Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting
Hospital Boardroom
Chair: Prof. Sir Christopher Edwards
Date: 9 February 2012 Time: 4.00pm

Agenda

		Lead	Time
1	**GENERAL BUSINESS**		
1.1	Welcome & Apologies	CE	4.00
1.2	Declaration of Interests	CE	
1.3	Minutes of Previous Meeting held on 1 December 2011	CE	
1.4	Matters Arising (attached)	CE	
1.5	Chairman's Report (oral)	CE	
1.5.1	Chief Executive's replacement (attached)	CE	4.20
2	**ITEMS FOR DISCUSSION/DECISION/APPROVAL**		
	COUNCIL OF GOVERNORS		
2.1	Feedback from 24 November Away Day	CE	4.30
2.2	Who do you think WE are? – developing Trust's values (attached)	TD/MG	4.40
2.3	Business Planning 2012/13 (attached)	AP	5.00
2.4	Governors' Questions (attached)		5.10
	End of Life Care - presentation by Dr Sarah Cox	TD	
2.5	Council of Governors Performance Evaluation Report – response to questionnaire (attached)	CE	5.20
2.6	Report on Senior Nurse/Governor Rounds (attached)	TP	5.30
2.7	Open Day 12 May 2012 – update (attached)	RMcB	5.45
2.8	Council of Governors Funding Report (attached)	VD	5.50
	QUALITY		
2.9	Quality Awards (attached)	CM	6.00
2.10	Chelsea and Westminster Star Awards 2012 (attached)	MG	
2.11	Quality Account Update (oral)	CM	6.10
2.12	Quality Sub-Committee report* (draft minutes of 24 January 2012 meeting attached)	MA	
	MEMBERSHIP		
2.13	Membership Sub-Committee report (oral)	ML	6.15
2.14	Membership Engagement and communication – update* (attached)	MAk	
2.15	Membership Report* (attached)	TP	
3	**ITEMS FOR INFORMATION**		
3.1	Finance Report – December 2011 (attached)	LB	
3.2	Performance Report – December 2011 (attached)	AP	
4	**ANY OTHER BUSINESS**		6.20
5	**DATE OF THE NEXT MEETING – 3 May 2012**		

***Items that have been starred will not be discussed unless a prior notice has been given to the Chairman**

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 9 February 2012

AGENDA ITEM NO.	1.3/Feb/12
PAPER	Draft Minutes of Council of Governors Meeting – 1 December 2011
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper outlines a record of proceedings at the previous meeting.
DECISION/ ACTION	1. To agree the minutes as a correct record. 2. The Chairman to sign the minutes.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting Minutes, 1 December 2011
Draft minutes

Prof. Sir Christopher	Edwards	Chairman		CE
Chris	Birch	Patient		CBir
Christine	Blewett	Public	Hammersmith and Fulham 2	CBle
Nicky	Brown	Appointed	The Royal Marsden NHS Foundation Trust	NB
Fergus	Cass	Appointed	NHS Kensington &Chelsea	FC
Alan	Cleary	Patient		ACle
Rosie	Glazebrook	Appointed	PCT NHS Hammersmith and Fulham	RG
Anne	Hodson-Pressinger	Patient		AH-P
Melvyn	Jeremiah	Public	Westminster 2	MJ
Martin	Lewis	Public	Westminster 1	ML
Kathryn	Mangold	Staff	Nursing and Midwifery	KM
William	Marrash	Patient		WM
Susan	Maxwell	Patient		SMax
Wendie	McWatters	Patient		
Henry	Morgan	Public	Wandsworth 1	HM
Cyril	Nemeth	Appointed	Westminster City Council	CN
Sandra	Smith-Gordon	Public	Kensington and Chelsea 2	SS-G
Frances	Taylor	Appointed	Royal Borough of Kensington and Chelsea	FT
Maddy	Than	Staff	Support, Admin & Clerical	MT
Alison	While	Appointed	King's College	AW

IN ATTENDANCE:

Sir John Baker	Non-executive Director	JB
Jeremy Loyd	Non-executive Director	JL
Sir Geoffrey Mulcahy	Non-executive Director	GM
Charlie Wilson (in part)	Non-executive Director	CW
Heather Lawrence	Chief Executive	HL
Mike Anderson	Medical Director	MA
Lorraine Bewes	Director of Finance	LB

Mark Gammage	Director of HR	MG
Catherine Mooney	Director of Governance and Corporate Affairs	CM
Axel Heitmueller	Director of Strategy and Business Development	AHe
Matt Akid	Head of Communications	MAk
Anthony Pritchard	Interim Deputy Chief Nurse	TP
Vida Djelic	Foundation Trust Secretary	VD

The meeting observed one minute's silence for Word AIDS Say.

1 GENERAL BUSINESS

1.1 Welcome & Apologies — CE

CE welcomed the two new governors to the Council and congratulated SS-G on being re-elected. (See 1.2)

Apologies were received from Cass J. Cass-Horne, Edward Coolen, Jenny Higham, Jacinto Jesus and Taryn Youngstein.

CE informed governors that David Finch, appointed governor from Wandsworth PCT resigned from the Council due to the constraints of his role as Joint Medical Director for SW London cluster. We will seek a replacement.

CE also informed governors that Charlotte Mackenzie Crooks, Staff Governor - Support, Admin & Clerical resigned due to moving house and having a baby. He noted her contributions re volunteer services and wished her well.

CE informed governors that the Chelsea and Westminster Hospital NHS Foundation Trust has been named the best hospital in England in the Dr Foster Hospital Guide for low mortality rates in the four indicators measured. ML thanked staff and the executive directors for the excellent performance. A copy of the relevant extract from the Dr Foster publication was tabled.

1.2 Announcement of results of elections — CE

CE informed governors that the results of the election were published on 25 November and the results are as follows:

- Anne Hodson-Pressinger – Patient Governor
- Sandra Smith-Gordon Public Governor – Kensington and Chelsea 2 re-elected
- Maddy Than – Staff Governor – Support, Admin and Clerical

1.3 Code of Conduct Acceptance **CE**

VD noted that the Code of Conduct acceptance had been sent to new governors to sign and return. These have been received.

1.4 Declaration of Interests **CE**

None.

1.5 Minutes of Previous Meeting held on 15 September 2011 **CE**

Minutes of the previous meeting were accepted as a true and accurate record of the meeting with the following changes:
- p. 1 HM represents the public constituency - Wandsworth Area 1
- p. 8 Dr Azadian Berge should read Dr Berge Azadian
- p. 8 should read 'meet a governor'

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

ACle commented on the previous minutes with ref. to item 2.7/Sep/11 and 7 areas of his concern for patients which was presented in his written report at the last meeting and said he had hoped to see reference to these points in the minutes.

ACle also commented with ref to his question on money spent on prevention he had expected a more detailed answer. He wanted to know if the proportion of money spent on prevention vs treatment was adequate.

HL responded that it would be difficult to indicate whether or not it is adequate. This would depend on the specialty, for example in HIV a significant amount is spent on prevention. She pointed out that our main role within the Trust is not prevention.

ACle also commented that the 'Fit for the Future' Report and 'Quality Oversight' should be debated by governors.

1.6 Matters Arising **CE**

<u>1.4/Sep/11 Room request from governors</u>

VD said that Helen Elkington, Head of Facilities and Estates had found a suitable room on the ground floor of the hospital and that it will be available in January 2012. The room will have a filing cabinet, desk, two chairs, some shelves and coat rack.

<u>2.5/Sep/11 Governors' generic email account proposal</u>

VD said that Bill Gordon, Acting Director of IT confirmed that IT are currently testing a solution which will be much more workable for governors. This will be a Hotmail or Gmail web based solution like most people use at home for their personal email. Access will be directly via a webpage to a secure Web Email Server and the users would logon similarly to Hotmail or Gmail. The email

address will be in the format of 'firstname.surname@governors.chelwest.nhs.uk' and will allow easy access without the need to login to our remote access.

Some governors will be invited to test the solution before Christmas (MJ, ML, CB volunteered). **Action: Governors to be invited to test the new solution.** **VD**

MJ also provided feedback on his experience from using the chelwest account.

All other items were noted as being completed.

1.6.1 Performance evaluation

CE outlined the background of the questionnaire circulated and stressed the importance of a periodic assessment of governors' performance. Relevant questions have been taken from Monitor's Governors Survey 2010 and governors were invited to discuss and agree the questionnaire.

The governors discussed and agreed the questionnaire with the following changes:

- p5 remove question 5.8

CBir queried the value of the exercise. CE responded that this will assess performance and allow to benchmark ourselves with the Monitor survey results.

Acton: VD to circulate the questionnaire to the governors to complete and send back by 19 January 2012. **VD/All**

1.7 Chairman's Report **CE**

CE reported on the tragic death of a young technician employed by the Trust who was found in a laboratory on the 5th floor of the St Stephen's Centre. This is space leased to the International AIDS vaccine initiative supported by Imperial College. A detailed investigation is being undertaken.

There are currently no significant risks and the laboratory is functioning. Education about the use of nitrogen has been set up for all staff working with nitrogen.

CE reported that he and HL attended a meeting chaired by Lord Darzi re establishing an Academic Health Sciences Partnership (AHSC) including Imperial College.

CE explained that there is £1 billion education and training budget held by the SHA. When the SHA is disbanded, money will be held by Local Education Training Boards (LETB). HL said that she will be setting up the NW London LETB. There will be an independent Chair and an independent CEO. The LETBs will be responsible for 1/3 of the London budget and this is separate from the clinical budget.

2 ITEMS FOR DISCUSSION/DECISION/APPROVAL

2.1 Terms of Reference of Agenda Sub-Committee* **CE**

This item was starred and therefore taken as read.

2.2 Report on the Chairman appraisal **JB**

CE and the Board of Directors left the room.

Sir John Baker, Vice Chair of the Board and Senior Independent Director introduced the item and invited Charlie Wilson, former Vice Chair and Senior Independent Director to present feedback on the Chairman's appraisal.

CW thanked all governors who had provided comments to Brian Gazzard, the Deputy Chair of the Council of Governors. CW said he collated all the comments including from the Board members and shared these with the Chairman. He described areas of excellence and areas where some improvement is needed.

CW said that he shared the comments with the Chairman who was thankful for the feedback.

There was some discussion emphasising the need to focus on strategy and more interaction with the Non-executive Directors.

ACle queried if the Chairman was appraised based on the last year's performance or the future performance. He commented he was told it based on both but he was not convinced.

JB clarified that the Chairman's performance review is based on his performance during the past and current year and taking into account looking forward.

The Chairman and Board of Directors returned.

JB left the room.

2.3 Remuneration for the Senior Independent Director and Chair of Audit Committee **CE**

CE outlined the paper and highlighted the need to consider remuneration for Sir John Baker as he has undertaken the post of the Chairman of Audit Committee and the role of the Senior Independent Director.

The Council of Governors agreed to the proposed remuneration of £20,000 for JB as the Chairman of Audit Committee and being the SID.

2.4 Council of Governors Funding Report **VD**

CE outlined the funding report.

MAk presented bids for funding of the membership engagement and communication activities which had been supported by the Membership Sub-Committee.

MAk highlighted the existing activities planned for 2011/12 outlined in paper 2.12

and proposals for 2012/13.

WMW commented that the Open Day is an excellent event and suggested that the opening is done by a celebrity as it is likely to get a wide media coverage.

HL commented that if we wished to advertise the event wider we would need to expand the budget.

The Council of Governors agreed to support funding of £11,648 for the engagement activities in 2011/12 as outlined in the paper.

The Council of Governors agreed to support additional funding of £22,592 for engagement activities in 2012/13 as outlined in the paper.

MAk outlined the funding request for a dedicated blog system as a method of communicating with members via the website.
The Council of Governors agreed to support funding of a dedicated blog system for £2,520.

MAk outlined a proposal for the Trust Open Day 2012 and said that it was presented to the Membership Sub-Committee at its meeting on 8 November. The sub-committee supported the proposal.
The Council of Governors agreed to support funding of the Open Day 2012 for £15,000.

ACle queried if we were going to involve sixth form schools and graduates in these activities.

RMB responded that we plan to engage with young people on a wider scale next year and there is already a partnership with the Westminster School.

SS-G suggested we should also invite the Chelsea Academy.

TP outlined the proposal for funding for health bus recruitment activities which was presented to the Membership Sub-Committee on 8 November. The sub-committee supported the proposal and the request was put to the Council for funding.
The Council of Governors agreed to support the funding for the recruitment activities totaling £3,300 for the reminder of the financial year.

2.5 Governors' Questions **HL**

2.5.1 Does the C&W NHS Foundation Trust have any obligations under the PFI (Private Finance Initiative) legislation? Harry Morgan

HL responded that the Chelsea and Westminster Hospital NHS Foundation Trust is not in the Private Finance Initiative (PFI) scheme and therefore there is no obligation. We were one of the last hospitals to be built without a PFI.

2.5.2 In the light of recent concerns over nursing, would the hospital consider setting up its own training scheme for both nurses and health care assistants, over and above regular training updates, and that lead to a, possibly unique, qualification

in bedside care? Sandra Smith-Gordon

HL responded that the Chelsea and Westminster Hospital NHS Foundation Trust provides training to pre-registration students and there are essential skills as part of their curriculum training. We work closely with universities to achieve these standards.

Not all nurses are trained via our system. Staff who are not registered healthcare assistants are required to go through a programme and there is potential to widen the programme for other groups of staff. The training and standards need to be integrated into the day to day job.

SS-G said she felt that the Chelsea and Westminster Healthcare NHS Foundation Trust should develop its own qualification.

HL responded that we could do it for care assistants, however, under the current arrangements we would not be able to provide nurses training.

MT said that the Trust provides the BEACH course for the HCAs and we also provide alert courses for doctors including external staff.

CE said that the health education in England is changing with the Academic Health Sciences Partnerships and referred to raising the academic profile of the Trust with Imperial College Local Education and Training Boards (LETB).

