Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting

Hospital Boardroom
Chair: Prof. Sir Christopher Edwards
Date: 21 April 2010
Time: 4.30pm

Agenda

		Lead	Time
1	**GENERAL BUSINESS**		
1.1	Welcome & Apologies	CE	4.30
1.2	Declaration of Interests	CE	
1.3	Minutes of Previous Meeting held on 3 February 2010 (attached)	CE	
1.4	Matters Arising (attached)	CE	
1.5	Chairman's Report (oral)	CE	4.35
2	**ITEMS FOR DISCUSSION/DECISION/APPROVAL**		
2.1	Chief Executive Update		4.45
2.1.1	Contracting implications 2010/11 linking to strategy (oral)	HL	
2.1.2	Lower Ground Floor Outpatient Plans (oral)	HL	
2.2	QUALITY		
2.2.1	Quality Accounts Update (attached)	CM	5.00
2.2.2	Quality Sub-Committee report (draft minutes of 26 March 2010 meeting attached)	CM	
2.2.3	Patient Experience (attached)	AMC	5.10
2.3	MEMBERSHIP		
2.3.1	Membership Sub-Committee report (draft minutes of 8 April 2010 meeting attached)	CB	5.20
2.3.2	Membership and Engagement Strategy (attached)	SN	
2.3.3	Membership Report (attached)	SN	
2.4	Funding Report* (attached)	VD	
2.5	Remuneration of NEDs and the Chairman (oral)	CE	5.35
2.6	FTGA/FTN Development Day 12 February & 23 March 2010 – feedback (attached)	SSG/WB	5.40
2.7	Proposed questionnaire for Council of Governors performance evaluation (attached)	VD	5.45
2.8	Governors chelwest e-mail account arrangements (oral)	CE	5.50
2.9	Council of Governors group photo (oral)	CE	6.00
2.10	Open Day – 8 May 2010 – update (oral)	MA	6.05
3	**ITEMS FOR INFORMATION**		
3.1	Finance Report – February 2010 (attached)	LB	
3.2	Performance Report – February 2010 (attached)	LB	
3.3	Foundation Trust Staff Governor Study (attached)	CE	
3.4	Appraisal of Chair and NEDs – FTGA publication (attached)	CE	

4	**ANY OTHER BUSINESS**	6.10
5	**DATE OF THE NEXT MEETING – 21 July 2010 at 4.30pm**	

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 21 April 2010

AGENDA ITEM NO.	1.3/Apr/10
PAPER	Draft minutes of the meeting of the Council of Governors meeting held on 3 February 2010
AUTHOR	Vida Djelic, 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.

Council of Governors Meeting Minutes, 3 February 2010
DRAFT

Prof. Sir Christopher	Edwards	Chairman		CE
Lucy	Ball	Staff	Allied Health Professionals, Scientific and Technical	LB
Walter	Balmford	Patient		WB
Chris	Birch	Patient		CBir
Christine	Blewett	Public	Hammersmith and Fulham 2	CBle
Nicky	Browne	Appointed	The Royal Marsden NHS Foundation Trust	NB
Cass	Cass-Horne	Patient		CC-H
Edward	Coolen	Patient		EC
Brian	Gazzard	Staff	Medical and Dental	BG
Rosie	Glazebrook	PCT	NHS Hammersmith and Fulham	RG
Jacinto	Jesus	Staff	Contracted	JJ
Catherine	Longworth	Appointed	Westminster PCT	CL
Susan	Maxwell	Patient		SM
Wendie	McWatters			WMW
Ann	Mills-Duggan	Public	Westminster 1	AMD
Edgar	Moyo	Appointed	NHS Kensington and Chelsea	EM
Jim	Smith	Patient		JS
Sue	Smith	Staff	Nursing and Midwifery	SS
Sandra	Smith Gordon	Public	Kensington and Chelsea 2	SS-G
Frances	Taylor	Appointed	Royal Borough of Ken & Chelsea	FT
Alison	While	Major Education Provider	King's College	AW
Taryn	Youngstein	Patient		TY

IN ATTENDANCE:

Richard Kitney	Non-Executive Director	RK
Charles Wilson	Non-Executive Director	CW
Heather Lawrence	Chief Executive	HL
Matt Akid	Head of Communications	MAk
Lorraine Bewes	Director of Finance	LB
Mark Gammage	Interim Deputy chief Executive	MG
Amit Khutti	Director of Strategy & Services Planning	AK
Sian Nelson	Membership and Engagement Manager	SN
Catherine Mooney	Director of Governance and Corporate Affairs	CM
Vida Djelic	Interim FT Secretary	VD

1 GENERAL BUSINESS

1.1 Welcome & Apologies — CE

CE noted the apologies tendered: June Bennett, Alan Cleary, Carol Dale, David Finch, Martin Lewis, Cyril Nemeth and Mary Symons.

1.2 Declaration of Interests — CE

CE invited declarations of interest. None were tendered.

1.3 Minutes of Previous Meeting held on 3 December 2009 — CE

The minutes of the previous meeting held on 3 December 2009 were agreed as a correct record of proceedings with the following changes:

- Apologies received from Catherine Longworth
- SN attended the meeting
- On p.7 it should read CBir instead of CE
- On p.7 CBir 4th para should read 'crazy' not 'a bit odd'
- On p.9 there should be put emphases on the extent to which the medical staff is involved in the decision making process

Vida to amend minutes in line with comments received. — **VD**

1.4 Matters Arising — CE

CE noted the actions and subsequent outcomes. He said the meeting with the new governors had been very helpful. He referred to item 1.3 and noted that all of the new governors had signed the Code of Conduct. Re item 2.4 CE said he was pleased at the number of volunteers and from the minutes it looked like a very successful set of discussions. Re item 4.2 election of the Deputy Chairman

of the Council of Governors he announced that Brian Gazzard was elected the Deputy Chairman with a vote of 16. VD added that there were also 2 other governors nominated, one of which received 4 votes and the other received 3 votes. CE congratulated BG.

Re item 4.3.2 Membership report, SN explained that membership ethnic classification is correct, as reported at the last meeting in December, and is the same as the Trust ethnic categories. It is externally set by a national classification - the NHS Data Model and Dictionary. This provides a reference point for assured information standards to support health care activities within the NHS in England. It has been developed for everyone who is actively involved in the collection of data and the management of information in the NHS.

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

CE congratulated Heather Lawrence, Chief Executive, on receiving the OBE. He said that not only has she been an outstanding Chief Executive, but she had also made national contributions e.g. she chairs the North West London Critical Care Network and was a lead negotiator on the Staff and Associate Specialist doctors contract.

CE said that it is very important time in the NHS and we need to make sure that interests of C&W Hospital are best represented. He reported a meeting with the West Middlesex Hospital Chair and the Chief Executive Officer regarding working in partnership. He added that the NHS London is predicting difficult times regarding finances and that there will be a significant reduction in the budget. It is still unclear how this reduction in the finances will be dealt with. He pointed out that this will have an effect on the income of C&W and that the new strategy is vital. CE said that HL will talk to it later in the meeting.

CE informed the Council of Governors that Lady Caroline Rhys Williams, the Chair of the Healthcare Charity, who was a remarkable lady and a tower of strength, suddenly died on 20 January 2010. He wanted to acknowledge appreciation of her work.

1.5.1 Results of election of the Deputy Chairman **CE**

This item was covered earlier in the meeting under matters arising item 4.2.

2 ITEMS FOR DISCUSSION/DECISION/APPROVAL

2.1 Strategy Update – presentation **HL**

HL said that following a presentation given to Governors in September 2009 to update them on what was happening in the NHS and what it meant for North West London and for C&W, the feedback obtained from the Council of Governors in response to questions posed was very useful, and helped to inform the discussions.

HL gave a presentation on strategy and business planning.

HL reminded the Council of Governors of the vision for the NHS in London and 5 principles of the future healthcare in Healthcare for London Report (2007):

- Services focussed on individual needs and choices
- Localise where possible, centralise where necessary

- Integrated care and partnership working, maximising the contribution of the entire workforce
- Prevention is better than cure
- A focus on health inequalities and diversity

She said that the meeting in September 2009 the NHS London vision for centralising specialist care and for delivering routine care outside of hospitals was discussed and public sector spending cuts accelerating NHS London plans and work by North West London PCTs which was likely to involve changes to hospitals.

HL said that in her view C&W was best considered as a specialist hospital also delivering local services. We are not a polyclinic, however, we have Dean Street, we are a teaching hospital and an elective surgery centre.

HL said that when the governors were asked if C&W should aim to be a specialist and local hospital the feedback was that we should promote the hospital as a specialist hospital for a range of services. Governors supported delivering specialist services, e.g. sexual health, over a broader geographic region.

On the question whether governors support C&W Trust in developing out of hospital care, the feedback was that we should develop services in polysystems. It was felt that acquiring community services was not core business, unless relevant to specific pathways, e.g. for children.

On the question of whether C&W needs to grow, if we should be acquiring a local hospital the feedback was that we would wish to consider this further and to understand the benefits particularly in relation to service synergies.

HL said she had discussed with governors if C&W should possibly acquire another hospital. It is been in the public domain that West Middlesex Hospital needs a partner or possibly to merge with another hospital.

HL said that Northwest London has developed a draft Integrated Strategic Plan and outlined their case for change, and she outlined the North West London sector conclusions so far for acute hospitals.

HL said that C&W had agreed 10% cost improvement for this financial year, which in her view was quite reasonable.

We have to make cuts and staff will find it challenging. We need to keep the double ‘excellent’ rating. As a result of changes to commissioning of education we might lose some training posts. We might get 30% of our tariff.

HL added that the Trust Board has refreshed the corporate objectives. These are as follows:

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

The Board agreed to add one additional high-level objective for 2010/11 that combines elements of the efficiency and sustainability agendas into a single objective. The provisional title of this new high-level objective is ‘ensure financial and environmental sustainability’.

HL asked for comments.

BG emphasised that there are some positive aspects as a consequence of the above changes. It is a great opportunity to improve healthcare and extend services into the community. He said there would be fewer emergency admissions if people were visited more at home.

CE said that he had met with Peter Molyneux, Chairman of Kensington and Chelsea PCT, to discuss the need to have a clear model on how polyclinic system might work. The hospital based approach is very expensive but patients need confidence in GPs and the question is how to build an interface between hospital and the community.

CE said that there is 0% uplift in the national tariff prices. There is also 3.5% efficiency requirement built into the trariff.

AMD asked when the Northwest London strategy was due to be finalised. HL responded that it should be published by March 2010. HL added that C&W is not dependant on North West London for its strategy but is dependant on our commissioners.

CBir asked about the objective on integrated care along care pathways and what that meant. HL responded that an example would be stroke care. For patients who have hand a stroke there is care pathway e.g. thrombolysis, CT scan, assessment within 24 hrs, physiotherapy etc. It is multidisciplinary and linked to primary care.

AMD said that in the Westminster there was a huge campaign on prevention due to start in June. CE commented that modern care is about prevention.

SM asked if we could use the Healthcare Charity Trust more. SN responded that she had met with the Charity recently and agreed information to go out in the newsletter. HL confirmed that the money donated to charity goes towards equipment only but not healthcare services provided.

2.2 Business Planning **HL**

This item was mainly covered in HL's presentation given earlier in the meeting. (item 2.1).

AK explained that QIPP (Quality, Innovation, Productivity and Prevention) was a DH banner covering what the NHS needed to do.

AMD commented that it is important for staff to understand their value. HL endorsed this and the importance of encouraging innovation.

BG asked if other governors have a role to play in the process e.g. decisions to be made. HL said that we had not had to make any hard decisions yet. She confirmed that when we are getting to crunch decisions, we will want governors to be involved.

HL added that we consult governors, and that an example would be whether we increase the car park charges; governors take the view that it should be free of charge.

FT asked about % of patients with alcohol problems in A&E. HL responded that about 30% of those come on Friday and Saturday night.

HL left the meeting.

2.3 Community Mobile Health Clinic – Projects **SN**

SN handed out a copy of the Mobile Health Clinic vehicle and announced the launch of the Community Mobile Health Clinic on 7 February 2010 at the Chelsea Football Club (CFC). She said that the mobile clinic was established with help from a pharmaceutical company, Abbot, who sponsored the project. We have now purchased the mobile health clinic, and the vehicle can be used by any service in the Trust. She added that Hammersmith & Fulham PCT have agreed to pay for clinical activity undertaken in the mobile clinic. We have two consultation rooms, 2 nurses, and some ground staff. The Mobile Clinic will be there for 4 hours. SN said that the aim was to access hard to reach groups in the community and to recruit members that we currently do not represent.

SN added that there will be good media coverage. John Hollins will be coming to the launch with his son Chris Hollins, who is a BBC presenter. An article about the launch was published in the Daily Mail last Thursday. SN said that John Hollins was previously a patient of the C&W Hospital and that that will be acknowledged in the campaign.

SN proposed to use three recruiters from Campaign Company to recruit new members. When asked about measuring the success of the project, SN answered that it would be difficult to prejudge but she felt that it would be worthwhile. She said that feedback and analysis of the project would be available weekly and it will compare static services against the mobile health clinic. She hoped that it should establish the way forward.

CE thanked SN and said this was a good way to explore the interface with the community.

WMW asked about possibility of unintended consequences. She felt that SN should focus on a small number of services to be offered. SN responded that the focus is on well persons screening, diabetes, BMI, smoking, cancer and cholesterol on request.

FT was concerned about the public coming from all over the England and not covering many of members from the local boroughs. SN responded that she talked to the PCT about it and that they were happy to treat patients even though they do not live locally.

WB asked about the use of the vehicle after the launch and where it would be parked. SN replied that there is designated space, it will arrive there prior to the match, and will be available for 4 hours and be removed afterwards. She confirmed that after the launch the vehicle would be taken to a secure area for parking.

WB suggested that the vehicle could be taken to the Duke of York Square.

SN proposed that the Council of Governors support funding of the Campaign Company for the membership recruitment cost of £3,539.10. The Council of Governors agreed.

2.4 Development of the Trust Website – presentation **MAk/GV**

MAk gave an overview of the development of the website project which was sponsored by the Council of Governors. He said that 35,000 people access the website every month and the number of users is on the increase. He pointed out that one of the reasons for the increase is that people use the internet to get information and also some areas had encouraged patients to use the website; one example is maternity and HIV which are the most used sections of the website. MAk added that there were two things that we introduced last year; one is to make appointments via the website and the other is a new dedicated section on the website for GPs and healthcare professionals.

GV gave a live demonstration of the new website design. The main points covered included:

- The redesign of the website has given it direction and focus and made it more visually appealing to patients.
- HIV appointments on-line
- Children's DVD
- Council of Governors page more consistent in quality and presentation
- On-line membership application form available – it has been noted that it is still in its old format but will soon redesigned.

RG felt that on the picture on the front the website looked great. However, she felt that the tone of a picture of a baby in NICU appearing under the maternity section was not appropriate. She also suggested that it would be useful to have some information available about how members made a difference e.g. to the way services are run.

2.5 Membership Sub-Committee

2.5.1 Membership Sub-Committee report **CBir**

CBir informed the Council of Governors that at the last meeting of Membership Sub-Committee it was announced that he was elected Chairman of this sub-committee. He said that the sub-committee lost 2 governors and that 2 new governors, namely SM and WMW joined the sub-committee.

He added that SN needs to finalise the newly approved membership leaflet following comments received from the sub-committee. The major point included that the OBE title be added to HL's name.

The sub-committee also discussed the Learning Disability Application Form which SN will draft soon. The Funding of the leaflet was discussed but was declined until draft copy had been received. CBir said that MAk said there were promised three new information screens to go live this week on the ground floor of the Hospital. He added that MAk mentioned the membership newsletter which would go to 15,000 members in April. MAk welcomed ideas on topics for inclusion in the membership newsletter.

CBir said that the sub-committee will have 6 meeting a year as their agenda is very long and that they will have one meeting to discuss membership development and in particular membership engagement. CBir hoped that Colin Glass, Non-Executive Director, would be available to attend that meeting.

NB said that she would like to note what a high quality publication Trust News is. It appeals to a wide range of audience and interests. She gave it whole hearted

support; it was money well spent.

2.5.2 Membership Report **SN**

SN said that the membership data was stable since the last report given in December 2009. She said that she needs to concentrate on communications and relationship with our current members. She added that in April mailing we will ask for an update on members contact details especially e-mails.

SN pointed out that affiliate members are not included in the total number and that they are not included in elections and therefore do not have voting rights. SN consulted governors whether they should be included in the membership. Some governors felt that they are useful group of members and that they should continue. CE concluded that they continue.

NB said that we have lots of members from the rest of the country and we would want to get wide audience.

WB suggested that it would be useful to have a break down of 22+ and 65+. AMD suggested that it would be useful to apply gender to age groups. **SN to provide.** **SN**

SN said that she will be working on developing a new category of members- Young Persons' Membership.

SSG queried that only 1 member left the membership. SN responded that that was the official information but that there might have been more members of which she is not aware yet.

CE said that he wished to emphasise the point re communicating with constituents which we nee to resolve.

2.6 Quality Sub-Committee report **CM**

CM said that the minutes of Quality Sub-Committee meeting held on 20 January 2010 were available and continued that it was their first meeting and she thanked every one who had attended and contributed.

2.7 Funding Report **VD**

VD said that part A of the funding report gave an update of the funds spent in 2009/10 from the Council of Governors budget.

VD updated the Council of Governors that at the last meeting held in December it was agreed that 15,000 would be provided for funding of the Open Day 2010. Also an additional charge of 155 relating VAT for the computer items was agreed.

VD said that approximately £82k was spent to date and that we will have approximately £19K remaining to be spent for this financial year.

CBir asked if money budgeted for the directory of Adults' Services was actually spent. VD responded that according to the report she received from the finance it looked as if it was spent. VD said that she would check this figure with the finance. MAk added that he was aware that some work on the Directory has started but though that hat it is not been completed.

VD to check if money budgeted for the Directory of Adults' Services was actually spent. **VD**

SN outlined that the proposal for the Learning Disability Membership Leaflet and informed the Council of Governors that the Trust needs to comply with indicators recently published by the Care Quality Commission with regards to support for people with Learning Disabilities. She added that the leaflet has not been developed yet and that it was discussed in the Membership Sub-Committee meeting and the funding of this leaflet was endorsed by the sub-committee providing SN sends a draft form to review.

It concluded that the Council of Governors will support funding of £1,304 for the development of the Learning Disability Membership Leaflet.

SN also proposed that the Council of Governors support funding of the membership recruitment campaign of £3,539.10 which was linked to the Trust's pilot of a Community Mobile Health Clinic. This was discussed earlier in the meeting item 2.3.

The Council of Governors agreed to report funding of membership recruitment.

3 ITEMS FOR INFORMATION

3.1 Finance Report – December 2009 LB

This item was taken as read.

3.2 Performance Report – December 2009 LB

This item was taken as read.

3.3 Care Quality Commission Registration CM

CM said that we submitted our registration with the Care Quality Commission (CQC). She felt that a suggestion to have it on the website was very good.

4 ANY OTHER BUSINESS

CE said that LB might want to communicate finance and performance reports in a slightly different way to the Council of Governors so that it is narrow and concise. LB said that it would certainly be useful to get some views from the Governors.

LB proposed that the future reports are more contextual.

5 DATE OF THE NEXT MEETING

The next meeting of the Council of Governors will be held on 21 April 2010 at 4.30pm.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 21 April 2010

AGENDA ITEM NO.	1.4/Apr/10
PAPER	Matters Arising from the meeting of the Council of Governors meetings held on 3 February 2010
AUTHOR	Vida Djelic, Interim FT 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.

