page 4 the total of joiners should be 2008, not 1355, and the total of leavers should be 2694, not 1228. He also said that it would be more helpful if the changes in membership figures were shown in the form of graphs. He noted that the graph on page 13 was more useful than previous information.

CE concluded that the Council of Governors supported the strategy.

2.15.1 Membership and Engagement Calendar of Events

SN noted that this supported the strategy document. She would like comments from governors on this and also information particularly if events are going on in the community.

Action: Governors who attended events to provide SN with comments. **All**

CE commented that this is useful and helpful if we could use our intelligence to get to the wider community.

2.16 Membership Report

SN noted that this had been redesigned. CE drew attention to 8.1 where it should read considerable not considerate. He thanked SN for all her hard work.

2.18 Open Day Evaluation Report **RMB**

RMB thanked the Council of Governors for funding this and ML and SM for being on the groups and, in particular, SM on the day for her enthusiasm. We had tried to attract younger people and CMC had done a particularly good job. We are not sure of the numbers who had attended because the clicker had failed but we had recruited 75 new members. She had particularly wanted to thank Jacinto Jesus and the ISS team who had done a great job. CE commented on how successful the escalators had been. CBi said it was a wonderful Open Day. He would be interested to know which newspapers had reported on it and how many column inches there had been. ML expressed his thanks to the Communications Team.

Action: MAk to inform CBi which newspapers had reported on the Open Day and how many column inches there had been. **MAk**

3 ITEMS FOR INFORMATION

3.1 Finance Report – May 2011 **LB**

This item was taken as read.

3.2 Performance Report – May 2011 **AP**

This item was taken as read.

3.3 Annual Report of the Voluntary Services & Work Experience Department **CMC**

This item was taken as read.

4 ANY OTHER BUSINESS **CE**

CE asked the Council of Governors to particularly note the Annual Report on Volunteers which he warmly recommended they should read.

He also said this would be LR's last meeting and he would formally like to thank her for all her hard work.

CBl wanted to draw attention to some comments in the Performance Report and noted the poor performance on discharge summaries.

5 DATE OF NEXT MEETING

The next Council of Governors meeting will take place on Thursday, 15 September at 3pm.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 15 September 2011

AGENDA ITEM NO.	1.4/Sep/11
PAPER	Matters Arising from the meeting of the Council of Governors meetings held on 14 July 2011
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper lists matters arising from previous meeting and the action taken or subsequent outcomes.
DECISION/ ACTION	The Council of Governors is asked to note the matters arising and the updates.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

MATTERS ARISING
Council of Governors Meeting
Hospital Boardroom
Chair: Prof. Sir Christopher Edwards
Date: 14 July 2011
Time: 4:00 – 6:30 pm

Ref	Description	Lead	Subsequent Actions or Outcomes
1.3/Jul/11	**Minutes of Previous Meeting held on 5 May 2011**		
	Action: LR to amend minutes in line with comments received.	**LR**	Completed
1.5/Jul/11	**Chairman's Report**		
	Action: CM to consider a small library for the governors to access paper documents.	**CM**	
	Action: The document 'Current practice in NHS foundation trust member recruitment and engagement' to be considered by the Membership Sub-Committee.	**TD**	
	Action: CM to set up a small group to review 'Survey of NHS Foundation Trust Governors 2010/11' to see what we can learn from it.	**CM**	The number of governors from our Trust who responded has been requested from Monitor. Depending on the numbers, proposal to repeat the survey amongst our governors, analyse the results and then use the Monitor survey as a benchmark. Results then to be considered by a small group and recommendations made. This would meet the requirement to review regularly the functioning of the Council. Aim to have results presented at the next meeting.
	Consider a small library for the governors to access paper documents.	**CM**	

2.7/Jul/11	**Governors' generic email account proposal (oral)**		
	Action: Invite IT to attend the next meeting of the Council of Governors and to explore the best option for communication.	**LR**	On agenda
2.8/Jul/11	**Chair Appraisal Process**		
	Action: BG to organise a meeting prior to the Council of Governors meeting in September to discuss the Chairman's performance.	**BG**	To be held at 2pm on 15 September
2.13/Jul/11	**The Friends Patient Support Project**		
	Action: To provide a report to the Council in six months time on progress with this initiative.	**TBC**	To be provided in 6 months time
	Action: Governors to assist with distribution of leaflets	**All**	
2.15.1/Jul/11	**Membership and Engagement Calendar of Events**		
	SN noted that this supported the strategy document. She would like comments from governors on this and also information particularly if events are going on in the community. **Action: Governors who attended events to provide SN with comments.**	**All**	
2.18/Jul/11	**Open Day Evaluation Report**		
	Action: MAk to inform CBi which newspapers had reported on the Open Day and how many column inches there had been.	**MAk**	There was a positive story and three photos in the local newspaper Kensington and Chelsea Chronicle (330sq cm) and the story also ran on the online version of the paper.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 15 September 2011

AGENDA ITEM NO.	2.1/Sep/11
PAPER	Non-executive Directors Term of Office
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Professor Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper outlines Non-executive Directors Term of Office.
DECISION/ ACTION	The Council of Governors is asked to formally approve the Non-executive Director appointment for Sir John Baker, Jeremy Loyd and Sir Geoffrey Mulcahy whose term of office will start on 1 November 2011 for three years.

Non-executive Directors Term of Office

1.0 Introduction

This paper outlines Non-executive Directors Term of Office.

2.0 Background

At the Council of Governors meeting held in 2 December 2010 it was proposed by the Council of Governors Nominations Committee for the appointment of Non-Executive Directors (NEDs), to appoint three Non-executive Directors Designate whose performance will be assessed after one year with a view to them becoming substantive NEDs. This was agreed by the Council of Governors.

3.0 Recommendation

As two NED posts are vacant from 1 November onwards the Chairman would like to formally recommend that all three Non-executive Directors Designate, namely Sir John Baker, Jeremy Loyd and Sir Geoffrey Mulcahy, become substantive Non-executive Directors.

4.0 Decision

The Council of Governors is asked to formally approve the Non-executive Director appointment for Sir John Baker, Jeremy Loyd and Sir Geoffrey Mulcahy whose term of office will start on 1 November 2011 for three years.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 15 September 2011

AGENDA ITEM NO.	2.10/Sep/11
PAPER	Membership Report
AUTHOR	Sian Nelson, Membership and Engagement Manager
LEAD	Therese Davis, Chief Nurse and Director of Patient Experience and Flow
EXECUTIVE SUMMARY	This paper reports on the membership numbers for the Trust which currently has a total membership of 14, 548.
DECISION/ ACTION	For information.

1.0 Membership size and movements

OVERALL MEMBERSHIP OVERVIEW	Last Year 1 Apr 10 – 31 Mar 11	Current Situation 31 August 11
As at start	**15,187**	**14,501**
New Members	2,008	934
Members leaving or changing constituency	2,694	887
TOTAL	**14,501**	**14,548**
PUBLIC MEMBERSHIP OVERVIEW	**Last Year 1 Apr 10 – 31 Mar 11**	**Current Situation 31 August 11**
As at start	**6,131**	**5,737**
New Members	257	403
Members leaving or changing constituency	651	243
TOTAL	**5,737**	**5,897**
PATIENT MEMBERSHIP	**Last Year 1 Apr 10 – 31 Mar 11**	**Current Situation 31 August 11**
As at start	**6,010**	**5,591**
New Members	396	23
Members leaving or changing constituency	815	195
TOTAL	**5,591**	**5,419**
STAFF MEMBERSHIP	**Last Year 1 Apr 10 – 31 Mar 11**	**Current Situation 31 August 11**
As at start	**3,046**	**3,173**
New Members	1,355	508
Members leaving or changing constituency	1,228	449
TOTAL	**3,173**	**3,232**

2.0 Membership Joiners and Leavers 2011/12

2.1 Public Membership – within the Public Membership there was a sharp increase in members leaving during August. A data cleanse (by Capita) was performed prior to the August membership mailing which will account for this loss.

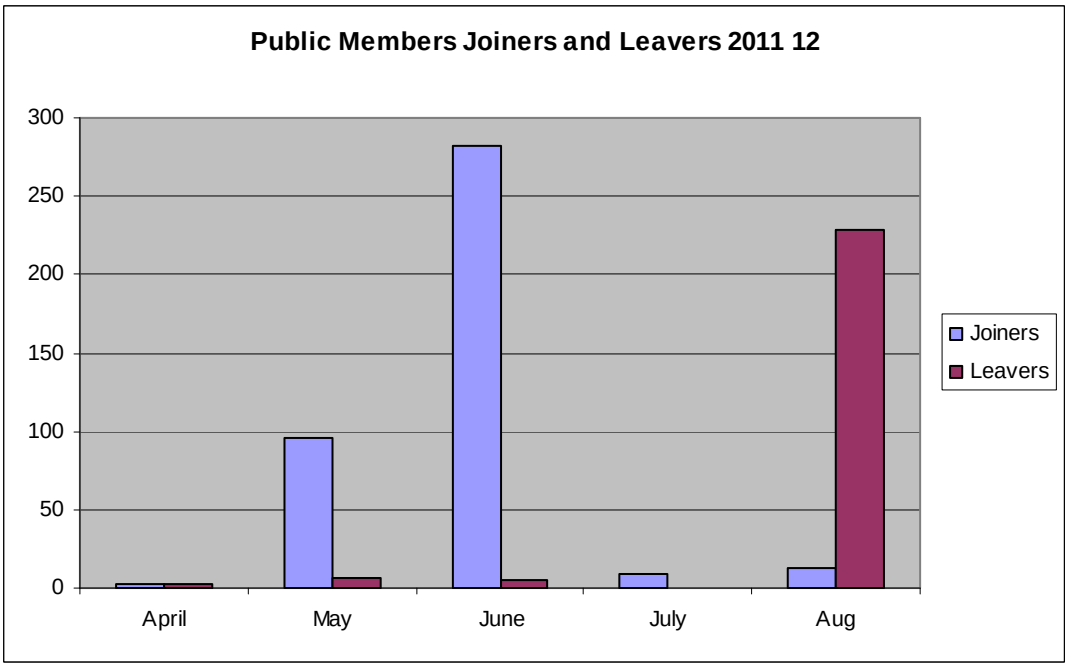


Table 2.0 Public Membership Joiners and Leavers 2011/12

2.2 Patient Membership – within the patient membership there was also a sharp decrease in the patient membership during August. A data cleanse (by Capita) was performed prior to the August membership mailing which will account for this loss.