2.6 Audit of Governors Skills **SS-G**

SS-G introduced the paper as a useful way of understanding governors' knowledge, skills and experience in order to help the hospital management deciding how to make best use of its governors.

SS-G provided a draft sample skills audit and suggested that the audit is conducted annually.

CE said that VD will circulate the skills audit to governors.

Action: VD to circulate the skills audit to governors. **VD**

2.7 Governor/Senior Nurse Patient Rounds Update **TP**

ML apologised for not providing a report following the visit to Burns Unit on 19 October.

TP outlined the main highlights of the visits.

2.8 Proposal for Governor Engagement in Senior Nurse and Midwifery Clinical Half Days **TP**

TP outlined a proposal for governor engagement in Senior Nursing and Midwifery Clinical Half days as an opportunity to participate in the assessment of core clinical standards based on the Care Quality Commission standards, as an alternative to the current senior nurse/governor rounds.

TP said that designated leads work with Matrons, Ward Sisters, General Managers and other staff to assess the standards of care and treatment within wards and clinical departments. They observe the clinical environment through discussing care and treatment with patients, families and staff.

TP proposed that the Senior Nurse and Midwifery Clinical Half Days replaces the current senior nurse/governor rounds.

HL suggested this should also be arranged at weekends. CBlew also suggested a visit at night.

This was agreed.

Action: TP to organise. **TP**

2.9 Feedback from 24 November Away Day **CE**

Due to time constraints CE suggested that VD circulates notes of the Away Day to governors and this can be discussed at the next meeting.

Action: VD to circulates notes of Away Day to governors **VD**
Action: VD to add to February Council of Governors agenda. **VD**

2.10 Quality Sub-Committee report - draft minutes of 16 November 2011meeting **MA**

CM highlighted the key points from the Council of Governors Quality Sub-Committee meeting held on 16 November 2011.

CM asked the Council of Governors to confirm the choice of the surgery objective as the local indicator for external audit.

CM noted that the Quality Sub-Committee agreed that the meetings of the sub-committee continue to be chaired by Dr Mike Anderson, Medical Director.

CM said that the sub-committee reviewed the priorities and these will probably be as follows:

- VTE – 6 cases to date against a target of zero.
- Surgery – good performance on waiting times but no data yet on nil by mouth time and communication with patients.
- Patient experience- good progress but a large objective and always recognised it would take some time.
- Patient experience/workforce - appraisal rates are less than we would like so progress could be better.

Council of Governors agreed to the surgery waiting time indicator as the local indicator for external audit.

Council of Governors agreed that the Quality Sub-Committee meetings continue to be chaired by Dr Anderson.

2.11 Membership Sub-Committee report - draft minutes of 8 November 2011 meeting **ML**

ML highlighted the main issues discussed and these were as follows:

- MA presented proposals for engagement with members
- CBir presented a paper on the Information Zone and how it is managed and recognised that it has recently been managed well
- Governors' chelwest email account was discussed and the need for each governor to have one and the responsibility to communicate with members
- WMW had some comments on Capita recruiters

2.12 Proposals for membership engagement and communication 2012 **MAk**

This item was discussed earlier in the meeting ref. item 2.4.

2.13 Calendar of membership engagement and communication events 2012 **MAk**

This item was discussed earlier in the meeting ref. item 2.4.

2.14 Open Day 2012 – proposals **RMB**

This item was discussed earlier in the meeting ref. item 2.4.

2.15 Membership Report* **TP**

This item was starred and therefore taken as read.

3 ITEMS FOR INFORMATION

3.1 Finance Report – October 2011 **LB**

This item was taken as read.

3.2 Performance Report – October 2011 **AP**

This item was taken as read.

3.3 Council of Governors meeting dates for 2012 **VD**

This item was taken as read.

4 ANY OTHER BUSINESS **CE**

Chitra Dun, a public member who attended the meeting commented on the meeting being very well run. He said that he would like to offer help re saving money in IT budget.

SS-G to reminded governors that the Friends Christmas raffle is on Wednesday, 14 December.

ACle said he would like to record his opposition to the Agenda Sub-Committee as he felt it acts as a blocking committee rather than ensuring that the meetings are productive. CE noted that this committee and its terms of reference had been agreed by the Council of Governors.

5 DATE OF THE NEXT MEETING

The next meeting of the Council of Governors will be held on 9 February 2012.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 9 February 2012

AGENDA ITEM NO.	1.4/Feb/12
PAPER	Matters Arising from the meeting of the Council of Governors meetings held on 1 December 2011
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper lists matters arising from previous meeting and the action taken or subsequent outcomes.
DECISION/ ACTION	The Council of Governors is asked to note the matters arising and the updates.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

MATTERS ARISING
Council of Governors Meeting
Hospital Boardroom
Chair: Prof. Sir Christopher Edwards
Date: 1 December 2011
Time: 4:00 – 6:30 pm

Ref	Description	Lead	Subsequent Actions or Outcomes
1.5/Dec/11	**Minutes of Previous Meeting held on 1 December 2011.**		
	VD to amend minutes in line with comments received.	**VD**	Completed
	Action: Governors to be invited to test the new solution.	**VD**	
1.6.1/Dec/11	**Performance evaluation**		
	VD to circulate the questionnaire to the governors to complete and send back by 19 January 2012.	**VD**	Completed. Report on agenda.
2/6/Dec/11	**Audit of Governors Skills**		
	VD to circulate the skills audit to governors.	**VD**	Circulated.
2.8/Dec/11	**Proposal for Governor Engagement in Senior Nurse and Midwifery Clinical Half Days**		
	TP proposed that the Senior Nurse and Midwifery Clinical Half Days replaces the current senior nurse/governor rounds. **TP to organise.**	**TP**	
2/9/Dec/11	**Feedback from 24 November Away Day**		
	VD to circulates notes of Away Day to governors	**VD**	Completed
	VD to add to February Council of Governors agenda.	**VD**	On agenda

Council of Governors Meeting, 9 February 2012

AGENDA ITEM NO.	1.5.1/Feb/12
PAPER	Chief Executive's Replacement
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper outlines the process for the appointment of the new Chief Executive. The Chairman will discuss the involvement of the governors at the meeting.
DECISION/ ACTION	The Council of Governors is asked to note the process for appointment of Chief Executive and to agree to an additional Council of Governors' meeting to approve the appointment of the new Chief Executive. The Council of Governors will also be asked to agree on governor involvement in the recruitment process.

Chief Executive Replacement

1. Introduction

This paper outlines the process for the appointment of the new Chief Executive. For information, the difference between the appointment of Non-executive Directors and Executive Directors is outlined in appendix 1.

2. Background

The legislation states that the appointment of a Chief Executive must be undertaken by the Non-executive Directors and with the approval of the Board of Governors.

Further detail is as follows (extract from the Monitor Code of Governance):

C.1.10 *It is a requirement of the 2006 Act that the chairman, the other Non-executive Directors and – except in the case of the appointment of a chief executive –the chief executive, are responsible for deciding the appointment of executive directors. The nominations committee with responsibility for executive director nominations should identify suitable candidates to fill executive director vacancies as they arise and make recommendations to the chairman, the other Non-executives Directors and, except in the case of the appointment of a chief executive, the chief executive.*

C.1.11 *It is for the Non-executive Directors to appoint and remove the chief executive. The appointment of a chief executive requires the approval of the Council of Governors.*

C.2.1 *Approval by the Council of Governors of the appointment of a chief executive should be a subject of the first general meeting after the appointment by a committee of the chairman and Non-executive Directors. All other executive directors should be appointed by a committee of the chief executive, the chairman and Non-executive Directors.*

3. Nominations Committee and Appointments Committee

The Nominations Committee consists of the Non-executive Directors and the Chairman (and the Chief Executive except in the case of their own appointment) with the addition of any additional member as deemed appropriate by the Board. The Director of Human Resources attends for advice and support. The Nominations Committee agrees the job description and person specification, agrees the search process and any assessment tests. They agree the short-list of not more than 5 candidates.

The Appointments Committee consists of the Non-executive Directors and the Chairman (and the Chief Executive except in the case of their own appointment) with the addition of any additional member as deemed appropriate by the Board. The Director of Human Resources attends for advice and support. This is similar to the Nominations Committee but the difference is that additional members may be different to the Nominations Committee. The Appointments Committee interviews and makes the decision on a candidate to recommend to the Council of Governors.

4. The involvement of the Council of Governors

The appointment of a Chief Executive requires the approval of the Council of Governors and the Chairman will discuss involvement of the governors in the recruitment process at the meeting.

5. Process to date

The Nominations Committee and Appointments Committee Terms of Reference were reviewed and agreed by the Board on 26 January 2012.

The Nominations Committee has held its first meeting and agreed on Saxton Bampfylde as the executive search agency from a shortlist of three agencies.

The job description and person specification is in the process of being reviewed.

A more detailed timeline will be drawn up when possible.

6. Approval by the Council of Governors

As the code states *the approval by the Council of Governors of the appointment of a chief executive should be a subject of the first general meeting after the appointment by a committee of the chairman and Non-executive Directors*.

The Appointments Committee will present to the Council a report confirming that

- the agreed appointment process has been followed
- the constitution has been followed
- the process has identified a candidate with sufficient experience, skills and behavioural attributes to fulfil all essential aspects of the job description

The next Council of Governors Meeting is in May which is felt to be too long a delay for appointment and it is proposed that an additional meeting will be called to approve the recommendation of the Appointments Panel. The exact date of this is to be agreed and will need to ensure sufficient attendance by governors.

7. Action/Decision

The Council of Governors is asked to note the process for appointment of the Chief Executive and to agree to an additional meeting to approve the appointment of the new Chief Executive. The Council of Governors will also be asked to agree on governor involvement in the recruitment process.

Area	**TERMS OF REFERENCE OF THE NOMINATIONS COMMITTEEOF THE COUNCIL OF GOVERNORS FOR THE APPOINTMENT OF NON-EXECUTIVE DIRECTORS**	**TERMS OF REFERENCE OF THE NOMINATIONS COMMITTEE OF THE BOARD OF DIRECTORS FOR THE APPOINTMENT OF EXECUTIVE DIRECTORS**
Coverage	Non-executive Directors	Executive Directors and the Secretary
Constitutional provisions for appointments	Constitution S12.2.1: Appointed by the Council of Governors	Constitution S12.2.2.1: Chief Executive – Appointed by Non-executive Directors subject to approval of the Council of Governors Constitution S12.2.2.2: Other Executive Directors – Appointed by the Chairman, Chief Executive and other Non-executive Directors (referred to as the Appointments Panel) Constitution S13.3: The Secretary – appointed and removed by the Board of Directors subject to the approval of the Council of Governors
Constitutional provisions for nominations	Constitution s12.5.3: Nominations Committee	Not applicable
Authority of each Nominations Committee	Standing Committee of the Council of Governors	Standing Committee of the Board of Directors
Reports its recommendations to	Council of Governors	Appointments Committee

Area	TERMS OF REFERENCE OF THE NOMINATIONS COMMITTEEOF THE COUNCIL OF GOVERNORS FOR THE APPOINTMENT OF NON-EXECUTIVE DIRECTORS	TERMS OF REFERENCE OF THE NOMINATIONS COMMITTEE OF THE BOARD OF DIRECTORS FOR THE APPOINTMENT OF EXECUTIVE DIRECTORS
Membership of Committee	Fixed according to Constitution	Flexible – members appointed by Board accommodating the range of skills required of assessors
Facilitation of Nomination of Internal Candidates or Personal Contacts	NOT APPLICABLE Identify appropriate candidates (not more than five for each vacancy) through a process of open competition and make recommendations	APPLICABLE Identify appropriate candidates (not more than five for each vacancy) through a process of open competition OR OTHERWISE and make recommendations
Skills and experience of appointees	To be identified by the Board of Directors	The Committee may invite any person to attend the Committee to provide advice and services which assist the committee in their consideration of any matter.
Responsibility to review of the size, structure and composition of the Board	The Constitution s12.5.1 establishes the duty of the Council of Governors to review NEDS only Incorporated into Terms of Reference (for NEDS)	The Code of Governance C.1.1 establishes duty of Nominations Committee to review full board. Incorporated into Terms of Reference (for EDS)

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 9 February 2012

AGENDA ITEM NO.	2.1/Feb/12
PAPER	Draft minutes of a joint Board/Council of Governors Away Day 24 November 2011
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper outlines a record of proceedings at a joint Board/Council of Governors Away Day held on 24 November 2011
DECISION/ ACTION	1. To agree the minutes as a correct record. 2. The Chairman to sign the minutes.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Joint Board/Council of Governors Away Day 24 November 2011 – draft

Council of Governors

Prof. Sir Christopher	Edwards	Chairman		CE
Chris	Birch	Patient		CBir
Christine	Blewett	Public	Hammersmith and Fulham 2	CBle
Nicky	Browne	Appointed	The Royal Marsden NHS Foundation Trust	NB
Anthony	Cadman	Patient		ACad
Fergus	Cass	Appointed	NHS Kensington &Chelsea	FC
Cass J.	Cass-Horne	Patient		CC-H
Alan	Cleary	Patient		ACle
Samantha	Culhane	Public	Hammersmith and Fulham 1	SC
Carol	Dale	Staff	Management	CD
Brian	Gazzard	Staff	Medical and Dental	BG
Rosie	Glazebrook	Appointed	PCT NHS Hammersmith and Fulham	RG
Jenny	Higham	Appointed	Imperial College London	JH
Melvyn	Jeremiah	Public	Westminster 2	MJ
Jacinto	Jesus	Staff	Contracted	JJ
Martin	Lewis	Public	Westminster 1	ML
Kathryn	Mangold	Staff	Nursing and Midwifery	KM
William	Marrash	Patient		WM
Susan	Maxwell	Patient		SMax
Wendie	McWatters	Patient		WMW
Cyril	Nemeth	Appointed	Westminster City Council	CN
Sandra	Smith-Gordon	Public	Kensington and Chelsea 2	SS-G
Frances	Taylor	Appointed	Royal Borough of Kensington and Chelsea	FT
Alison	While	Appointed	King's College	AW

Board

Sir John Baker	Non-executive Director	JB
Richard Kitney	Non-executive Director	RK
Jeremy Loyd	Non-executive Director	JL
Sir Geoffrey Mulcahy	Non-executive Director	GM
Karin Norman	Non-executive Director	KN
Heather Lawrence	Chief Executive	HL
Amanda Pritchard	Deputy Chief Executive	AP
Mike Anderson	Medical Director	MA
Lorraine Bewes	Director of Finance	LB
Therese Davis	Chief Nurse and Director of patient Experience and Flow	TD

In attendance

Mark Gammage	Director of HR	MG
Catherine Mooney (in part)	Director of Governance and Corporate Affairs	CM
Axel Heitmueller	Director of Strategy and Business Development	AH
Matt Akid	Head of Communications	MA
Anthony Pritchard	Interim Deputy Chief Nurse	AP
Zoe Penn	Divisional Medical Director	ZP
Vida Djelic	Foundation Trust Secretary	VD

Apologies were received from Eddie Adams, Edward Coolen and Taryn Youngstein.