MATTERS ARISING
Council of Governors Meeting
Hospital Boardroom
Chair: Prof. Sir Christopher Edwards
Date: 3 February 2010
Time: 4:30 – 6:30 pm

Ref	Description	Lead	Subsequent Actions or Outcomes
1.3	**Minutes of Previous Meeting held on 3 December 2009** **VD to amend minutes in line with comments received.**	**VD**	Completed
2.5.2	**Membership Report** WB suggested that it would be useful to have a break down of 22+ and 65 +. AMD suggested that it would be useful to apply gender to age groups. **SN to provide.**	**SN**	Included in the membership report.
2.7	**Funding Report** **VD to check if money budgeted for the directory of Adults' Services was actually spent.**	**VD**	The project is been undertaken and it is at the stage of the information collection. Not money has been spent yet and it is planned to be used for the design and printing stage, which will commence once the information collection stage is complete.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 21 April 2010

AGENDA ITEM NO.	2.2.1/Apr/10
PAPER	Quality Accounts Update
AUTHOR	Catherine Mooney, Director of Governance and Corporate Affairs
LEAD	Catherine Mooney, Director of Governance and Corporate Affairs
EXECUTIVE SUMMARY	This paper provides an update on progress with the Quality Account with a particular emphasis on stakeholder engagement and involvement.
DECISION/ ACTION	The Council is asked to comment on the engagement process and in particular if there are any gaps.

1. Introduction

This paper provides an update on progress with the Quality Account with a particular emphasis on stakeholder engagement and involvement.

2. Background

Quality Accounts are annual reports to the public from organisations which provide NHS services. They provide information about the quality of the services which the organisation delivers.

The public, patients and others with an interest will use a Quality Account to understand:

- what an organisation is doing well;
- where improvements in service quality are required;
- what the organisation's priorities for improvement are for the coming year; and,
- how the organisation has involved people who use their services, staff, and others with an interest in their organisation, in determining these priorities for improvement.

Quality Accounts aim to enhance accountability to the public and engage the leaders of an organisation in their quality improvement agenda.

The Council of Governors agreed to the creation of a Quality Sub-Committee which met for the first time in January 2010. Their remit includes helping identify priorities for quality improvement and advising on the content and structure of the Quality Account.

3. Identifying areas for improvement and prioritisation

A wide range of measures have been used to identify areas of concern. These include business planning sessions, focus groups, special reviews (e.g. maternity), Trust meetings such as Trust Executive Clinical Governance and the Nursing and Midwifery Advisory Committee (NMAC) and Trust data such as complaints and concerns and incidents. Areas identified in other Trusts were also considered. In addition staff views were determined using an online survey.

In order to help prioritise, criteria were identified. These are as follows:

- Initiatives associated with CQUINS (Commissioning for Quality and Innovation) to have priority as they are associated with funding.
- Indicators/priorities relate to where we have knowledge of areas requiring improvement e.g. through incidents, claims and complaints
- Evidence based methods for improving care e.g. Patient Safety First initiatives, care bundles
- Policy drivers e.g. High Impact Changes for Nursing
- National surveys e.g. outpatients
- Keep change to current priorities to a minimum – need to embed initiatives and recognise that quality is a journey

The Quality Sub-Committee considered a paper which listed all the concerns that had been identified from the sources described above.

4. Staff engagement – survey

The staff governors initiated a survey and the four questions that were asked and the themes from the answers from 29 members of staff are seen in the table below.

Question	Themes from responses
Have you noticed anything in the last year affecting patients' safety that the Trust should be working on?	Availability of notes ; infection control and cleanliness ; administrative support and IT; security of patients; slippery floors; discharge into social care; medical devices training
Have you noticed anything in the last year affecting patients' experience that the Trust should be working on?	Workload of staff; privacy and dignity; appointment waiting times; signage; lifts; building work on Fulham Road; reception staff customer care; PET – staff influencing the questions; side room availability; patient moves; up to date website
Is there anything specifically you have done as an individual or as a member of a team in the last year that has improved patients safety?	Observation charts; chased up and corrected appointments to prevent delays; pointed out things that are wrong; developed patient information leaflets; audited handover and Urinary Tract Infection; highlighted risks to staff about using equipment they are not trained for
Is there anything specifically you have done as an individual or as a member of a team in the last year that has improved patients overall experience?	Worked unpaid overtime; came in when snowed; good team work; planned discharges; DNA audit ; monitored waiting times and diverted resources if increasing; called people back; provided directions; opened doors - being courteous; changed the way complaints are dealt with; given flexible appointment dates

5. Other factors

The writing and clarification of progress on the quality objectives has led to changes in the focus of some objectives. These are explained in the account e.g. the objective for venous thromboembolism has been changed from a 'reduction of 15%' to 'implementing strategies to work towards no preventable VTE'.

6. Outcome

The Board will make the final decision on the Quality Accounts but progress to date suggests that we will retain the three priorities from last year although with some changes in focus, and possibly add in a fourth priority relating to falls. Based on feedback, we have also included further indicators of quality (safety, effectiveness and patient experience) in the Quality Account. We are currently confirming that data is available before these are published.

An important consideration is how to address the other areas for improvement that have been raised. An example is discharge which was raised as an area of concern by the Quality Sub-Committee and this was supported by the NMAC. The Trust executive have recently received a report and agreed further actions and it is an area covered by CQUINs. We will be working on this further with the governors and the operational lead will be invited to the Quality Sub-Committee to agree the best approach.

A number of indicators have been suggested for which we have no centrally available data but we will work on systems to collect and monitor these with a view to incorporating into next years Quality Account. An example is patient moves i.e. the number of times patients are moved from one ward to another, which is related to infection control as well as patient experience.

7. The Quality of the Quality Account

There are some elements of quality assurance built into the process e.g. the requirement for the PCT to comment. However we have, through the Quality Sub-Committee, asked governors to read and comment on the various sections, not only for readability but also to consider if we have adequately and fairly described our progress. This has been extremely valuable and their time and prompt responses is much appreciated.

8. Next steps

The PCT and Local Involvement Area Networks (LINKs) have been sent a draft for comment. The draft Quality Account will be considered by the Board in April with the final approval in May 2010.

9. Action required from the Council of Governors

The Council is asked to comment on the engagement process and in particular if there are any gaps.

Catherine Mooney
Director of Governance and Corporate Affairs

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 21 April 2010

AGENDA ITEM NO.	2.2.2/Apr/10
PAPER	Draft minutes of the meeting of the Council of Governance Quality Sub-Committee held on 26 March 2010
AUTHOR	Vida Djelic, Interim FT Secretary
LEAD	Catherine Mooney, Director of Governance and Corporate Affairs
EXECUTIVE SUMMARY	This is a draft of proceedings at the meeting held on 26 March 2010
DECISION/ ACTION	The Council is asked to note the draft minutes.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Quality Sub-Committee, 26 March 2010

Draft Minutes

Attendees:	Chris Birch	CB	Patient Governor
	Carol Dale	CD	Staff – Staff Governor
	Susan Maxwell	SM	Patient Governor
	Martin Lewis	ML	Public Governor - Westminster 2
	Cyril Nemeth	CN	Appointed Governor - Westminster City Council
	Jim Smith	JS	Patient Governor
	Mike Anderson	MA	Chair, Medical Director
	Andrew MacCallum	AMC	Director of Nursing
	Elaine Manderson	EM	Clinical Nurse Specialist in Intensive Care
	Catherine Mooney	CM	Director of Governance and Corporate Affairs
	Vida Djelic	VD	Interim FT Secretary

Prior to the start of the meeting CM circulated a copy of FTGA's Headline Brief: Quality Accounts and asked the sub-committee to read it before the meeting commenced, as it gave some useful background on the role of governors in Quality Accounts.

1 Welcome and Apologies

Apologies were received from Wendie McWatters, Rosie Glazebrook and Sandra Smith-Gordon.

CM introduced Elaine Manderson to the sub-committee and explained that she will be assisting with the quality accounts. Elaine is a Clinical Nurse Specialist in Intensive Care. CM invited governors to introduce themselves.

2 Minutes of pervious meeting

Minutes of the previous meeting were accepted as a true and accurate record with the following changes:
- the Trust staff attended rather than in attendance
- p.2 last para should read AMC instead of MAC

3 Matters Arising

CM said that her actions were covered in the briefing paper.

5/Jan/10 Quality Accounts – how to present progress (productive ward messages) and communication
CM said that arranging input into the mock up would be done when draft reports were available.

4 Update on Quality Accounts

CM gave an update on Quality Accounts. The requirements were published in February 2010. We are currently on the draft three and are working on the information given so far. There is a Quality Accounts Toolkit which is advisory guidance for producing quality accounts. Governors were interested in seeing the toolkit. **VD to send a link to the sub-committee.** **VD**

CM said that the FTGA's Headline Brief on Quality Accounts was very helpful. We agreed our priorities last year but have a bit of flexibility to change them.

CN asked if there were any significant comments from the submission made last year. CM responded that we did not submit quality accounts last year but we did do a Quality Report as part of the Trust's Annual Report 2008/09. However, Monitor did not provide a commentary.

CM added that this year we will have to publish the accounts and they will be reviewed by auditors. It is likely that they will look at the process as well as content.

CM clarified that the DH requires Trusts to produce Quality Accounts, whereas Monitor requires additional information in the form of a Quality Report.

ML asked which stakeholders have been involved. CM said staff, via a survey, Council of Governors, Council of Governors Sub-Committees and clinical staff are involved.

To SM's question regarding communication with members CM responded that we have identified who we should liaise with. CM suggested that it would be a good idea to look at the results of the GP survey to see if anything identified of relevance. CM introduced the idea of the 'survey monkey'.

CD suggested that we keep the survey to four questions. AMC agreed. CM said that the survey is anonymous but there is an option to include the name. CM said that there is an incentive to complete the survey of £50 voucher.

5 Quality Accounts Briefing

CM invited governors to discuss priorities outlined in the document. She explained some of the initiatives in more detail.

An important consideration is Commissioning for Quality and Innovation (CQUIN). CM said that funding is linked to achievement of

targets.

CM said that there are two national CQUINs.

1. VTE
2. Improve responsiveness to personal needs of patients, which was composite indicator. JS asked how these were measured. AMC said that these are related to the national patient survey which contained some elements that we already measure.

MA said that for VTE we get £300,000 if we get the risk assessment done. We chose VTE as one of our priorities so we feel confident we can achieve it.

Regional CQUINs
1. Global trigger tool - is a tool used to measure harm through review of notes.

2. Enhanced recovery programme
MA explained that this referred to an evidence based process relating to some elective surgery which meant patients get better quicker.

3. Increase effectiveness of inpatient discharge information

4. Effective discharges
MA explained that one element related to changes in drug therapy while in hospital and ensuring GPs are aware.

MA pointed out that we need to work better with social services. CM said that there was a meeting at which discharge was discussed and it was agreed at that meeting to ask HL to take it further.

ML asked how we are tracking it at the present. MA responded that the Trust has a discharge team which monitors it.

5. Outpatient care planning

6. Dementia pathway

7. Improve care safety and experience of patients with long-term conditions

Local CQUINs agreed with PCTs
Medicine reconciliation is one proposal currently.
CM said that medicines reconciliation is about assuring that patient drug therapy on admission is correct, i.e. reconciled with GPs records. This also applies to discharge.

High Impact Actions for Nurses and Midwives
CM said that AMC was at a meeting last week where falls, pressure ulcer and catheters reduction in use were discussed.

CM stressed that we have to set our priorities for next year. These include objectives and indicators.

CM commented that during the last two months we have had some serious falls, and this was an area to consider.

CM said that the Trust's current priorities are:

- Patent Safety (to reduce VTE rate by 15% in the next year)
- Patient Experience (to ensure that 90% of women have an 'Excellent' experience of our maternity services)
- Clinical Effectiveness (to reduce delays of more that 24 hours to selected non-elective urgent surgery)

CM said that the Trust Board has chosen 9 indicators to measure the Trust's performance.

CM said that we are reviewing if the CQUINs where achievable. ML added that in the short term some are not achievable. She said that resources also need to be considered and the cost: benefit ratio. CM added that there will be need for data collection.

MA said that the Trust needs to make changes on the discharge summary and we now have a 24 hours target i.e. 90% discharge summaries will have to be completed within 24 hours. There was a discussion on discharge and JS suggested that we should invite the discharge group to come to one sub-committee meeting and Hannah Coffey, Director of Operations. AMC said we need to work on some indicators about discharge. SM suggested that data collected this year could be ready for next year.

CM invited some comments.

SM asked what the main problem was regarding falls. MA responded that it is to do with vulnerable patients and the risk they are exposed to, e.g. typically on the way to the toilet.

CM invited the governors to volunteer to review sections of the report and the following has been agreed:

Jim Smith – indicator 9
Susan Maxwell – indicator 2
Martin Lewis – indicator 3&5
Carol Dale – indicator 2&4
Chris Birch – indicator 7&8

CM and EM will contact Sandra Smith Gordon, Rosie Glazebrook and Wendie McWatters to find out which indicators they would like to cover. **CM/EM**

6 Feedback from Governors on patient experience

Each governor to ask five friends/contacts for feedback on their experience. **All**

7 Priorities for safety, effectiveness and patient experience

This item was covered in the previous item.

8 Next steps

Report to be sent out for comments. **CM**

9 Any other business

None.

10 Date of next meeting

The next meeting will be held on Wednesday, 19 May 2010 at 4pm.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting , 21 April 2010

AGENDA ITEM NO.	2.2.3/Apr/10
PAPER	Patient Experience Tracker
AUTHOR	Andrew MacCallum, Director of Nursing Sian Nelson, Membership and Engagement Manager
LEAD	Andrew MacCallum, Director of Nursing
EXECUTIVE SUMMARY	This paper describes progress on the implementation of the Patient Experience Tracker. Phase I of the implementation of the Patient Experience Tracker started in May 2009 and included all in patient adult and post natal wards. Phase II started in November 2009 with the inclusion of outpatients and other departments. The paper contains aggregated satisfaction scores for Phase I that shows an overall satisfaction rating of 86%.
DECISION / ACTION	The Council of Governors is asked to note the information.

PATIENT EXPERIENCE TRACKER

1.0 Introduction

1.1 The Patient Experience Steering Group (PESG) has been established to manage the outputs from the Trust's contracts with Dr Foster and Picker Europe. The Terms of Reference is attached in Appendix I.

1.2 The PESG has met monthly since April 2009. The dominant activity of the Group during this period has been the implementation of the Patient Experience Tracker (PET).

1.3 The Patient Experience Improvement Group (PEIG) is the key group for coordinating patient feedback activity, particularly, agreeing and tracking the actions taken in response to feedback. This group meets quarterly and there have been three meetings since April 2009.

1.4 The Trust has set an ambitious target of achieving an 80% response rate for the PET. A 40% response rate has been agreed with Kensington and Chelsea PCT as a CQUIN with a value of £110,000.

1.5 The Trust in March 2010 achieved a response rate of 76% thus achieving the locally set CQUIN target.

2.0 Progress to Date

2.1 Implementation of the Patient Experience Tracker

2.2 Information and communication were identified as issues in the In-Patient Survey 2008. As such, it was decided that the five questions on the Patient Experience Tracker for the adult wards would focus on questions relating to communication including seeking the views of patients on the overall quality of care they have received. This decision was made following consultation with members of both the PEIG and PESG.

PHASE I

2.2.1 Adult Ward Questions

	Questions				
1.	Were you kept well informed about your care and treatment by staff during your stay?	Always	Most of the time	Sometimes	Seldom
2.	Did you feel involved in decisions made regarding your care and treatment?	Always	Most of the time	Sometimes	Seldom
3.	Did staff answer your questions in a way that you could understand?	Always	Most of the time	Sometimes	Seldom
4.	Were the staff friendly and approachable?	Always	Most of the time	Sometimes	Seldom
5.	Overall how would you rate your experience on this ward?	Always	Most of the time	Sometimes	Seldom

2.3 13 In-patient Adult wards have been using the PET since June 2009. Each week the Sister/Charge Nurse of the ward receives the report via email. This report also goes to the Matron / Clinical Nurse Lead (CNL). The monthly report is sent to all CNLs and General Managers.

2.4 Since June 2009 the adult in-patient wards show an overall volume response (response per question) of 21490 with overall volume response (response per person) of 4298. The overall patient satisfaction score was 86% against a target score of 90%.

2.5 The charts below shows the overall patient response (since June 2009) for all questions asked. Satisfaction is calculated by giving each rating (i.e. always most of the time etc) a value (i.e. Always 100 Most of the time 75 etc) which is then multiplied by the number of responses. This gives a score for each rating. These scores are then added up to give a total score for each question. This score is then divided by the total number of responses to the question which gives the satisfaction score as a percentage.

Fig 1 Were you kept well informed about your care and treatment by staff during your stay? Satisfaction rate: 85%

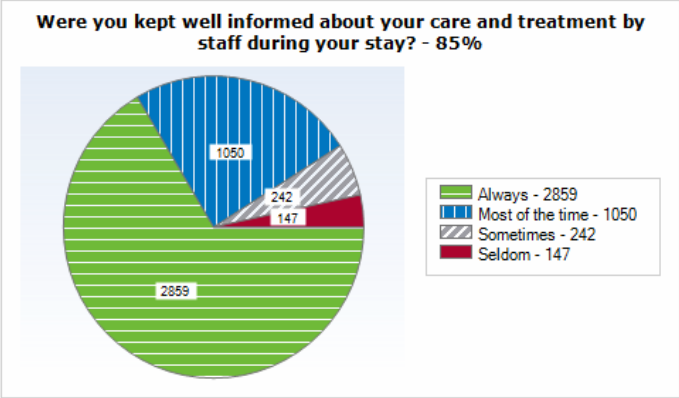


Fig 2 Did you feel involved in decisions made regarding your care and treatment? Satisfaction rate: 81%

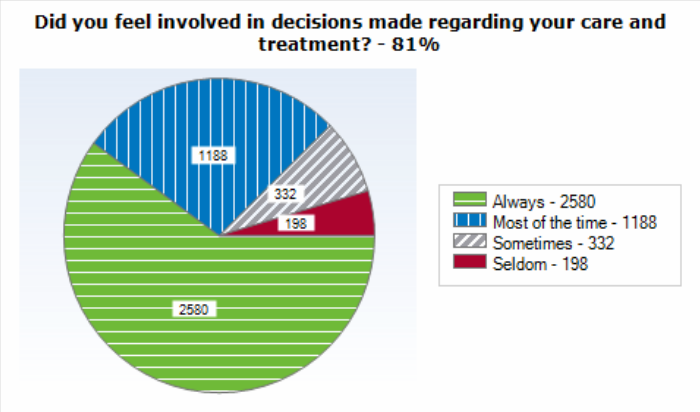


Fig 3 Did staff answer your questions in a way that you could understand? Satisfaction rate: 88%