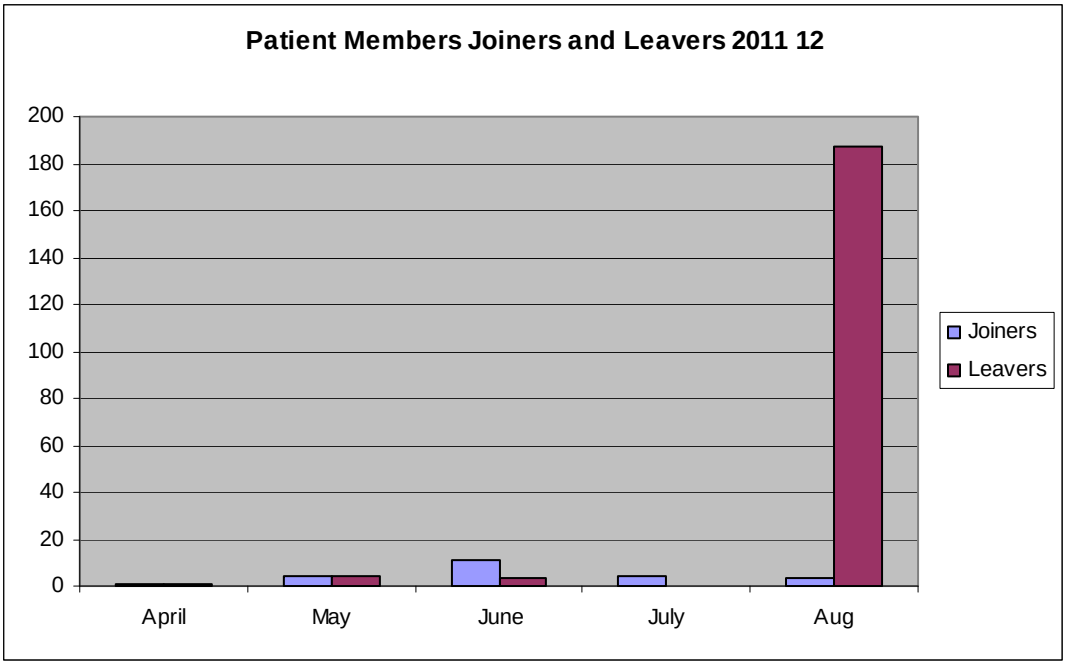


Table 2.1 Patient Membership Joiners and Leavers 2011/12

3.0 Public Membership Ethnicity September 2011

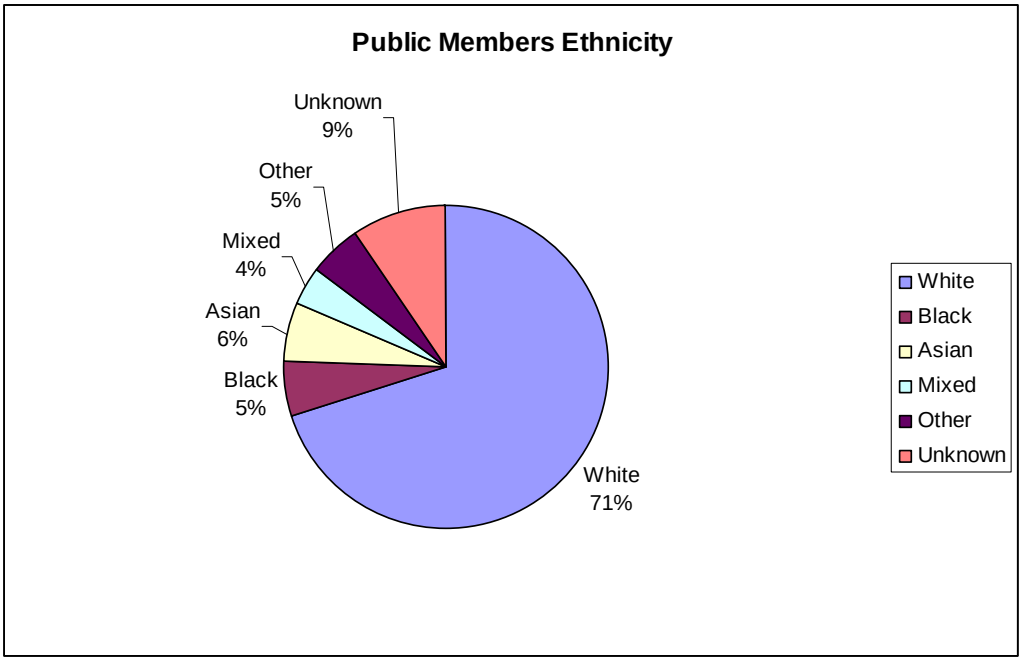
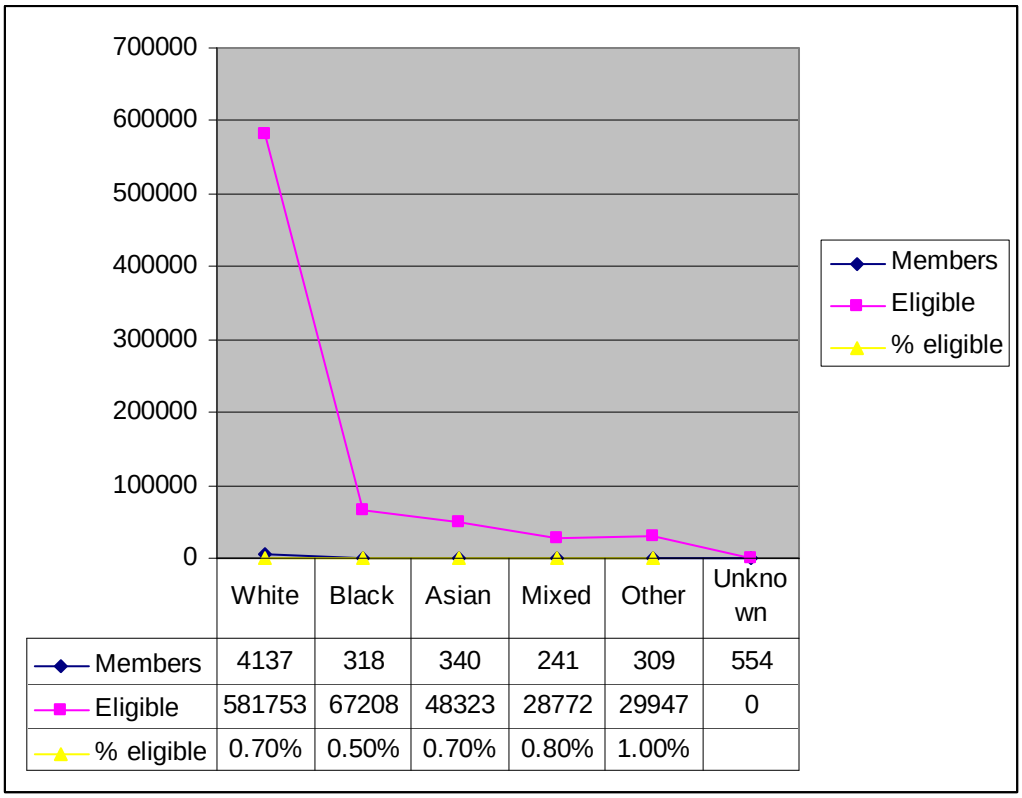


Table 3.0 Public Membership Ethnicity June 2011

The highest proportion of ethnicity is within the white category, and the lowest representation remains in the mixed ethnic group. The Black membership ethnic group has risen by 2% in 2011/12.

3.1 Public Membership Ethnicity – comparison against local eligible population



	White	Black	Asian	Mixed	Other	Unknown
Members	4137	318	340	241	309	554
Eligible	581753	67208	48323	28772	29947	0
% eligible	0.70%	0.50%	0.70%	0.80%	1.00%	

Table 3.1 Public Membership ethnicity comparison against local eligible population June 2011

Representation of ethnic groups in comparison to the eligible population shows a different perspective. The lowest representation remains in the Black ethnic group followed by the White and Asian ethnicity. The highest representation is demonstrated in 'other' and mixed group.
The profile of historically low representative ethnic groups is improving. The Black ethnic group has risen from 0.4% to 0.7% of the eligible population since May 2011.

4.0 Public Membership Age

Public membership representation peaks at age group 40-49 years and is lowest in the age group 16-19 years.

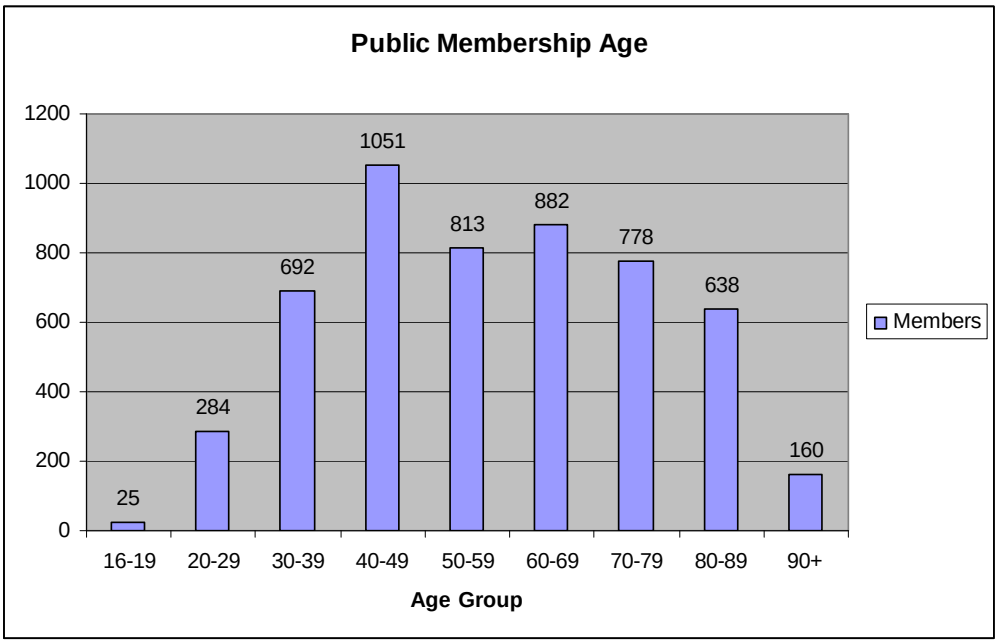
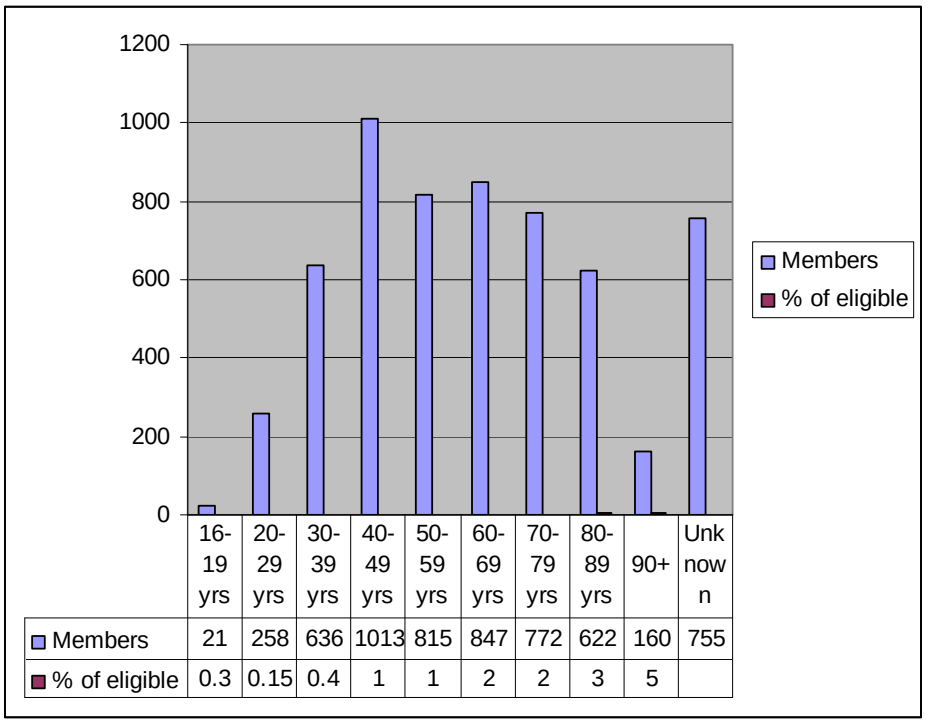


Table 4.0 Public Membership Age June 2011

4.1 Public Membership Age – Comparison against local eligible population

Comparing members to the local eligible population shows a different perspective: the age group 90 years+ shows a 5% representation of public members but representation gradually lowers with the younger age groups.