The Chairman welcomed those attending.

The Chairman gave a brief overview of the day and said that it was a very useful opportunity for the Board members and Governors to interact and exchange views.

The Chairman invited attendees to introduce themselves.

Focus on Values

Jeremy Loyd, Non-executive Director with a particular interest in patient experience, gave a presentation on values in the context of the NHS constitution and provided examples of successful organisations. He stressed the importance of these values being embedded in the Trust.

It was recognised that C&W provides good specialist clinical services. However, we aim to improve patient care in all aspects of experience of the hospital, in particular in non-clinical areas. The two most important drivers are attitude and communication (behavior).

Axel Heitmueller, Director of Strategy and Business Development gave a presentation on some good practice examples and what these companies have done in order to achieve excellent customer service. Most of these companies use IT technology to better understand customers.

Axel discussed the recruitment processes and how values play an important part in recruitment.

It was recognised that the key elements of the approach to customer service used by most commercial companies can be applied to the health sector. However, healthcare is complex and the nature of the business is very different and these make it difficult to be excellent at all times.

HL introduced the NHS values.

There were roundtable discussions which were based around the NHS Values; 6 tables were set up and each table was asked to discuss one value and provide feedback on three key points relating to the following two questions:

1. Related to your value, if you were a member of staff, patient or family member what would you expect to experience in relation to this value?

2. How can we engage staff, patients and families in developing our values?

Feedback on the question 1 consisted of the following:

Table 1 - Value: Respect and dignity
- Courtesy
- How we behave
- Know background/do not waste time

Table 2 – Value: Commitment to quality care
- Good communication attitude
- Accountability/ownership of staff
- Mutual respect

Table 3 – Value: Compassion
- First point of contact important
- Not patient's fault if wrong
- Respect time – not waiting
- Value staff and what they do
- Treat colleagues as you would like to be treated

Table 4 – Value: Improving lives
- Communication – 'in my shoes', respect, people with learning difficulties
- Inclusive/diversity
- Respect/kindness/compassion
- Partnership with patients/families
- Wellness
- Prevention
- Promotion

Table 5 – Value: Working together for patients
- Communication
- Who staff are – ID
- Discharge problems/keeping in touch with GPs
- Use of IT – appropriate records

Table 6 – Value: Everyone counts
- Details of treatment
- Two way communication
- Leadership from top
- Rewarding good behavior

Feedback on the question 2 consisted of the following:

- Training/respect
- Use complaints recognition
- Develop forums
- Quality questionnaires
- Improve from complaints
- Training/role play
- Start at recruitment
- Integrate at every level all activities
- Link to staff morale
- Present to staff what are barriers
- Look at patient journey
- Learn from complaints
- Improve communication
- Experience of being customer mystery shopper
- Encourage personal responsibility
- Encourage positive/negative feedback

Mark Gammage, Director of HR presented on how the values discussed might be incorporated in the HR process of the Trust. We look at competence for some senior appointments via the use of assessment centres.

We need to look at how we recruit based on values. We have to be clear on values and behaviors to expect and build in the competence.

JL summarised the main discussion points on values and assured the attendees that feedback will be taken on board in order to improve patient experience at the Chelsea and Westminster Hospital.

The Chairman concluded the session on values by recognising that the majority of staff already provide excellent care and those that do not need to transform.

Netherton Grove extension - Paediatrics and HIV

Branding of New Children's hospital

Zoe Penn, Divisional Medical Director presented on the branding of the new children's hospital. A branding company had advised us on the branding.

The feedback was that we should focus on telling the patients we are 'modern, professional and the services we provide are excellent'.

Some governors felt they should have been involved in the branding exercise earlier and that they should have been consulted on the name of children's hospital. They felt that the name should have been selected on the historical basis so that it reflects both Chelsea and Westminster areas and institutions.

Other governors disagreed and felt that it is not their area of expertise and therefore irrelevant whether they were consulted or not.

Heather Lawrence, apologised for not involving governors but emphasised that this was an example of empowering staff. She agreed that it is important to keep archives relating to Westminster Children's Hospital, however, the advice of the branding consultants was that it is important to have a new name as a recognisable brand.

HL emphasized that the most important fact is the message of the brand which is that the door of the hospital is open to all patients regardless of the area they live in.

ML said the governors fully supported the development and suggested that either a ward or department is called after the Westminster Children's Hospital.

HL responded that it might be difficult because of the theme which has already been chosen. However, we can do something at the entrance re heritage.

The Chairman made the point that the heritage could be very useful in fundraising.

CBir said that the strap lines are good but should be directed at children and families. MAk explained that it was an identity for a children's hospital. CBir felt that it should be clear that the Chelsea Children's Hospital is part of the Chelsea and Westminster Hospital.

Chairman said that this will be ensured and gave an example of Dean St and St Stephen's Centre.

BG briefly outlined the HIV development project and said that there will be a new ward and a lot of effort has been put into improving patient experience. There have been major changes in the treatment of patients over the years.

There were some suggestions as to who to invite to opening of the new HIV facilities.

HL informed the governors that there will be two official openings in 2012, one of the Children's hospital and the other of the HIV facilities.

Open Board meetings

The Chairman informed the governors that the format of the Trust's Board meetings is likely to change with publication of the new Health Act which will be announced in 2012. There will be more opportunity to interface with the Board members as suggested by governors.

There were discussions about the structure and possible agendas for joint Council of Governors/Board meetings.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 9 February 2012

AGENDA ITEM NO.	2.2/Feb/12
PAPER	'Who do you think WE are?' – Values campaign
AUTHOR	Matt Akid, Head of Communications
LEADS	Therese Davis, Chief Nurse and Director of Patient Experience and Flow & Mark Gammage, Director of HR
EXECUTIVE SUMMARY	This paper outlines a campaign of communication and engagement with patients, members of the public, staff and other key stakeholders to develop the Trust's values. The campaign has built on discussions at the joint Council of Governors/Trust Board away day on 24 November 2011.
DECISION / ACTION	Governors are invited to give their feedback on the campaign and to register to attend one of the values focus groups for Foundation Trust members and other key stakeholder groups which are taking place on 21, 23 and 29 February.

‘WHO DO YOU THINK WE ARE?’ – VALUES CAMPAIGN

1.0 Introduction

Improving the patient experience is one of the Trust’s four corporate objectives. Linked to this corporate objective is the need to define our values so that patients know what to expect when they come to Chelsea and Westminster and staff know what is expected of them, in order to drive improvements in staff behaviours and patient experience.

The process of developing a set of values for the Trust began with a discussion at the joint Council of Governors and Trust Board away day on 24 November 2011. A ‘longlist’ of 30 values was then whittled down to a shortlist of 12 values agreed by the Chief Executive, Director of HR, and Chief Nurse and Director of Patient Experience and Flow.

The Trust is consulting on this shortlist of 12 values through a campaign of communication and engagement with patients, members of the public, staff and other key stakeholders – ‘Who do you think WE are?’.

The campaign is running throughout February to invite people to vote for their top 4 values and to encourage discussion and debate about the staff behaviours linked to these values.

Work on the campaign has been led by Tony Pritchard (Interim Deputy Chief Nurse), Carol Dale (Learning and Organisational Development Manager) and Matt Akid (Head of Communications).

Our values will be agreed at the Trust Board meeting on 29 March and launched publicly at the hospital Open Day on 12 May.

2.0 Aim

Why do we need values? Chief Executive, Heather Lawrence says:

“The key to improving the experience of patients at our hospital is for all staff to understand the values of our organisation and what behaviours we expect from our staff to ensure that we uphold these values – so that, in turn, patients know what they should expect from us.”

3.0 Campaign activity

A programme of activity has been organised to take place throughout February to engage as many people as possible in the ‘Who do you think WE are?’ campaign to develop our values and then to publicise them when are agreed.

This activity includes focus groups, online and hard copy voting forms, *Trust News*, the Chief Executive’s Blog, Twitter, the Trust website, and Foundation Trust membership mailings - see section xx for details and a timeline.

4.0 Campaign target audiences

Target audiences are in 2 main groups:

- **Internal** – Staff
- **External** - Patients and members of the public, Foundation Trust Governors and members, key local stakeholder groups such as Kensington & Chelsea LINk, charities and volunteers associated with the Trust

5.0 Communication and engagement to agree our values

Date	Activity	Target audience
w/c 23 Jan	Trust News membership mailing	FT members (patients/public)
w/c 23 Jan	Trust website news story	Patients/public
w/c 23 Jan	Trust website link to online voting form	Patients/public
23 Jan	Chief Executive's Blog	Key stakeholders & staff
w/c 30 Jan	Hard copy voting forms distributed	Patients/public & staff
w/c 30 Jan	PC Desktop icon to encourage voting	Staff
w/c 30 Jan	Posters in public areas of hospital	Patients/public & staff
w/c 30 Jan	Daily Noticeboard email bulletin	Staff
w/c 30 Jan	Trust Twitter feed	Patients/public
date TBC	GP newsletter	GPs
w/c 6 Feb	Press release	Media
3 Feb	Team Briefing	Staff
3 Feb	Members' News membership e-newsletter	FT members (patients/public)
6 Feb	Monday morning Execs meeting	Directors
9 Feb	Council of Governors meeting	FT Governors
20 Feb	Staff focus group, 10-11am	Staff
20 Feb	Information Zone drop-in session, 2-4pm	Patients/public
20 Feb	Staff focus group, 2.30-3.30pm	Staff
21 Feb	Information Zone drop-in session, 2-4pm	Patients/public
21 Feb	Patient/public focus group, 2.30-3.30pm	FT members (patients/public)*
22 Feb	Staff focus group, 10-11am	Staff
22 Feb	Information Zone drop-in session, 2-4pm	Patients/public
22 Feb	Staff focus group, 2.30-3.30pm	Staff
23 Feb	Information Zone drop-in session, 2-4pm	Patients/public
23 Feb	Patient/public focus group, 2.30-3.30pm	FT members (patients/public)*
24 Feb	Staff focus group, 10-11am	Staff
24 Feb	Information Zone drop-in session, 2-4pm	Patients/public
24 Feb	Staff focus group, 2.30-3.30pm	Staff
29 Feb	Patient/public focus group, 2.30-3.30pm	FT members (patients/public)*
2 Mar	Deadline for voting on values	Patients/public & staff

*Kensington & Chelsea Local Involvement Network (LINk), St Stephen's Volunteers, the Friends, Volunteers, and various patient groups and forums in the Trust have also been invited to send representatives to the 3 patient and public focus groups

In addition, Directors and Divisional management teams have been asked to help publicise the 'Who do you think WE are?' campaign by discussing our values with staff, handing out values voting forms to staff, and making development of the values an agenda item at meetings and forums including:

- **Senior Operational Group** - General Managers and other senior managers
- **Joint Management and Trade Union Committee (JMTUC)** – Staffside reps
- **Local Negotiating Committee (LNC)** – consultants
- **Grand Round** – doctors (consultants and junior doctors)
- **Teaching sessions** – junior doctors
- **Nursing and Midwifery Advisory Committee (NMAC)** – senior nurses and midwives
- **Divisional Board meetings and other team meetings** – all staff
- **Designated Directors walkabouts** – Directors to encourage staff to get involved
- **Equality & Diversity Steering Group**

6.0 Communication to publicise our agreed values

The results of February's campaign to engage as many people as possible in the development of the Trust's values will be analysed and presented in a report to be discussed at the Trust Board meeting on 29 March.

Date	Activity	Target audience
29 Mar	Trust Board to formally approve values	Trust Board (Execs & Non-Execs)
13 Apr	Team Briefing	Staff
13 Apr	Members' News membership e-newsletter	FT members (patients/public)
date TBC	GP newsletter	GPs
w/c 16 Apr	PC Desktop icon to publicise values	Staff
w/c 16 Apr	Posters/banners to publicise values	Patients/public & staff
16 Apr	Chief Executive's Blog	Key stakeholders & staff
w/c 23 Apr	Trust Twitter feed	Patients/public
w/c 23 Apr	Trust website news story	Patients/public
w/c 23 Apr	Trust News membership mailing	FT members (patients/public)
12 May	Open Day – public launch	Patients/public & staff

7.0 For action

a) Governors are invited to give their feedback on the 'Who do you think WE are?' campaign.

b) Governors are invited to register to attend one of the values focus groups for Foundation Trust members and other key stakeholder groups which are taking place as follows:

Tue 21 Feb, 2.30pm, Gleeson Lecture Theatre
Thurs 23 Feb, 2.30pm, Mansfield Conference Room
Weds 29 Feb, 6.30pm, Gleeson Lecture Theatre

Please contact Matt Akid (Head of Communications) to book a place:

matthew.akid@chelwest.nhs.uk
020 3315 6828

Matt Akid
Head of Communications
February 2012

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 9 February 2012

AGENDA ITEM NO.	2.3/Feb/12
PAPER	Business Planning 2012/13
AUTHOR	Axel Heitmueller, Director of Strategy Amanda Pritchard, Deputy Chief Executive
LEAD	Heather Lawrence Chief Executive
EXECUTIVE SUMMARY	This paper sets out our vision, key strategic priorities and corporate objectives for 2012/13. It also sets out significant short and medium term issues that need to be considered as part of the business planning process.
DECISION/ ACTION	The Council of Governors is asked to note this report and to support the proposal to run two business planning workshops in order to facilitate more detailed discussion.