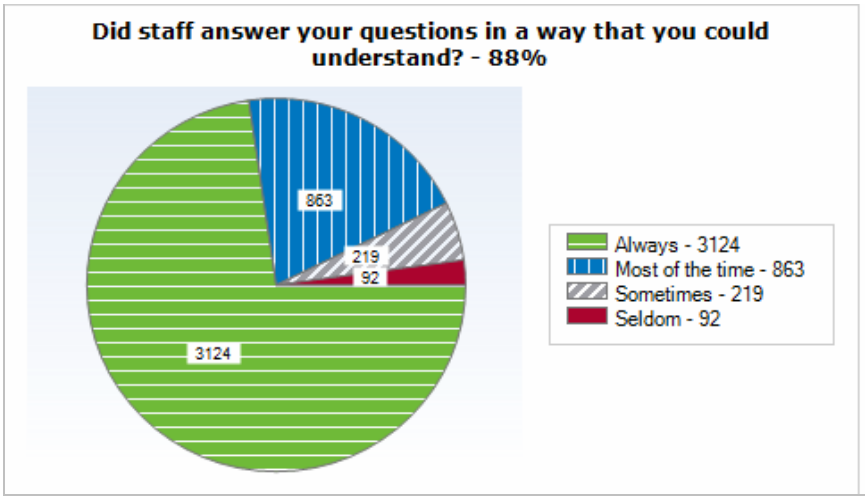


Fig 4 Were staff friendly and approachable? Satisfaction rate: 90%

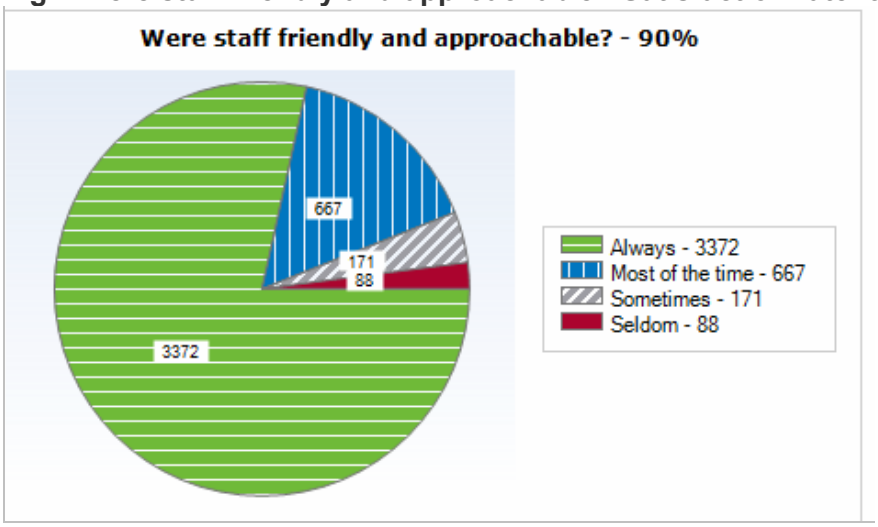
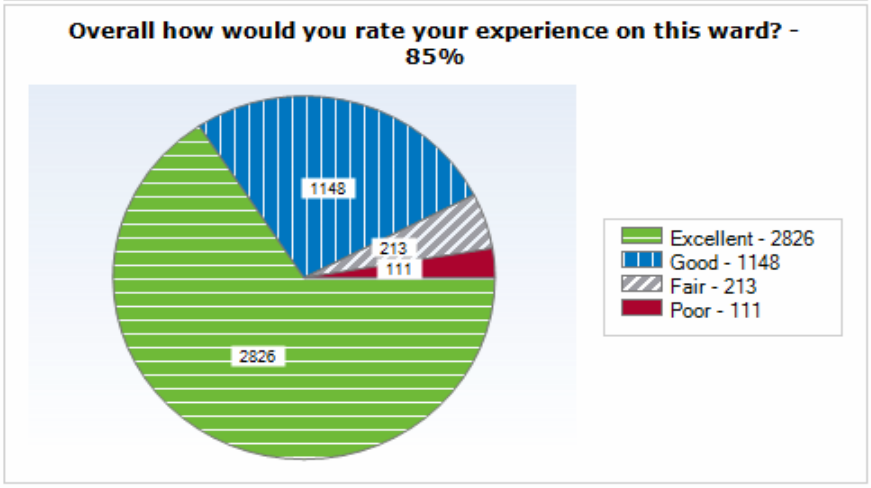


Fig 5 How would you rate your experience on this ward? Satisfaction rate: 85%



2.6 Post-natal Ward Questions

2.6.1 Questions for the post-natal ward were chosen as a result of the feedback obtained through the Maternity Project (McKinsey – Monitor).

	Questions				
1.	Do you feel the ward is clean enough?	Always	Most of the time	Sometimes	Seldom
2.	Did you feel welcomed when you arrived?	Always	Most of the time	Sometimes	Seldom
3.	Did you get information you could understand?	Always	Most of the time	Sometimes	Seldom
4.	Were the staff kind and caring?	Always	Most of the time	Sometimes	Seldom
5.	Overall how would you rate your experience on this ward?	Always	Most of the time	Sometimes	Seldom

2.6.2 Since the implementation PET in June 2009 the post-natal ward has shown an overall volume response (response per question) of 9585 and a response per person of 1917. The overall patient satisfaction score was 82% against the target of 90%.

2.6.3 The charts below show the overall patient response (since January 2010) for all questions asked.

Fig 6 Do you feel the ward is clean enough? Satisfaction rate: 77%

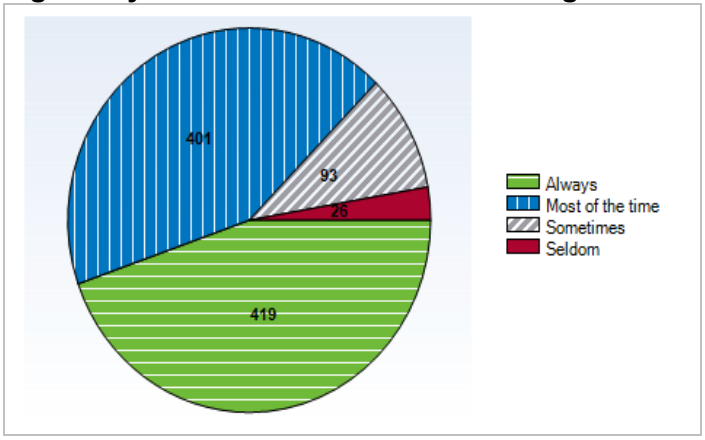


Fig 7 Did you feel welcomed when you arrived? Satisfaction rate: 85%

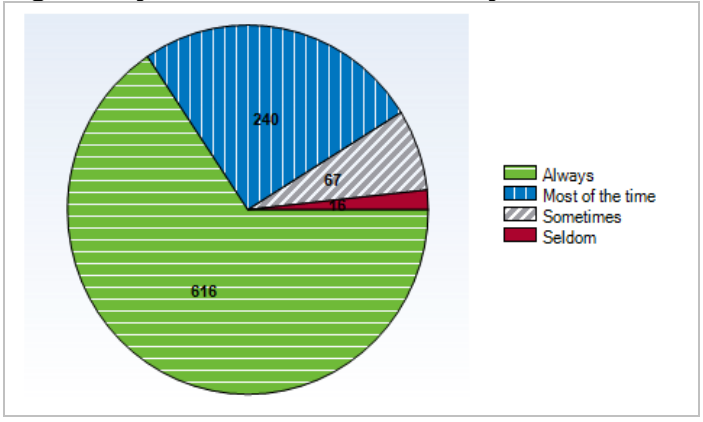


Fig 8 Did you get information you could understand: 85%

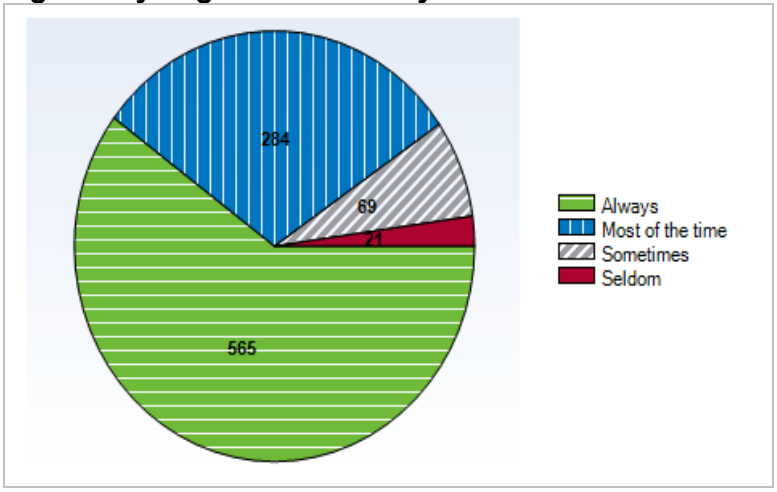


Fig 9 Were staff kind and caring? Satisfaction rate 84%

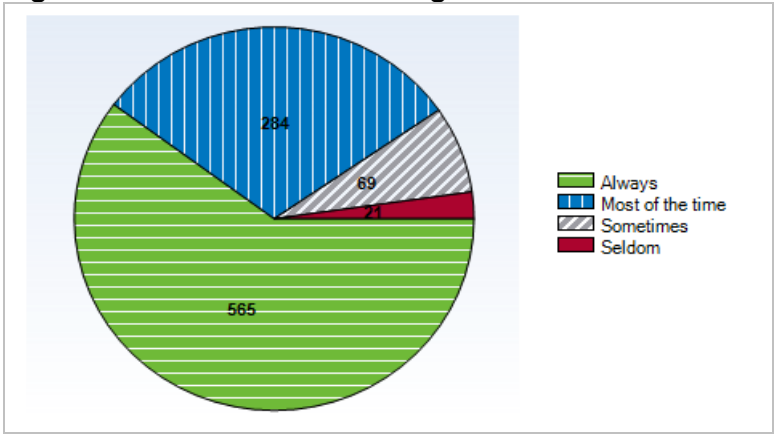
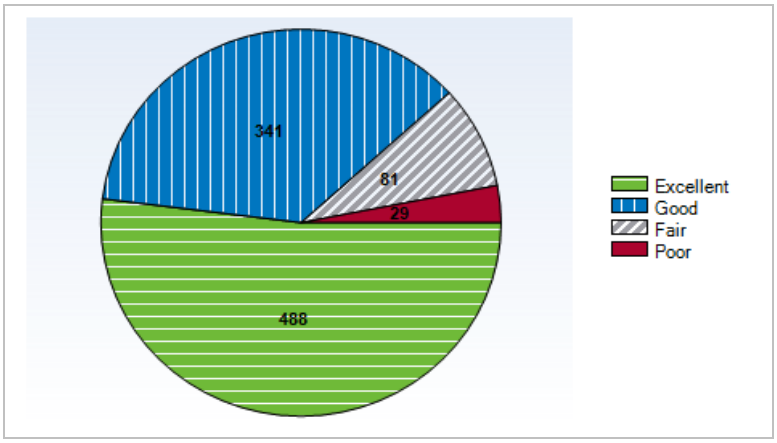


Fig 10 Overall, how would you rate your experience on this ward? Satisfaction rate: 79%



PHASE II

2.7 Implementation to Outpatient and Non-Ward Areas

On 25th November 2009 16 PETS were rolled out in Outpatients, NICU, Paediatric ward and non-ward areas. All areas received training and received their PET device. Patient recruitment was implemented on 26th November. The graph below shows the patient respondent numbers since implementation of Phase I PET.

2.8 The five questions for these areas are (Fig 11 and Fig 12)

Fig 11 **Current Patient Tracker Question in the NICU Clinic**

1.	Were the staff friendly and approachable during your baby's admission to the unit
2.	Did you feel adequately informed about your baby's progress during your stay
3.	Were you satisfied with the facilities available for you as a parent on the unit
4.	Were you satisfied with the clinical environment where your baby was cared for?
5.	Did the staff prepare you well for taking your baby home?

Fig 12 **Current Patient Tracker Question in the Adult Outpatient Clinic**

1.	How would you rate the process of booking of your appointment?
2.	How would you rate the level of waiting time for your appointment?
3.	Were staff friendly and approachable in outpatients today?
4.	How would you rate the level of information supplied about any future appointments or treatment?
5.	Were your questions answered in a way that you could understand?

2.9 The charts below shows the overall patient response in Phase II areas (since January 2010) for all questions asked.

2.10 Since November 2009 the NICU wards show an overall volume response (response per question) of 60 with overall volume response (response per person) of 12. The overall patient satisfaction score was 84% against a target score of 90% (Fig 13. 14. 15. 16, 17)).

Fig 13

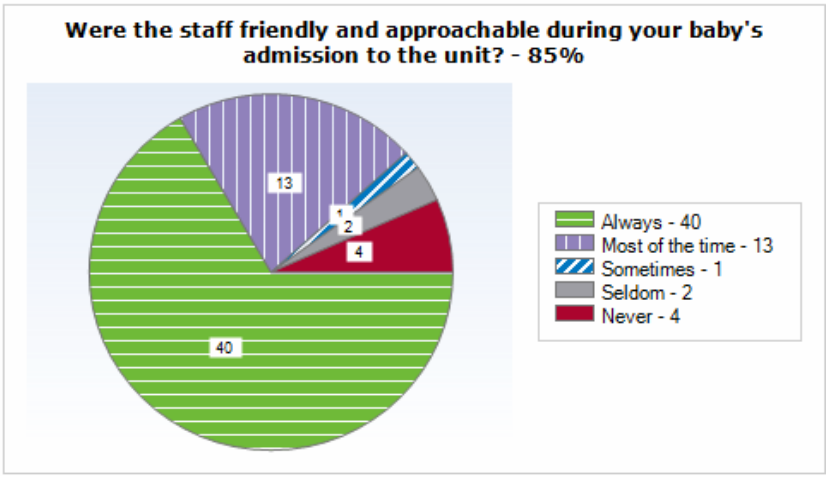


Fig 14

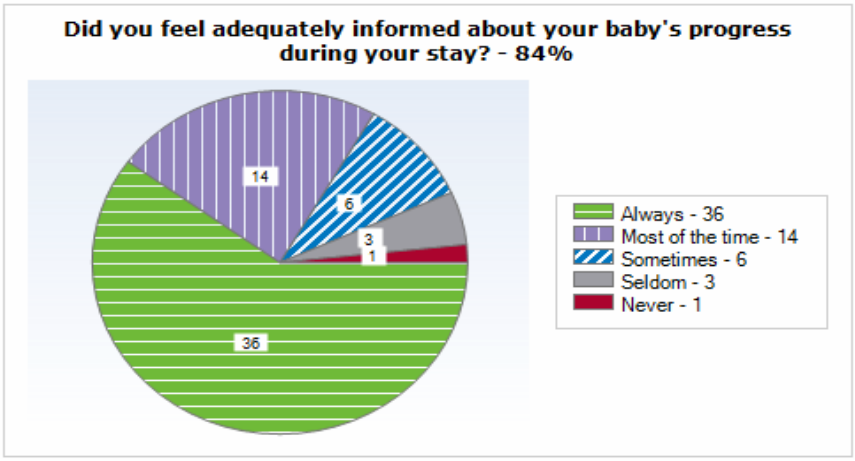


Fig 15

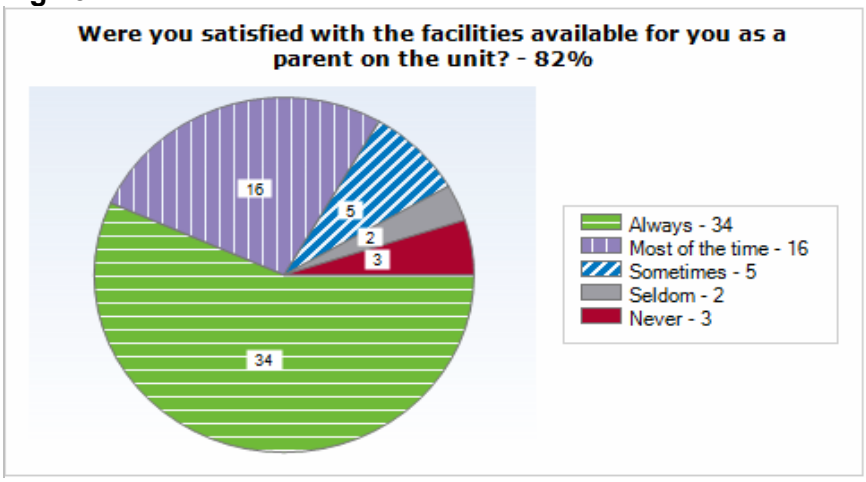


Fig 16

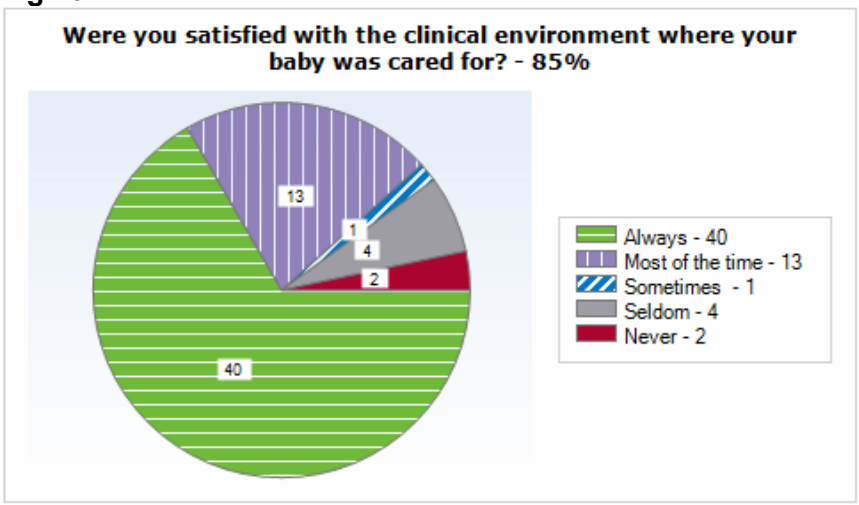


Fig 17

2.11 Since November 2009 the Adults Outpatients Departments wards show an overall volume response (response per question) of 15,590 with overall volume response (response per person) of 3,118 to January 2010. The overall patient satisfaction score was 83% against a target score of 90% (Figs. 18,19,20,21,22)).