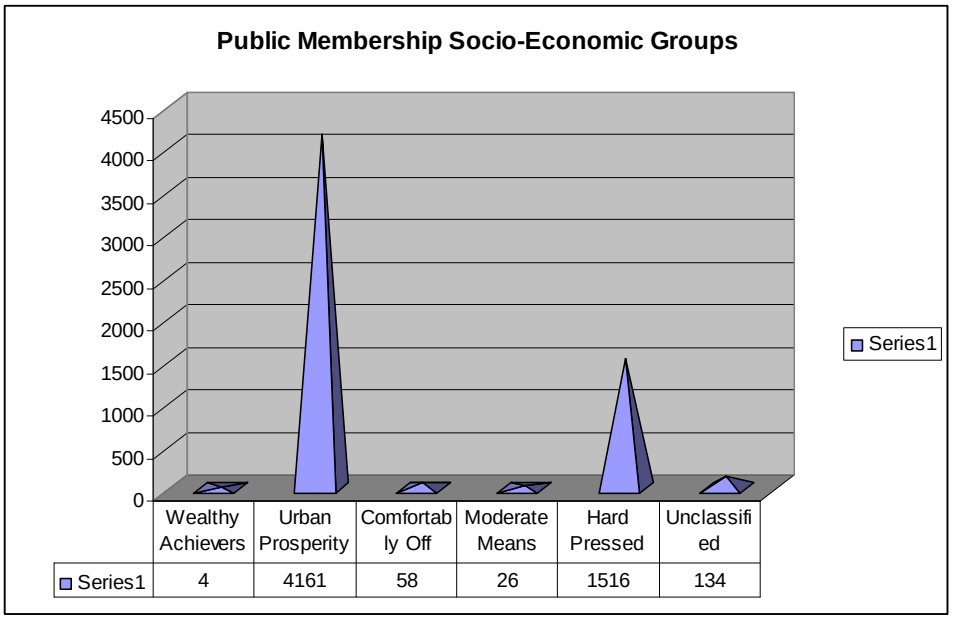


	16-19 yrs	20-29 yrs	30-39 yrs	40-49 yrs	50-59 yrs	60-69 yrs	70-79 yrs	80-89 yrs	90+	Unknown
Members	21	258	636	1013	815	847	772	622	160	755
% of eligible	0.3	0.15	0.4	1	1	2	2	3	5	

Table 4.1 Public Membership Age and Comparison (%) against local eligible population

5.0 Public Membership - Socio-economic grouping

In September 2011 the highest representation remains in the category of Urban Prosperity.



	Wealthy Achievers	Urban Prosperity	Comfortably Off	Moderate Means	Hard Pressed	Unclassified
Series1	4	4161	58	26	1516	134

Table 5.1 Public Membership - Socio-Economic Groups*

6.0 Membership Recruitment and Engagement

6.1 Since April 2011 a total of 934 members have joined membership and 887 have left membership.

6.2 A data cleanse is performed twice per year before member mailing which removes those members not at the same address or who have been registered deceased. In addition Capita is notified monthly for requests of members' removal from the database.

6.3 The Membership Development Sub-Committee of the Council of Governors develops and reviews the Membership Development and Communications Strategy. The proposal for the Membership Action Plan 2011/12 was approved at the Council of Governors meeting in May 2011 The final Membership Development and Engagement Strategy 2011/12 and Action Plan 2011/12 was approved at the July 2011 Council of Governors meeting and is for ongoing review.

6.4 The Membership – Patient Advice and Liaison Services (M-PALS) support membership promotion and any visitor to the M-PALS office will receive a membership application form (when appropriate). The forms are sent with all patient response letters from M-PALS.

6.5 A member's email database has been updated with over 3,000 emails registered. This will be used for low cost, rapid response membership consultation and most recently updated to send the Chief Executive's monthly 'Blog'.

6.6 A discharge booklet, funded by the Council of Governors is currently being updated and will be given to patients on admission and includes a membership application form.

6.7 Recruitment can now be tracked to events with database coding. This will help us to measure the success of membership recruitment.

7.0 Developing a Representative Membership

7.1 Analysis of the membership database by age, gender and ethnicity ensures we work towards representative memberships within the communities we serve. Actions taken to ensure representative membership include:

7.2 The community mobile health clinic continues its screening activities and when possible recruiters join the services to recruit new members alongside screening. The services from the mobile health clinic aim to target 'hard to reach' groups in the community. The Public Governor Melvyn Jeremiah was invited to and accepted as Governor Representation on the Mobile Health Steering Group. The group plan activities and decide how Governors can link with Trust activities in the community (especially where membership is underrepresented) and decide on appropriate outreach services for these areas. The Mobile Health Clinic is visiting Shepherds Bush market area

every month and focuses on health screening/outreach work with Black, Minority and Ethnic groups.

7.4 Governors host 'Meet a Governor' session at the Ground floor Information Zone. Patients, public, staff and members have the opportunity to meet a Governor to discuss issues important to them. This is publicised on the Trust website, a text messaging board in the Information Zone (Ground Floor) and posters are displayed throughout the hospital.

7.5 To create equal representation, It is recognised that membership recruitment should focus on increasing its numbers and engagement with Black, Ethnic and Minority groups. The Governor elections in 2011 will be adequately promoted to these groups.

7.6 The Council of Governors funded the Westfield Community 'road show' during the week commencing 28th March 2011 at the Westfield Shopping Centre, in the Borough of Hammersmith and Fulham. Recruiters aimed to recruit 300 new members here, however did not achieve this figure but will re-recruit at a future date. A DVD of Chelsea and Westminster Hospital Foundation Trust services which contained a 30 second promotion of membership was displayed on a giant plasma screen, and the same DVD will be shown at G.P. surgeries and is currently shown on the trust website.

7.7 Governors had a stand at the 2011 Open Day which was a great success. Bags and pens with membership logos were handed out and the Governors recruited 79 new patient and public members. The newly recruited members will be reflected in the May 2011 report.

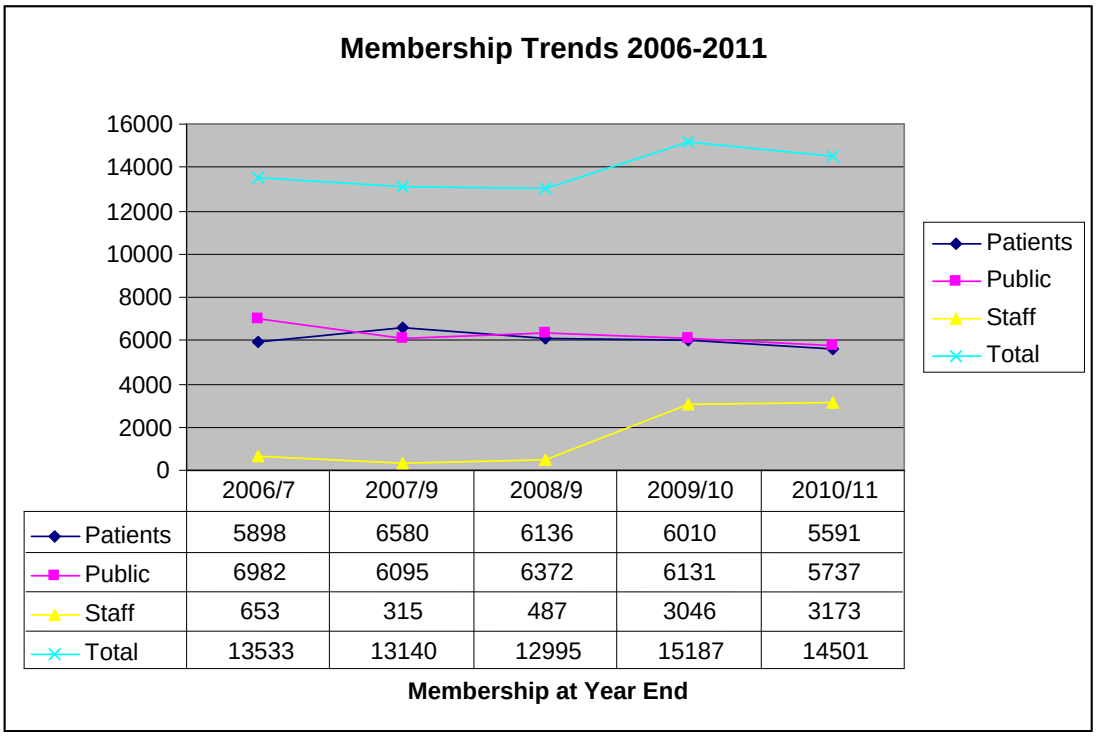
7.8 Capita Recruitment Campaign in Hammersmith and Fulham Area 1 and 2.
Recruitment in this borough was decided by the Membership Sub-Committee because the GP surgeries across the borough were displaying the hospital's new promotional DVD. The hope was that the Chelsea and Westminster Hospital services would be fresh in people's minds and encourage membership take-up. Recruiters conducted a feedback exercise to evaluate the effect of the hospital's DVD on patients in the surgeries. The target number of 300 new members was achieved. This is Capita's first recruitment campaign for Chelsea and Westminster Hospital and the quality of service delivered was excellent, and has out won the previous provider, 'The Campaign Company'.

Capita Recruitment began a recruitment campaign within the hospital on Wednesday 7th September focusing on patient recruitment. The target recruitment is 300 new Patient Members. In addition Capita Recruitment began a recruitment campaign in the Borough of Westminster at the start of September in the 56 Dean Street Clinic and will continue in G.P surgeries throughout Westminster and Wandsworth at the end of September. The target recruitment is 600 new Public Members.

8.0 Summary

8.1 Chelsea and Westminster Hospital Foundation Trust gained Foundation Trust status in 2006 and at year end 2006/07 totalled 13,533 members. Membership numbers peaked in 2009 when staff members' status changed from 'opt in' to 'opt out'.
There needs to be considerate effort to recruit members to equal the 'leavers' each month so we can balance the numbers before concentrating on increasing total numbers.

The table below outlines the membership trends from 2006-2011.



	2006/7	2007/9	2008/9	2009/10	2010/11
Patients	5898	6580	6136	6010	5591
Public	6982	6095	6372	6131	5737
Staff	653	315	487	3046	3173
Total	13533	13140	12995	15187	14501

Table 8.1 Membership trends 2006-2011

8.2 The Membership Development and Engagement Strategy 2011/12 focuses on five key areas for membership development: In-house recruitment, the black ethnic group, communicating with younger members, low-representation in certain geographical areas (Wandsworth Area 1), and ensuring representation from disability groups.

8.3 The Membership Development and Engagement Strategy 2011-12 and Calendar of Events present a plan for 2011-12 that outline realistic targets and actions to follow to achieve the overall membership development.

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Membership Recruitment Achievements 2011/12

Month	Event	Total Recruited	Report Date
April	No events		
May	Open Day	79	31st May 2011
June	• Capita Recruitment Campaign H&F • Mobile clinic at Shepherds Bush Market • Meet a Governor Session	• 300 Public Members	• 31st June 2011 • 30th June 2011
September	• Capita Recruitment Campaign – aim for 300 patients and public members within the hospital • Capita Recruitment - aim for 300 Westminster and Wandsworth Public members	• To be confirmed at end of September 2011 • To be confirmed at end of September 2011	• 30th September 2011 • 30th September 2011

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 15 September 2011

AGENDA ITEM NO.	2.2/Sep/11
PAPER	Senior Independent Director (SID)
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Professor Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	In accordance with the Monitor Code of Governance A.3.3 it is recommended that the Board of Directors should appoint an independent Non-executive Director to be the Senior Independent Director, in consultation with the Council of Governors. The current SID is Charlie Wilson whose term of office expires on 31 October 2011.
DECISION/ ACTION	The Council of Governors is asked to agree the paper.

Senior Independent Director (SID)

1.0 Introduction

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

2.0 Background

The Monitor Code of Governance recommends that the Board of Directors should appoint an independent Non-executive Director to be the Senior Independent Director, in consultation with the Council of Governors.
This appointment is not specified in the Trust's constitution as the Trust's constitution was published before the Code of Governance was published.

3.0 Role of the Senior Independent Director

According to the Code of Governance the Senior Independent Director should be available to members and governors if they have concerns which contact through the normal channels of Chairman, Chief Executive or Finance Director has failed to resolve or for which such contact is inappropriate. The Code of Governance states that the senior independent director could be the deputy chairman.

The Code of Governance also recommends that led by the Senior Independent Director, the Non-executive Directors should meet without the Chairman at least annually to evaluate the Chairman's performance, as part of a process which should be agreed with the board of governors, for appraising the Chair and on such other occasions as are deemed appropriate.

The Code of Governance suggests that the Senior Independent Director should attend sufficient meetings with governors to listen to their views in order to help develop a balanced understanding of the issues and concerns of governors.

4.0 Recommendation

It was agreed previously that the Vice Chairman of the Board becomes the SID. It has been suggested that once the Vice Chairman of the Board of Directors has been elected then the Vice Chairman become the SID, as previously.

5.0 Decision/Action

The Council of Governors is asked to note that once the Vice Chairman of the Board of Directors has been agreed by the Board then the Vice Chairman will also become the SID.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 15 September 2011

AGENDA ITEM NO.	2.3/Sep/11
PAPER	Council of Governors Funding Report*
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Cathy Mooney, Director of Governance and Corporate Affairs
EXECUTIVE SUMMARY	The report provides an overview of the use of the Council of Governors budget to Month 3 of FY 11/12.
DECISION/ ACTION	The Council of Governors is asked to note the report.