Business Planning 2012/13

The purpose of this paper is to update the Council of Governors on our business planning process and to invite Governors to attend business planning workshops in order to discuss some of the issues in more detail.

1. Wider Policy context

Chelsea and Westminster's business planning need to be considered in the context of national and regional strategic developments as well as the valuable work that Jeremy Lloyd and Therese Davis are leading on developing on our values.

2 Vision

2.1 The Trust has maintained a consistent vision over recent years:

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

2.2 While we have made significant progress on our journey to achieve this vision, there are a number of significant internal and external challenges and opportunities that need to be addressed as we go into 2012/13 and beyond.

3. Strategic priorities

3.2 We have made significant progress on the three strategic priorities agreed last year:

- maintaining clinical specialities
- exploring growth opportunities
- ensuring sustainability

3.2. For 2012/13, we believe these strategic priorities remain relevant, particularly in light of the current strategic medium to long-term challenges. These include:

- The precise form of the **Health and Social Care Bill**, which has attracted widespread opposition and is currently in its report stage in the House of Lords before going into the third and final reading stage in February. There is a distinct possibility that the Bill will then have to go back into the House of Commons before Royal Assent which is scheduled for late March. One of the key changes contained in the Bill is the proposal to allow the private patient income cap to be lifted to 49%. If this goes ahead, it would enable the Trust to grow private patient income to cross subsidise NHS activity and offset the expected reduction in income as a result of commissioner led demand management initiatives.

- NHS North West London (NWL) has begun a **reconfiguration programme** to look at possible proposals for service change following approval by the NWL Cluster Board. A three month public

consultation will commence in June and until then a process of identifying and shortlisting options for configuration will be developed with a number of working groups already been convened. The Trust has senior representation on all these groups including the Medical Director on the Clinical Board, the Finance Director on the Finance Group and the Chief Nurse on the Out-of-Hospital Care Group. The Chief Executive sits on the Programme Board.

3.4. In 2012/13, we intend to focus particularly on the following strategic priorities. Please note, these will be further refined during the business planning process:

3.5 Maintaining and developing our key clinical specialties

- Maintain our key specialities to secure our future both in terms of financial sustainability and reputation.
- Support services where there are externally driven opportunities and challenges including HIV, cancer, and burns because there is a drive within the North West London sector and across London for greater centralisation of specialist services.
- Influence the NWL tertiary paediatrics review to secure a positive outcome for patients and Chelsea Children's Hospital.

3.6 Exploring opportunities for growth

- Work in collaboration with partners in NWL on a number of priority projects through the Academic Health Science Partnership.
- Proactively develop business propositions in areas that are likely to grow in the years to come including community activity as part of the NWL reconfiguration work.
- Grow private patient income through short-term and long-term opportunities – if and when the cap on private patient activity is lifted, to compensate for activity that may be lost as a result of NHS efficiency savings and our commissioners' demand management initiatives.

3.7 Ensuring sustainability

- Develop and embed our values through the "Who do you think WE are" project to improve patient and staff experience of the Trust.
- Maintain financial and environmental sustainability, through initiatives such as the infrastructure project and full implementation of the potential sharing of 'back office' functions with other hospitals, including our partner hospitals on the Fulham Road.
- Drive efficiency across the organisation, building on the successful first wave Service Line Reviews in 2011.

4. Corporate Objectives

4.1. We propose that we retain our four high level corporate objectives for 2012/13. Business planning is currently under way and the detail beneath each of the four objectives is subject to further change as part of this process, in particular in relation to our quality priorities.

4.2 The proposed deliverables under the four corporate objectives for 2012/13 are as follows:

4.3 Corporate Objective 1: Improve patient safety and clinical effectiveness

- **Patient safety**
  Have no hospital acquired preventable venous thromboembolism (VTE)
  This will continue for 2012/13

- **Clinical effectiveness**
  Considering a range of potential priorities, including readmissions and development of clinical quality indicators
  To be confirmed for 2012/13

4.4 Corporate Objective 2: Improve the patient experience

- **Values**
  Develop and embed our values through the "Who do you think WE are" project to improve patient and staff experience of the Trust.

- **Patient Experience**
  Detail to be confirmed – strong link with Values
  This will be a major focus for 2012/13, but needs further detail

4.5 Corporate Objective 3: Deliver excellence in teaching and research

- Join the North West London Academic Health Science Partnership (AHSP) to improve patient care by benefiting from greater coordination of research, training and education across the sector and the wider London Life Sciences programme

- Work closely with the new Local Education and Training Board (LETB) to retain our place as a leading provider of education and training

- Foster the synergies between the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for Northwest London, North West London Higher Education and Innovation Cluster (HIEC) and Training for Innovation (TFI)

- Implement the Trust's Research Strategy and continue to build upon the Trust's research capacity and capability to support improved patient outcomes

4.6 Corporate Objective 4: Ensure financial and environment sustainability

- Deliver a financial risk rating of no less than 3 (where 1 is 'high risk' and 5 is 'low risk') in each of the next three years and deliver the financial plan in each year
  This assumes no significant change in configuration and this will need to be reviewed as the strategy for NW London reconfiguration is clarified.

- As part of the cost improvement target deliver a minimum savings of 1% of turnover through improved procurement

- Improve environmental sustainability by exceeding the NHS national target of 10% carbon reduction by 2015

5. Business Planning Process and Key Issues

With these objectives in mind, we are currently holding a series of bilateral meetings to agree capacity and strategic priorities for each of the three divisions and wider services. This will inform our contract offer to the commissioners.

5.1 The main issues for this year's business planning are:

- ***Progress on Cost Improvement Programme (CIP)*****:** we have modelled the likely impact of commissioner demand management intentions (i.e. reduction in funding of certain activities as a result of the £20bn challenge) and believe that they do not materially change our financial plan. The CIP target remains challenging. However, this cannot be finally confirmed until contract negotiations have been concluded.

- ***Impact of planned increase in services provided in the community*****:** the intention is to reduce outpatient follow-up visits by around 70% by 2014/15. We have previously made allowances for increased community activity in our financial planning and believe that the more detailed proposals will not fundamentally affect us beyond what has already been taken into consideration.

- ***Changes in tariffs for certain services*****:** there are a number of services that will either no longer be paid for or attract lower tariffs

5.2 While these mostly relate to the financial objectives of the trust, there are also a number of specific issues related to the other objectives particularly patient experience. Examples include:

- ***Netherton Grove Extension***: all planned paediatric theatre activity has moved to the new development and the new ward and day care area is being commissioned

- ***Signage project*****:** we are working on a wider project to improve the signage in the main hospital building

- ***Diagnostic Centre*****:** we will be building a new diagnostic centre on the 2nd floor of the hospital in 2012, bringing together Endoscopy, lung function, cardiology and neurophysiology testing.

5.3 We are intending to run two business planning workshops, which we would like to invite Governors to attend along with staff from the Trust. These workshops will provide an opportunity to refine our strategic priorities as well as the detailed deliverables under the four corporate objectives for 2012/13. The Foundation Trust Secretary will liaise with Governors to arrange a convenient time for the workshops.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 9 February 2012

AGENDA ITEM NO.	2.4/Feb/12
PAPER	Governors' Questions
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	In response to a question from Alan Cleary, patient Governors as follows: The Health and Social Services Group, chaired by Rabbi Julia Neuberger for Age Concern's "Millennium Debate of the Age" in the late 1990 's, identified (and saw published in 1999) 12 principles of a good death, to help dispel the fear of dying which many older patients and residents have. Has the Trust made any comment or response to these principles? May one please be circulated? Dr Sarah Cox has been invited to give a presentation on how this is addresses and to answer the specific question.
DECISION/ ACTION	The Council of Governors is asked to note that Dr Sarah Cox will provide a presentation.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 9 February 2012

AGENDA ITEM NO.	2.5/Feb/12
PAPER	Council of Governors Performance Evaluation Report – response to questionnaire
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper outlines the responses to a survey undertaken by the governors.
DECISION/ ACTION	The Council of Governors is asked to agree the issues and way forward.

Council of Governors Performance Evaluation Report
Response to Questionnaire

1.0 Introduction

This paper outlines the responses to a survey undertaken by the governors.

2.0 Background

Monitor published results of its national survey of NHS Foundation Trust governors in July 2011.

The governors agreed to use the relevant questions to undertake their review.

3.0 Proposal

Summary of issues raise and suggested leads to take forward.

3.1 Administration of meetings /governors participation. (Chairman)

a) Minutes to be circulated as soon as practicable after every governors meeting (this to be used as an opportunity to correct errors and save time in Council of Governors meetings).

3.2 Communicating by the governors on what the Trust is doing for the local community, for patients services and trust membership. (Membership Sub-Committee)

3.3 Relationship/contact with Non-Executive Directors (NEDs) and Executive Directors (EDs) and being informed about the activities of the Trust Board. (Chairman)

3.4 Induction and training. (Director of Governance and Corporate Affairs)

3.5 Governors roles and responsibilities. (Chairman and Director of Governance and Corporate Affairs)

3.6 Usefulness and discussion on Quality Accounts (Director of Governance and Corporate Affairs)

4.0 Action/Decision

The Council of Governors is asked to agree the issues and way forward outlined above.

Introduction

Out of 30 governors, in total 14 questionnaires were completed either online or in hard copy.

Overall response rate was 47% (42%Monitor).

7% = 1 governor
21% = 2 governors

	About you					
No	**Question**	**Appointed**	**Patient**	**Public**	**Staff**	**% Overall Response**
1	**What type of governor are you?**	3	6	4	1	14
	%Chelsea and Westminster Governors	21	43	29	7	47
	%Monitor results	16	11	55	18	42

		Less than 3 months	**3-6 months**	**6-12 months**	**12-24 months**	**Longer than 2 years**	**Since the Trust was authorised**
2	**How long have you been a governor?**			2	3	9	
	%Chelsea and Westminster Governors			14	21	64	
	%Monitor results	6	9	13	23	43	34

64% of governors have been in the post longer than 2 years (43% Monitor), with 21% in post between 1 to 2 years (23% Monitor).

4	Please indicate the frequency of each of the following. Please tick one box for each statement.	Always	Most of the time	Sometimes	Never	No opinion/ Do not know	Not applicable
4.1	Agenda and supporting documents are circulated in good time for each meeting.	7	4		1	1	1
	%Chelsea and Westminster Governors	50	29		7	7	7
	%Monitor results	67	25	7	1		
4.2	Minutes are circulated after every governors meeting	8	1	1	3	1	
	% Chelsea and Westminster Governors	57	7	7	21	7	
	% Monitor results	78	10	3			
4.3	Minutes of the meeting are circulated in good time for the next meeting	7	4	1		2	
	%Chelsea and Westminster Governors	50	29	7			
	%Monitor results	67	25	7			
4.4	Action points are followed up by the governors responsible	4	7	2			1
	%Chelsea and Westminster Governors	29	50	14			7
	%Monitor results	50	36				
4.5	The Chair follows up the action points for which he or she is responsible	11	1	2			
	%Chelsea and Westminster Governors	79	7	14			
	%Monitor results	71	20	5			
4.6	The attending executive board members follow up the action points for which they are responsible	6	5	1			2
	%Chelsea and Westminster Governors	43	36	7			14
	%Monitor results	53	32	7			
4.7	Governor meetings are productive	3	3	6	1		1
	%Chelsea and Westminster Governors	21	21	43	7		7
	%Monitor results	39	39	19			

43% The majority of governors say that meetings are productive sometimes (19% Monitor). 21% of governors say that meetings are productive all of the time (39% Monitor) and 21% most of the time (39% Monitor).

50% of governors say that agenda and supporting documents are always circulated in good time for each meeting (67% Monitor) and 29% most of the time (25% Monitor).

57% say that minutes are always circulated after every governors meeting (78% Monitor) and 21% say never.

50% say minutes of the meeting are always circulated in good time for the next meeting (67% Monitor) and 29% most of the time (25% Monitor)

29% say action points are always followed up by the governors responsible (50% Monitor) and 50% most of the time (36% Monitor).

79% say the Chair always follows up the action points for which he or she is responsible (71% Monitor) and 14% say sometimes (5% Monitor).

43% say the attending executive board members always follow up the action points for which they are responsible (53% Monitor) and 36% most of the time (32% Monitor).

Comments received were as follows:

- Agenda, minutes and paperwork for the next Council of Governors meeting, usually 3 to 4 days before the actual meeting
- Minutes are not circulated after meetings until just before the following meeting.
- The Chair never follows up the action points for which he is responsible
- Governor meetings would be a lot more productive if they were not hijacked by governor members who appear to have their own agenda, rather than to play the role of a ‘critical friend’
- Governor meetings are too long.
- Certain governors’ monologue should be better controlled.
- At least once, agenda and papers got lost in the post.
- Other than production of the Annual Report and some financial reporting, the processes, background rules and their observance lack the professionalism, discipline, clarity, relevance and focus appropriate to the governing body of a major teaching hospital.