Fig 18

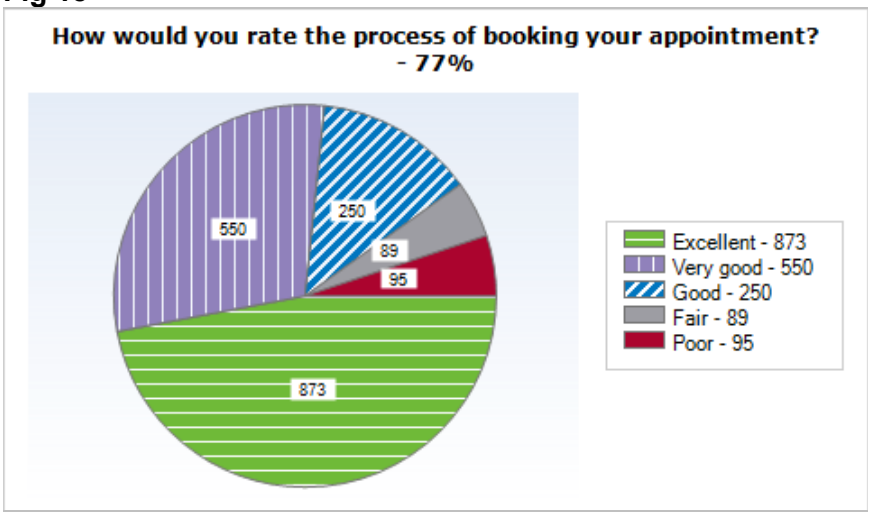


Fig 19

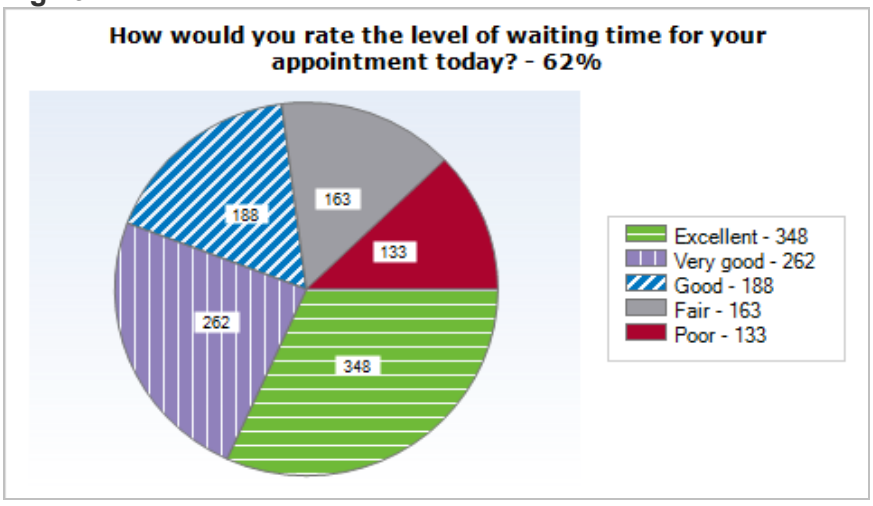


Fig 20

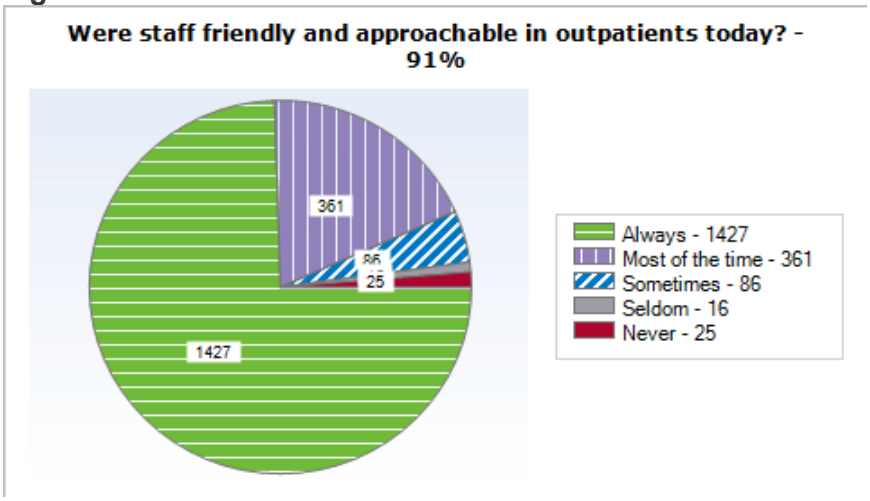


Fig 21

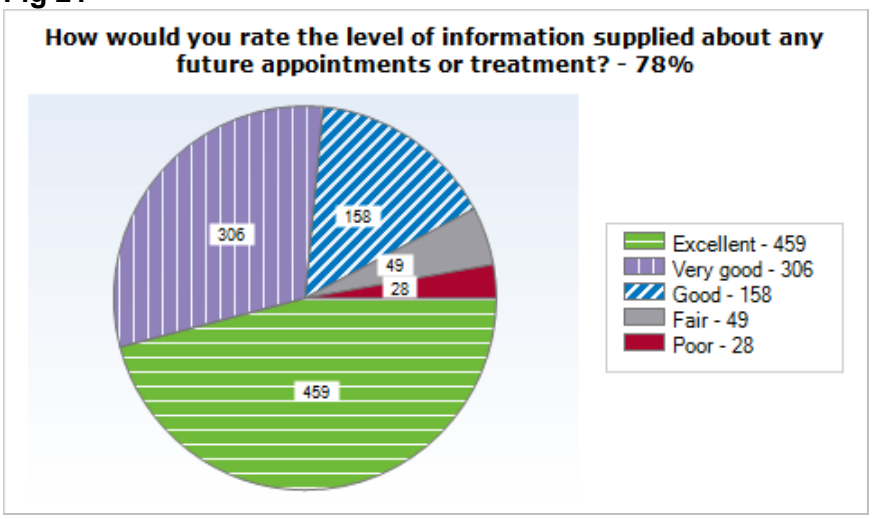
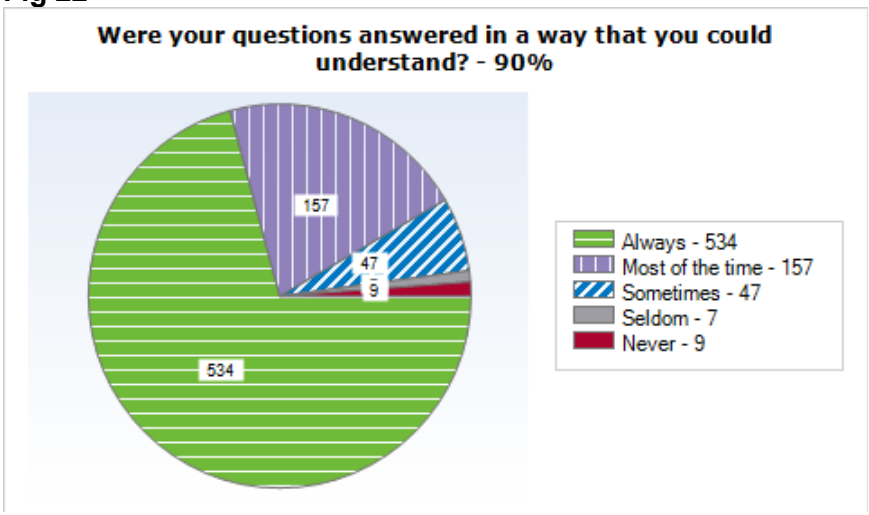


Fig 22



2.12 Since November 2009 the Emergency Department show an overall volume response (response per question) of 1,750 with overall volume response (response per person) of 352. The overall patient satisfaction score was 85% against a target score of 90%.

The five questions asked in this are:

Fig 23 Current Patient Tracker Question in the Emergency Department

1.	Was your privacy maintained through your visit?
2.	Were you able to question staff on your condition and treatment?
3.	Based on your experience would you recommend us to others?
4.	Were you updated of expected waiting times?
5.	Was your pain controlled throughout your stay?

Fig 24

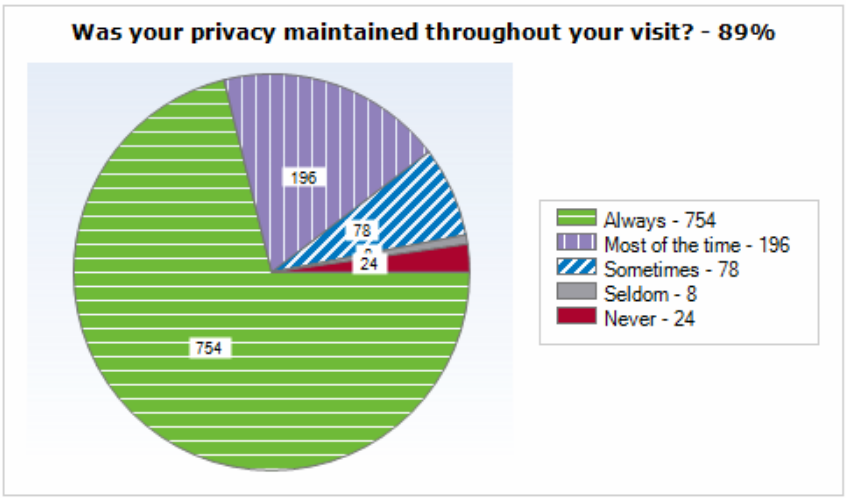


Fig 25

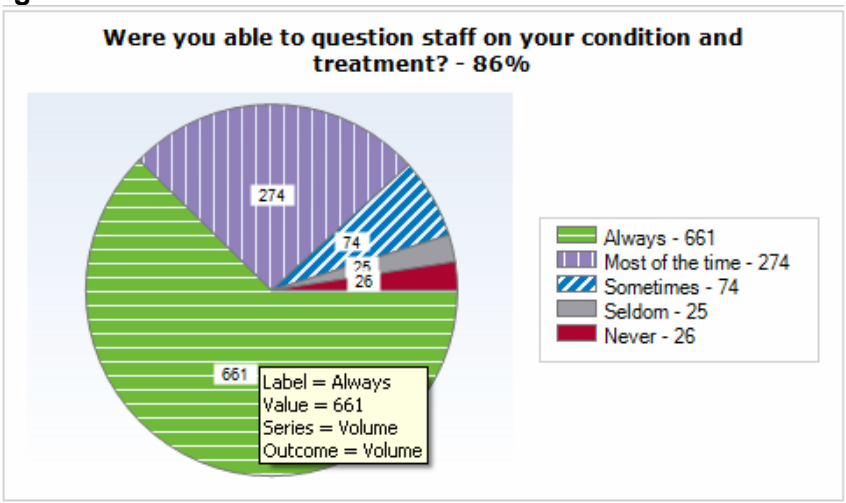


Fig 26

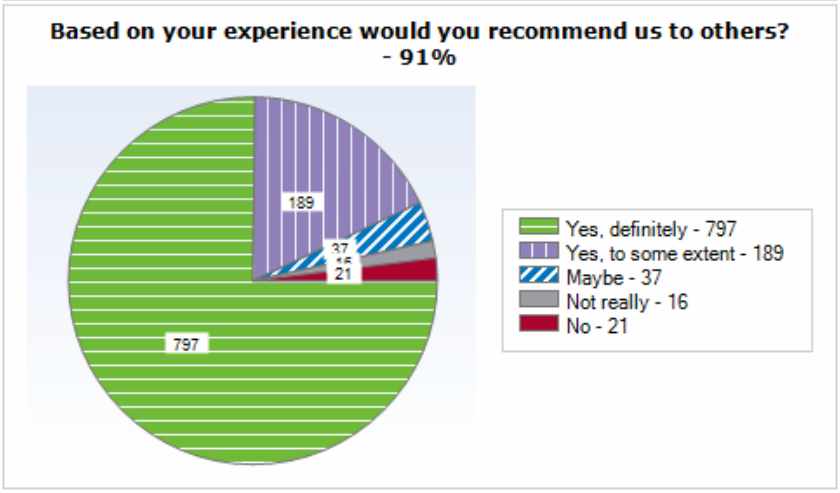


Fig 27

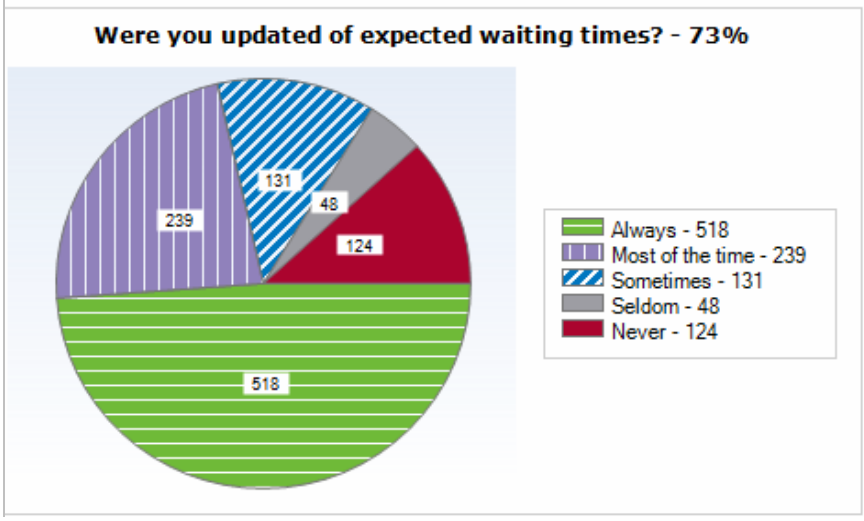
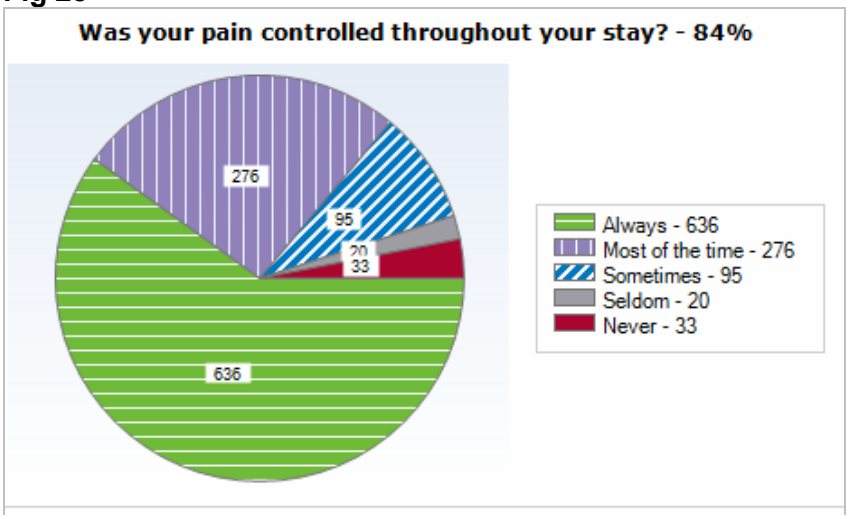


Fig 28



3.0 Conclusion and Next Steps

3.1 Obtaining sufficient responses form patients to ensure the validity of the PET survey has been a key challenge since the introduction of PETs to the Trust. However over the last three weeks the Trust has achieved a 76% response rate will exceeded the locally set CQUIN and within striking distance of the Trusts own target of 80%.

3.2 In March 2010, 'Dr Foster', the company that operates PETs ran four workshops for 41 staff; the workshops were designed to share best practice on using the PET in clinical areas but importantly also allowed staff to give feedback. The key messages from staff where about being involved in the selection of survey questions in the future and that questions should be directly relevant to the clinical area.

3.3 An important part of the workshops were on how feedback is vital to patients on what wards and departments have done in response to the feedback they have received.

3.4 The Trust's forthcoming Quality Account will make reference to how the PET will be used to track progress on five key areas linked to national CQUIN which are: patients involvement in decision making; patients ability to discuss cancers with staff, privacy when discussing concerns, information on the side effects of medicine, information on discharge.

Andrew MacCallum, Director of Nursing
Sian Nelson, Membership and Engagement Manager
April 2010

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 21 April 2010

AGENDA ITEM NO.	2.3.1/Apr/10
PAPER	Draft minutes of the meeting of the Council of Governance Membership Sub-Committee held on 8 April 2010
AUTHOR	Vida Djelic, Interim FT Secretary
LEAD	Chris Birch, Chairman
EXECUTIVE SUMMARY	This is a draft of proceedings at the meeting held on 8 April 2010
DECISION/ ACTION	The Council is asked to note the draft minutes

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Membership Sub-Committee, 8 April 2010

Draft

Present	Chris Birch	CB	Chairman
	Martin Lewis	ML	Public Governor – Westminster 2
	Susan Maxwell	SM	Patient Governor
	Jim Smith	JS	Patient Governor
	Sandra Smith-Gordon	SS-G	Public Governor – Kensington & Chelsea 2
In attendance	Priti Bhatt	PB	Equality and Diversity Manager
	Colin Glass	CG	Non-Executive Director
	Jonathan Upton		The Campaign Company
	Renae McBride	RMB	Editor of Trust News/Communications Manager
	Sian Nelson	SN	Membership and Engagement Manager
	Andrew MacCallum	AMC	Director of Nursing
	Catherine Mooney	CM	Director of Governance and Corporate Affairs
	Matthew Whiting	MW	M-PALS Officer
	Vida Djelic	VD	Interim FT Secretary

1. Welcome & Apologies **CB**

CB said that apologies were received Wendie McWatters who had her knee injured while on holiday.

CB informed the sub-committee that June Bennett left the Council of Governors and that he wrote a letter to her to thank her for her contributions.

CB welcomed Colin Glass, Non-Executive Director and Jonathan Upton of the Campaign Company to the Membership sub-committee meeting.

2. Minutes of previous meeting held on 26 January 2010 **CB**

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

- p3, item 4 Matters arising, 1st line should read 'letters were' instead of 'letters was'
- p3, item 4 Matters arising, 4/Nov/09, 7th para, 2nd line should read 'mailing Trust News' instead of 'it'
- p7, item 8 Community Mobile Health Clinic, 9th para should read 'supported the request' instead of 'approved funding'
- p9, item 12 Council of Governors Election, 3rd para, 3rd line

should read 'seats' instead of 'sets'
- p9, item 12 Council of Governors Election, 4th para delete the last sentence which reads: 'The committee felt,….'

3. Matters Arising **CB**

4.2/Jan/10 Welcome Pack Letter
SN said that she circulated a draft letter which was tabled at 26 January 2010 meeting. **AMC said that SN should circulate a revised draft welcome pack letter.** **SN**

7/Jan/10 Learning Disability Membership Application Form
SN said that the action was been clarified and completed.

4. Membership Engagement **CB/AMC/SN**

SS-G raised her concerns about the website based membership form which has not yet been updated to reflect comments raised at the previous sub-committee meeting regarding different categories for the membership that the Trust has. SN said that the process of developing the website has not yet been completed and that it will be completed soon.

CG commented that the Thrust's website performance was poor when he last accessed it.

AMC gave a presentation on the Membership Development and Communications Strategy and outlined the importance of refreshing the strategy and having a plan on how to engage with members.

AMC said that the key aim for the Trust is to build and maintain a vibrant membership. He said that we are required by Monitor to have representatives from public, patient and staff constituencies. He added that the Trust is aware that young people are underrepresented and that we should look at the ways of making it more attractive for young people to join considering that we are in a relatively affluent area.

AMC outlined the main objectives:

- Recruitment – we need to ask members which area they are interested in;
- Membership engagement - we want to demonstrate why public and patients should be involved
- Communication with members – examples include Open Day 2009, Annual Members Meeting 2009, election 2009
- Measurement and evaluation of success

AMC presented slide 3 regarding diversity of the membership.

CB added that membership was below 1% of the population in six of our eight public constituencies. He suggested that we should seek help from Mary Symons who is a public governor from Wandsworth 1 Constituency.

CB said that he circulated a paper titled the Membership Engagement

regarding the current situation about the membership engagement and some suggestions. He pointed out that we engage with a tiny minority of our members which counts around 15,000 and that we should look at ways to improve it.

CB introduced the slide 9 which referred to public constituencies and pointed out that we are underrepresented in Kensington & Chelsea Area 1, Hammersmith & Fulham Area 1 and Wandsworth Area 2.

CB informed the sub-committee that he contacted his friend who lives in Kensington & Chelsea Area 1 and had sent him the application form hoping that he could help either by being interested himself to stand at the next election or suggest to somebody else. He suggested that other Governors could do a similar exercise.

CB felt that there has not been a great use of the Information Zone and suggested that we could get 1 or 2 patient governors there who could listen to patient complaints and provide answers. He said that similar attempt was made in 2008 and that it was not a great success. However, he felt that we should repeat it this year.

CB added that Carol Dale, Staff Management Governor held a meeting in the staff constituency and only 5 managers attended.

CB said that we are currently under our recruitment target.

CB said that he checked membership figures and that in 2009 total membership grew 18% as a result of opt out. He said that we lost 749 public and patient members in just under two years. According to figures there has been a steady decline despite all our efforts to recruit more members.

SN said that she has had an updated membership profile and handed out a copy. She agreed with CB that there has been a steady decline in public and patient numbers.

Jonathan Upton from the Campaign Company introduced himself and gave a presentation on how well we know our membership. As a way of introduction he said that the Campaign Company has been supporting the Trust since it become the foundation trust and also works with other 70 foundation trusts in the UK. He identified that all of trusts he has a contact with have a problem with how to make it easy for members to join. He said that motivation to join was the key and what we might do to motivate people to join.

JU pointed out that a small number of people would naturally join an organisation if they have been asked. However, many more people would join if asked in the right way. The starting point might be finding out if people are interested in joining, whether they are members of any other organisations, if they are then they are more likely to join. It is also of importance to find out what position these people hold in organisations that they are already members of. Once we have identified our potential members we would then want to get an insight into their behaviour so that we identify reasons for such behaviour and what motivates them. He stressed that it is very important to

understand people and their interests rather that just targeting the recruitment process.

CG said that he had a very different view of the membership and felt that the main purpose is to identify what we do and suggested that we need to consider the following points:

- How the hospital is managed in a statutory way
- Patient experience (MPALS)

CG then suggested that we need to consider the purpose of members and how to motivate them.

CB pointed out that as far as Monitor is concerned it is important to have required membership number.

SN said that she agreed with CG's views and that we need to engage with the current members and we need to look at ways how we achieve this. She felt that it would be a good idea to achieve both the required number by Monitor and successful engagement.