Council of Governors Funding Report

1.0 Background

The decision was made at the November 2008 Council of Governors meeting that a recurring budget of £100,000 per financial year was to be made available to the Council of Governors to spend at their discretion on relevant projects.

It was agreed at the Trust budget setting meetings in January 2011 that the Council of Governors fund should be reduced in line with the Trust's overall cost improvement programme to £95,000.

2.0 Update

At the last meeting the Council of Governors agreed to support funding of Maternity and Children's Services Events for £5,000.

The Council of Governors agreed to support extra funding for Members Recruitment Campaign 2011 for £2,340.

The Council of Governors agreed to support funding for a table and chairs in the Information Zone for £580.80.

The Council of Governors also agreed to support funding of badges for governors for £104.40.

3.0 Funding Overview

Of the £95,000 circa £35k has been accrued for the activities listed in the table below which were approved by the Council of Governors. It leaves circa £60k in the budget to be spent for the remainder of the 2011/12 FY.

4.0 Use of funds FY 10/11

TABLE 1

Activity 11/12	Estimate
Open Day	£15,000
Face to Face Recruitment Campaign	£2,000
Recruitment Campaign for the Annual Members' Meeting	£2,000
Learning Disability Membership Leaflet	£1,304
Quality Award	£2,400
Communications campaign to publicise the Trust's 4 priorities for quality improvement – from 10/11	£4,000
Maternity and Children's Services Events	£5,000
Members Recruitment Campaign 2011 extra funding	£2,340
table and chairs in the Information Zone	£580.80
Badges for governors	£104.40
TOTAL	**£34,729.20**
From previous years – revised bids to be presented	
Discharge Booklet	£8,200

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 15 September 2011

AGENDA ITEM NO.	2.6/Sep/11
PAPER	Report on Senior Nurse/Governor Rounds
AUTHORS	Tristram Mills, Matron, Medicine and Surgery Division Mr. Harry Morgan, Public Governor, Wandsworth Area Melanie Guinan, Matron, Paediatric Services Mrs. Wendie McWatters, Patient Governor Jane Tippett, Acting Assistant Director of Nursing
LEAD	Therese Davis, Chief Nurse and Director of Patient Experience and Flow
EXECUTIVE SUMMARY	This paper provides feedback from the Senior Nurse/ Governor Rounds undertaken on 15th July 2011 and Tuesday 9th August 2011. It includes personal accounts from Mr. Harry Morgan, Public Governor, Wandsworth Area and Mrs. Wendie McWatters, Patient Governor.
DECISION / ACTION	For information.

Report on Senior Nurse/Governor Rounds

1.0 Introduction

1.1 This paper describes two further Senior Nurse/Governor rounds in 2011.

1.2 On the 15th July 2011, Tristram Mills, Matron, Medicine and Surgery Division agreed to meet with Mr. Harry Morgan, Public Governor, Wandsworth Area, and facilitate the session. They visited Nell Gwynne Ward and Lord Wigram Ward.

1.3 On 9th August 2011, Melanie Guinan, Matron, Paediatric Services met with Mrs. Wendie McWatters, Patient Governor, to visit areas in the Paediatric Directorate.

2.0 Feedback from visit to Nell Gwynne Ward and Lord Wigram Ward

2.1 Mr. Morgan met with Mr Tristram Mills, Matron, Medicine and Surgery Division and discussed which clinical area he would like to visit. Mr. Morgan had a particular interest in visiting our ward that cares for patients who have had a stroke.

2.2 Prior to the walk round of Nell Gwynne Ward, Tristram and Mr. Morgan discussed a number of pertinent aspects of the care of patients in this clinical area:

- The benefits of the Multi-Disciplinary Team (MDT) approach and how it has enhanced patient experience. The inpatient stroke questionnaire was provided and an explanation of how the weekly MDT meetings function.
- The challenges of ensuring adequate staffing on the ward were addressed. The recruitment process was explained, which is led by the Acting Ward Manager. The trust and ward induction was also explained. In addition the Stroke Service provides an annual two day training programme for all staff.
- Patient Safety was raised by Mr. Morgan and Tristram agreed to provide information visually on the walk round.
- Tristram had identified a patient who was happy to talk to Mr. Morgan. The patient had been on the ward for a number for weeks.

2.3 The ward tour began with introductions to all staff members, in particular, Angela Honan the ward clerk. Tristram explained Angela's role and how she supports the whole team and patients.

2.4 Tristram provided an explanation on the patient information boards that are located outside each bay. Mr. Morgan was impressed with the information that was on the boards and this was discussed in regards to patient safety and nutritional aspects of nursing care.

2.5 Tristram spoke about the ward gym and how the occupational therapy and physiotherapy assessments are undertaken. Mr. Morgan was able to see how extremely important these assessments are in promoting patients' independence.

2.6 Throughout the walk round Mr. Morgan was shown the bathrooms and the plans by the MDT for the refurbishment of two bathrooms to wet rooms. Mr. Morgan was specifically interested in how this would improve the patients' experience. Tristram explained that converting bathrooms to wet rooms would enable patients who have had strokes to use the facilities and maintain their privacy. Mr. Morgan was impressed with the project.

2.7 Throughout the ward visit Mr. Morgan was shown areas that needed further refurbishment to benefit both patients and staff. Mr. Morgan noted that the ward was of a good standard and very clean throughout.

2.8 Mr. Morgan was introduced to one patient and they discussed his experience on Nell Gwynne ward. Mr. Morgan fed back to Tristram and the staff that he was impressed with the standard of care that he had been described.

2.9 After the visit to Nell Gwynne, Tristram took Mr. Morgan to Lord Wigram ward to compare the ward environment as Lord Wigram is currently undergoing some refurbishment which will be completed by December 2011.

3.0 Feedback from Mr. Harry Morgan

3.1 Tristram's guided tour of Nell Gwynne ward was extensive and informative.

3.2 l was introduced to members of his staff as well as some of the ward patients. Impressed with what I saw and heard during the visit. Impressed by the staff's caring attitude towards patients and the aids provided for their rehabilitation.

Impressed, especially, by the state of cleanliness of the ward and lack of unnecessary clutter.

After leaving Nell Gwynne and as a means of before-and-after comparison, I was taken by Tristram and ward sister Sophie Western to Lord Wigram ward which was in the process of being upgraded to improve standards already attained at Nell Gwynne.

3.3 A worthwhile visit made all the more memorable by Matron Tristram Mill's obvious mastery of the job.

4.0 Feedback from visit to the Paediatric Directorate

4.1 Melanie Guinan, Matron, Paediatric Services took Mrs. Wendie McWatters to visit the following Paediatric wards and departments:

- Saturn, Mercury, Jupiter and Neptune Wards
- The Paediatric High Dependency Unit (HDU)
- The Paediatric Ambulatory Care Centre (PACC)
- The School

4.2 Mrs. McWatters also attended the daily bed meeting where decisions are made with respect to admissions/discharges over the following 24 hours. This is attended by senior nursing staff from all the clinical areas. Mrs. McWatters was able to observe how staff ensure adequate capacity and staffing is available across the unit.

4.3 Melanie and Mrs. McWatters had the opportunity to talk about all the different specialities within paediatrics and visited some babies and children with complex needs, who have required a prolonged hospital stay. Mrs. McWatters commented on the services for adolescents noting how staff work hard to meet their needs whilst respecting their privacy and dignity.

4.4 Mrs. McWatters noted how the school is committed to meeting the educational needs of the children and adolescents and how it contributes to the overall hospital experience.

4.5 Mrs. McWatters has discussed a further follow-up visit with Melanie as not all the clinical areas were possible to visit on the day.

5.0 Feedback from Mrs. Wendie McWatters

5.1 The visit was extremely impressive. I found the atmosphere in the wards non-threatening for the children, a calm and happy atmosphere. Also the decor was cheerful and fun. I sat in on the bed management meeting which was very interesting and extremely efficient. All the staff seemed to know exactly what was going on and reported in an extremely efficient and professional manner.

5.2 The way teenagers were handled was admirable and the nursing staff wearing special t-shirts and treating patients like young adults.

5.3 The school was fascinating, and I would very much like to return. Was impressed with the care for special needs patients. The parent's room seemed to cater for all needs. The playroom was very friendly and obviously the play-therapists play an important role, particularly when preparing children for the theatre.

6.0 Summary

6.1 The introduction of Senior Nurse/Governor Rounds has been a valuable experience for both staff and Governors to visit clinical areas, talk to patients and staff and most importantly see where there are opportunities to improve care for patients.

6.2 There were no specific actions or feedback to follow-up on from the previous Senior Nurse Round undertaken in May 2011.

6.3 The next Senior Nurse/Governor rounds will be posted on the Trust website. They will be:

Tuesday 27th September 2011- 2-4pm
Wednesday 19th October 2011- 2-4pm
Friday 25th November 2011- 2-4pm

6.4 Finally, we would like to thank Mr. Harry Morgan and Mrs. Wendie McWatters for their time and valuable feedback to ensure that this joint work continues to help us focus on improving patient experience.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 15 September 2011

AGENDA ITEM NO.	2.7/Sep/11
PAPER	FTGA/FTN Development Day 22 July 2011 – feedback
AUTHOR	Chris Birch – Patient Governor Alan Cleary – Patient Governor
LEAD	Chris Birch – Patient Governor Alan Cleary – Patient Governor
EXECUTIVE SUMMARY	This paper provides feedback from the FTGA/FTN Development Day held on 22 July 2011.
DECISION/ ACTION	The Council is asked to note the paper.

FTGA/FTN Development Day 22 July 2011

Feedback from Chris Birch

Alan Cleary and I represented the Trust at a FTGA/FTN Joint Development Day for Foundation Trust Governors on 22 July. I have attended several such days organised by the FTGA but this was for me the first one organised jointly with the FTN. It did not seem to me to any different from the others.

Alan and I were in different groups, and he will give you his own impressions of the event. But I think he will agree that we made ourselves known. The very first question at the first session came from Alan, and I asked the second.

Irrespective of what was on the agenda, the main value of these events for me has always been the sharing of experiences and learning how other Trusts do things differently from us, and the realisation that we do some things much better than other Trusts do. For example, the other governors in my group were extremely envious of the attendances we get at our Annual Members' Meetings and our Open Days.

It would be tedious for me and for you to go through a detailed account of the five hours we spent at the Holiday Inn. For me, as a member of our Membership sub-committee, the most interesting part of the agenda was the roundtable discussion on Foundation Trust Recruitment and Engagement.

Inevitably old ground was re-ploughed, but I was interested to note that our 30 June 2011 membership of 14,935 was almost 1,000 more than the average trust membership of 13,962, and that we were actively engaging in many of the so-called 'more sophisticated' methods of membership engagement, eg use of emails, websites, Facebook and Twitter.

Our establishment of a dedicated Information Zone with photographs of governors, plasma screen, touch terminal, leaflets and the opportunity for the public and members to meet a governor was noted with interest by other governors.

Large memberships are expensive in terms of mailing costs, and it was suggested that efforts should be concentrated on engaging with existing members rather than on recruiting new ones. 56% of trusts are now concentrating on engagement rather than on recruitment. And we were reminded that "While many may join, only a few will participate; of those who participate, only a few will be very active. And of those activists, only a proportion will want to stand for election as governor."

There were some ideas new to me that we might consider trying ourselves. At one trust, every patient who receives an appointment letter also gets a letter from the chairman inviting the patient to join the trust. Another trust, offers members (not just governors) the chance to shadow nurses in order to learn how the hospital works.

At Rushmoor, talks for members on subjects such as alcohol-related liver damage or depression have been successful, especially when there was a carrot in the form of a blood pressure check. And it was suggested that meeting should be held at different times in order to find out what times attracted the largest numbers.

Above all we were reminded to recognise people's concerns about the future of the NHS and to bear this in mind when planning events for our members.

Feedback from Alan Cleary

My attendance at this event resulted from three places having been allocated to the Trust. A copy of the programme is attached.