About your role as a governor

5	For each of the following statements, please tick to indicate the extent of which you agree or disagree:	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	No opinion	Not applicable
5.1	Overall, I am clear about my roles and responsibilities as a governor	5	6	2		1		
	%Chelsea and Westminster Governors	36	43	14		7		
	%Monitor results	40	48	7		1		
5.2	I am clear about what the local healthcare priorities are for my Trust	4	7	1	1	1		
	%Chelsea and Westminster Governors	29	50	7	7	7		
	%Monitor results	38	49	8	3			
5.3	I am clear about what the priorities are for my Trust's patients/service users	6	6	1		1		
	%Chelsea and Westminster Governors	43	43	7		7		
	%Monitor results	44	45	8	2	1		
5.4	Governors should be representing the broad healthcare/mental health needs of their local community	8	5				1	
	%Chelsea and Westminster Governors		93*				7	
	%Monitor results		90*					
5.5	Governors should be representing the broad healthcare needs of the Trust's Patients/Service users	8	5	1				
	%Chelsea and Westminster Governors		93*	7				
	%Monitor results		95*					
5.6	Governors should be representing the views of the Trust membership	9	3	1	1			
	%Chelsea and Westminster Governors		85*	7	7			
	%Monitor results		49*		20			
5.7	Governors should be representing the views of the Trust's patients/service users	7	4	2	1			
	%Chelsea and Westminster Governors		79*	14	7			
	%Monitor results		95*					

5	For each of the following statements, please tick to indicate the extent of which you agree or disagree:	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	No opinion	Not applicable
5.8	I am confident that as a governor I could represent/I am representing the needs of the local community	3	6	3	1	1		
	%Chelsea and Westminster Governors		64*	21	7	7		
	%Monitor results		75*		7			
5.9	I am confident that as a governor I could represent/I am representing the needs of the Trust's patients/service users	5	4	3	2			
	%Chelsea and Westminster Governors		65*	21	14			
	%Monitor results		77*		6			
5.10	The governors at my Trust are good at communicating what the Trust is doing for the local community	2	3	4	2	3		
	%Chelsea and Westminster Governors		35*	29	14	21		
	%Monitor results		59*		12			
5.11	The governors at my Trust are good at communicating what the Trust is doing for patients services	3	2	5	2	2		
	%Chelsea and Westminster Governors		35*	36	14	14		
	%Monitor results		66*		10			
5.12	The governors at my Trust are good at communicating what the Trust is doing for the Trust membership	3	4	4	1	2		
	%Chelsea and Westminster Governors		50*	29	7	14		
	%Monitor results		66*		10			
5.13	I understand what it means to hold my Trust's executive board to account	9	3		1	1		
	%Chelsea and Westminster Governors		85*		7	7		
	%Monitor results		90*		40			
5.14	I feel I have the power as a governor to hold my Trust's executive board to account	5	4		2	1	2	
	%Chelsea and Westminster Governors		65*		14	7	14	
	%Monitor results		70*		17			

* very well informed and fairly well informed

43% of governors tend to agree that they are clear about their roles and responsibilities as a governor (48% Monitor) and 36% strongly agree (40% Monitor).

50% of governors tend to agree they are clear about the local healthcare priorities for the Trust (49% Monitor) and 29% strongly agree (38% Monitor).

43% of governors strongly agree they are clear about the priorities for the Trust's patients/service users (44% Monitor) and 43% tend to agree (45% Monitor).

93% of governors strongly agree/tend to agree that governors should be representing the broad healthcare/mental health needs of their local community (90% Monitor).

93% of governors strongly agree/tend to agree that governors should be representing the broad healthcare needs of the Trust's Patients/Service users (95% Monitor).

85% of governors strongly agree/tend to agree that governors should be representing the views of the Trust membership (49% Monitor).

79% of governors strongly agree/tend to agree that governors should be representing the views of the Trust's patients/service users (95% Monitor).

64% of governors strongly agree/tend to agree they are confident that as a governor they could represent/are representing the needs of the local community (75% Monitor). 14% say they neither agree nor disagree (7% Monitor).

65% of governors strongly agree/tend to agree they are confident that as a governor they could represent/are representing the needs of the Trust's patients/service users (77% Monitor).14% say they neither agree nor disagree (6% Monitor).

35% of governors strongly agree/tend to agree that the governors are good at communicating what the Trust is doing for the local community (59% Monitor). 35% say they neither agree nor disagree (12% Monitor).

35% of the governors strongly agree/tend to agree that the governors are good at communicating what the Trust is doing for patient's services (66% Monitor). 28% say they neither agree nor disagree (10% Monitor).

50% of governors strongly agree/tend to agree that the governors are good at communicating what the Trust is doing for the Trust membership (66% Monitor). 21% say they neither agree nor disagree (10% Monitor).

85% of governors strongly agree/tend to agree that they understand what it means to hold the Trust's executive board to account (90% Monitor). 14% say they neither agree nor disagree (40% Monitor).

65% of governors strongly agree/tend to agree they have the power as a governor to hold the Trust's executive board to account (70% Monitor). 21% say tend to disagree/strongly disagree (17% Monitor).

Comments received were as follows:

- Not sufficient contact between executive Board/NEDs and governors.
- Despite a lot of effort, I feel the governors (both patient and public) have not yet reached a good and substantial interactive relationship with the Trust membership. I am hoping the forthcoming Website feedback from the governor blogs (in the pipeline) will become a useful tool for a more integrated communication system.
- Hard to tell whether I am representing the views of the local community/membership as it is difficult to find out what their views are.
- I do not know how to distinguish between the health care needs of the community and the health care needs of our Trust members.

About how you work with your Trust

		Very well informed	Fairly well informed	Not very informed	Not at all informed	Don't know
6	**Thinking about the information you need to perform your role as a foundation trust governor, how well informed do you think the Trust keeps you about its activities?**	5	7	2		
			86*	21		
	%Chelsea and Westminster Governors					
	%Monitor results		94*			

* very well informed and fairly well informed

86% of governors believe that the Trust keeps them very well or fairly well informed about its activities (94% Monitor).

		Very confident	Fairly confident	Not very confident	Not at all confident	Don't know
7	**Thinking about your Trust's strategy or forward planning, how confident would you feel in explaining this to a new governor?**	2	7	4	1	
	%Chelsea and Westminster Governors	14	50	29	7	
	%Monitor results	34	9	1		

50% say they feel fairly confident about explaining the Trust's strategy or forward plan to a new governor (9% Monitor) and 14% feel very confident (34%) whereas 29% do not feel confident (1% Monitor).

Comment received was as follows:

- Governors are generally sidelined and information in this area edited to reduce controversy

		Very satisfied	Fairly satisfied	Neither satisfied nor dissatisfied	Fairly dissatisfied	Very dissatisfied	Don't know
8	**In your role as a governor, how satisfied or dissatisfied are you with the amount of contact you have with members of the Board of Directors?**	8 EDs 7 NEDs	1 2		3 3	2 2	
	%Chelsea and Westminster Governors	57 EDs 50 NEDs	7 14		21 21	14 14	
	%Monitor results	74 EDs 65 NEDs					

*Very satisfied and fairly satisfied

57% of governors feel very satisfied/fairly satisfied with the amount of contact with EDs (74% Monitor) and 50% are satisfied/fairly satisfied with the amount of contact with NEDs (65% Monitor).

Comments received were as follows:

- We have requested regular meetings with the NEDs in order to get to know them better and to become familiar with their progress in whatever their direct objectives are within the Trust. We have been promised that such opportunities will definitely be planned for 2012 … so hopefully these meetings will remedy our current ignorance of their work and how they are progressing.
- I do feel that the quarterly Council of Governors meetings (which are official) are not sufficient for the governors to get to know the NEDs and the Executive Board members. The meetings are structure around an Agenda and most people rush off straight afterwards. Our one annual Away Day is so structured that we tend to spend the majority of the time undertaking exercises. Time should also be given to just sitting with coffee and socializing. This breaks down barriers.
- One of the defects of the administrative system is that these people are held apart and don't synergise.

9	Please indicate the extent to which you agree or disagree with each of the following statements:	Strongly agree	Tend to agree	Neither	Tend to disagree	Strongly disagree	No opinion
9.1	The Chair of my Trust keep me as a member of the governing body, informed about the activities of the executive board of my Trust	4	4	3	1		2
	%Chelsea and Westminster Governors	29	29	21	7		14
	%Monitor results	47	38		5		
9.2	I wouldn't hesitate to approach the Chair with a query or issue	10	2	1	1		
	%Chelsea and Westminster Governors	71	14	7	7		
	%Monitor results	74	16				
9.3	I wouldn't hesitate to approach any executive board member with a query or issue	6	5	1	1		1
	%Chelsea and Westminster Governors	43	36	7	7		
	%Monitor results	59	26				
9.4	Overall, my Chair is doing a good job	10	3	1			
	%Chelsea and Westminster Governors	71	21	7			
	%Monitor results	68	21				
9.5	My executive Board is supportive of the Council of Governors and view it as an asset	3	5	2	2		2
	%Chelsea and Westminster Governors	21	36	14	14		
	%Monitor results	43	33				

29% of governors strongly agree (47% Monitor) and 29% tend to agree (38% Monitor) with the statement 'The Chair of my Trust keep me as a member of the governing body, informed about the activities of the executive board of my Trust.' 7% tend to disagree or strongly disagree (5% Monitor).

71% of governors strongly agree (74% Monitor) and 14% tend to agree (16% Monitor) with the statement 'I wouldn't hesitate to approach the Chair with a query or issue'.

43% of governors strongly agree (59% Monitor) and 36% tend to agree (26% Monitor) with the statement 'I wouldn't hesitate to approach any executive board member with a query or issue'.

71% of governors strongly agree (68% Monitor) and 21% tend to agree (21% Monitor) with the statement 'Overall, my Chair is doing a good job'.

36% tend to agree (33% Monitor) and 21% strongly agree (43% Monitor) with the statement 'My executive Board is supportive of the Council of Governors and view it as an asset'

Comments received were as follows:

The governors are not always aware of what has been decided by the Executive Board (just lately we were not included in (or indeed informed of) consultations about the decision to turn the new Netherton Grove paediatric extension into a separately named Children's' Hospital). I felt that this decision should have been mentioned in the Council of Governors. This didn't affect the otherwise efficient running of the Trust, nor is it important in the greater scheme of things, but it goes toward my answers to 5.12 and 9.1 since it meant we were not thought of as a part of the Trust team, thus giving some of us the impression of being sidelined.

Away Days have been very helpful.

Governors tend to be sidelined; meaningful issues are rarely discussed. When they are discussed arbitrary time limits are imposed.

Training and briefings

		Yes	No	Don't know
10	**Thinking back to when you first became a foundation trust governor, were you given any training or briefings to enable you to do the role**	10	3	1
	%Chelsea and Westminster Governors	71	21	7
	%Monitor results	84	15	

71% say they were given training or briefings to enable them to do the role when they first became a FT governor (84% Monitor) and 21% say they have not (15% Monitor).

		Yes	No	Don't know
11	**Since any initial training or briefing you may have had, have you been invited to any further training or briefings to help you develop in your role as governor?**	10	4	
	%Chelsea and Westminster Governors	71	29	
	%Monitor results	80	17	

71% say they have been invited to further training or briefings to help them develop in their role as governor (80% Monitor) and 29% say they have not (17% Monitor).

		Very satisfied	Fairly satisfied	Neither	Fairly Dis.	Very Dis.	Don't know
12	**Thinking about all the training and/or briefings the Trust has provided, in general how satisfied are you with the quality?**	4	4	5		1	
	%Chelsea and Westminster Governors	29	29	36		7	
	%Monitor results	34	46		6		

36% of governors are neither satisfied not dissatisfied with all the training and/or briefings the Trust has provided, 29% very satisfied (34% Monitor) and 29% fairly satisfied (46% Monitor).

Comments received were as follows:

My induction as a new governor by the Chairman was clear and extremely informative, with more than adequate manuals and other useful paperwork given for further perusal.
I also got very helpful Monitor and FTGA seminar/training opportunities and this was a great advantage in understanding the role of the governor.

Have not been able to take up the opportunity of further training.

No further training. Briefings have not been to do with role as governor.

Initial induction was too much information crammed into too little time.

My fault as I did not have enough time to take on all opportunities.

I produced written comments for a Governors' Meeting in 2011 Why not request a copy?

		Yes	No	Don't Know
13	**If you felt you did need training to help you in your role as a governor, do you think you would be able to secure it from your Trust?**	9	1	4
	%Chelsea and Westminster Governors	64	7	21
	%Monitor results	81	4	

64% say they would be able to secure training from the Trust if they needed training (81% Monitor), 21% do not know and 7% say no (4% Monitor).

		NHS finance	NHS structure	Different roles of organisations within the NHS	The role of FT governor	Practical ways to carry out the statutory roles	Recruitment	Performance evaluation	Financial reporting and accounts	Quality Accounts	Communications	Don't need any training	Don't know
14	**Please indicate below which, if any, types of further training you might find beneficial? Please tick all that apply.**	5	4	2	2	7		2	1	3	2	2	
	%Chelsea and Westminster Governors	36	29	14	14	50		14	7	21	14	14	
	%Monitor results	37	31	41	25	53	13	35	24	28	20	8	2

50% of governors say they need practical help with carrying out the statutory roles (54% Monitor) and 36 say NHS Finance (37% Monitor), 29 % NHS structure (31 Monitor) and 21% Quality Accounts (28% Monitor), 14% Different roles of organisations with the NHS (41% Monitor), 14% the role of FT governor (25), 14% Performance Evaluation (35 Monitor), 14% Communications (20% Monitor) and 14% Do not need any training (8%).

Foundation trust governors in the future

15 What would you say have been your main achievements as a governor?

Being an active and involved governor.

Identifying relevant issues and questions.

I have now been a patient governor for two years. During the initial few months I noticed that there wasn't a means for patients to get in touch with governors on a strictly private level (having to go through an NHS employee – the FT secretary). I requested Chelwest email accounts for each governor (should they want one) … this to help toward giving the patients an openly available and direct contact with their governor representative. The Chairman was most helpful in obtaining these for us.