ML said that he agreed with CG but was concerned with underrepresentation of certain groups on the membership, lack of black and other minorities and lack of young people being represented.

JS thought that we should not pursue people to sign up as it is unlikely that we will achieve our target.

SM agreed with JS's point and thought that we could engage members via surgery at the Information Zone on the ground floor of the hospital. She also suggested that governors should have a chelwest e-mail address so that members from their constituencies could contact them. She said that targeting the Notting Hill carnival might be a good way of getting some young people to join, and also local schools. She added that also local community need to be embraced.

SS-G said that members would need to feel they are welcome and useful to the Trust and that patient feedback is very important.

JS pointed that there are not that many opportunities for members to communicate and meet up except for the Annual Open Day and Annual Members Meeting.

CG raised a question about having M-PALS and Council of Governors, two bodies which deal with the same problem - complaints. He felt that these should go via one route only. SS-G responded that complaints from patients are dealt with in a more impartial and confidential way via PALS. RMB added that people worry about complaining in any other way as they might get less treatment. JS agreed with CG and said that complaints that go to PALS we never hear of as opposed to going to the Council of Governors.

AMC referred to JU's presentation re point on values based segmentation and said that sustenance driven people who are family oriented people are our patients and outer directed people would be

our public members.
CG said that he felt that the Trust was at its best when it had to support a bid for the Trust's stroke services' campaign. It created a very strong bond and the focus for governors.

CB asked JU if we could include in the membership application form a question if they are members of any other organisations and their position in these organisations. JU agreed and said that once we have identified that we will have to segment members according to what predominantly drives them to be a member and why they should be engaged.

SM said that we need to be more inspiring if we were to get some young people to join. SS-G commented that she was not sure whether or not young people would be interested in joining.

ML said that regarding recruiting new members Trust needs to make use of magazines, Trust News, and also to seek governors' support.

CB said that in his paper on membership engagement he mentioned that it had been proposed, but not yet decided by the Board of Directors, to re-target every issue of Trust News to patients and the public as well as staff and that it should carry commercial advertising.

CM said that the Membership Development and Communications Strategy June 2009 was developed from a heavy document. She said that it is very important that we capture Governors thoughts which should help us update the current strategy. The main focus needs to be on engagement and we also need to consider how we measure success. Monitor does not require us to have engagement strategy but it is the Care Quality Commission (CQC) requirement.

AMC said that the draft membership development action plan paper will address CM's points.

JU said that we need to find ways of identifying why members want to be engaged and then develop the strategy. The strategy should address needs of different groups of members. AMC said that young people are likely not to ne interested in health services we offer, but they might be interested in the future prospects it could give them (e.g. employment).

RMB said that we should be proud of £35m extension built on the hospital site and that this should be published. JS agreed with RMB point and added that with a new paediatric wing, HIV& Cancer Ward and considering the current financial climate we should be very proud.

SM suggested that we should include a question on membership expectations in the membership pack.

SS-G said that the hospital needs to regard its membership as a valuable asset.

SS-G congratulated the communications department on a good job on

the website development, Trust News, signage in the hospital which is only managed by three members of staff.

SS-G also raised a question regarding patient forums. CB said that he was interested in patient forums and HIV forum but has not had any information relating to meetings. **SN said that she will look into it.** **SN**

RMB said that the Trust has patient forums and they help with various projects i.e. raising money, decorating rooms, etc.

AMC suggested that in the membership development work plan we identify areas for members involvement.

CG suggested that we need consider doctors and GPs in the members strategy and to get them engaged.

SN said that we have a draft action plan which outlines key actions for the forthcoming year to deliver the strategy and to provide the framework for the Membership Sub-Committee to monitor membership development activity and to report to the Council of Governors.

AMC suggested that we update the draft action plan with points from the sub-committee discussion. **SN to update the draft membership development action plan.** **SN**

5. Any Other Business

CM informed the sub-committee that we will run election on 23 April 2010 and that as a part of it we need to consider how we can increase interest, numbers of candidates and voting turnout. We will also have to ensure the recruitment campaign is set up.

It has been suggested that at the Open Day we should advertise that we are running election.

AMC suggested that we need to ensure that people with learning disability get engaged.

It was suggested that SN writes to governors who are to be involved in the Open Day. **SN to e-mail governors.** **SN**

6. Date of Next Meeting – 13 May 2010 at 4pm

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 21 April 2010

AGENDA ITEM NO.	2.3.2/Apr/10
PAPER	Membership Development and Communications Strategy
AUTHOR	Sian Nelson, Membership and Engagement Manager
LEAD	Andrew MacCallum, Director of Nursing
EXECUTIVE SUMMARY	The Membership Development and Communications Strategy has been updated by the Communications Sub-group; Attention is brought to the Membership Development Action Plan for 2010-2011 in Appendix 12.
DECISION/ ACTION	The Council of Governors is asked to note the report.

Membership Development and Communications Strategy

June 2009

(updated April 2010)

Content

1.0 Introduction

Building and maintaining a vibrant membership is a key aim for Chelsea and Westminster Hospital NHS Foundation Trust. This document defines the membership community and describes how the Trust will grow the membership, ensure diversity and encourage engagement.

2.0 Our Membership

The Trust will focus in 2010-11 on maintaining its current membership across all constituencies.

The Council of Governors will have a membership engagement plan for 2010-11 (see Appendix 12).

Public
The Trust's objective is to maintain the size of the membership in the public constituency in 2010-11. The public have to actively join the Hospital's membership. and within London have a number of foundation trusts to choose from. This means the Trust's membership offering has to be compelling and different from other Trusts.

Patients
In the patient constituency, the Trust aims to maintain numbers and to balance new members against those who leave. The merger of membership services with the Patient Advice and Liaison Service (PALS), created an opportunity to promote membership

Staff
The Trust received approval from Monitor for an 'opt out' system for staff and this has been implemented.

3.0 Ensuring the Diversity of Our Membership

The Trust recognises the need for membership of the public constituency to be representative of the communities which it serves. The Trust has identified three (3) areas for further development:

Geographical[1]
Penetration in the Wandsworth One sub-constituency is significantly below the benchmark of 1% at 0.3% of the local population. This includes the catchment area of Earlsfield, Fairfield, Roehampton, Southfields, Thamesfield, Tooting, Wandsworth Common, Westhhill and West Putney.

Age[2]
The distribution of the membership in the under-40 age group is significantly lower than the general population; however, the trend reversed over the age of 40.

Socio-Economic Groups[3]
Based on profiling by postcode, the highest proportion of members per socio-economic classification is those in the ABC1 and E groups. ABC1 is made up of the upper middle, middle and lower middle class group and E is those at the lower end of subsistence. There is underrepresentation of skilled working class (C2) and working class members (D).

3.1 Our local population

We would like the public membership to be representative of our geographical location and reflect the age, gender, ethnicity and socio-economic groups of our local population. It will be important to continue to recruit members to the Foundation Trust in order to reflect the changing population we serve.

The communities that will be represented in the membership are staff, patients of the hospital and their carers, and those residents within the local authority boundaries of The City of Westminster, The Royal Borough of Kensington and Chelsea, the Borough of Hammersmith and Fulham and the Borough of Wandsworth. According to the Office for National Statistics (last updated Nov 2004), this represents a population of 765,827 residents.

The area is densely populated with a predominantly young and ethnically diverse population, while there are areas of extreme affluence there are also areas of deprivation in close proximity. A brief health profile for each of our local boroughs is provided below to help us target membership.

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[1] Analysis by Computershare -See Appendix 1
[2] Analysis by Computershare – See Appendix 2
[3] Analysis by Computershare – see Appendix 3

General Health Profile[4]
Overall, the health of people in Kensington and Chelsea is significantly better than the England average. Data sourced from the Office for National Statistics (last updated Nov 2004) indicate that there is a higher percentage of persons in good health in the Trust's catchment area than in London or England.

The percentage of persons in good health in these four boroughs ranged from 72.4% to 75.2%. This exceeded the average London of 70.8% and the average for England of 68.8%.

Age Profile[5]
There are a number of features in common among these boroughs. Compared to the UK average:

- There is a higher distribution in the 20-39 age group
- There is a lower distribution in the 5-19 age group
- There is a lower distribution in the 45+ age group; except for Kensington and Chelsea where the turning point is at 65+
- There is an even distribution in the under 5 age group; except for Westminster, where the figure is slightly lower.

Ethnicity Profile[6]
Data sourced from the Office for National Statistics (last updated Nov 2004) indicate that there is a higher percentage of persons of White, Mixed and Chinese ethnicity in the Trust's catchment area than in London or England and a lower percentage of persons of Black or Asian ethnicity.

The most significant variation occurs in the group *Whites*. With the exception of Wandsworth, there is a lower percentage of *Whites: British* than in London. In all boroughs there is a significantly higher percentage of *Whites: Other White*.

Socio-economic profile
The Trust's catchment area is a relatively affluent segment of London with very little variation between boroughs in the under £60k income category.[7]

% of households with income	Average	Standard Deviation
Under £15k (London average £22k)	17	1
Under £30k (London average £53k)	45	2
Under 60k (London average £85k)	79	1

Data sourced from the Office for National Statistics (last updated Nov 2004) indicate that there is a significantly higher percentage of persons in managerial and professional

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[4] See Appendix 4
[5] See Appendix 5 - 8
[6] See Appendix 9
[7] See Appendix 10

occupations in the Trust's catchment area than in London or England and a significantly lower percentage of persons in other socio-economic groups.[8]

The Trust is committed to encouraging all qualifying individuals to become active members of Chelsea and Westminster.

4.0 Resources for Membership Development

The Membership Development and Communications Strategy will be overseen by the combined team efforts of the Membership and Engagement Manager and the MPALS Office under the direction of the Director of Nursing and the Head of Communications under the direction of the Director of Governance and Corporate Affairs.

A recurring budget of £100,000 per financial year is made available to the Members' Council to spend at their discretion on relevant projects.

5.0 Objectives

Chelsea and Westminster Hospital NHS Foundation Trust is a public benefit organisation; open to all our patients, their carers, people who live in our public constituencies and staff, without gender, social, racial, political, or religious discrimination.

In conjunction with the Members' Council, the Trust will deliver the objectives outlined below.

5.1 Objectives - membership recruitment

- To provide a simple, accessible and publicised process for becoming a member which meets the needs of our diverse population.
- To set and meet targets for increasing membership in each constituency as set out in the annual plan.
- To maintain accurate and informative databases of members to meet regulatory requirements and to be a tool for developing membership.
- To conduct a regular recruitment drive focussed on patients and the public.
- To agree a schedule for Council Members to recruit within the hospital on a regular basis.
- To maximise PALS as a resource for recruitment and feedback.
- To work in partnership with other organisations to increase membership e.g. PCTs

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[8] See Appendix 11

5.2 Objectives – membership engagement

- To record those members who are interested in getting involved with the Trust, e.g. Open Day, Focus Groups, AGM, Consultations, and to encourage them and give them ample opportunities to stand for election to the Members Council.

- To link with the Trust's existing work and strategies on user and public involvement particularly working with existing user groups and representatives.

- To inform members and obtain support and involvement where relevant on the Trust's future direction and developments and service provision. To consult on issues of relevance e.g. access to services.

- To demonstrate why the public should be involved with this hospital as opposed to another FT.

5.3 Communication

The Trust will maintain contact with our members through the range of methods including members' meetings and meetings of the Members' Council, road shows, the Annual report, website and the Information Zone.

Objectives – communicating with members

- To maintain membership communications strategy and evaluate methods of communication used.

- To ensure communications are used to stimulate membership involvement as well as members to run for the Members' Council.

- To identify opportunities for and facilitate two-way communications between membership and Members' Council

- To maximise use of the Information Zone where members can learn more about the Trust, identify and meet with their Council Representative and meet other members.

- To be responsive to members' feedback and ensure that Information Zone contains up-to-date information.

- To utilise our Council of Governors as a link to their constituents and promote the Trust

- To ensure staff and the directorates use the membership mailing to communicate on service developments and other relevant information

6.0 Measurement and Evaluation of Success

The Members' Council and the Communications Sub-Committee will have a key role in implementing and monitoring the effectiveness of this strategy and ensuring that it remains a meaningful and relevant document as the membership of the trust matures.

The Members' Council and the Trust Board will:

Objectives

- Assess the composition of membership to ensure that it reflects the diversity of the local communities in which we operate.

- Monitor the contribution membership has made to service development and improvement.

- Ensure all comments, suggestions and queries are logged and action is taken in a timely manner and reported to the Members' Council.

- To review the objectives included in this strategy and monitor progress.

APPENDICES


Kensington and Chelsea 1 Kensington and Chelsea 2 City of Westminster 1 City of Westminster 2 Hammersmith and Fulham 1 Hammersmith and Fulham 2 Wandsworth 1 Wandsworth 20.0% 0.5% 1.0% 1.5% 2.0% 2.5% 1
0.00%2.00%4.00%6.00%8.00%10.00%12.00%14.00%16.00%18.00%Aged 15 to 19Aged 20 to 24Aged 25 to 29Aged 30 to 34Aged 35 to 39Aged 40 to 44Aged 45 to 49Aged 50 to 54Aged 55 to 59Aged 60 to 64Aged 65 to 69Aged 70 to 74Aged 75 to 79Aged 80 to 84Aged 85 to 89Aged 90 to 94Aged 95 to 99Aged 100 and overPopulationM'ship

GENERAL HEALTH	Kensington and Chelsea	Hammersmith and Fulham	Westminster	Wandsworth	London	England
All People (Persons)1	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Good Health (Persons)1	75.2%	73.0%	72.4%	74.6%	70.8%	68.8%
Fairly Good Health (Persons)1	17.3%	18.8%	19.0%	18.3%	20.9%	22.2%
Not Good Health (Persons)1	7.5%	8.2%	8.6%	7.2%	8.3%	9.0%

Appendices 5 - 8
The figures are taken from
http://www.statistics.gov.uk/census2001/pyramids/pages/00bj.asp

Kensington and Chelsea

return to previous version

The percentages on the pyramid represent the percentage of 'all males' (to the left) and the percentage of 'all females' (to the right) that are in that age group.

Age Range	Total Males Females
0 - 4	
	9953
	5104
	4849
5 - 9	
	7643
	4074
	3569
10 - 14	
	6093
	3036
	3057
15 - 19	
	6397
	3168
	3229
20 - 24	
	11662
	5222
	6440
25 - 29	
	17388
	7890
	9498
30 - 34	
	17817
	8648
	9169
35 - 39	
	14952
	7565
	7387
40 - 44	
	11737
	5989
	5748
45 - 49	
	9378
	4451
	4927
50 - 54	
	10798
	5172
	5626
55 - 59	
	8660
	3990
	4670
60 - 64	

	7026
	3339
	3687
65 - 69	
	5235
	2470
	2765
70 - 74	
	4924
	2184
	2740
75 - 79	
	3857
	1742
	2115
80 - 84	
	2893
	1121
	1772
85 - 89	
	1649
	611
	1038
90 and over	
	857
	183
	674
Totals	
	158919
	75959
	82960

Hammersmith and Fulham printer friendly version

The percentages on the pyramid represent the percentage of 'all males' (to the left) and the percentage of 'all females' (to the right) that are in that age group.

Age Range	Total Males Females
0 - 4	
	10195
	5282
	4913
5 - 9	
	8292
	4056
	4236
10 - 14	
	7377
	3610
	3767
15 - 19	
	7189
	3579
	3610
20 - 24	
	14938
	6827
	8111
25 - 29	
	24453
	11427
	13026
30 - 34	
	20347
	10193
	10154
35 - 39	
	14609
	7090
	7519
40 - 44	
	11022
	5283
	5739
45 - 49	
	8657
	4221
	4436
50 - 54	
	8378
	4238
	4140
55 - 59	
	6320
	2976
	3344
60 - 64	
	6123
	2903

	3220
65 - 69	
	4854
	2392
	2462
70 - 74	
	4264
	1953
	2311
75 - 79	
	3678
	1537
	2141
80 - 84	
	2441
	862
	1579
85 - 89	
	1436
	420
	1016
90 and over	
	669
	144
	525
Totals	
	165242
	78993
	86249

Westminster printer friendly version

The percentages on the pyramid represent the percentage of 'all males' (to the left) and the percentage of 'all females' (to the right) that are in that age group.

Age Range	Total Males Females
0 - 4	
	9452
	4842
	4610
5 - 9	
	7436
	3783
	3653
10 - 14	
	6477
	3218
	3259
15 - 19	
	8049
	4194
	3855
20 - 24	
	17369
	8140
	9229
25 - 29	
	24028
	11730
	12298
30 - 34	
	20912
	10693
	10219
35 - 39	
	16103
	8270
	7833
40 - 44	
	12200
	6239
	5961
45 - 49	
	9614
	4572
	5042
50 - 54	
	10956
	5410
	5546
55 - 59	
	8946
	4356
	4590
60 - 64	
	7333
	3625
	3708

65 - 69	
	6388
	3038
	3350
70 - 74	
	5688
	2693
	2995
75 - 79	
	4542
	1928
	2614
80 - 84	
	3060
	1238
	1822
85 - 89	
	1851
	612
	1239
90 and over	
	882
	226
	656
Totals	
	181286
	88807
	92479

Wandsworth printer friendly version

The percentages on the pyramid represent the percentage of 'all males' (to the left) and the percentage of 'all females' (to the right) that are in that age group.