I have been asked and set out below some observations in the hope that in a minor way these might prove helpful informing fellow Governors here and for planning future programmes of a similar kind.

This was essentially a conference of Governors, ie people expecting to become better and more meaningfully informed on NHS issues than the general public. Together Governors contributed some 550 man hours in their attendance. Whether resultant benefits were proportionate to that effort is questionable.

Generally, the various speakers delivered their addresses in a polished way. During the morning direct questions were posed and fluently answered though not in terms admitting practical application.

For the afternoon sessions questions were not permitted. Instead delegates discussed issues in groups round the tables at which they were sitting, with a summary delivered by a spokesperson for each table at the end. This is always useful as a means to encourage more diffident delegates to begin speaking in public. Against that it insulates speakers from any questions of a direct and probing kind.

There are several current problems each of which if permitted to remain and fester contains the potential to destroy the National Health Service as we know it. Some of these are numbered below. Each is of concern to patients but not one attracted debate or answers in the day's programme. It is true the NHS no longer forms (as it once did) part of a taxpayer-funded system providing free cigarettes, sugar-filled cough mixtures and ill-fitting dentures in enormous quantities, often to recipients who did not need them. Yet in organisational terms we have not travelled very far from that primitive approach in the sense that tricky questions of underlying principle are nowhere addressed openly and decided.

1. An ever increasing proportion of scarce resources is being devoted to soothing the incapacities of old age and inadequate amounts applied to advancing acute services, improving clinical tools and funding leading edge research much of which has potential for enormous public benefit at home with huge earnings overseas. All the world's a stage.....but there is no prospect of consensus among GPs and authorities seem determined to withhold painless means of exit to old people seeking to time their own departure.

2. The unnecessary complexity of NHS management systems (at least 7 or 8 layers) with established machinery for meddling but lacking important controls such as in relation to claimants' legal costs (£285m expended in the last full year). Thus there exists always an over-extended learning curve for outside professional observers wishing to contribute improvements and large numbers of medically unproductive posts soaking up resources which ought rather to provide doctors, nurses and improved clinical techniques.

3. The wideranging ignorance how it is year after year the NHS delivers better outcomes for patients at lower levels of expenditure than the healthcare systems of practically all other countries. The answer lies largely in a unique driving force stemming from a relentless and focused striving for clinical excellence by consultants and their teams. (Pressures to change the basic character of the NHS into a "getting and spending"

organisation as if it were entirely private-insurance based are ill-advised. That formula might create easier comparison with overseas providers but it would remain a spurious “apples and pears” comparison rather than a sensible exercise with practical value).

4. The absence of day to day contracting and negotiating skills within the NHS for acquiring new installations, equipment and services resulting in overpricing, poor quality specifications, inadequate enforcement and constant cost overruns for ongoing projects, when very often local authority expertise may exist already nearby and could suggest some good answers.

5. Failure to recognise and accept the NHS Sustainable Development Unit Report of September 2009 - “Fit for the Future” - as a policy route map not a piece of fiction, despite its broad accuracy and the cost and effort expended in its formulation by 28 health professionals. This means no official use on any meaningful scale of applied group dynamics and group pressures to reduce demand for unnecessary cures and encourage widespread changes to healthy routines among the public. Local Planning Authorities often do their bit by requiring showers, kit lockers and bike parking at new employment locations but their scope is limited.

6. Unwritten social acceptance of utter physical inactivity - passive, sedentary, exercise-free, spectator lifestyles, chronic overeating, consuming mildly poisonous soft drinks, salty sugared fats and ciders which would be placed last at any agricultural show. This will surely continue so long as advertising and marketing standards remain largely self regulating and the NHS gives little balancing stimulus.

7. There is an unhappy no man’s land in relation to the independent observation of routine practices and activity in hospitals. The agreed objective is surely that anything doubtful must become exposed and properly resolved. It demands an uncomplicated choice which people can readily understand. If Governors are to do their job in that respect they have to be trusted to act in a reasonable way. They should be entitled to visit any part of the hospital unannounced, requiring an explanation for anything which strikes them as unsatisfactory and to require the matter to be placed on the Agenda for the next Governors’ Meeting. Either that or we are stuck with a continuing reliance on doubtful combinations of informers, whistle blowers and investigative journalists.

In conclusion Programmes like this are infrequently held and places are limited. They must be Governor-focused. They need to simplify, modify and unify to achieve the best possible impact for Governors attending. Systems require to be simplified and explained by a careful combination of plain English and clear diagrams so that they can be understood and thus enable every Governor to contribute their full potential. There should be explanations how NHS practices and activities are being modified to reflect better know-how and changing needs, old things being discarded and new methods being evolved. That would enable Governors to feel unified in the knowledge passed to them, the plans being formulated in relation to their work and to appreciate the individual role they can play in monitoring and implementation.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 15 September 2011

AGENDA ITEM NO.	2.8/Sep/11
PAPER	Draft Minutes of the Council of Governors Quality Sub-Committee meeting held on 24 August 2011
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Mike Anderson, Chairman of the Quality Sub-Committee
EXECUTIVE SUMMARY	Draft minutes are enclosed.
ACTION	To note.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Quality Sub-Committee meeting, 24 August 2011

Draft Minutes

Attendees	Carol Dale	CD	Staff Governor – Management
	Melvyn Jeremiah	MJ	Public Governor – Westminster 2
	Susan Maxwell	SM	Patient Governor
	Sandra Smith-Gordon	SS-G	Public Governor – Kensington & Chelsea 2
	Mike Anderson	MA	Medical Director, Chairman
	Cathy Mooney		Director of Governance and Corporate Affairs
	Therese Davis	TD	Chief Nurse and Director of Patient Flow and Patient Experience
	Patricia Gani	PG	LINk representative
	Amanda Pritchard (in part)	AP	Deputy Chief Executive
	Scott Bennett (in part)	SB	General Manager of Operations
	Mike Delahunty (in part)	MD	Head of Booking and Outpatient Services
	Matt Akid (in part)	MAk	Head of Communications
	Vida Djelic	VD	Foundation Trust Secretary

1	**Welcome and Apologies**	**MA**
	Apologies were received from Wendie McWatters and Cyril Nemeth.	
2	**Minutes of previous meeting 24 June 2011**	**MA**
	The minutes were approved as a true and accurate record of the previous meeting with the following changes: - p.4 item 6 should read K&C not KNC - p.5 5th para should read 'and had met her in the Information Zone and wrote a report on that meeting. The report' - CM commented on p.2 re minutes of the previous meeting 20 April 2011 if "Heart" Hospitals' was name of the hospital or place. This was still outstanding. - SS-G commented that on p.4 she raised the points about dermatology and AAU not SM.	
	VD to amend the minutes as above.	**VD**
3	**Matters arising**	**MA**
	3/April/11 Leaving Hospital Booklet CM said Scott Bennett is leading on the booklet and it should be completed by the end of September. **4/April/11 Medicines management issues** CM said Deidre Linnard will ensure this is put on the next agenda of the	

	Medicine Group. In the context of home delivery of medicines CM said that Deirdre Linnard has reported that the Trust has a target to get to 70% home delivery for HIV medicines by 2013. MA clarified that this means that 70% of patients should be on home delivery. **4/Jun/11 Patient Experience Committee (PEC) Terms of Reference** TD is formalising communication with the committee and governors interested in joining the committee should let her know. SM and PG expressed interest. Jeremy Loyd, Non-executive Director, chairs this committee and they meet every 6 weeks on Monday morning for 2 hours. The committee cover the whole patient experience. PG expressed interest in a LINk representative joining the committee and TD said she would discuss it with the Chair. **Action: To discuss LINKs representation on the Patient Experience Committee with the Chair.** MAk joined. **6/Jun/11 Response from KNC LINk on the Quality Account** JT said that the Nutrition Group is meeting on 15 September. Re appointments and outpatients CM said that this is on agenda. **7/Jun/11 The Council of Governors Quality Sub-Committee Terms of Reference** CM confirmed that this was completed. **8/Jun/11 Feedback from Committee Members** Re a patient being moved from AAU, JT said the information on the website is inconsistent with current practice. This will be reviewed with Ward Sisters and Charge Nurses to ensure website reflects current practice. Re a paediatric burns incident in A&E, JT said that the parents did not submit a comment card or formal complaint. In the context of appointments being cancelled in the pain clinic CM reported that this had been investigated and Mike Delahunty had looked at repeat cancellations to see if there was a problem/pattern with any particular speciality. He will report at the next meeting. **Action: MD to report on repeat cancellations at the next meeting.** Re a complaint from an elderly lady whose husband had died in December 2010, JT said that a meeting is to be arranged by Complaints with Dr Morgan once he has returned from leave. TD announced that JT will is leaving the Trust on 12 September to take up a new challenge at the Royal Free Hospital. Anthony Pritchard will be covering the post of the Deputy Chief Nurse and will be joining the Quality Sub-Committee. The sub-committee thanked JT for all her hard work and support.	**TD** **MD**

	SB said that his replacement will be announced shortly who will then take over when MAk finishes editing the leaving hospital booklet.	
4	**Feedback from governors on patient experience**	**All**
	ML received feedback from some hospital visitors expressing concern re the hydrotherapy pool closure. **Action: MA to find out about the hydrotherapy pool closure and to inform ML and PG.** Other comments ML received were about the telephone system, the main entrance door not working properly sometimes and not having enough lifts in the hospital. SS-G said she had received positive feedback that hand surgery and subsequent physiotherapy was excellent. MJ said that he received congratulations on the excellent A&E service from somebody who had arrived at A%E and was at the Brompton Hospital in 20 mins and had a stent put in within 30mins. PG said that she received some comments re PG handling of calls (i.e. misdirected calls).	**MA**
5	**Emergency Department Quality Indicators**	**AP/SB**
	AP introduced the paper. We are required to publish our performance on the website. We are meeting indicators in all areas but one, which is re-attendances. SB gave an overview of data collection and how we present this data. He invited comments from the sub-committee on the format. The comments received included: - to define data quality - use of term 'children' rather than 'paediatric' - blue boxes to appear one below another - the sub-committee agreed with the use of colours overall - yellow is not good against the white colour - clarify what 03:56 total time in the A&E means (is it minimum, maxim or median) - to change order, time to treatment first then initial assessment then total time (bottom page 1) - suggestion to put under 4 hours rather than 03:56 and put the detail of actual time - if possible find out why patients leave without being seen - medium wait should say 1 min not 0.01 - PG felt that that 3h.56mins is long time and it looks suspicious that all the numbers are the same. To check. - difference in emphasis between choosing not to wait and leaving without being seen – both used in same graph, top of page 2 SB clarified that 4 hours is either you are discharged or readmitted; p.5 time to initial assessment is below the threshold; we need to include time to treatment and it does not start after the initial assessment, it is after the arrival. Mike Delahunty joined.	