I am a member of the Membership sub-committee (we governors on this committee work hard to find ways of communicating with our constituents and we put forward the initial idea for the ***Meet a Governor*** project, which has since been copied by the matrons). I'm also a member of the Quality sub-committee (contributing to the Quality Accounts); the Website Steering group (helping to make the web site more patient-friendly to read) and I edit the Governors' blog section. I am also the patient representative on the Wayfinding/Signage steering group (helping to make the hospital more user friendly by way of good signage), and am an ongoing patient representative on various NIHR CLARHRC projects. I also take part in the Senior Nurse rounds initiative within Chelwest, set up to enable governors to have more contact with patients on the wards. Additionally, I am a governor representative on the Patient Environment Action Team monthly committee meetings – and also take part in cleaning audits on a regular basis.

Some of the extra activities I have taken part in are as a governor representative on the Open Day Steering Group; also as the patient governor representative on a yellow card appeal committee; as the governor representative on the recent Fulham Road Collaboration for the procurement of soft services; and as the governor representative on the interviewing panel for an interim manager for the PALS office (nine month contract covering maternity leave). I also write articles for the ***Trust News***.

I'm pleased to be a participant in the above activities and feel that I am a creative and functional governor. I hope to continue to contribute to the work that the Trust does in their continual efforts to make the patient experience a good one.

16 And how has this benefited your Trust, patients / service users, membership and/or local community?

They have an active representative but it is hard to say how this has benefited them.

Assuring patients that some of their principal concerns are being raised somewhere.

The individual Chelwest email accounts and the ***Meet a Governor*** sessions have made those governors who participate much more accessible to the membership.

The contribution/feedback at the various sub-committees is given as a representative (the voice, if you like) of the patients of the Trust. Hopefully the membership can readily see that there are governors who are listening and passing on their ideas, suggestions and complaints to actual members of the Executive Board.

The information flow from the various sub-committees (and particularly from PEAT Committee meetings) give me the secure knowledge to answer questions more fully and to inform patients of exactly how stringent the infection control measures are (I get the current MRSA and C.Diff figures from my monthly PEAT Committee meetings and I can also now point out the new Transparency web page where they can look for themselves). I can also tell patients how often bathrooms/toilets are cleaned and notated on the doors of wards and on the timed clocks within the public areas on the ground floor. From the Quality Accounts I can tell patients what the priorities are and can quote facts and figures where necessary.

		Fully aware	Slightly aware	Not really aware	Not all aware	Not sure
17	**Are you aware that, as a result of the proposals in the recent White Paper and related consultations, the role of FT governors in holding their Board of Directors to account when issues arise is likely to become even more important?**	7	4	1	1	1
	%Chelsea and Westminster Governors	50	29	7	7	
	%Monitor results	50	33	10	5	

50% of governors say they are fully aware (50% Monitor) that, as a result of the proposals in the recent White Paper and related consultations, the role of FT governors in holding their Board of Directors to account when issues arise is likely to become even more important and 29% say slightly aware (33% Monitor) and 14% are not aware (15% Monitor).
Comments receiver were as follows:

The administrative machinery and local management system are ineffective in securing a contribution from individual governors commensurate with their skills and experience

		Yes, fully	Not Sure	Not prepared	Want training	Don't know
18	**Would you be prepared to take on greater responsibility to your Trust in the future, in terms of identifying issues and ensuring that the Board of Directors addresses them?**	8	3			3
	%Chelsea and Westminster Governors	57	21			21
	Monitor results	64	21	3	11	1

57% say they would be fully prepared to take on greater responsibility to the Trust in the future, in terms of identifying issues and ensuring that the Board of Directors addresses them (64% Monitor) and 21% not sure (21% Monitor) and 21 do not know (1% Monitor).

Comments received were as follows:

Depends on time required.

They have an active representative but it is hard to say how this has benefited them.

19 Thinking about the role of foundation trust governors in the future, what, if anything needs to happen to make it more effective?

I am not sure about this. If the role of Governors is enhanced the Board's scope is likely to be affected. Governors play an important role as a sounding board and as a channel of communication with the public. They also have designated responsibilities in relation to appointments. But whether they should have more influence over the strategic direction and management of the Trust is debatable.

Utilize the skills of governors more in terms of allowing them to become more active with ongoing projects, monitoring, evaluation, quality assurance, etc.

Formal feedback in turns from all governors on their constituency, this will ensure that the governors are active in obtaining feedback from public, patients and staff with the objective of making the Trust board and Exec team aware of these views.

Further engagement with membership and local community.

Clarification of governors' duties to the Trust.

Improve ways of communicating with constituents.

Have more powers.

A written Q&A facility would be beneficial and could save time at meetings.

Other governors understanding their roles rather than a personal agenda.

The role is not effective at all at present. There is no question of increasing what is not there. Governors are responsible, reasonable people. They should be entitled:

(i)to go into any part of the hospital (with reasonable safeguards) and be entitled to an explanation for anything they consider amiss

(ii) Have the undisputed right to have any issue they choose placed on the next Agenda.

(iii)Be entitled to investigate any activity or expenditure

Anything less defeats transparency and will ensure the role remains ineffective.

		Extremely helpful	Very helpful	Helpful	Slightly helpful	Fairly helpful	Very unhelpful
20	**How useful have you found quality accounts / quality reports in understanding what is happening in your Trust?**	5	4	5			
	%Chelsea and Westminster Governors	36	29	36			
	%Monitor results						

72% say they find quality accounts / quality reports extremely helpful/helpful and 29% say very helpful.

Monitor did not publish results on this.

		We discuss them at every meeting	We discuss them at most meetings	We have discussed them on a few occasions	Once or twice	Never
21	**How often have you discussed quality accounts / quality reports at formal governors meetings?**		3	7	3	1
	%Chelsea and Westminster Governors		21	50	21	7
	%Monitor results					

50% say they have discussed quality accounts / quality reports on a few occasions and 21% say they have discussed at most of meetings and 21% once or twice.

Monitor did not publish results on this.

		Involved throughout the process in setting the priorities	Some level of involvement in setting the priorities	Small degree of involvement	Almost no involvement	No involvement
22	**To what extent have you been involved in formulating the priorities for quality improvement articulated in the quality accounts / reports?**	4	3	1	1	5
	%Chelsea and Westminster Governors	29	21	7	7	36
	%Monitor results					

38% say they were not involved; this might be because this falls under the Council of Governors Quality Sub-Committee remit.

29% say they are involved throughout the process in setting the priorities.

Monitor did not publish results on this.

Comments received were as follows:

Being a member of the Quality sub-committee means I am fully involved when priorities are discussed.

The 2008 Report to Parliament should be revisited and the 5 essential issues considered afresh

Final Question

23 Final question - is there anything else you would like to add?

I have doubts about the usefulness of this survey.

It is not clear whether it is an evaluation of the performance of the governing body in general or of individual governors.

I am fairly satisfied with my involvement as a governor bearing in mind comparatively short time since my election and non-specific nature of some questions.

Not impressed with the purpose, value or slant of this questionnaire.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 9 February 2012

AGENDA ITEM NO.	2.6/Feb/12
PAPER	Report on Senior Nurse/Governor Rounds
AUTHORS	Tony Pritchard. Interim Deputy Chief Nurse
LEAD	Therese Davis, Chief Nurse and Director of Patient Experience and Flow
EXECUTIVE SUMMARY	This report provides a summary of a Senior Nursing and Midwifery Clinical Round which was joined by 3 Governors on Wednesday, February 1st and of 2 Governor visits to areas within the Trust during December and January.
DECISION / ACTION	For information.

Report on Senior Nurse/Governor Rounds

1.0 Introduction

This report provides a summary of a Senior Nursing and Midwifery Clinical Round on Wednesday February 1st which was joined by 3 Governors. This focussed on the assessment of Care Quality Commission (CQC) standard 8 – Cleanliness and infection control. The report also provides a summary from 2 Governor visits to areas of the Trust during December 2011 and January 2012.

2.0 Clinical Half Days

In October 2011, the Senior Nursing and Midwifery Committee initiated clinical half days for the team. During these clinical sessions, designated leads work with Matrons, Ward Sisters, General Managers and other staff to assess the standards of our care and treatment within wards and clinical departments. This is completed through observing the clinical environment and through discussing care and treatment with patients, families and staff.

This assessment is aligned to the 16 CQC essential standards for quality and safety relating to clinical care. A local toolkit has been developed to enable of assessment of these standards across our wards and departments. In September 2011, a proposal was presented to the Council of Governors for them to join us during these clinical half days, so that they could work alongside our staff in assessing these standards.

3.0 Clinical half day with Governors on February 1st

Three Governors joined the senior nursing and midwifery team during their clinical half day on February 1st. During this session, the team assessed our compliance against CQC standard 8 – Cleanliness and Infection Control. Our local toolkit provides a number of prompts for assessment through observing the clinical environment and practice of staff, discussing knowledge of policies and procedures with staff and through gaining feedback from patients and families on their perception of care and treatment. Following assessment across our clinical areas, the team meet to share their findings, and contribute to the development of an action plan.

4.0 ndividual feedback from Governors

4.1. Governor Wendie McWatters visited David Erskine ward with Matron Tristram Mills. Key points from this were;

- The use of patient journals
- The use of care and comfort rounds
- The use of the ‘Synbiotix’ system to record and monitor infection control standards
- Excellence in ward leadership demonstrated by the Ward Sister
- An example of how a ward can be run
- The potential for a cleaning award

4.2. Governor Melvyn Jeremiah visited the Intensive Care and High Dependency Unit with Head Nurse Jane Marie Hamil. Key points were;

- Some aspects of practice need to be adapted to the specialist nature of the environment
- Staff were skilled and expert in their practice
- Feedback from patients and relatives was positive
- Some inconsistency in the use of aprons

- The need to look at a ‘scrub’ facility for those undertaking invasive procedures.

4.3. Governor Susan Maxwell visited the new paediatric high dependency area, Neptune and Jupiter wards with Charge Nurse Noel Palmer. Key points from this were;

- Toilets in the new facility required cleaning schedules on the doors
- Jupiter and Neptune ward looked ‘tired’ in comparison to the new area, but were clean
- Bathrooms and toilets, though worn, were clean
- There was some inconsistent labelling of equipment
- A hospital leaflet may be useful for children and parents in addition to the DVD that they are sent

5.0 Evaluation by Governors

Overall, the Governors felt that this process was valuable as it allowed them to consider individual standards in detail, and to understand the components of these. The summary discussion and sharing of ideas was seen to be valuable in learning from one another. The Governors questioned how we assure the validity of infection control audits that are conducted by staff in clinical areas. This is achieved by random audit9ing by the infection control nurse and independent auditing of cleaning standards by Matrons.

6.0 Individual Governor Visits

6.1. Governor Harry Morgan visited on Friday 20th January with a particular interest in music and other therapies for the young. Mr Morgan met with Deryn Watts, the Acting Paediatric Therapy Lead who discussed a range of therapies that are offered. Mr Morgan summaries his visit as follows;

It was very useful in helping newish governors such as me better understand the extent of treatments available to babies and children at Chelsea and Westminster. I was also extremely impressed by the dedication shown by those administering the treatments. There was clearly more to see and I would like to fit in another visit to the unit some time in the future. Thanks again and best wishes

6.2. Governor Chris Birch visited Thomas Macaulay ward on December 9th 2011 and provided the following summary

In May I visited all the different parts of the hospital's sexual health and HIV services in the St Stephen's Centre, the main hospital building, the West London Centre for Sexual Health and 56 Dean Street, six different areas in all. I was lucky to have Jane Bruton, Clinical Nurse Lead for HIV, as my guide, and the tour including two taxi journeys took 4 ½ hours.

At the Kobler Clinic I was allowed to sit in on the consultation of a friend of mine with Dr Mark Nelson. That apart, unsurprisingly, there was no time to talk to any of the patients, and consequently I was promised a return visit to the Thomas Macaulay ward to remedy that omission.

That return visit took place on 9 December last year, and I was accompanied by Interim Deputy Chief Nurse Tony Pritchard and Matron Lesley Sinclair. I had an extremely interesting and useful discussion with Lesley Sinclair but, after a brief tour of the ward, I was given the opportunity to talk to only one patient. I did not query this, as I formed the impression that she and Tony Pritchard were probably unaware that one of the main objects of these Senior Nurse/Governor rounds was supposed to be to allow governors to talk to patients and to gain feedback about their patience experience.

In fact, when the Senior Nurse/Governor rounds were introduced last February, we were told that their aim was to give governors "the opportunity to visit a ward or department with a Senior Nurse. This would enable the governor with the Senior Nurse **to engage with patients, obtaining feedback**." [My emphasis]

I had already formed the impression that the Senior Nurse/Governor rounds that had taken place during 2011 had resulted in relatively few discussions between patients and governors. So I decided that I should share my concerns with Senior Nurse Therese Davis rather than with Matron Lesley Sinclair. This I have done but, at the time of writing this report, have not yet had a response. No doubt she will have responded before the Council meeting, and her response will, of course, be shared with the Council.

The one patient to whom I was able to speak was, in fact, a former patient of Thomas Macaulay ward who happened to be in the HIV Day Care Unit, which is next door to T Mac. He was full of praise for all aspects of the treatment he had received but complained that meals were sometimes not as hot as they should be. Apparently, meals on other wards are served from heated trolleys but T Mac has its own kitchen on the ward and, although the food is exceptionally good, the trolleys are not heated. Perhaps they should be. Hot food should be hot.

During the 1990s, I was a fairly frequent visitor to Thomas Macaulay ward and to Elizabeth Gaskell, its sister HIV-dedicated ward, which thankfully is no longer needed. Not much has changed on the ward itself. It is a 20-bed medical ward with two bays of six beds each, four side-rooms and another four negative-pressure rooms. There is a self-help tea bar and, as already mentioned, a ward-based kitchen serving excellent hot or not-so-hot meals.

Very importantly, there is a team of St Stephen's volunteers who support the ward, providing tea and cakes and individual patient support.