Age Range	Total Males Females
0 - 4	
	16660
	8503
	8157
5 - 9	
	13069
	6616
	6453
10 - 14	
	10952
	5590
	5362
15 - 19	
	10742
	5179
	5563
20 - 24	
	24223
	10630
	13593
25 - 29	
	42020
	19851
	22169
30 - 34	
	32669
	16332
	16337
35 - 39	
	23862
	11561
	12301
40 - 44	
	17250
	8593
	8657
45 - 49	
	11837
	5667
	6170
50 - 54	
	11877
	5624
	6253
55 - 59	
	9310
	4348
	4962
60 - 64	
	8752
	4277
	4475

65 - 69	
	7474
	3531
	3943
70 - 74	
	6424
	2848
	3576
75 - 79	
	5658
	2289
	3369
80 - 84	
	3954
	1381
	2573
85 - 89	
	2386
	671
	1715
90 and over	
	1261
	251
	1010
Totals	
	260380
	123742
	136638

Appendix 9
Data sourced from the Office for National Statistics (last updated Nov 2004)

ETHNICITY	Kensington and Chelsea	Hammersmith and Fulham	Westminster	Wandsworth	London	England
All People (Persons)1	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
White (Persons)1	78.6%	77.8%	73.2%	78.0%	71.2%	90.9%
White: British (Persons)1	50.1%	58.0%	48.5%	64.8%	59.8%	87.0%
White: Irish (Persons)1	3.3%	4.8%	3.6%	3.1%	3.1%	1.3%
White: Other White (Persons)1	25.3%	15.0%	21.1%	10.0%	8.3%	2.7%
Mixed (Persons)1	4.1%	3.8%	4.1%	3.4%	3.2%	1.3%
Mixed: White and Black Caribbean (Persons)1	0.8%	1.2%	0.8%	1.1%	1.0%	0.5%
Mixed: White and Black African (Persons)1	0.7%	0.6%	0.7%	0.5%	0.5%	0.2%
Mixed: White and Asian (Persons)1	1.2%	1.0%	1.3%	0.9%	0.8%	0.4%
Mixed: Other Mixed (Persons)1	1.4%	1.0%	1.4%	0.9%	0.9%	0.3%
Asian or Asian British (Persons)1	4.9%	4.4%	8.9%	6.9%	12.1%	4.6%
Asian or Asian British: Indian (Persons)1	2.0%	1.7%	3.1%	2.8%	6.1%	2.1%
Asian or Asian British: Pakistani (Persons)1	0.8%	1.0%	1.0%	2.1%	2.0%	1.4%
Asian or Asian British: Bangladeshi (Persons)1	0.7%	0.6%	2.8%	0.4%	2.1%	0.6%
Asian or Asian British:	1.4%	1.1%	2.0%	1.6%	1.9%	0.5%

Other Asian (Persons)1						
Black or Black British (Persons)1	7.0%	11.1%	7.4%	9.6%	10.9%	2.3%
Black or Black British: Caribbean (Persons)1	2.6%	5.2%	3.1%	4.9%	4.8%	1.1%
Black or Black British: African (Persons)1	3.8%	4.9%	3.7%	3.8%	5.3%	1.0%
Black or Black British: Other Black (Persons)1	0.6%	1.1%	0.7%	0.9%	0.8%	0.2%
Chinese or Other Ethnic Group (Persons)1	5.5%	2.8%	6.3%	2.1%	2.7%	0.9%
Chinese or Other Ethnic Group: Chinese (Persons)1	1.6%	0.8%	2.2%	0.9%	1.1%	0.4%
Chinese or Other Ethnic Group: Other Ethnic Group (Persons)1	3.8%	2.0%	4.1%	1.3%	1.6%	0.4%

Appendix 10
The figures are taken from
http://www.londoncouncils.gov.uk/londonfacts/londonstatistics/Householdincomedistributionin200607.htm

Appendix 11

Data sourced from the Office for National Statistics (last updated Nov 2004)

SOCIO_ECONOMIC	Kensington and Chelsea	Hammersmith and Fulham	Westminster	Wandsworth	London	England
All People (Persons)1	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
1. Higher managerial and professional occupations (Persons)1	20.3%	17.9%	18.6%	19.5%	12.1%	8.6%
2. Lower managerial and professional occupations (Persons)1	25.8%	26.2%	24.2%	28.0%	22.2%	18.7%
3. Intermediate occupations (Persons)1	5.9%	8.2%	7.2%	9.0%	10.2%	9.5%
4. Small employers and own account workers (Persons)1	7.0%	6.1%	6.0%	5.5%	6.4%	7.0%
5. Lower supervisory and technical occupations (Persons)1	2.8%	3.6%	3.3%	3.6%	5.0%	7.1%
6. Semi-routine occupations (Persons)1	5.7%	6.7%	6.5%	6.7%	9.0%	11.7%
7. Routine occupations (Persons)1	3.7%	4.6%	4.0%	4.2%	5.8%	9.0%
8. Never worked and long-term unemployed (Persons)1	5.7%	5.5%	6.4%	4.2%	6.0%	3.7%
Not Classified (Persons)1	23.1%	21.0%	23.7%	19.3%	23.2%	24.7%

Appendix 12

Chelsea and Westminster Hospital NHS Foundation Trust

DRAFT MEMBERSHIP DEVELOPMENT ACTION PLAN

2010 – 2011

This action plan is based on the Membership Development and Communication Strategy that is designed to ensure the Trust has a vibrant and representative membership. The action plan outlines key actions for the forthcoming year to deliver the strategy and will proved a frame work for the Membership Sub-committee to monitor membership development activity and to report to the Council of Governors.

Governor Leads for some areas still need to be confirmed, the delivery of the plan will be supported by the Director of Nursing Assistant Director of Nursing Membership and Engagement Manager, the Communions Team and the M-PALS Team.

THE MEMBERSHIP DEVELOPMENT ACTION PLAN

ISSUE	OBJECTIVE	ACTION	LEAD	DATE DUE	NOTES
1. Information Zone	To improve communication between Members and Governors within the Council of Governors dedicated information zone in the hospital.	• Develop open, drop in sessions for members and potential members to meet Governors. • Develop a roster for Governors to be present in the zone to perform question and answer sessions. • Advertise/give notice to patients, public and staff of such events. • Erect pictures of Governors, with contact details in the Information Zone.	CB SN	May 2010	To be launched at the Annual Open Day, 8th May 2010.
2. Seasonal Working Conference for Hospital Staff	To create a forum through which Governors can communicate with Members on key issues of patient care.	• Governor presentation at the Seasonal Working Conference. • Governor stand at the Seasonal Working Conference. • Invite a group of Members to the Seasonal Working Conference through the bi-annual mailings or email.	TBC	July 2010	To commence at the Summer Seasonal Conference July 2010.
3. Patient Forums	To actively participate in patient forums to receive direct feedback from patients users.	• Circulates to Governors list of existing patient forums. • Governors to participate in chosen patient forum. • Governors to feedback important	TBC	May 2010	

THE MEMBERSHIP DEVELOPMENT ACTION PLAN

ISSUE	OBJECTIVE	ACTION	LEAD	DATE DUE	NOTES
		messages to the -appropriate Council of Governors Sub-Committee and action plan as appropriate. • Establish relationship with local LINKs.			
4. Recruitment Campaigns	To recruit new members to all constituencies and aim for a representative membership.	• Membership Sub-Committee to review membership bi-monthly and identify opportunities for recruitment and agree a recruitment plan and funding for 2010/11 with the Council of Governors.	TBC	July 2010	To be present at the next Council of Governors meeting in July 2010.
5. Bi-annual membership mailings	To effectively use the bi-annual membership mailings to inform the membership of key issues and explore how the Trust can elicit feedback from members.	• Sub-committee to agree the purpose and content of each mail shot.	SM SN RMcB	Date of next mail out when is it?	Trust News to be sent to all members bi-annually. The content of the member's Trust News should target patients and the public as well as staff. Ensure Membership engagement is a priority in membership mailings. Requests to members for their feedback on specific issues or invitations to the Trust should be integrated in each mail shot. Update members on developments within the hospital and consult with members on key issues for example the hospital extension, Quality Accounts).
6. Email communication with Members	Establish an effective use of email communication with Members.	• Sub Committee to agree purpose and content of email communication. • Update Members email details and	SM SN RMcB	April 2010	

THE MEMBERSHIP DEVELOPMENT ACTION PLAN

ISSUE	OBJECTIVE	ACTION	LEAD	DATE DUE	NOTES
		encourage use of email in membership literature. • Send regular and targeted emails (inc. Trust News link) with Trust updates. • Send requests for patient involvement as requested by Trust committees, for example, PEAT, or other patient panels.			
7. Website	To utilise the C&W Hospital website to promote membership involvement and the Council of Governors.	• Membership Sub-Committee to work with the in house team to refresh web membership pages.	TBC	Sep 2010	Web page will include clear identification of Governors and the constituencies they represent; explanation of the role of the Governor; clear process for contacting Governors, Members feedback box for Governors, On-line Members application form, information regarding Members events and other Trust invites or activities.
8. Council of Governors Elections	To ensure members have the information they need to confidently stand for elections	• Agree through the Membership Sub-Committee types of events to support members considering standing for election.	CB SN	May 2010	
9. Staff Constituency	Encourage staff representatives to agree an annual program of events with staff members including meetings.	• Agree annual program of events e.g. meetings, column in Trust News.	CD, LB, JJ, BG, SS	April 2010	Carol Dale, Staff Governor for the management constituency has established this approach in her constituency and her method can be applied to the other staff constituencies.

THE MEMBERSHIP DEVELOPMENT ACTION PLAN

ISSUE	OBJECTIVE	ACTION	LEAD	DATE DUE	NOTES
10. Reaching underrepresented groups in the Membership	To improve representation of under-represented groups	• Membership Sub-Committee to review membership bi-monthly and identify underrepresented groups and agree plans for recruitment and engagement in these groups, e.g. young people.	ALL ML SN	Ongoing	The mobile community clinic at Chelsea Football Club signed up users of the 'well persons' clinic to membership. The users have given their permission to be contacted for further feedback. A grant has been sought to fund a 'community services user's panel' who will feedback their experience of the service. The feedback can be used as evidence to continue or improve the service accordingly.
11. Young Persons Membership Group	To create a Young Persons Membership Group to strengthen the membership of young people	• Membership Sub-Committee to agree a proposed 'terms of reference for the group'. • Propose the idea of a Young Persons Membership at the next Annual Members Meeting. • Identify a Young Persons 'Champion' to lead the membership group. • Work with the existing children's forums to understand how we can gain insight into the needs of this group, reach this group and offer membership for their benefit. • Link to schools through volunteering, work placements and training opportunities.	ML SN SM	July 2010	

THE MEMBERSHIP DEVELOPMENT ACTION PLAN

ISSUE	OBJECTIVE	ACTION	LEAD	DATE DUE	NOTES
12. Quality Accounts	To engage members and seek feedback on the Trusts Quality Account	• Governors to seek the views of members regarding the Trusts Quality Accounts through engagement activities: mail shots, email/website, seasonal working conference and the Governors session in the Information Zone.	TBC	May 2010	
13. Members with Learning Disability	For Governors to seek the views of people with Learning Disability on the experience they have of using the Trusts services	• Creation of a learning disability patient forum to seek feedback from members with a learning disability with regards to the Hospital's services and provision of suitable information including leaflets and signage. • Collaborate with agencies (for example, LINks) in the community to gain feedback from the local community on services for people with Learning Disability.	SN		
14. Service Development	To consult members on service developments within the Trust	• Council of Governors to agree with Directors' service developments for the forthcoming year on which feedback from Members would be valued. • Consult with members on service development within the Trust e.g. request feedback through mail shots, email/website seasonal working conference and Governors sessions in the Information Zone.	SN	May 2010	

THE MEMBERSHIP DEVELOPMENT ACTION PLAN

Named Personnel:

AMacC	Andrew MacCallum	Director of Nursing
CM	Cathy Mooney	Director of Governance and Corporate Affairs
SN	Sian Nelson	Membership and Engagement Manager/MPALS
VD	Vida Djelić	Foundation Trust Secretary
MA	Matthew Akid	Communications Manager
JT	Jane Tippett	Assistant Director of Nursing
CB	Chris Birch	Patient Governor and Chairman of the Membership Sub-Committee
SM	Susan Maxwell	Patient Governor
SGS	Sandra Gordon Smith	Public Governor, Kensington and Chelsea Area 2
ML	Martin Lewis	Public Governor Westminster Area 1
JS	Jim Smith	Patient Governor
CD	Carol Dale	Staff Governor, Management
JJ	Jacinto Jesus	Staff Governor, Contracted
LB	Lucy Ball	Staff Governor, Allied Health Professional, Scientific and Technical Staff
SS	Sue Smith	Staff Governor, Nursing and Midwifery
BG	Brian Gazzard	Staff Governor, Medical and Dental
RMcB	Renae McBride	Communications Manager

CONFIDENTIAL
Board of Directors Meeting, 29 April 2010

AGENDA ITEM NO.	2.3.3/Apr/10
PAPER	Council of Governors Membership Report
AUTHOR	Sian Nelson, Membership and Engagement Manager
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper reports on the membership numbers for the Trust which currently has a total membership of 15,186.
DECISION/ ACTION	For information

DISTRIBUTION	Board only ☐	Directors ☐	Trust Exec ☐	General ☒

Council of Governors Membership Report

1. Introduction

This paper sets out the present membership of Chelsea and Westminster Hospital Foundation Trust.

2. Member Constituencies

There are three Member Constituencies, Patient, Public and Staff. Membership for each constituency is illustrated in Table 1. The information in this report was updated to the beginning of April 2010.

Constituency	Members	Affiliate members	Total	Percentage
Staff	3,046	0	3,046	20%
Patient	6,010	1	6,011	39%
Public	6,130	242	6,372	41%
Total	**15,186**	**243**	**15,429**	

Table 1: Membership

Monitor currently require different levels of analysis for each constituency and this is reflected in the report.

2.1 Patient Constituency

Patient members for 2009/10 is currently at 6,010. The Trust aims for growth of 5% in 2009/10, hence a further 300 new patient members will be required to achieve our target. The number of patient members who have left currently stands 426 (2009/10). The reasons for members leaving is generally either because of movement of address outside of the eligible constituency, or death.

Analysis of current patient membership requires us to report only on age. These figures are reflected in Table 2 below.

Age (years)	
0-16	1
17-21	63
22+	5,946
Unknown	2,857

Table 2: Patient membership by age range

2.2 Public Constituency

The Trust's target is to maintain the size of membership in the public constituency in 2010/11. Currently we have 6,130 public members. To date there have been 185 new members this year compared to 195 for 2008/09.

Ethnicity in this constituency demonstrates the highest proportion of membership within the Caucasian category and gender distribution remains higher in females than males. Analysis of the public constituency is represented in Table 3.

Ethnicity:	
White	4,364
Mixed	247
Asian	339
Black	287
Other	893
Socio-economic groupings	
ABC1	5,296
C2	4
D	0
E	830
Gender analysis	
Male	2,433
Female	3,697

Table 3: Analysis of Public membership

2.3 Staff Constituency

Staff membership has been updated to include all staff (deducting those who opt out, 15 staff). Table 4 shows staff members numbers were 487 as of the start of 1 April 2009. However, these were staff who applied to become members before the 'opt out' system was in place.

Staff constituency	
As at start April 1st 2009	487 prior to 'opt-out' system
New Members	2,874
Members leaving including (Opt Out)	315
April 2010	3,046

Table 4: Analysis of Staff membership

Staff membership is further broken down into occupational category. There has been an increase of 67 staff members joining and 18 leaving the Trust since September 2009. The main increase is within the category of Administrative and Clerical and Nursing and Midwifery whilst the decrease has been within the category of Medical and Dental.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 21 April 2010

AGENDA ITEM NO.	2.4/Apr/10
PAPER	Council of Governors Funding Report *
AUTHOR	Vida Djelic, Interim FT Secretary
LEAD	Vida Djelic, Interim FT Secretary
EXECUTIVE SUMMARY	This paper provides an overview of the use of the Council of Governors budget to Month 11 of FY 09/10
DECISION/ ACTION	The Council of Governors is asked to note the report and to consider how the funding for 2010/11 should be allocated and are invited to submit ideas or proposals to the Foundation Trust Secretary.

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. This budget was made available as of the financial year (1 April 2009).

The recurring budget was adjusted in the following financial year (2009/10) for the effect of inflation which is estimated at £500 bringing the total budget available in 2009/10 to £100,500.

2.0 Update

At the last meeting of the Council of Governors it was agreed that £1,304 will be provided for funding for the development of the Learning Disability Membership Leaflet.

The Council of Governors also agreed to support funding of membership recruitment campaign of £3,539.10 which was linked to the Trust's pilot of a Community Mobile Health Clinic.

3.0 Funding Overview

Of the £100,500 circa £62K has been spent. In addition to that circa £38K remains in the budget, of which the following will be accrued for 2010/11: Directory of Adults services (£19,817), Learning Disability Membership Leaflet (£1,304) and membership recruitment via Mobile Health Clinic (£3, 539.10) leaving a net of £14K.

4.0 Use of funds FY 09/10

TABLE 1

Activity 09/10	Estimate	Actual
Trust Open Day 2009	£15,000	£12,334
Recruitment Campaign for Open Day 2009	£2,574	£2,574
Recruitment Campaign for Annual Members' Meeting	£2,574	£2,574
Recruitment of new members via Campaign for pre-election	£5,930	£2,956
Discharge Leaflets	£8,200	£8,200
Directory of Adults services	£19,817	–
Information Zone seating, screen & wing art	£16,085	£16,236
Information Zone Security Kiosk move	£305	£305

Information zone Sec frame to TV, Kiosk move contingency, Project management fees	£3,763	£3,763
Website development	£12,800	£12,800
Computer items which relate to VAT	£115	£115
Learning Disability Membership Leaflet	£1,304	–
Membership recruitment via Mobile Health Clinic	£3, 539.10	–
TOTAL:	**£92,006.10**	**£61,857**

5.0 Council of Governors Budget for 2010/11

The Council of Governors is asked to note that a draft budget for 2010/11 has to be agreed by the Board on 29 April and an update on the budget will be brought to the Council meeting on 21 April 2010.

Governors are asked to consider how the funding for 2010/11 should be allocated and are invited to submit ideas or proposals to the Foundation Trust Secretary.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 21 April 2010

AGENDA ITEM NO.	2.6/Apr/10
PAPER	FTGA/FTN Development Day 12 February & 23 March 2010 – feedback
AUTHOR	Sandra Smith Gordon – 12 February 2010 Walter Balmford and Susan Maxwell – 23 March 2010
LEAD	Sandra Smith Gordon – 12 February 2010 Walter Balmford – 23 March 2010
EXECUTIVE SUMMARY	This paper provides feedback from the FTGA/FTN Development Day held on February and March 2010.
DECISION/ ACTION	For information.

Development Day for Foundation Trust Governors 12 February 2010

The Development Day was organised jointly by the Foundation Trust Governors' Association (FTGA) and the Foundation Trust Network (FTN).

The following governors attended from Chelsea & Westminster Hospital NHS Foundation Trust: Alan Cleary, Susan Maxwell, Wendie McWatters, Sandra Smith-Gordon.

The following subjects were covered:

1. Today's NHS – The National Perspective
   A brief outline emphasising the changes being made and the funding cuts to be expected.

   Points picked up:
   - Existence of LINks (Local Involvement Networks) a Department of Health initiative of which we had not all been aware.

2. Governors Making a Difference – sharing best practice through the FGTA
   An outline of some best practice found in a survey of some governors.

   Points picked up:
   - Need for an audit of governors' skills
   - Governors involvement with quality improvement, eg on PEAT teams; Quality Committees
   - Possible need for some governors to be trained in recruitment/assessment procedures/processes when appointments of Chairs and Non-Executive Directors are made.
   - Governors' participation in trust committees especially where their background or skills might be useful.
   - New governors may need time and help to fit into their role to become effective.

3. Facing the Economic Climate Together – The challenges for directors and governors -Monitor's view on the governors' role in a foundation trust.
   An outline of what Monitor does and does not do/expect

   Points picked up:
   - Need to keep an open mind about change
   - Need to keep trying to reach out to those who could join trust or governors who currently do not.
   - NEDs feeding back to governors on how board is doing
   - Governors feeding back to members/community
   - Need for trust between governors and executive to facilitate critical partnership
   - Need for governors to be well-informed, engaged, objective and thoughtful in their responses to board initiatives.
   - Go for quality rather than quantity when recruiting members
   - Total Place: potential new way of organising public services

4. What are Foundation trusts achieving 6 years on and what is your trust achieving?
   Group discussions sharing information

Points picked up:

- Some trust chairmen have a surgery for governors
- Mentoring scheme for new governors
- Need for right sub-committees to achieve aims

5. Workshops

➢ An introduction to NHS Finance

Points picked up:

- Warnings about likelihood of severe reduction in funding. London to get smallest increase in 2009/10, zero uplift for 2010/11
- Information about how reductions might be made
- Funding from local PCTs – contracts with trusts to provide healthcare
- Quality agenda and payment by results will go ahead despite reduction in funds.

➢ Accountability in action – how directors and governors are working together

Points picked up:

- "Your Statutory Duties - a reference guide for NHS foundation trust governors." This booklet is very useful to all governors (previously unknown to some).
- Importance of governors and management working together

➢ NEDs and governors working together

FGTA represents governors – motto: Debate, Exchange, Learn.
They publish Essential Brief notes and various booklets,
see their web site: www.ftgovernors.org.uk
They arrange regular development days for governors

FTN represents management of trusts. Web site:
www.foundationtrustnetwork.org.uk

Development Day for Foundation Trust Governors 12 February 2010

Walter Balmford and Susan Maxwell attended from Chelsea and Westminster Hospital NHS Foundation Trust.

After registration, there was time to network before the proceedings were opened by Sharon Carr – Brown (Chair of FTGA) from the Royal Bournemouth & Christchurch Hospitals Foundation Trust who welcomed all delegates and introduced two new members of staff.

After running through the arrangements for the day Sharon introduced Peter Hunt, the Chief Executive of Mutuo, an organization he founded in 2001 to work within the Mutual Sector and give relevant advice to Government & Trust Boards.