	AP thanked the committee for the useful comments.	
5.1	**Leading the way in transparency of information for patients**	**MAk**
	MAk introduced the paper and informed the sub-committee that government will require more detailed information for patients be published on the website and there is the opportunity to be proactive and publish information in a transparent and honest way. We have identified a list of information patients may be interested in. Two key questions are: what information should be published and how should we present information so that is easy to understand. The information for patients on the website will be collated in one section. MAk suggested we should adopt the American way of presenting information which is less information and also easy to understand. MJ said it must not over simplify - better to present well than too much. We are working on a directory of doctors. In the longer term we would like to publish information about our consultants e.g. how many times they have done procedure and how well they performed. MAk said that he will consult the Membership Sub-Committee on 22 September also on this paper. ML suggested we include other staff as well as consultants e.g. specialist nurses, physiotherapists. MAk invited governors interested in this exercise to work with him. SS-G, SM and MJ volunteered. CM asked the Committee if they thought there was anything missing. The following comments were raised: - to include readmission rates (although some disagreement as difficult to explain) - it is not good to publish mortality rates without explaining them - to look at the CQC and Dr Foster results - groupings are reasonable - to publish MRSA rate and the triple excellent PEAT results - to publish information about nutrition and feeding which is of concern to elderly patients - to address complex needs and learning difficulties - consider publishing position on NPSA Safety alerts MA invited the sub-committee to visit links included in the paper re good practice examples of healthcare organisation that publish information transparently and invited the sub-committee to forward any further comments to MAk.	
	Quality Sub-Committee to forward further comments to MAk.	**All**
	PG asked if we consult with disability organisations about the website. MAk responded that the website can be read by partially sighted visitors. TD added that we work with disability organisations on the signage project. PG emphasised that considering disability is about awareness of	

	needs.	
6	**Focus on Outpatients followed by tour of Outpatients Department for those interested**	**MD**
	Mike Delahunty, Head of Booking and Outpatient Services referred to feedback he received re outpatients and the current issues. There are phone issues within the outpatients department. Currently the average waiting time on the phone is 90 seconds and we aim to reduce it to 1min or under. MD said that waiting time for an appointment will be broken down by speciality. The waiting time in clinics varies and we encourage staff to talk to patients and explain the reason for waiting. We will also get this information displayed on the screens in outpatients. We need to find out how to improve the patient experience, make cultural changes and improve the admin side of the problem e.g. letters to patients. The sub-committee recognised that there was a need to improve communication and that the automatic check in was popular. The sub-committee had a tour of the new Outpatients Department.	
7	**Any other business**	
	MJ said that as a member of the Membership Sub-Committee he has joined the Mobile Health Clinic Steering Group.	
8	**Date of next meeting – 18 November 2011 at 3pm in the Verney House Boardroom**	

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 15 September 2011

AGENDA ITEM NO.	2.9/Sept/11
PAPER	Draft Minutes of the Council of Governors Membership Sub-Committee meeting held on 26 July 2011.
AUTHOR	Liz Revell, Interim FT Secretary
LEAD	Chris Birch, Deputy Chairman
EXECUTIVE SUMMARY	This is a draft of proceedings at the meeting held on 26 July 2011.
DECISION/ ACTION	The meeting is asked to agree the minutes as a correct record of proceedings.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Membership Sub-Committee, 26 July 2011

Attendees	Chris Birch	CBi	Patient Governor (Acting Chair)
	Melvyn Jeremiah	MJ	Public Governor – Westminster 2
	Sam Culhane	SC	Public Governor – Hammersmith 1
	Susan Maxwell	SM	Patient Governor
	Wendie McWatters	WMW	Patient Governor
	Charlotte Mackenzie Crooks	CMC	Staff Governor
In attendance	Jane Tippett	JT	Acting Assistant Director of Nursing
	Sian Nelson	SN	Membership and Engagement Manager
	Renae McBride	RMB	Communications Manager
	Liz Revell	LR	Interim FT Secretary

1.	**Welcome and Apologies**	**ML**
	Apologies were received from Cathy Mooney, Therese Davis, Martin Lewis, Matt Akid, Priti Bhatt and LINk.	
2.	**Minutes of previous meeting held on 25 May 2011**	**ML**
	The minutes were accepted as a true and accurate record except for the following amendments: Page 2: It should read “St Stephen’s Volunteers are eligible to be members of the Trust”. Page 2: “CBi said that the figures were the opposite way round” should be deleted Page 2: “heath checks” should be “health checks”. Page 3: JG should read MJ Page 3: Recruitment should read recruited. Page 3.4: Membership Development and Engagement Strategy” – to add ‘CBi congratulated SN on her document and said it was much better and more focussed than the previous one’. Page 3: Five lines from bottom of page – “members” to read volunteers” and the sentence attributed to SM re volunteers being allowed to vote. Page 4: It had not been asked if governors were allowed to vote. The line will be deleted. Page 5, 2nd para, line 2: the sentence should read “be in July” Page 5, There are some typing errors: WMC should read WMW and Portabello should read Portobello. Page 5: SM was congratulated not on decorating the governors’ stall but on having “the brilliant idea to give free bags to people who signed up as members of the Trust”.	
3.	**Matters Arising**	**ML**

	The Matters Arising were noted.	
4.	**Volunteers Report**	**CMC**
	The total number of Chelsea and Westminster Foundation Trust (Chelwest FT) volunteers changes regularly as there is a constant turnover. The motivation of volunteers differ between locals who have a strong link with the hospital and those who become volunteers for other reasons e.g. to develop skills and undertake work experience. All volunteers are required to attend induction meetings. It is currently optional for volunteers to become members. However, there is a tick box on the form for those who wish to do so. There is a similar promotion of volunteering at St Stephens Centre but not so much updated data available. CMC has also spoken to colleagues in ten or fifteen other Trusts to gauge their approach to volunteers. She discovered that there is a similar mix of motives for volunteering at other Trusts. No other Trust treats their volunteers as staff and there is a reluctance to do so. In general there is a lot of apathy amongst volunteers about becoming members. The difference between the patient, public and staff constituencies is that staff governors are also employed by their Trust whereas patient and public members are not. It is difficult to find a suitable category for volunteers to belong to; they have various roles so no one category will fit all. There is a high turnover of volunteers over six to nine months and it is not always possible to recruit volunteers as members immediately. The long-term committed are more likely to do so. The Trust's legal position regarding volunteers is constrained by our Constitution. Andrew Lansley hopes that the Health and Social Care Bill in the spring of 2012. Recruitment of volunteers as staff members has, therefore, been put on hold. CMC said that it is not explicit which constituency they fall under. CMC said that trying to move them into a constituency area is restricted and also said that the 10%, who travel long distances to the hospital have different reasons for volunteering other than loyalty to the Trust and do not normally stay longer than six months. She also believed that if a volunteer had been a patient within three years they could be patient members. SM said that volunteers could be in the patient constituency and some in the public constituency. She thought the current approach was "very bitty". CBi congratulated CMC on her "very thoughtful paper". He said that he was "obsessed" with the issue of volunteers. He believes that it should be possible to recruit them as soon as they register with the hospital. They are a diverse group of people whilst those at St Stephens tend to be patients with HIV or those who've lost partners and have a strong commitment. Many volunteers at St Stephens have been registered for at least ten years. MJ thought that CMC's paper was "first class" and thanked her for it. He agreed with her conclusion but asked for clarity as to the make up of volunteers force. CMC explained that there are two Volunteer Managers who manage the registered volunteers who work in such areas as the Macmillan chaplaincies, transport or hospital radio. Volunteers are recruited in line with hospital policies. MJ asked if the Hospital Friends are internal or external. CMC clarified that they are charities who fundraise for the hospital e.g. for equipment. WMW confirmed that she is a Friend but had never been approached to become a volunteer. CMC said that the Friends group is exceedingly loyal to the hospital and is currently an untapped group for membership.	

	MJ spoke of another organisation which had concerns about insurance cover for volunteers. This charity had sought legal advice for clarification on the health and safety laws regarding volunteers. MJ said that the advice was "interesting"; volunteers should receive a full explanation of the structure of the organisation and an official registration document. However, unlike staff, volunteers are not paid (otherwise they are no longer volunteers). CMC confirmed that Chelsea and Westminster FT volunteers are unpaid and have no employment rights. The Volunteering and the law document sets out their legal position. She suggested that she and MJ discuss further outside of the meeting. Volunteers are very different from staff. CMC reiterated that they normally have different motivations and are managed differently. JT asked MJ to clarify his main concern. He believed that the arguments did not stand up, that there isn't a single category that fits volunteers and the situation is "very bitty". CMC said that fifty volunteers would be a small number to have a constituency of its own. Furthermore, many volunteers live outside of the constituency. MJ asked if volunteers are encouraged to be members after twelve months. SN said they could join either the public or patient constituencies rather than the staff constituency. SM said it would be interesting to see exactly how many there are. MJ said we are talking about a very small minority. CBi said that, despite the numbers involved it would be more democratic for there to be a staff constituency for volunteers with their own representative but in order for this to happen the Constitution would have to be amended. SN explained that the database system has a filter which recognises new members by a code. She confirmed that that it is only possible to join one constituency as the database replicates. CMC agreed that it is not possible for them to become patient and public constituency members simultaneously. MJ asked if there anything in the Constitution which prevents them being part of both. SM replied that she had been in one category and had had to change to another. JT said that although a decision cannot be made until the Constitution has changed the argument has been discussed a number of times. She asked the committee to think about any issues and what their preference would be. CBi concluded that he would like the committee to consider the issue further. Volunteers have a commitment to the hospital. He said that there is no reason for us not to come to a conclusion. JT advised the committee to hold off for a year when the situation might have changed and advocated considering it further. She asked how much influence we have. CMC said it was important to clarify the figures before forming an opinion and said that the volunteers' membership form does not have a box for the staff constituency. CBi said he was very grateful to CMC for this paper. It was agreed that Capita would formulate suitable questions for the form.	
5.	**Annual Members Meeting – a proposal**	**RMB**
	Items 5 and 5.1 were presented together as one item. CBi queried why the same paper that had been presented to the Council of Governors' meeting was now being brought to the Membership Sub-Committee. RMB explained that there had been some further updates since MAk had taken the paper to the Council of Governors and RMB also asked the committee for input into the agenda of the Annual Members Meeting (AMM).	

	The Annual Members Meeting is normally well attended but aims, this year, to draw in more young people and mothers with young children. This paper proposed some themes for the Annual Members Meeting (IT Development; discharge; older people and communication) and discussed events associated with it. HL had said during the Council of Governors meeting that the AMM should not focus exclusively on the theme of older people but ML was particularly keen on that idea. RMB clarified that HL's aim is to attract younger members to the meeting but not, necessarily, exclude the other themes which, she confirmed, would be included on the agenda: i.e. improving information, communication, and discharge. JT said that there had been nation-wide debate on all three issues following the recent publication of the Ombudsman's Report and it was a great opportunity for Chelsea and Westminster FT to focus on them. RMB explained that as well as events on 15 September there would be events earlier that week in order to draw people in from the local area. The start time of the AMM (5.30pm) is not an ideal time of day for young families and, as a result, Communications had considered other ways of engaging with young people during that week. SN agreed it was important to capture young mothers for the purposes of recruitment. CMC suggested approaching those that aren't from our usual membership. RMB said that the non-medicalisation of birth (which relates to Ian Bell's campaign on midwifery) would be part of the programme. There is also a proposal for site tours of Netherton Grove but these are restricted by Project Services' Health and Safety rules. RMB congratulated the committee on their "brilliant" ideas and input. SM said that there were some bags left from Open Day and SN said some new members had been recruited on Open Day. CMC praised both the Information Zone and the Outpatients Department. RMB said that it was quite surprising that from 10,000 letters that had been sent only a few responses had been received. CMC said that the tours on Open Day had been well attended. RMB said that there are thousands of members but it is important to decide how we engage with them. She wondered what other Trusts do regarding Membership and Engagement. SM suggested demonstrations of kidney stones being taken out of bladders and tubes being put down people's throats to attract interest. CMC suggested hospital tours as younger people often want to become medical students and would be interested in participating in these.	
5.1	**Annual Members Meeting associated events**	**RMB**
	See above.	
6	**Membership Calendar of Events**	**SN**
	SN confirmed that the Council of Governors Membership Calendar of Events will be updated in September and also that she had discussed the forthcoming recruitment campaign in Westminster with ML and MJ (for which funding had recently been approved). August is normally a quiet month due to the holiday season so the recruitment campaign will start at the beginning of September (prior to the Annual Members Meeting on 15 September). The membership target is currently 300 members. The recruitment campaign will be discussed at the Steering Group on 14 August and will focus on recruiting more members from the BME groups. SC queried the purpose of recruitment and how we can engage with members once recruited. SN said that Monitor	

	stipulates that we recruit a certain number of new members and RMB agreed that Monitor stipulate a quota when hospitals first apply to become a Foundation Trust. WMW advised to push ahead with the campaign in order to maintain the membership total. CMC said that Chelsea and Westminster FT should reach out and engage with local communities. MJ said that a flourishing membership signifies good governorship that is responsive to those who use the service i.e. the patients. Chelsea and Westminster FT should encourage them to fully engage with the hospital. A Foundation Trust justifies itself through its governance. Chelsea and Westminster FT should study what other Trusts do to maintain their membership and "stop people from falling away drastically". It is, however, difficult to fix a certain number of members. SN reiterated that it is important to maintain numbers which are annually submitted to Monitor, whom we assume are happy with our engagement strategy. However, in order to maintain our numbers it is important to develop more vibrant engagement activities through the Calendar of Events. WMW said that, according to the calendar, the mobile clinic is due to visit Shepherds Bush Market at least six times during the forthcoming year. SN explained that West London Sexual Health funding is given for specific purposes and don't have total influence over where we can go with the mobile clinic. She asked the committee for input as to future uses of the bus. SM thought that the bus is effective. The Steering Group will discuss 56 Dean Street in two weeks time. There is currently no activity in Wandsworth which, WMW, said is a difficult area for recruitment. CBi asked whether the 75 members recruited were actual or a target? JT confirmed that September will be a busy month for events. Communication activities are included on both the calendar and the Trust website for which she suggested the committee select a few events. CBi asked SN to amend the calendar and re-circulate it.	
7,	**Any Other Business**	
	1. SM asked if the tables for the Information Zone have been ordered. She said it was important to decide where they are going to be placed before being nailed down. 2. It was confirmed that Priti Bhatt, Diversity and Equality Manager offers Diversity Training for governors. 3. JT confirmed that CM is going to put together a small Task and Finish Group to discuss the recent Monitor Reports that had been circulated to governors. She thought it would be useful to consider the Trust's policy for increasing membership.	
8.	**Date of next meeting**	**ML**
	The next meeting will be held on 22 September 2011 at 4pm	