The only two changes I noticed are the 'modernised' board showing where the different patients (identified by their initials) are, proposed dates of discharge etc. And the fact that the Thomas Macaulay ward's philosophy (see appendix) is no longer framed and hung on a wall where everyone can see it. I think this is a great pity.

But big changes are about to take place. Very soon, possibly even before the next meeting of the Council, the Thomas Macaulay ward will be closed, and all the current HIV patients will be transferred to the brand-new 19-bed Ron Johnson ward, part of the Netherton Grove project. All the rooms will be single with *en suite* facilities. I hope this is what the patients want. At London Lighthouse (the centre in north Kensington for people infected with or affected by HIV, where I worked from 1990 to 1998), we found that, while some patients wanted single rooms, most preferred to be in rooms shared with other patients.

The name of Jim Smith, the governor who died on T Mac in May 2010, is to be commemorated on the new Ron Johnson ward. In HIV circles in this country, the name Thomas Macaulay ward is as well as or perhaps even better known than the name of Thomas Macaulay, the poet, historian and Whig politician. It would be good if a way could be found of linking his name also with the new Ron Johnson ward.

Thomas Macaulay Ward Philosophy

- We would like your stay on Thomas Macaulay Ward to be a positive experience
- We will respect your individuality and aim to be non-judgemental
- We will maintain your privacy and confidentiality
- We will promote and encourage your independence
- We aim to provide high quality care

- We aim to care for your whole person and not just your illness
- We will share information with you honestly
- We will try and support your choices
- We will try to be as flexible as possible
- We will be approachable and friendly
- We will learn from each other and from you
- We will try and make the environment homely and informal
- We will show you respect and hope that respect will be returned

7.0 Summary

This report has provided a summary of a clinical half day which was joined by 3 Governors with the purpose of assessing patient care and treatment against CQC standard 8 – cleanliness and infection control. It has also provided feedback from 2 Governors who completed visits to the Trust in December and January.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 9 February 2012

AGENDA ITEM NO.	2.7/Feb/12
PAPER	Open Day 2012 – Update
AUTHOR	Renae McBride, Communications Manager
LEAD	Heather Lawrence, Chief Executive
EXECUTIVE SUMMARY	This paper provides an update on planning for the Trust Open Day 2012 following approval of funding of £15,000 at the Council of Governors meeting on 1 December 2011.
DECISION/ ACTION	Governors are invited to provide feedback and to nominate themselves as Governor representatives on the Open Day Steering and Operational Groups

Open Day 2012 – Update

1. Introduction

1.1 The annual Chelsea and Westminster Hospital Open Day has grown in popularity in recent years. It is now the flagship event in the Trust's public and patient engagement programme. It is known within the healthcare sector as one of the most successful hospital Open Days and providers including North West London Hospital NHS Trust and West Middlesex Hospital have actively tried to learn from and replicate the event in their organisations.

1.2 The event is an opportunity for the Trust to place itself at the heart of its community by opening its doors to local people and giving them a chance to become more involved in their local hospital.

1.3 Last year's Open Day on Saturday 7 May 2011 attracted around 1,200 visitors, including local MP Sir Malcolm Rifkind, Cllr Harvey Marshall (Deputy Lord Mayor of Westminster), Cllr Adronie Alford (Mayor of Hammersmith and Fulham), Cllr James Husband (Mayor of the Royal Borough of Kensington and Chelsea), NHS North West London Cluster Chair Peter Molyneux and Chair of West Middlesex Hospital Tom Hayhoe.

1.4 Visitors to last year's Open Day were invited to give their feedback by using the Patient Experience Tracker:

- 99% rated the Open Day as 'Excellent' or 'Good' (up from 97% in 2010)
- 92% would definitely recommend the Open Day to friends and family (up from 86% in 2010)
- 94% said staff at the Open Day were friendly and approachable (up from 93% in 2010)

1.5 Thanks to the hard work of Governors who attended, 75 new Foundation Trust members were recruited during the Open Day.

1.6 Open Day 2012 will be held from 11am—3pm on Saturday 12 May.

1.7 Planning for the Open Day has begun and a paper was on the agenda for the Trust Board meeting on Thursday 26 January.

2. Aims

2.1 The aims of Open Day 2012 are to:

- Market the Trust to Foundation Trust members and local residents
- Promote the achievements of the hospital
- Develop communication between Council of Governor's representatives and Foundation Trust members
- Encourage Open Day visitors to become Foundation Trust members
- Promote health, fitness and wellbeing
- Showcase developments such as the Lower Ground Floor Outpatient Department and the new children's operating theatres on the 1st Floor
- Foster partnership working

- Improve staff morale
- Utilise the day as a fundraising opportunity for the Chelsea and Westminster Health Charity and other associated charities

3. Implementation

3.1 As in previous years a Steering Group and Operational Group will be established to implement the project:

- Steering Group – to provide high-level oversight of the Open Day. Membership to include as a minimum the Chief Executive, a Non-Executive Director and a Council of Governors representative.

- Operational Group – to manage planning and implementation of the Open Day. Membership to include a Council of Governors representative, as well as representatives of Trust charities, directorates and departments in the Trust, and contractors including ISS Mediclean.

- The Communications Manager will be responsible for project managing the Open Day including publicity, logistics, liaison with Trust staff and partner organisations.

4. Funding

The Council of Governors has agreed to fund £15,000 for the Open Day.

5. Programme

5.1 Early discussions are taking place in order to plan the major attractions and events which will take place during the Open Day. A number of ideas have been proposed including:

- Official public launch of the Trust's values
- Official public launch of the new Chelsea Children's Hospital branding
- Use of the Lower Ground Floor Outpatients to provide health checks (for example diabetes, blood pressure, BMI) for members of the public
- Teddy Bear Hospital in Paediatrics area
- Live music organised by Hospital Arts to run all day
- Focus on key services offered by the hospital including paediatrics, elderly care, diabetes, stroke and HIV/Sexual Health
- Careers in the NHS event aimed at 14-17 age group
- Tours – various areas but this could include Paediatric Theatres, Antenatal, Assisted Conception Unit, as well as those linked to specific care pathways

6. VIP attendance

6.1 Discussions are underway with the Chief Executive to help plan VIP involvement in the Open Day.

Renae McBride
Communications Manager
January 2012

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 9 February 2012

AGENDA ITEM NO.	2.8/Feb/12
PAPER	Council of Governors Funding Report
AUTHOR	Vida Djelic, Foundation Trust Secretary Part A: Tony Pritchard , Interim Deputy Chief Nurse Part B: George Vasilopoulos, Web Communications & Graphic Part C: Melanie van Limborgh, Head of Quality and Assurance
LEAD	Cathy Mooney, Director of Governance and Corporate Affairs
EXECUTIVE SUMMARY	The report provides an overview of projects to date and also outlines requests for funding in part A, B and C of the report.
DECISION/ ACTION	The Council of Governors is asked to note the report and agree requests for funding.

Council of Governors Funding Report

1.0 Background

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

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

2.0 Update

At the last meeting the Council of Governors agreed to support funding of the Capita recruitment sessions for £3,300 (lead - Tony Pritchard).

The Council of Governors agreed to support funding of dedicated blog system for £2,520 (lead Matt Akid).

The Council of Governors agreed to support funding of £11,420 for the following engagement activities (lead - Matt Akid):

- 1 extra membership mailing (Jan 2012) £10,000
- 2 monthly emails (Feb & March 2012) £420
- 1 'Medicine for Members' event (Feb 2012) £1,000

The Council of Governors agreed to support funding of £22,592 for engagement activities in 2012/13 (lead Matt Akid).

The Council of Governors agreed to support funding of the Open Day 2012 for £15,000 (lead Matt Akid).

3.0 Funding Overview

Of the £95,000 circa £67k has been accrued for the activities listed in the table below which were approved by the Council of Governors. It leaves circa £28k available to be spent for the remainder of the 2011/12 FY.

4.0 Use of funds FY 11/12

TABLE 1

Activity 11/12	Estimate
Open Day 2011	£15,000
Web Optimisation	£7,000
Discharge Booklet	£8,200
Face to Face Recruitment Campaign	£2,000
Recruitment Campaign for the Annual Members' Meeting	£2,000
Learning Disability Membership Leaflet	£1,304
Quality Award	£2,400
Communications campaign to publicise the Trust's 4 priorities for quality improvement – from 10/11	£4,000
Maternity and Children's Services Events	£5,000
Members Recruitment Campaign 2011 extra funding	£2,340

table and chairs in the Information Zone	£580.80
Badges for governors	£104.40
Capita Membership Recruitment	£3,300
Blog system	£2,520
Engagement activities	£11,420
TOTAL	**£67,169.52**

5.0 Summary of Requests for funding for 2011/12 FY

5.1 The Membership Sub-Committee will be asked to support the request for funding of £144 for the Council of Governors Handbook at their meeting on 3rd Feb. **See Part A**

5.2 The Quality Sub-Committee agreed to support a request for funding from the Quality Account Planning Group to support a copywriter, survey of the current Quality Account and a designer. The funding request is for £8,980. **See Part C**

6.0 Requests for 2012/13 FY

6.1 The Membership Sub-Committee will be asked to support the request for funding of £2,340 for the Members Recruitment Campaign at their meeting on 3rd Feb. **See Part B**

7.0 Already approved for 2012/13 FY

7.1 The Council of Governors agreed to support funding of £22,592 for engagement activities in 2012/13 (lead Matt Akid).

7.2 The Council of Governors agreed to support funding of the Open Day 2012 for £15,000 (lead Matt Akid).

Part A

FUNDING REQUEST FOR PRINTING OF COUNCIL OF GOVERNORS HANDBOOK

1. BACKGROUND

The Council of Governors Handbook, which was first produced in September 2010, has recently been updated to reflect changes in the composition of the Council following elections in November 2011 and also to incorporate changes suggested by Governors.

It provides information specific to the Council of Governors including meeting dates and biographies of all Governors and Trust Board Directors—it aims to help Governors find out more about their colleagues.

2. REQUEST FOR FUNDING

The Council of Governors is requested to fund printing of 50 copies of the updated Handbook at a cost of £144 including VAT.

All Governors and Directors will be provided with a copy of the Handbook – it is not intended for wider circulation.

Part B

Members Recruitment Campaign 2012

1. Introduction

1.1. In December 2012, our total trust membership was 14,803 comprising of 5,859 public, 5,713 patient and 3,231 staff members. Our membership figures demonstrate a need for ongoing recruitment in order to maintain our Trust membership. During the first 3 quarters of 2011/12, 1,210 people left Trust membership.

1.2. Since 2006 there have been a static two face to face membership recruitment campaigns per annum. The first membership recruitment campaign for 2011/12 was conducted in June. 'Capita Recruitment' successfully recruited 300 new members in the borough of Hammersmith and Fulham. A second recruitment campaign was conducted in September 2011 within the hospital to recruit a further 300 members and to promote the Annual Members Meeting and forthcoming Governor Elections of November 2011. Capita Recruitment has shown strength in recruiting and guarantees 300 members per campaign. This was proven in the June 2011 campaign. We now wish to propose planned recruitment campaigns for May and September 2012.

2. Aims

2.1. It is proposed that we commission Capita, our recruitment providers, to provide 2 recruitment events in May and September of 2012. Through each of these events we would plan to recruit 300 members. The May recruitment event would also be used to promote the Trust Open Day whilst the September event would be used to promote both the Governor elections and the Trust Annual General Meeting.

The member's recruitment campaign will be conducted by 'Capita Recruitment'. Capita will provide the following services:

- Recruitment of 300 members
- Provide high quality, experienced staff.
- Data input onto Capita membership database
- Gather any other feedback with regards to Chelsea and Westminster Hospital Foundation Trust.

3. Funding

The Trust is very grateful for the financial support provided by the Council of Governors.

We would like to ask the Council to consider funding the cost of the Members Recruitment Campaign at a cost of £2,340 (inclusive of VAT @20%).

4. Actions for the Council of Governors

The Council are asked to approve the request for funding of the project.

Part C

On behalf of the Council of Governors Quality Sub Committee Quality account Planning Group

1.0 Background

The Department of Heath requires every NHS Trust to compile a report, (or more accurately an account) aimed at providing information for users of Trust services.

This document, the Quality Account, is mandatory and is required to be produced annually to represent the quality of services provided by an NHS organisation. The Quality Account should be made available to the general public and users of the Trust's services. It should seek to provide a transparent overview of the quality of these services.

.

The Quality Account in demonstrating how the quality of services is provided should also show how these are measured and should be defined by addressing:

- patient safety
- the effectiveness of treatments that patients receive
- patient feedback about the care provided

There are mandatory sections to a Quality Account that must be adhered to, but also a section for the Trust to be able to highlight particular areas of quality important to the organisation. The account should show quality objectives already achieved during the year as well as those planned for the future. This account presents an excellent opportunity for the Trust to highlight the benefits of its services to patients.

The Council of Governors' Quality Sub Group has taken a responsibility to provide input and views into the Quality Account. To further enhance the Quality Account in 2012, a Quality Account Planning Group has been formed by the Sub Committee.

This group is planning to be a key part of the planning for the Quality Account in terms of future readability, presentation and availability of the document for the users of Trust services. This group will hold an important role in ensuring the presentation of the account will be suitable for the intended recipients of the final document.

2.0 Evaluating the 2011 Quality Account and planning for 2012

The Quality Account Planning Group is a task and finish group and met for the first time in January. The group was established to consider the timely review and comment to the versions of the Quality Account document.

It was agreed the work of this group would be required from the evaluation of the 2010/2011 document, up to the end of April 2012 when the new document is published. The group will in particular, assess document suitability and suggest on-going improvement to:

- presentation
- readability
- appropriateness of written information
- making the document valuable and effective for patients and other stakeholders

The group will provide views regarding the distribution and circulation of the final quality account in order to plan for the most effective exposure of the quality account to the Trust's patients and other relevant people.