The key message was "Foundation Trusts must be accountable to their Members" and that "Membership must be representative of the community".

He had stressed the vital role played by the Chairman, the Chief Executive and the Company Secretary plus in some instances the Vice-Chairman and suggested that Staff Governors should be actively encouraged to use their experience & expertise within the decision making process.

In conclusion he put forward two sets of challenges for all Governors under the heading "What can Governors do to maintain and improve the quality of their Trusts".

1. A three point challenge to your Trust Board to
   a) insist that Membership is properly supported & funded
   b) insist that they work beyond Governors and activate Membership
   c) insist that they demonstrate an open accountable culture

2. A two point challenge to Monitor
   a) insist that Monitor ensures that all statutory requirement are met including representative membership
   b) Monitor should develop a Code of Practice for Membership

An interesting Question & Answer session followed.

The Chair then introduced the Workshop part of the agenda and invited delegates to move to other rooms depending on which on the four discussion groups they had chosen.

Both Walter and Susan attended the workshop titled "General Election Outcomes". This session was run by Ruth Thorlby, a fellow in health policy of the King's Fund. The concluding remarks were that Public Opinion Polls continued to show that the NHS ranked at the top of priority listing for funding were inevitable and Trusts must carefully examine their structures and introduce prudent housekeeping.

Susan Maxwell attended Quality Accounts – The Audit Commission workshop in the afternoon. This session was run by Mark Hodgson (CPFA), the Audit Commission's Trust Practice Engagement Lead and Kirsty Beasley also from the Audit Commission.

Mark Hodgson talked about the Audit Commission and then passed on the actual workshop session to Kirsty Beasley. The most concise summary would be to state that an auditor would be looking to find that data underpinning indicators is robust and reliable.

The Audit Commission offered to send a copy of Taking It On Trust (a review of how boards of NHS trust and foundation trusts get their assurance) to anyone who left their name and address. Susan Maxwell obtained four copies of this publication. Susan is happy to distribute three spare copies to other governors of the Quality Sub-Committee.

Both Susan Maxwell and Walter Balmford felt that the development day was a wholly worthwhile and informative.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 21 April 2010

AGENDA ITEM NO.	2.7/Apr/10
PAPER	Proposed questionnaire for Council of Governors performance evaluation
AUTHOR	Vida Djelic, Interim FT Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	Monitor's *Code of Governance* sets out the provision: 'D.2.2 *Led by the chairman, the Council of Governors should periodically assess their collective performance and they should regularly communicate to members details on how they have discharged their responsibilities, including their impact and effectiveness on:* ■ *advising the board on the forward plans of the NHS foundation trust; and* ■ *communicating with their member constituencies and transmitting their views to the board of directors.* *The Council of Governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice.'* This paper updates the questionnaire used previously for the evaluation of the Council of Governors performance. Changes include grouping of questions and an additional question relating to the Quality Account. The aim of the questionnaire is to evaluate and improve the performance of the Council of Governors. The following process is suggested: • Draft Questionnaire to be agreed at the Council of Governors meeting on 21 April 2010 • Questionnaires to be distributed to Governors by e-mail on 26 April 2010 • Questionnaires to be completed and returned to the Trust Secretary by 10 May 2010 • Summary report, including any recommended developmental

	actions, to be prepared and presented by the Chair to the Council of Governors meeting on 21 July 2010
DECISION/ ACTION	The Council is asked to agree the questionnaire and process.

1.0 Background

The Monitor Code of Governance states in provision **D.2.2** that **'***Led by the chairman, the Council of Governors should periodically assess their collective performance and they should regularly communicate to members details on how they have discharged their responsibilities, including their impact and effectiveness on:*
■ *advising the board on the forward plans of the NHS foundation trust; and*
■ *communicating with their member constituencies and transmitting their views to the board of directors.*
The Council of Governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice.'

2.0 The Role of the Council of Governors

In order to devise an effective process for evaluation of the Council of Governors, it is important to have a clear description of the role of the Council is to play in relation to the Trust. An overview of the role of the Council, as it is communicated to all new Governors upon their induction, is attached at Appendix 1.

3.0 Process

This paper provides a questionnaire to be used for a self-evaluation of the Council of Governors performance. The evaluation is to be carried out and an analysis of the results should be led by the Chairman.

Options on how we administer the evaluation are:

1. Governors would be asked to complete the form individually. They could do so anonymously or include their name on the form. A report of the results would then be brought back to the Council highlighting areas of poor performance and areas where there were discrepancies for consideration and action.

2. The evaluation would be completed jointly at a Council of Governors meeting with a collective discussion around each question regarding performance.

4.0 Questionnaire

The self-evaluation questionnaire is attached at Appendix 2.

5.0 Action

The Council is asked to agree the questionnaire and process.

Appendix 1

ROLES AND RESPONSIBILITIES OF THE COUNCIL OF GOVERNORS

1.0 INTRODUCTION

Foundation trusts were established with a governance model that is rooted in the concept of local accountability: local people were given a genuine opportunity to influence the provision of acute hospital and mental health services in their area.

Governors are the individuals that bind the Trust to its patients, staff and local stakeholders. They are direct representatives of local interests within the governance structure of the Trust. The functions they perform go beyond community liaison; they have statutory responsibilities with the potential to have a significant effect on the management of the Trust.

The governance structure of all foundation trusts is made up of the following components:

Members: patients, service users, staff and the general public from the local community. Members vote to elect representatives on the Council of Governors. These elected representatives are called Governors.

Council of Governors: represents the interest of the members and partner organisations in the local community and holds the board to account for the performance of the Trust and exercises statutory duties.

Board of directors: made up of executive and non-executive board members with collective responsibility for the performance of the Trust and exercises power on behalf of the Trust.

As required by law, the chair of the Board of Directors also acts as chair of the Council of Governors.

2.0 KEY ROLES OF COUNCIL OF GOVERNORS

2.1 Representation of constituencies and stakeholder organisations

The Council of Governors represents the interest of the members of the Trust and partner organisations in the local health economy in the governance of the Trust.

The Council of Governors comprises:

- Eight (8) elected Public Governors from each of the 8 geographic regions;
- Ten (10) elected Patient Governors;
- Six (6) elected Staff Governors;
- Four (4) appointed PCT Governors;
- Two (2) appointed Local Authority Governors;
- One (1) appointed University / Medical School Governor; and
- Three (3) appointed Partnership Governors.

The Council of Governors should give regular feedback about the Trust, its vision and its performance to the constituencies and the stakeholders that either elected or appointed them.

2.2 Trust Performance

The Council of Governors should hold the Board to account for the performance of the Trust, including ensuring that the Board acts so that the Trust does not breach the terms of its authorisation.

3.0 KEY RESPONSIBILITIES

3.1 Statutory responsibilities of the Council of Governors

As part of their overall role in scrutinising the performance of the Trust and representing members, Governors are required to fulfil certain statutory duties.

The Council of Governors:

a) Appoints and removes the Chairman and the other non-executive directors;
b) Approves the appointment (by the non-executive directors) of the Chief Executive;
c) Decides the remuneration and allowances, and other terms and conditions of office, of the non-executive directors;
d) Appoints and removes the Trust's financial auditors;
e) Appoints and removes any other external auditor appointed to review and publish a report on any aspect of the Trust's affairs; and
f) Is presented with the annual accounts, any report of the financial auditor on them and the annual report;
g) Provides views to the board of directors when the board is preparing the document containing information about the Trust's forward planning;
h) Responds as appropriate when consulted by the Board;
i) Undertakes such functions as the board shall time to time request;
j) Prepares and from time to time reviews the Trust's Membership Strategy and its policy for the composition of the Council of Governors;
k) When appropriate, makes recommendations for the revision of the Constitution;
l) Reports on steps taken to secure a representative membership, the progress of the membership strategy, and any proposed changes to the policy for the composition of the Council of Governors and the non-executive directors;

Therefore, the Council of Governors is in a position of considerable responsibility. They have genuine powers at their disposal and provide the Trust with a direct link to its membership base.

Notwithstanding, the Council of Governors should acknowledge the overall responsibility of the board of directors for running the Trust and should not try to use the power of the Council of Governors to veto decisions of the Board of Directors.

3.2 Statutory responsibilities of individual Governors

Each individual Governor also has a statutory responsibility for:

a) Acting in the best interests of the Trust and adhering to the trust's values and Code of Conduct

b) Signing and delivering the prescribed form confirming acceptance of the Code of Conduct for Governors;
c) Disclosing all material interests; and
d) Undertaking any training which the Council of Governors requires all Governors to undertake.

3.3 Responsibilities of individual Governors for building effective relationships

Governors represent the views of the trust membership. Governors are responsible for engaging members in their respective constituencies using a range of techniques including direct contact with individual members.

Maintaining contact between the Council of Governors and the non-executive and executive directors is essential for Governors to be informed about the work of the Trust and more broadly about the workings of the NHS.

Governors are responsible for:

a) Attending formal meetings of the Council of Governors which are held regularly with the directors in attendance;
b) Adopting formal methods of joint working and communication between the Council of Governors and the Board of Directors;
c) Developing informal relationships with other Governors, the Chairman, executive and non-executive directors; and
d) Undertaking any induction and development programmes which are required.

3.4 Responsibilities of the Council of Governors for the engagement of members

The Council of Governors is responsible for engaging its members and encouraging participation in the Trust's activities, for example, The Annual General Meeting, the Annual Open Day, focus groups, and the Seasonal Working Conference.

Members will be informed in a variety of ways including semi-annual members' editions of Trust News, the Annual General Meeting, a dedicated Membership Area with screens and kiosks, www.chelwest.nhs.uk, educational events and direct contact.

3.5 Responsibilities of the Council of Governors for representation of the Trust

The Council of Governors are responsible for participating and representing the Trust, where it is reasonable, in 'Task & Finish' groups, local focus groups, and local area networks.

3.6 Responsibilities of individual Governors undertaking specific responsibilities

Governors are responsible for ensuring that, where they undertake specific responsibilities, for example, nominations, they are equipped with the relevant skills and experience, or alternatively, they request access to expert consultation at the Trust's expense.

4.0 CONFLICT RESOLUTION

The Council of Governors is responsible for attempting to resolve any concerns at a local level.

The Trust Chairman is responsible for chairing both the Council of Governors and the Board of Directors and will arbitrate on any disagreements:

- Should a resolution not be reached, the Chairman may ask the Senior Independent Director and the Deputy Chairman of the Council of Governors to review the matter further; and
- In the event that they cannot reach a decision, the matter will be referred back to the Chairman for a final decision.

Appendix 2

Council of Governors
Performance Evaluation

Chelsea and Westminster Hospital NHS Foundation Trust

1. Please read the questions and tick the most appropriate box

2. Please answer all questions using knowledge gained as a Governor

3. Please add any appropriate comments

4. Please return the questionnaire to Vida Djelic, Interim Foundation Trust Secretary by e-mail (vida.djelic@chelwest.nhs.uk)

No	Question	Excellent	Good	Adequate	Weak	Do not know	Not applicable	Comments
	Council of Governors meetings							
1.	How well balanced do you feel the agenda is in covering both procedural as well as strategic matters?							
2.	How would you rate your level of engagement during the debates held at the Council of Governors meetings?							
3.	How would you rate the meeting schedule and time of the meetings?							
4.	How would you rate the balance of discussion between clinical and business issues?							
5.	How would you rate the balance of discussion between long-term vision and immediate needs?							
6.	How would you rate the time given for discussion and decision-making at meetings?							
7.	How would you rate Council meetings in terms of ensuring open communication, meaningful participation and timely resolution of issues?							

No	Question	Excellent	Good	Adequate	Weak	Do not know	Not applicable	Comments
8.	How would you rate the Council of Governors papers in terms of receiving timely and accurate minutes; advance written agendas and meeting notices, and clear and concise background material prepared in advance of the meeting?							
9.	How would you rate the quality of the finance and performance reports?							
	Council of Governors knowledge							
10.	How would you rate your knowledge and understanding of the Trust's aims and values?							
11.	How would you rate your understanding of the role of the Council of Governors?							
12.	How would you rate the information you receive about the required standards of performance from Monitor?							
13.	How would you rate your awareness of the number and nature of the Council of Governors sub-committees and their focus of work?							

No	Question	Excellent	Good	Adequate	Weak	Do not know	Not applicable	Comments
	Council of Governors influence							
14.	How well do you feel the Council of Governors collectively discusses the strategy?							
15.	How would you rate the Council's performance in discharging its governance responsibilities appropriately? E.g. approval of financial auditor, self-evaluation, reporting at the annual membership meeting							
16.	How would you rate the incorporation of Governor views into the business plan?							
17.	How would you rate the incorporation of Governor views into the Quality Account?							
18.	How would you rate your level of contact with your constituent members? **(Elected Governors)**							
19.	How would you rate the impact of the Council of Governors on the overall performance of the organisation?							

No	Question	Excellent	Good	Adequate	Weak	Do not know	Not applicable	Comments
20.	How would you rate the level of opportunity you have been given to implement and review the Trust's Membership Strategy?							
21.	How would you rate the opportunities you have had to serve the interests of the community or organisation that you represent?							
	Miscellaneous							
22.	If you are on a sub-committee, how would you rate the membership of the committee in terms of appropriate skill set for the task at hand?							
23.	How would you rate your level of contact with the board of directors?							
24.	If a conflict of view occurs, how would you rate the process for conflict resolution in terms of being dealt with in as an open, positive manner?							

No	Question	Excellent	Good	Adequate	Weak	Do not know	Not applicable	Comments
25.	How would you rate your corporate induction which you should have received prior to your first Council meeting? Please use the space provided to suggest additional information/areas to be covered.							
26.	How would you rate the current form of the Annual Members' Meeting? Please use the space provided to make further suggestions for future meetings.							
27.	How would you rate the information your have received about future training sessions? E.g. FTGA							

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 21 April 2010

AGENDA ITEM NO.	2.8/Apr/10
PAPER	Governors chelwest e-mail account arrangements
AUTHOR	Vida Djelic, Interim FT Secretary
LEAD	Christopher Edwards, Chairman
SUMMARY	Governors have been discussing for some time the issue of having a chelwest e-mail account. We have discussed this with the Director of IT and he confirmed that providing the Governors
DECISION/ ACTION	The Council is asked to note and discuss the paper.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 21 April 2010

AGENDA ITEM NO.	3.1/Apr/10
PAPER	Finance Report – February 2010
AUTHOR	Kelda Alleyne, Deputy Director of Finance
LEAD	Lorraine Bewes, Executive Director of Finance and Information
EXECUTIVE SUMMARY	The reported financial position for the Trust for the eleven months to 28th February 2010 is a surplus of £5.16m, which is £0.20m ahead of plan YTD and EBITDA is now behind plan by £2.52m at 7.4% (plan 8.8%). This is offset by a favourable variance of £2.71m on depreciation and financing. The EBITDA position in February is ahead of plan by £0.20m. Income was above plan largely due to recognition of education and training income of £0.5m which had been deferred. Pay budgets were under spent in February by £0.37m but this was more than offset by overspends on non pay by £0.43m. The net surplus for February was £0.47m better than plan due to a continued benefit on depreciation. The forecast EBITDA position is that the Trust will be behind plan at year-end. The forecast EBITDA shortfall has improved marginally from £2.46m to £2.44m. The full year forecast surplus is £6.92m against £6.4m planned. The financial risk rating for February remains at a '4' (excellent), and the forecast is also for the Trust to meet the criteria for a '4' FRR at 31st March 2010. The cash position at the close of February was £24.4m compared with the Monitor Plan of £20.7m, i.e. £3.7m higher than plan.
DECISION/ ACTION	The Council is asked to note the financial position for the period to 28th February 2010 and the updates in this report.

Financial Report to the Council of Governors of Chelsea & Westminster Hospital NHS Foundation Trust
8th April 2010

1.0 INTRODUCTION

This report to the Board of Directors sets out an analysis of the financial performance of the Trust for the 11 month period ended 28th February 2010.

2.0 OVERALL INCOME AND EXPENDITURE

The Trust recorded a net surplus of £0.13m in the month of February 2010 bringing the cumulative surplus for the ten months to £5.16m with an EBITDA[1] of £7.4%, which is £0.20m ahead of plan. The Trust's full year forecast is for a surplus of £6.92m at the end of the twelve month period. The quarterly analysis of the forecast surplus with details of the forecast for income is illustrated in Table 1 below. It should be noted that a key driver for the increase in the EBITDA in March is the number of operational elective days which is one of the highest of the year (23 vs 20 in February) and this is expected to increase income by c£2m compared with the prior 2 months:

Table 1

Quarterly Analysis of Surplus / (Deficit)

	Quarter 1	Quarter 2	Quarter 3	Months 10 and 11 (historical)	Month 12 (forecast)	Quarter 4 (forecast)	Total (forecast)
	£m	£m	£m	£m	£m	£m	£m
Income (see below for details)	77.41	75.26	76.66	49.99	27.53	77.52	306.85
Pay	(40.28)	(39.89)	(41.03)	(26.71)	(14.09)	(40.80)	(162.00)
Non-Pay	(30.16)	(30.86)	(29.98)	(19.85)	(10.21)	(30.06)	(121.06)
EBITDA	6.98	4.52	5.65	3.43	3.23	6.66	23.79
Non-Operational	(5.01)	(3.37)	(4.15)	(2.87)	(1.47)	(4.34)	(16.87)
Surplus / Deficit	1.97	1.15	1.51	0.56	1.76	2.32	6.92
EBITDA Ratio	9.0%	6.0%	7.4%	6.9%	11.7%	8.6%	7.8%

		Months 10 and 11 (historical)	Month 12 (forecast)
		£m	£m
Analysis of Quarter 4 Income	**Forecast Assumptions**		
NHS Clinical Contract Income	Loss of Burns £0.79m; higher number of elective days in March.	40.90	22.91
Education & Training Income	Reduction in MADEL Flexible Trainees and Drawdown of prior years' Deferred MADEL Income	4.70	2.21

Table 1 (continued)

		Months 10 and 11 (historical)	Month 12 (forecast)

[1] Earnings before Interest, taxes, depreciation and amortisation

Analysis of Quarter 4 Income	Forecast Assumptions	£m	£m
Misc other operating income	TFI £0.5m	1.77	1.44
Private Patient Income	Recovery after isolation discharges	1.44	0.80
Research & Development Income	Deferral to match project costs in next financial year	0.72	(0.05)
Other non-NHS Clinical revenue		0.21	0.11
Other NHS non tariff		0.25	0.11
Total		**49.99**	**27.53**

A Recovery Plan was implemented at the start of Q3 to improve the EBITDA position by £2.79m. However the Chief Executive's view is that this was overoptimistic and part of the recovery in Private Patients has been impacted by infection in ITU which has led to ITU patients stepping down into the Chelsea Wing rather than the wards. Since its inception, £0.54 has been achieved.

The in-month, year-to-date and forecast variances are illustrated in Table 2 below.

Table 2
Analysis of Variances

	Month 11	YTD	Month 12 (forecast)	Full Year (forecast)
	£m	£m	£m	£m
Income	(0.26)	(3.01)	0.69	(2.32)
Pay	(0.17)	2.34	(0.96)	1.38
Non-Pay	0.23	3.19	0.19	3.38
EBITDA	(0.20)	2.52	(0.08)	2.44
Non-Operational	(0.27)	(2.72)	(0.25)	(2.97)
(Surplus) / Deficit	(0.47)	(0.20)	(0.33)	(0.53)

The EBITDA performance exceeded target by £0.20m in February 2010. The EBITDA favourable variance comprised income £0.26m and pay £0.17m. This was offset by adverse non-pay variances of £0.23m.