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 15 September 2011

AGENDA ITEM NO.	3.1/Sep/11
PAPER	Finance Report – July 2011
AUTHOR	Mike Fox, Chief Management Accountant
LEAD	Lorraine Bewes, Director of Finance
EXECUTIVE SUMMARY	The Trust has achieved an EBITDA of £2.6m (£0.2m ahead of plan) and a net surplus of £1.0m (£0.4m ahead of plan) during July, Month 4. One of the drivers of this performance were increased clinical activity in Critical Care and Paediatrics which generated increased income for the Trust with costs associated with this increase activity being lower than income received. Year-to-date, the EBITDA is £9.0m (£0.1m behind plan) and the surplus is £2.5m (£0.2m behind plan). The Trust is continuing to focus on maintaining control of pay costs, ensuring that any increases in staffing are limited to those required to deliver activity. The Trust has identified £19.4m of CIP (99% of the £19.7m target) but is forecasting to achieve £17.7m (90% of target). The Trust's Management Executive is focussing on managing successful implementation of identified schemes and the mitigation of any shortfall in CIP through either increased income or under-spends in other budgets. The Trust is currently forecasting a surplus of £8.1m for 2011/12 (£0.3m below plan), this has been impacted by the forecast shortfall in CIP which is being partially offset by increase income being delivered at marginal costs.
DECISION/ ACTION	The Council is asked to note the financial position for the financial year to July 2011.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 15 September 2011

AGENDA ITEM NO.	3.2/Sep/11
PAPER	Performance Report – July 2011
AUTHOR	Sherryn Elsworth, Head of Performance Improvement
LEAD	Amanda Pritchard, Deputy Chief Executive
EXECUTIVE SUMMARY	The purpose of this report is to update the Council of Governors on the Foundation Trust's performance for the period ending 31st July 2011 (the latest period to have been reported to the Foundation Trust Board) and to highlight performance risks going forward. There are a number of significant changes to the Trust's performance requirements for 2011/12. These relate particularly to the Monitor Compliance Framework, contractual requirements, internally set targets relating to quality and the new CQUINs. There is 1 main area of risk to achievement of the new Monitor requirements, the Clostridium Difficile target, which does not take into account the sensitivity of the new test. In August Monitor amended the compliance framework to only include 1 A&E indicator. However, the Trust still intends to continue to focus on performance against all 8 new indicators. In addition, the Trust's MRSA targets remain static in 2011/12 at 3 (Department of Health) and 6 (Monitor). There were 6 hospital acquired MRSA bacteraemias reported in the Trust in 2010/11 so this target remains challenging. The Trust has performed well in month 4, achieving the required performance level in ten of eleven Monitor indicators which could be measured. The Trust is failing the 2 Week Wait Cancer target for the 2nd quarter. However, the position is anticipated to be recovered by quarter end. The Clostridium Difficile position may not remain within target (see above) and there are a range of contractual and internally set targets that require further attention. Following previous discussion at the Board, a review of the Trust's performance framework is in train with the aim of creating a new dashboard which will incorporate the areas that are most important to the organisation, as well as reflecting 'must do' targets.

DECISION/ ACTION	The Council of Governors is asked to note this report.

PERFORMANCE REPORT FOR THE PERIOD JULY 2011

1. Introduction

Chelsea & Westminster track around 70 metrics to ensure the Trust is adequately measuring the indicators which are of importance to our patients, other key stakeholders, Monitor who are who are responsible for regulating Foundation Trusts and commissioners who contract with Chelsea & Westminster for the provision of a range of services at a defined level of quality. Performance against these metrics is reported monthly to the Foundation Trust Board and summarised via a high level Performance Dashboard (attached).

2.1 There are a number of changes to the Monitor Compliance Framework for 2011/12. On the basis of current performance, there is 1 main area of risk to achievement of the new Monitor requirements. This is:

- Clostridium Difficile, where the national target for the Trust (31) does not take account of the impact of the more sensitive test that is now used. Last year the new test was used and on a like for like basis 55 cases were recorded. This is currently declared as a red risk for the Trust as Monitor will continue to measure our performance against the national target of 31. However year to date incidents of clinical significant is 7 – on that basis the Trust is on track to be inside the Monitor threshold.

- As previously discussed, the 8 new A&E indicators will be challenging. However, in quarter 2 Monitor amended its compliance framework in relation to the A&E clinical indicators set out in the 2011/12 Operating Framework. Monitor will only monitor performance against the proportion of patients who have waited less than 4 hours, with a target threshold of 95%. The Trust will continue to monitor performance against 5 of the new indicators to comply with contractual requirements with the commissioners. On current performance the Trust would meet the Monitor A&E requirement but breach two of the other 4 indicators. Work is ongoing to ensure all five indicators are achieved and there is confidence at least four of the indicators can be achieved from the beginning of quarter two with a slightly longer timescale required to achieve the required reduction in A&E re-attendances.

2.2 There are a range of new key performance indicators (KPIs) that will form part of the contract the Trust has signed with commissioners for 2011/12. The risk relating to the contract KPIs is predominantly financial, as there are penalties attached to underperformance. Agreement on KPIs has now been reached and the performance dashboard will be updated to reflect this from Quarter 2 when financial penalties could potentially apply.

2.3 The following priorities have been agreed for the 2011/12 Quality Account:

- VTE prevention
- Improving patient experience
- Reducing waiting times for emergency surgery and the time that patients are nil by mouth
- To remain in the top 20% of acute Trusts nationally for staff engagement and to be in the top 20% for staff appraisals

2.4 The Trust has agreed 8 Commissioning for Quality and Innovation targets (CQUINs) for 2011/12, which are worth a total of £3,016,672 based on the Trust's income plan.

3. Overall Performance

The Trust has performed well year to month 4, achieving the required performance level of ten of eleven scored Monitor indicators which could be measured.

There are some areas where the Trust is not achieving the required performance level and the Foundation Trust management team is seeking the support of colleagues to help improve performance in future months.

Target	**Performance**
Cancer: Two Week Wait from referral to date first seen comprising all cancers	Year to date 94.63% against a target of 93%. Performance dropped in Q2 to 91.67%, mainly because of patients choosing to wait longer. An action plan is in place to retrieve the position by quarter end.
A&E: Time to initial assessment (95th percentile)	Year to date 17 minutes against a target of 15 minutes. Performance had improved in July to 15 minutes and the Trust has moved nearer to achieving this target on a consistent basis.
A&E: Unplanned re-attendance rate	Year to date 7.02% against a target of less than 5%. A significant proportion of returning patients are regular attenders or re-attend following discharge from inpatient care.
Day Case rate (Basket procedures)	80.70% in month against a target of 95%. This means some of our patients may experience unnecessary overnight stay.
Choose and Book slot issues	Year to date slot issues with 5.67% of bookings against a contractual target of no more than 4%. This means GPs are having difficulty booking their patients into our outpatient clinics.
Discharge summary within 24 hours	Year to date 76.66% against a contractual target of 100%. This is one of the key concerns for local GPs.
Single Sex Accommodation	There were 4 single sex accommodation breaches in July 2011 and 11 breaches year to date.
18 weeks guarantee	47 patients on non-admitted pathways and 76 patients on admitted pathways treated in July 2011 waited more than 18 weeks for capacity reasons or other reasons within the Trust's control
Patients with a catheter	Year to date 16.17% against a local Quality Account threshold of 12.5%.
Expedited surgery cases operated within 4 days of booking	Year to date 95.09% against a local Quality Account target of 100%

The Trust has performed within target year to date in the following areas but there are concerns regarding the Trust's ability to maintain this performance going forward:

Target	**Issue**
C Difficile	The full year national target of 31 may not be achieved given like for like 2010/11 performance was 55.
Cancer Performance	Remedial action is required to recover the quarter 2 Week Wait position. Looking forward continued achievement is expected, but constant vigilance is required because total cancer patient numbers are low so any individual breach of the cancer target has a disproportionately high impact on overall performance.
MRSA Screening Rates	The Trust's overall ratio of admissions to MRSA tests is acceptable but detailed analysis shows that some patients are tested more than once and some patients may not be screened at all. The Chief Nurse is leading a project to improve performance in this area.

4. Planned FUTURE CHANGES TO THE PERFORMANCE REPORTING FRAMEWORK

Following previous discussion at the Board, a review of the Trust's performance framework has begun with the aim of creating a new dashboard which incorporates the areas that are most important to the organisation, as well as reflecting 'must do' targets

5. Action

The Council is asked to note the report. Feedback on the format and content of this report to the Head of Performance Improvement will be welcomed and used to tailor future reports to the requirements of the Council.

TRUST PERFORMANCE DASHBOARD JULY 2011											
	Indicator Name	Monitored by/ Submission to	Trustwide Target/Threshold	Trustwide Performance YTD	Trustwide Performance in Month	Medicine and Surgery YTD	Medicine and Surgery in Month	Women's, Neonatology, Children's and Young people's, HIV, Sexual Health and Dermatology YTD	Women's, Neonatology, Children's and Young people's, HIV, Sexual Health and Dermatology in Month	Clinical support YTD	Clinical Support in Month
QUALITY	Incidence of Clostridium difficile --Hospital Acquired	DoH, Monitor, CQC, Local Stretch	10.33	7	1	5	1	0	0	2	0
	Incidence of E. coli bloodstream infections	DOH, Local	NA	11	6	8	4	1	0	2	2
	Incidence of Meticillin Sensitive Staphylococcus Aureus (MSSA) --Hospital Acquired	DOH, Local	NA	3	0	1	0	2	0	0	0
	Incidence of MRSA Bacteraemia --Hospital Acquired	DoH, Monitor, CQC, Local Stretch	1.00	0	0	0	0	0	0	0	0
	Hand Hygiene Compliance	Quality Account	90%	93.50%	95.00%	92.75%	94.00%	93.50%	94.00%	94.25%	95.00%
	Hand Hygiene Completion	Quality Account	100%	92.13%	94.44%	88.46%	88.24%	96.25%	100.00%	88.80%	90.91%
	% of observation charts completed accurately	Quality Account	85%	To be audited later this year	To be audited later this year	Not reported by Division					
	Resuscitation calls due to failure to escalate	Quality Account	TBC	6	1	Not reported by Division					
	% patients with International Normalised Ratio (INR) less than 5	Quality Account	96%	96.79%	97.00%	Not reported by Division					
	Mortality (HSMR) - 2 months behind	Quality Account	TBC	63.74	65.93	58.65	63.77	147.06	111.11	142.86	0.00
	% of patients with a catheter (1 month behind)	Quality Account	12.5%	16.17%	16.90%	Not reported by Division					
	% expedited surgery cases operated on within 4 days of booking	Quality Account	100%	95.09%	86.00%	Not reported by Division					
	Central line continuing care—compliance with Care bundles	Quality Account	90%	95.50%	100.00%	Not reported by Division					
	Peripheral line continuing care—compliance with Care bundles	Quality Account	90%	75.50%	78.00%	Not reported by Division					
	Urinary catheters continuing care—compliance with Care bundles	Quality Account	90%	93.50%	100.00%	Not reported by Division					
	Numbers of pressure ulcers—grade 2	Quality Account	50% reduction	15	4	Not reported by Division					
	Numbers of pressure ulcers—grades 3 and 4	Quality Account	25% reduction	9	4	Not reported by Division					
	% of patients 'fit' for discharge waiting only for medicines	Quality Account	<=10%	Start measuring in September	Start measuring in September	Not reported by Division					
	Infant health & Inequalities: % Women known to be smokers	DoH, CQC	4.13%	4.99%	6.37%	N/A	N/A	4.99%	6.37%	N/A	N/A
	Infant health & Inequalities:% Mothers known to initiate breastfeeding	DoH, CQC	91%	92.12%	91.65%	N/A	N/A	92.12%	91.65%	N/A	N/A
	Maternity: % Women seen a midwife or obs for assessment by 12+6 (trajectory)	DoH, CQC, Contract	90%	91.58%	91.46%	N/A	N/A	91.58%	91.46%	N/A	N/A
	Breach of Same Sex Accommodation	DoH, CQC, Contract, Quality Account	0	11	4	3	0	0	0	15	11
	Never Events	DoH, CQC, Contract, Quality Account	0	0	0	0	0	0	0	0	0
	Serious Untowards Incidents (Red incidents)	DoH, CQC, Contract, Quality Account	0	0	0	0	0	0	0	0	0
	Patient falls resulting in moderate or major harm	DoH, CQC, Contract, Quality Account	2.3	3	1	3	1	0	0	0	0
	Rapid Access Chest Pain Clinic	DoH, CQC, Contract	98%	100.00%	100.00%	100.00%	100.00%	N/A	N/A	N/A	N/A
	Stroke: Patients who had a stroke who spend at least 90% on a stroke unit	DoH, Contract	80%	86.67%	76.92%	86.67%	76.92%	N/A	N/A	N/A	N/A
	Stroke: High risk TIA patients assessed and treated within 24 hours	DoH, Contract	60%	100.00%	100.00%	100.00%	100.00%	N/A	N/A	N/A	N/A
	VTE Assessment	DoH, CQUIN	90%	90.95%	91.42%	87.15%	87.23%	94.17%	95.65%	97.02%	95.88%
	Discharge Summaries within 24 hours	Contract	100%	76.66%	74.11%	78.36%	78.20%	74.48%	68.98%	76.58%	77.41%
	Complaints re-opened	Quality Account	3	7	0	Not reported by Division					
	Complaints and concerns for admissions and appointments	Quality Account	TBC	121	43	61	25	50	17	5	0
	Formal complaints responded in 25 working days (1 month behind)	Quality Account	90%	75.25%	75.00%	75.47%	80.00%	65.71%	58.33%	100.00%	100.00%
	Best Patient Experience (BPE) - 1 month behind	CQC, Quality Account	90%	88.25%	94.00%	85.98%	92.00%	90.31%	95.38%	N/A	N/A
	Patient Experience Tracker Completion rate	CQC, Quality Account	80%	34.24%	22.98%	24.02%	10.68%	39.84%	20.07%	52.59%	62.25%
	Patient Experience Tracker overall satisfaction scores (Accident & Emergency)	CQC, Quality Account	90%	93.10%	94.90%	93.10%	94.90%	N/A	N/A	N/A	N/A
	Patient Experience Tracker overall satisfaction scores (Outpatients)	CQC, Quality Account	90%	84.00%	82.20%	84.40%	84.80%	83.25%	82.00%	96.35%	0.00%
	Patient Experience Tracker overall satisfaction scores (Inpatients)	CQC, Quality Account	90%	93.75%	94.60%	91.63%	91.60%	91.15%	88.80%	98.95%	99.20%

	Indicator Name	Monitored by / Submission to	Trustwide Target / Threshold	Trustwide Performance YTD	Trustwide Performance in Month	Medicine and Surgery YTD	Medicine and Surgery in Month	Women's, Neonatology, Children's and Young people's, HIV, Sexual Health and Dermatology YTD	Women's, Neonatology, Children's and Young people's, HIV, Sexual Health and Dermatology in Month	Clinical support YTD	Clinical Support in Month
ACCESS	A&E: Total time in A&E (95th Percentile)	DoH, CQC, Contract	<=4 hours	03:56	03:56	03:56	03:56	N/A	N/A	N/A	N/A
	A&E: Time to initial assessment (95th percentile)	DoH, CQC, Contract	<=15 minutes	00:17	00:15	00:17	00:15	N/A	N/A	N/A	N/A
	A&E: Time to treatment decision (median)	DoH, CQC, Contract	<=60 minutes	00:53	00:52	00:53	00:52	N/A	N/A	N/A	N/A
	A&E: Unplanned re-attendance rate	DoH, CQC, Contract	Between 1% and 5%	7.02%	6.12%	7.02%	6.12%	N/A	N/A	N/A	N/A
	A&E: Left without being seen	DoH, CQC, Contract	<=5%	3.76%	3.95%	3.76%	3.95%	N/A	N/A	N/A	N/A
	Total time in spent in A&E< 4hours (All activity types)	DoH, Monitor, Contract	98%	98.60%	98.80%	98.60%	98.80%	N/A	N/A	N/A	N/A
	Total time in spent in A&E< 4hours (Type 1 by site)	DoH, CQC, Contract	95%	98.60%	98.80%	98.60%	98.80%	N/A	N/A	N/A	N/A
	Percentage of A& E attendances for cellulitis that end in admission	DoH, Contract	NA	31.58%	21.01%	31.58%	21.01%	N/A	N/A	N/A	N/A
	Percentage of A& E attendances for DVT that end in admission	DoH, Contract	NA	30.00%	0.00%	30.00%	0.00%	N/A	N/A	N/A	N/A
	All cancers: 31-day wait from diagnosis to treatment	DoH, Monitor, CQC	96%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	N/A	N/A
	All cancers: 31-day wait for second or subsequent treatment Surgery	DoH, Monitor, CQC	94%	100.00%	100.00%	100.00%	100.00%	N/A	N/A	N/A	N/A
	All cancers: 31-day wait for second or subsequent treatment anti cancer drug treatments	DoH, Monitor, CQC	98%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	N/A	N/A
	All cancers: 31-day wait for second or subsequent treatment radiotherapy	DoH, Monitor, CQC	94%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	All cancers:62-day wait for first treatment from urgent GP referral to treatment	DoH, Monitor, CQC	85%	92.86%	90.00%	94.29%	100.00%	90.48%	81.82%	N/A	N/A
	All cancers:62-day wait for first treatment from consultant screening referral	DoH, Monitor, CQC	90%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Cancer: Two Week Wait from referral to date first seen comprising all cancers	DoH, Monitor, CQC	93%	94.63%	91.67%	97.63%	96.20%	92.81%	89.05%	N/A	N/A
	Cancer: Two Week Wait from referral to date first seen comprising symptomatic breast patients (cancer not initially suspected)	DoH, Monitor, CQC	93%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Cancelled operations by the hospital for non-clinical reasons on the day of or after admission, who were not treated within 28 days.	DoH, Contract, CQC	<=2%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	N/A	N/A
	Cancelled operations by the hospital for non-clinical reasons on the day of or after admission	DoH, Contract, CQC	<=0.8%	0.32%	0.48%	0.70%	1.04%	0.00%	0.00%	N/A	N/A
	Outpatient Encountering compliance	DoH, CQC	100.0%	97.44%	97.58%	97.37%	96.06%	97.94%	98.40%	N/A	N/A
	Outpatient Outcomes compliance	DoH, CQC	100.0%	96.67%	97.31%	97.17%	95.90%	97.17%	98.09%	N/A	N/A
	RTT Outcomes compliance	DoH, CQC	100.0%	95.65%	97.34%	96.39%	96.75%	96.11%	98.20%	N/A	N/A
	Data Quality on ethnic coding	DoH, CQC	95.0%	94.57%	93.25%	97.60%	97.53%	91.72%	89.03%	93.94%	93.71%
	Delayed Transfers of Care	DoH, CQC	3.5%	1.01%	1.08%	1.61%	1.78%	0.00%	0.00%	0.00%	0.00%
	Diagnostic >=6 Weeks	Contract	0	0	0	0	0	0	0	0	0
	GUM Access within 48 hours	DoH, CQC	98%	100.00%	100.00%	N/A	N/A	100.00%	100.00%	N/A	N/A
	Referral to treatment: Admitted (Admissions) 95th Percentile - YTD refers to the reporting quarter	DoH, Monitor, CQC	23.00	22.45	22.45	22.33	22.33	22.94	22.94	9.38	9.38
	Referral to treatment: Non Admitted (OP Attendances) 95th Percentile - YTD refers to the reporting quarter	DoH, Monitor, CQC	18.30	10.71	10.71	15.98	15.98	7.08	7.08	0.00	0.00
	Referral to treatment: Incomplete 95th Percentile -YTD refers to the reporting quarter	DoH, CQC	28.00	19.72	19.72	19.24	19.24	20.14	20.14	20.69	20.69
	Referral to treatment: Admitted (Admissions) Median - YTD refers to the reporting quarter	DoH, CQC	11.10	7.49	7.49	7.55	7.55	7.77	7.77	3.00	3.00
	Referral to treatment: Non Admitted (OP Attendances) Median - YTD refers to the reporting quarter	DoH, CQC	6.60	0.75	0.75	4.91	4.91	0.64	0.64	0.00	0.00
	Referral to treatment: Incomplete Median -YTD refers to the reporting quarter	DoH, CQC	7.20	5.23	5.23	5.10	5.10	5.45	5.45	5.55	5.55
	Slot Issues per DBS booking (trajectory)	DoH, Contract	<=4%	5.67%	4.84%	Not reported by Division					
Activity	Regular Day Attender	Contract	2643	2203	502	457	104	1744	398	2	0
	Same day procedure	Contract	6705	7086	1695	3027	692	2283	558	1776	445
	Elective Against Plan	Contract	2085	2018	538	1204	337	793	195	21	6
	Non-Elective Against Plan	Contract	13124	13043	3404	5301	1355	7705	2036	36	13
	Outpatient New	Contract	62246	61076	15563	14066	3362	40996	10633	5812	1495
	Outpatient Follow Up	Contract	82472	84282	19594	37346	8925	32521	7237	10696	2680
Finance	Clinical Activity Value (Variance)	Contract	£90,012,361	£1,591,093.32	-£90,536.64	£159,417.54	-£20,425.83	£1,567,801.19	£287,631.18	£415,217.25	-£47,107.97
	Follow Up Value above Plan (Variance)	Contract	0	-£315,761.36	-£84,461.67	-£257,471.33	-£57,932.81	-£58,290.03	-£26,528.86	£0.00	£0.00
	Emergency Activity above Threshold (Variance)	Contract	£0	-£344,847.21	£0.00	-£64,525.44	£0.00	-£258,242.01	£0.00	-£22,079.77	£0.00
Workforce	Turnover Rate	Internal	13.00%	9.21%	0.91%	9.03%	1.04%	10.62%	0.98%	9.18%	0.88%
	Vacancy Rate	Internal	9.75%	10.06%	10.36%	11.25%	12.08%	12.97%	12.43%	5.10%	5.95%
	Sickness Rate	Internal	3.60%	3.63%	3.83%	3.77%	3.35%	3.85%	4.47%	2.63%	2.97%
Efficiency	Elective length of stay	Internal	3.00	4.11	4.40	5.08	5.62	2.91	2.81	2.63	1.04
	Non-Elective length of stay	Internal	3.08	3.20	3.01	4.92	4.82	2.14	1.95	13.39	3.36
	Total Length of Stay	Internal	3.04	3.35	3.23	4.96	5.01	2.23	2.05	10.24	3.18
	Daycase rate	Internal	78%	77.83%	75.91%	71.54%	67.25%	74.22%	74.10%	98.83%	98.67%
	Basket Daycase Rate	Contract	95%	80.70%	73.06%	85.63%	79.29%	75.53%	67.52%	N/A	N/A