The challenges for future performance remain:

- Income: The outlook for strong elective activity in Clinical Contract Income and containment of GUM under-performance in the final month is offset by the deferral of the Burns Development. Also, deferred 2009/10 activity in both *Research & Development* and *Training for Innovation* will be offset by a drawdown of Medical & Dental education Levy (MADEL) Deferred Income.

- Pay: Included in the last month's forecast is budget for the Burns Development and other Corporate Development, both of which have either been deferred or delayed, hence the expected positive variance in month 12. Frontline areas are forecast to manage within budget in Month 12 and maintain their quota systems for nursing staff and to continue to manage the vacancy rates.
- Non-Pay: The trend for Clinical Supplies is expected to continue in the final month. Clinical supplies including Pathology, MSSE and Prosthetic costs are expected to exceed budget by £0.69. These are expected to be offset by £0.66 on non-clinical supplies due to a release of reserves.

The CIP[2] target to Month 11 is £8.8m and of this 84% or £7.44m has been delivered. The full year forecast for achievement has fallen to 84%.

BALANCE SHEET

3.0 WORKING CAPITAL DAYS

The working capital days versus plan are set out in the table below. NHS Trade Debtor days have decreased to 9 days from 15 last month, versus a year end plan of 8 days.

Table 16
Working Capital Days

	Feb 10	Mar 10	
	Current Month Actual	Forecast	Monitor Plan
Stock days	25	29	35
NHS Trade Debtor days	9	9	8
Non-NHS Trade Debtor days	5	9	21
Trade Creditor days *	*(28)/14	*(27)/13	*(35)/16
Liquid Ratio (days)	28	27	27
Return on Assets Employed	4.8%	5.5%	5.0%

* This ratio is based on the Trust's methodology which excludes payroll and bank staff however it should be noted that Monitor calculate this ratio using total operating expenditure which results in a relatively lower ratio.

4.0 CASH FLOW (F9)

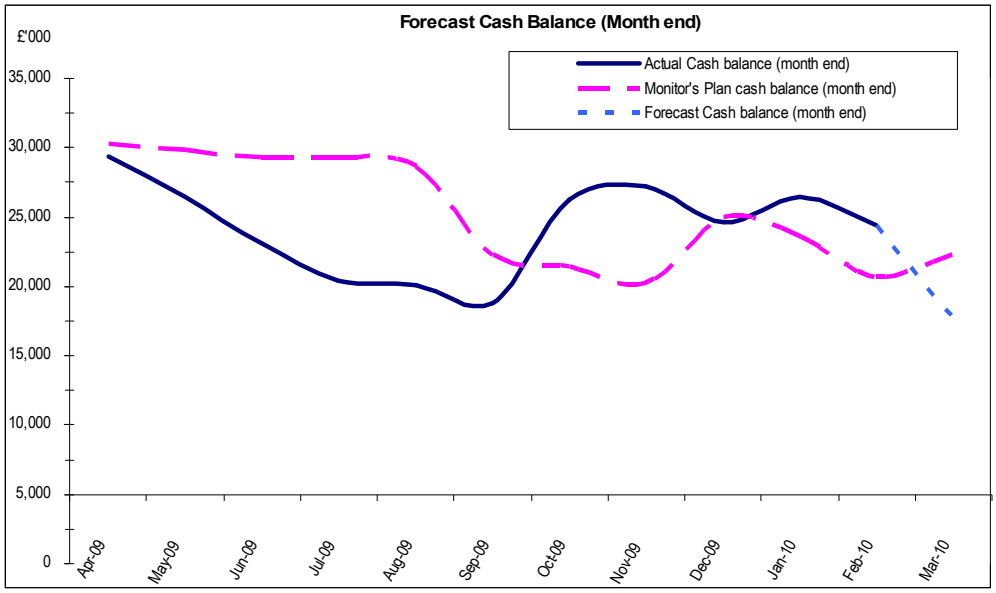
4.1 The cash position at the close of the month was £24.4m compared with the Monitor plan of £20.7m which is higher than plan by £3.7m. However within this position it should be noted that the Trust received an early payment relating to the K&C SLA of £7.8m.

4.2 The graph below shows the actual/forecast cash balance for the financial year compared to the Monitor Plan:

[2] Cost Improvement Programme

Table 6

Forecast Cash Balance



4.3 The year end forecast cash balance is £4.6m lower than the Monitor plan.

5.0 CAPITAL PROGRAMME

5.1 The Capital Budget for the year submitted to Monitor is £35.5m. The revised budget for the year at 28 February 2010 is £23.7m. The budget is represented by £8.0m of schemes carried forward from last financial year and new projects of £15.7m, the largest of which is the Netherton Grove expansion and Paediatric development at £3.7m (Including the medical equipment element) in 2009/10. Slippage of £7.4m has been identified to date at the meetings held with the budget holders and will be put forward for approval to the Capital Board for carrying forward to the next financial year.

5.2 The Netherton Grove project budget approved by the Board of Directors at £36.278m has increased by a total of £2.909m to **£39.187m.**

6.0 I&E Forecast

6.1 The forecast for the year end is a net surplus of £6.92m, which is £0.52m above the planned surplus of £6.40m. This forecast represents an improvement of £0.01m compared to the forecast reported at Month 10.

6.2 The key risks within the position are:

- The income forecast assumes delivery of the capacity plan over the remaining year and market share remains at current levels.
- Increased Pay costs to maintain high levels of activity

- Delivery of locally agreed stretch targets with K&C PCT on MRSA and CDiff.

Lorraine Bewes
Director of Finance and Information
6th April 2010

Monitor February 2010

Monitor Indicators								
Indicator Name	**YTD Target**	**Q1 (M1 to M3) Performance**	**Q2 (M4 to M6) Performance**	**Q3 Performance (M7 to M9)**	**Q4 Performance (M10 to M11)**	**Score Year to Date**	**Score Expected at Year End**	**Weight of Indicator**
Clostrium difficile cases	100	7	17	5	3	1.0	1.0	1.0
MRSA cases	15.8	1	4	4	1	1.0	1.0	1.0
18 Week Maximum Wait for Admitted Patients from Point of Referral to Treatment*	90%	93.07%	94.69%	93.65%	92.50%	1.0	1.0	1.0
18 Week Maximum Wait for Non Admitted Patients from Point of Referral to Treatment*	95%	98.86%	98.96%	98.99%	99.07%	1.0	1.0	1.0
Max time in A&E of 4 hours from arrival to admission, transfer or discharge	98%	98.64%	98.67%	98.30%	99.18%	0.5	0.5	0.5
Screening all elective in-patients for MRSA	1.0	1.30	1.36	1.44	1.51	0.5	0.5	0.5
31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	96%	100.00%	99.08%	97.92%	96.36%	0.5	0.5	0.5
31-Day Wait For Second Or Subsequent Treatment: Surgery	94%		96.49%	100.00%	100.00%			
31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	98%		100.00%	100.00%	100.00%	1.0	1.0	1.0
62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	85%	96.23%	97.65%	92.03%	87.23%			
62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers	90%	N/A	N/A	N/A	N/A	1.0	1.0	1.0
All Cancer Two Week Wait	93%	97.88%	97.2%	95.95%	93.97%	0.5	0.5	0.5
People suffering heart attack to receive Thrombolysis within 60 mins of call		N/A	N/A	N/A				
						8.0		**8.0**

Key		Total Score
The Trust is on track to meet this target		<1
It does not seem likely that the Trust will meet this target.		1+
It is not possible to accurately assess performance in this area.		

**** The Operating Framework sets the aim of moving towards achievement of these target in each specialty. Where an NHS foundation trust has failed to meet the thresholds for admitted (90%) or nonadmitted (95%) patients with respect to any individual speciality (defined as treatment function) over a quarter it is required to report each specialty to Monitor as part of its normal quarterly monitoring. Monitor may then require an action plan from the Trust to address the position.***

Care Quality Commission February 2010

	Indicator Name	YTD Performance	Performance Last Month	Target	Actual Banding	Predicted Banding	Comments
EXISTING COMMITMENTS INDICATORS	**Access to genito-urinary medicine clinics (48 hours)**	100.00%	100.00%	98%	Fully Met	Fully Met	
	Ethnic coding data quality	96.07%	94.56%	95%	Fully Met	Fully Met	CQC assessment will take on account **only** the data source and period from April 2008 to December 2009. However, the Trust will continue monitoring performance on ethnic coding. Performance YTD refers to April 2008 to December 09 and Performance last month refers to December 09.
	Delayed transfers of care	1.17%	2.93%	3.5%	Fully Met	Fully Met	CQC assessment will take on account **only** the data source and period from April 2008 to December 2009. However, the Trust will continue monitoring performance on ethnic coding. Performance YTD refers to April 2008 to December 09 and Performance last month refers to December 09.
	A&E waiting times (4 hours of less)	98.64%	99.21%	98.0%	Fully Met	Fully Met	
	Inpatients waiting longer than the 26 week standard	0.031%	0.00%	0.03%	Almost Met	Fully Met	1 plastic surgery breaches in April and 1 General Surgery patient breached in June, July, August and September and 1 Ophthalmology in October. YTD breaches = 6
	Outpatients waiting longer than the 13 week standard	0.02200%	0.02202%	0.03%	Fully Met	Fully Met	4x Ophthalmology, 1x Trauma and Orthopaedics, 1x General Surgery, 3x Paediatric Plastic Surgery, 1 Dermatology patient breache in January and same pateint breached in February. YTD breaches = 11
	Rapid Access chest pain clinic waiting times	99.69%	100.00%	98.0%	Fully Met	Fully Met	1 breach in November.
	Cancelled operations: Cancelled operations by the hospital for non-clinical reasons on the day of or after admission	0.51%	0.47%	0.8%	Fully Met	Fully Met	
	Cancelled operations by the hospital for non-clinical reasons on the day of or after admission, who were treated within 28 days.	5.30%	0.00%	5.0%			1 Urology breach in April, 1 General Surgery breach in May ,1 Plastic Surgery breach in November, 3 General Surgery breaches in December and 1 General Surgery in January. YTD = 7 breaches
	Reperfusion waiting times	N/A	N/A				
	Revascularisation waiting times (13 weeks)	Not applicable					
NATIONAL PRIORITY INDICATORS	**Smoking during pregnancy and breastfeeding initiation rates:** Infant health & Inequalities: Women known to be smokers at the time of delivery (2009/10)	4.30%	3.17%	4.81%	Fully Met	Fully Met	The Trust will be assessed as Achieved if the Smoking: difference is <=0% as compared with previous year or national average in 2008/09 and Breastfeeding initiation: difference is >=-5% (negative value) compared with previous year or national average in 2008/09. Trusts reporting more than 5% of status not know for 2009/10 data submission will fail this validation and will be categorised as "data not returned". These indicators are below target due to busy period in October and November when there was high usage of handwritten data entry proforma that made it difficult for the ward clerks to enter initiation correctly. This was compounded a higher than normal number of births.
	Infant health & Inequalities: Mothers known to initiate breastfeeding (2009/10	90.58%	94.20%	85.11%			
	Infant health & Inequalities: Smoking data completeness	99.28%	98.94%	95.0%			
	Infant health & Inequalities: Breastfeeding data completeness	99.98%	100.00%	95.0%			
	Quality of stroke care: Patients who spend at least 90% of their time on a stroke unit	95.09%	100.00%	70% expected target	Fully Met	Fully Met	135 patients out of 142 spent at least 90% of their time on the stroke unit. While the CQC has removed the assessment of trust performance on quality of high-risk TIA care from the indicator, it is important to continue maintaining high quality care in regards to TIA patients. It is CQC's intention that an assessment of trust performance against TIA care is reinstated in the 2010/11 assessment year.
	Maternity Hospital Episodes Statistics: data quality indicator					Fully Met (*last year*)	
	Incidence of MRSA Bacteraemia	10	0	17.4	Fully Met	Fully Met	2x Acute Medical Unit, 2x Lord Wigram, 1x Mercury, 2x Accident & Emergency, 1x Kobler Day Care, 2x Neonatal and 1x Mercury. YTD = 10 breaches
	Incidence of Clostridium difficile	32	2	54.5	Fully Met	Fully Met	1xAcute Medical Unit, 6x David Erskine, 3x Edgar Horne, 1x Maria Celeste, 4x Nell Gwynne, 1x HDU, 2x ICU, 1x Burns, 5x Chelsea, 2x Lord Wigram, 2x Rainsford Mowlem, 3x St. Mary Abbotts, 1x Mercury YTD = 32
	18 week referral to treatment waiting times: Patients who were admitted in *April to June 2009* who waited 18 weeks or less, reported in the referral to treatment times data collection.	93.07%		90.0%	Fully Met	Fully Met	The Trust has achieved the 18 weeks for admitted and non-admitted performance for Q1, Q2 and Q3 s far. There was one specialty breach (Urology) in November. Data completeness must be between 80% and 120% on both admitted pathways and nor admitted to pass the data quality test
	Patients who were admitted in *July to September 2009* , reported in the referral to treatment times data collection	94.69%		90.0%			
	Patients who were admitted in *October to December* 2009 who waited 18 weeks or less, reported in the referral to treatment times data collection.	93.65%		90.0%			
	Patients who were admitted in *January to March 2010* who waited 18 weeks or less, reported in the referral to treatment times data collection.	92.50%		90.0%			
	Non-admitted patients with completed pathways in April to June 2009 who waited 18 weeks or less, reported in the referral to treatment times data collection plus the number of direct access audiology patients with completed pathways in April to June 2009 who waited 18 weeks or less, reported in the direct access audiology waiting times collection.	98.86%		95.0%			
	Non-admitted patients with completed pathways in July to September 2009 who waited 18 weeks or less, reported in the referral to treatment times data collection plus the number of direct access audiology patients with completed pathways in July to September 2009 who waited 18 weeks or less, reported in the direct access audiology waiting times collection.	98.96%		95.0%			
	Non-admitted patients with completed pathways in October to December 2009 who waited 18 weeks or less, reported in the referral to treatment times data collection plus the number of direct access audiology patients with completed pathways in October to December 2009 who waited 18 weeks or less, reported in the direct access audiology waiting times collection.	98.99%		95.0%			
	Non-admitted patients with completed pathways in January to March 2010 who waited 18 weeks or less, reported in the referral to treatment times data collection plus the number of direct access audiology patients with completed pathways in January to March 2010 who waited 18 weeks or less, reported in the direct access audiology waiting times collection.	99.07%		95.0%			

Care Quality Commission February 2010

NATIONAL PRIORITY INDICATORS

Indicator Name	YTD Performance	Performance Last Month	Target	Actual Banding	Predicted Banding	Comments
Percentage of treatment functions achieving the 90% standard for admitted patients plus the number of treatment functions achieving the 95% standard for non-admitted and direct access audiology patients during the year, reported on the referral to treatment times collection and the direct access audiology waiting times collection over the fourth quarter of the year against total number of treatment functions for admitted patients plus the total number of treatment functions for non-admitted and direct access audiology patients during the year, reported on the referral to treatment times collection and the direct access audiology waiting times collection over the fourth quarter of the year.	**94.64%**					
Data completeness for 18 weeks Admitted	**97.08%**					
Data completeness for 18 weeks Non-Admitted	**90.31%**					
Cancer diagnosis to treatment waiting times: 31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	**98.64%**	**96.30%**	**96.0%**	**Fully Met**	**Fully Met**	*YTD breaches:* 3x Skin, 2x Lower Gastro
31-Day Wait For Second Or Subsequent Treatment: Surgery	**97.98%**	**100.00%**	**94.0%**			*YTD breaches:* 1x Urology
31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	**100.00%**	**100.00%**	**98.0%**			
31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments	**N/A**	**N/A**	**94.0%**			
Cancer urgent referral to treatment waiting times: 62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	**93.57%**	**93.33%**	**85.0%**	**Fully Met**	**Fully Met**	*YTD breaches:3x Haematology, 6x* Lower Gastro, 2x Urology, 1x Gynae
62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers	**N/A**	**N/A**	**90.0%**			
Cancer urgent referral to first outpatient appointment waiting times: All Cancer Two Week Wait	**96.64%**	**94.34%**	**93.0%**	**Fully Met**	**Fully Met**	*YTD breaches*: 1Xx Lung, 1x Head and Neck,30x Skin, 3x Upper Gastro, 9x Urology, 8x Gynaecology
Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected, April 2009 to March 2010	**N/A**	**N/A**	**93.0%**	**Fully Met**	**Fully Met**	
Experience of patients					**Fully Met *(last year)***	Care Quality Commission Emergency and Inpatient survey.
NHS staff satisfaction					**Fully Met *(last year)***	Care Quality Commission Staff survey.
Participation in heart disease audits: Participation heart disease audits: MINAP >=90% completion for key fields	**YES**	**YES**	**YES**	**Fully Met**	**Fully Met**	**MINAP completion of key fields:** Quarter 1: 98.7%, Quarter 2: 97.5%, Quarter 3: 100% and Quarter 4 will be available after the 31/12/2009 **MINAP data validation exercise:** For the 2008 data validation study which we undertook in the firs few months of 2009, our Trust achieved a score of 90%. The 2009 study is not planned until January 2010. **Trust does not participate** in the cardiac surgery or congenital heart audits as we do not offer those services here
Trust took part annual 2009 MINAP data validation exercise and achieved an agreement score of at least 80%	**YES**	**YES**	**YES**			
Trust provides PCI procedures participated in BCIS-CCAD audit with monthly uploading CCAD servers	**Not applicable**					
Trust provides PCI>=90% completion of key fields recorded by BCIS-CCAD project	**Not applicable**					
Trust participation in audit cardiac surgery audit	**Not applicable**					
Trust participation in cardiac rhythm management audit	**YES**	**YES**	**YES**			
Trust participation in heart failure audit	**YES**	**YES**	**YES**			
Trust participation in congenital heart disease	**Not applicable**					
Access to healthcare for people with a learning disability:						Trust position not yet confirmed. Assessment being undertaken by equality and diversity group. This indicator will not be included in the scored assessment for 2009/10. However, the Trust will be expected to collect the requisite information and report on it separately and the CQC will publish this along side the results of the review to ensure visibility. The Trust will be assessed on the responses to the six questions, based on the recommendations set out in 'Healthcare for all' (2008) – the Independent Inquiry into Access to Healthcare for People with learning Disabilities.
Does the trust have a mechanism in place to identify and flag patients with learning disabilities* and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients?						
In accordance with the Disability Equality Duty of the Disability Discrimination Act (2005), does the trust provide readily available and comprehensible information**						
Does the trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities, including the provision of information regarding learning disabilities, relevant legislation*** and carers' rights?						
Does the trust have protocols in place to routinely include training on learning disability awareness, relevant legislation***, human rights, communication techniques for working with people with learning disabilities and person centred approaches in their staff development and/or induction programmes for all staff?						
Does the trust have protocols in place to encourage representation of people with learning disabilities and their family carers within Trust Boards, local groups and other relevant forums, which seek to incorporate their views and interests in the planning and development of health services?						
Does the trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?						
Engagement in clinical audits					**Fully Met *(last year)***	Indicator currently being developed

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 21 April 2010

AGENDA ITEM NO.	3.3/Apr/10
PAPER	Foundation Trust Staff Governor Study
AUTHOR	Vida Djelic, Interim FT Secretary
LEAD	Christopher Edwards, Chairman
SUMMARY	Please find enclosed a hard copy of the Foundation Trust Staff Governor Study Report which was commissioned by the FTN and produced by the IPA.
DECISION/ ACTION	The Council is asked to note the study.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 21 April 2010

AGENDA ITEM NO.	3.4/Apr/10
PAPER	Appraisal of the Chair and NEDs – FTGA publication
AUTHOR	Vida Djelic, Interim FT Secretary
LEAD	Christopher Edwards, Chairman
SUMMARY	Please find enclosed a hard copy of FTGA essential brief – appraisal of the chair and non-executive directors for information.
DECISION/ ACTION	The Council is asked to note the essential brief.