It was reported that in one London Trust who questioned their patients if they had read the Quality Account produced in that Trust, that the answer was no from all respondents involved. As a result of this learning the Quality Account Planning Group wishes to ensure the new version of the Account is attractive, accessible and readable by patients.

Feedback from the group has suggested certain modifications from last year's account to the 2012 document, making the account even more relevant to patients, and by providing data in an interesting form. Specific comments include the provision of:

- a brief and easy to read overview of the account and its key points
- To establish patients' views of the last account and how the information could be presented in the most interesting and relevant manner.
- Gain views from LINk and the Overview and Scrutiny Committee.
- To support the further development of the Quality Account to meet the patients' needs it has been suggested by governors that it would be helpful to ask patients their views directly. It is proposed if funding is available from the Council of Governors that the services of Capita (who undertake the current membership recruitment for the Trust) could undertake a short survey of up to 40 patients.

This survey could involve asking patients how the current Quality Account could be improved and what they would find useful to include. To support patients talking to Capita or other representatives in the Outpatient Department by undertaking the short survey, it is suggested they could be offered a refreshment voucher in return. The budget to facilitate this would be helpful.

The Planning Group has suggested that in terms of the presentation of the document, the new 2012 document the Quality Account should include:

- The use of varying types of headings/boxes complying with a Trust 'house style'
- all healthcare definitions in the document to have been explained
- consideration to include small quotes/stories from patients regarding the quality of care they have received
- ensuring the text takes on a clear and non-crowded form
- an acceptable quality of paper for the final document in printed form

3.0 Recommendations from the Communications Team to support the Quality Account Planning Group

As part of the Planning Group's work, specialist advice was provided by the communications team and the team agreed all the suggestions from the Quality Account Planning Group. They added the value of the services of a professional copywriter who could assist the development of the document to become a 'clearer to read' document for patients in the future.

An additional enhancement to the Trust's Quality Account was suggested to provide a 'mock up' of a preferred style of Quality Account for the Quality Account Planning Group to consider before a final document format is agreed. These services could be provided by a specialist designer.

To obtain the maximum quality of the finished Quality account document it was recommended that the document should in future be professionally printed. This would prevent the need to produce the document on a basic hospital provided printer and would facilitate the production of a higher quality document.

A final recommendation raised at the meeting was to consider the provision of a separate and summarised document to be printed professionally reflect only the key messages of

the quality account to provide a quick and easy to read overview for all patients and users of Trust services. This document could be made available in public areas such as Outpatient areas, MPALS offices as well as clinical areas

In consideration that the Quality Account aims to be a useful resource to patients it was agreed that as enhancements are recommended, but not possible to achieve under current Trust budget arrangements. It was suggested to therefore submit a paper to the Council of Governors to request support for funding.

4.0 Funding requests presented to the Council of Governors

The Council of Governors is kindly asked if they could support funding for the following 6 items for the Quality Account Planning Group outlined in this paper. This will greatly assist the high quality enhancement and development of the Account over the next 3 months and to publication:

The survey of patients to gain their views will help the Quality Account Planning Group understand the patient's needs for a Quality Account and the offer of complimentary refreshment voucher for patients will assist the developmental stages.

In order to ensure the final document is more likely to be attractive, useful and ultimately read by patients, the skills of a designer will greatly assist the presentation of the final document and a copywriter will be able to format the document into an easier to read and understand resource which if printed professionally, will be a significant advantage for the full and summarised papers.

The 6 streams of funding will greatly enhance the 2012 document from the presentation of the 2011 document. Support from the Council of Governors will ensure the patient's needs are more greatly met as is the intention from the Department of Health with the Quality Account. All prices below are inclusive of VAT.

1	Representatives to assist initial survey	£ 380
2	Refreshment vouchers for up to 40 patients	£ 80
3	Designer to produce a mock-up of the Quality Account style	£ 800
4	Copywriter, 12 days at £350 a day	£ 4200
5	Professional printing of the final Quality Account	£ 3010
6	Professional printing of the final Quality Account(summarised version)	£ 510
	TOTAL	£8980

5.0 Actions requested from the Council of Governors

The Council of Governors is invited to comment on the proposal and is asked to kindly support the request for funding to facilitate the 6 listed items.

The provision of the specialist support and resources will aid the enhancements required for the 2012 Quality Account as suggested by the Council of Governors' Quality Sub Committee Quality Account Planning Group.

The group aims to support the document to be designed to be a helpful resource for patients and in a style that is attractive to patients, rather than a document that just addresses the mandatory requirements required of the Trust as required by the Department of Health.

Melanie van Limborgh Head of Quality and Assurance January 30th 2012

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 9 February 2012

AGENDA ITEM NO.	2.9/Feb/12
PAPER	Quality Awards
AUTHOR	Melanie van Limborgh, Head of Quality and Assurance
LEAD	Catherine Mooney, Director of Governance and Corporate Affairs
EXECUTIVE SUMMARY	The Council of Governors Quality Awards led by the Council of Governors Quality Sub Committee is awarded for Patient Safety, Patient Experience and Clinical Effectiveness. The awards have been in operation in the Trust since January 2011. An awarding criterion is in place to provide a template for the selection of the successful winners which is judged by members of the Council of Governors Quality Sub Committee. The award winners were agreed at the November Council of Governors Quality Sub Committee Meeting. Three winning teams were chosen for their work contributing to improvement for quality patient care. The awards will be highlighted at the Council of Governors Meeting in February when the winning teams will be present.
DECISION / ACTION	The Council is asked to note the content of this paper to gain an overview of the objectives and deliverables of the Council of Governors Quality Award and the most recent winners.

Quality Awards

1.0 Introduction

1.1 The aim of the Trust's Quality Award is to recognise and reward contributions to quality initiatives in the Trust from an individual or team who have made a contribution to quality for patients under three categories:

- Patient Safety
- Patient Experience
- Clinical Effectiveness

1.2 This award is open to Chelsea and Westminster Trust employees as all staff have the potential to directly or indirectly improve quality through improving the patient's experience. The award can be received for a project, an initiative or a change in the work of staff that as a result provide benefit to quality care.

1.3 Aside of the award recognition the winners have the opportunity to meet with the Medical Director, Chief Nurse and Director of Patient Flow, Director of Governance and Corporate Affairs and governors from the Council of Governors Quality Sub Committee. This provides award winners the time to discuss their initiatives and highlight the value of their achievements.

1.4 A final benefit of the award is that the winners receive £100 for an individual submission and £250 for a team submission to benefit the work of their department. This finance is generously supported by the Council of Governors.

2.0 Background

2.1 The Council of Governors Quality Awards has been in operation from January 2011, supported and directed by the Council of Governors Quality Sub Committee. The Quality Awards have traditionally followed a quarterly programme of applications and awarding is led by the Director of Governance and Corporate Affairs on behalf of the Council of Governors Quality Sub Committee. The applicants are required in the documentation submitted for an award to provide an overview of:

- The context of the initiative that is being taken forward, e.g. where this work is done, the specific staff/patient groups that were involved and the specific problem or system dysfunction being addressed and how that was affecting patient care
- How the assessment of the problem and analysis of its causes is handled, how the applicants quantified the issue, how staff were involved, how the causes of the problem were addressed and what solutions/changes were needed to make improvements
- The applicants are required to describe the intervention employed and the strategy for implementing a proposed change and how the results were disseminated
- How plans for change to the groups involved with/affected by the planned change, the timetable for change and how improvement was measured, any analytical methods used if used any results obtained.
- Applicants are asked about the effects of changes, how far these changes resolved the problem that triggered the work, how this improved patient/client care and problems encountered with the process of changes or with the changes themselves.

2.2 Finally, on the award application applicants have to state the lessons they have learnt from the work they have undertaken that would be applied elsewhere.

2.3 Recent developments

2.3.1 Since the Head of Quality and Assurance came into post in September 2011, there have been some changes to the management of the Quality Award. The future awards will see the Head of Quality and Assurance manage the Quality Awards process. This post-holder will additionally encourage applications and provide assistance where required to potential applicants to develop their Quality Award applications.

2.3.2 From January 2012 to recognise the winners of the work and to enhance organisational learning they will be invited to attend the Council of Governors Committee to have an opportunity to meet the Governors and Trust Directors in person. This will be taking place for the first time at the Council of Governors Meeting on the 9th February.

3.0 The Quality Award winners

3.1 The Council of Governors' Quality Sub Committee agreed the Quality Awards at the Council of Governors Meeting on the 30th November with three winners and three teams of runners up. The Council of Governors awarding panel was comprised of Mike Anderson, Medical Director, Cathy Mooney Director of Governance and Corporate Affairs, Therese Davis, Chief Nurse and Director of Patient Experience, Carol Dale, Learning and Organisational Development Manager and Trust Governors Melvyn Jeremiah, Martin Lewis, Susan Maxwell, Wendie McWatters and Sandra Smith Gordon.

3.2 In recognising and rewarding contributions to quality initiatives in the Trust for individuals or teams who have made a contribution to quality for patients under the three categories listed above, the winners for the autumn 2011 Award are as follows:

3.2.1 The Phlebotomy Team, Diagnostics

This team submitted an entry under the criteria of Effectiveness and Patient experience.

The application outlined a new working approach adopted when an incoming manager, Lorrayne Kilburn, with experience of other NHS phlebotomy departments was appointed. Lorrayne Kilburn introduced a new regime that took the best from other organisations and capitalised on the existing Chelsea and Westminster phlebotomy team.

Some practical measures were introduced, for example, each phlebotomist would occupy their own working space within the clinical area and take ownership of that area. The start times for work were staggered to cover peak patient attendances without unduly affecting the less busy times. Ward services and the rotations to those areas were amended so that inpatients and out patients received the best attention when most required. Initially, a combination of permanent and bank staff were employed to maximise the flexibility of the workforce, but this was replaced to recruit staff into permanent positions.

There had been a concern regarding delayed discharges over periods of heavy demand. To address this Phlebotomy team volunteered to introduce early starts for ward blood tests for the Acute Admissions Unit. This change relieved pressure in the unit on several occasions when the focus had been directed to reducing length of stay.

Equally important changes have been made to the working life of the phlebotomy staff such as uniforms being introduced and this is thought to have given a sense of identity

and professionalism to the team. Additionally, improvements to label printing for the specimen tubes resulted in reduced repeats tests and improvements to the output of the pathology team.

The phlebotomists and their administrative support also now regularly check the waiting area and check with volunteers in the area to determine the number of patients waiting to have blood taken and appraise the time in minutes that they have been waiting in order to institute any required improvement to the service.

Information from the accurate records that the MPALS team have kept over the last two years, demonstrates that patients have reported increased levels of patient satisfaction from the service. To add to this is the receipt of weekly 'comment cards' of positive feedback from patients. These patients have experienced the long delays in the past for their blood tests and are now very pleasantly surprised by the new service. The volunteers who work with the phlebotomy team also report a much improved atmosphere both in the waiting area as well as in the clinical area.

Activity statistics prove that the number of patients attending for blood tests has not reduced which indicates that the improvements are real and worthwhile.
The volunteers independently monitor waiting times that demonstrate waiting times are on average reduced to 10 – 15 minutes in duration from an average of 3.5 to 4 hours before this work was undertaken (even though activity levels have not reduced).

Lessons learnt from this project are many and the importance of strong effective leadership, team work and ownership of responsibilities as key components of safe and effective patient care.

3.2.2 The Musculoskeletal Physiotherapy Team

The application received from Siobhan Burnett, Senior Musculoskeletal Physiotherapist obtained a team Quality Award for effectiveness and patient experience for their work in determining the service their patients wish to receive and demonstrating improvement.

This was obtained by a targeted survey sent to patients and from this key objectives for a three year plan was set for the department to achieve. The survey has enabled the physiotherapy team to positively improve patient care based on patient need and make their service more efficient and effective.

The aims and objectives of this patient experience project included:

- Determining the level of satisfaction of patients referred to our service, delivered at the Chelsea and Westminster Hospital site and 8 community locations in Kensington and Chelsea.
- To attempt to ensure patients have quick and easy access to the service
- Determining the aspects of physiotherapy are most important to patients including; the ability to self-refer, choice of location, number of appointments, waiting times and access to traditional and non-traditional treatments such as acupuncture, hydrotherapy and rehabilitation classes
- Finding out about the appointment preferences of patients e.g. times of day/days of week
- Identifying areas where improvements could be made to enhance the patient experience
- Moving to ensure improvements in patients' experience compared to previous survey findings namely:
  - Ensuring physiotherapists use language that patients understand.

- Ensuring there are equal waiting times across all 9 physiotherapy sites.
- Ensuring 95% of patients are seen within 5 weeks (5% allocated to patients who choose to wait longer for personal reasons).
- Ensuring that patients are always offered a choice of appointments.
- To improve directions given to patients and investigate ways to improve patient communication with physiotherapists at community sites.

Thee questionnaire was devised from other national patient surveys questions and from the questionnaires used by the MSK physiotherapy team in 2008 and 2009. New questions were added to achieve the project's aims (see above) and the wording of the questionnaire was improved following feedback from the 2009/10 survey. The survey format was also improved to enable the questionnaire to be completed on–line.

The new questionnaire was sequentially sent to 500 patients following discharge from physiotherapy during a 4 month period from November 2010 to February 2011. All patients were given a chance to give their feedback, including those who did not complete their course of treatment. These patients were included to try to find out the reasons why they did not complete their treatment. The aim was to use this feedback to try and help to improve access and / or attendance rates. All questionnaire responses were anonymous.

In addition to returning the questionnaire by post, patients were also given the option of completing the questionnaire on-line if they preferred. The aim of this was to increase the ease for patients to complete the survey and we hoped it would have the added benefit of increasing the response rate compared to previous paper-based questionnaires.

There was an excellent 41% response rate to the questionnaire (204 out of 500 replies) strengthening the validity and value of the results. Carrying out a patient experience survey over 3 consecutive years has positively improved patient care and made the service more efficient and effective.

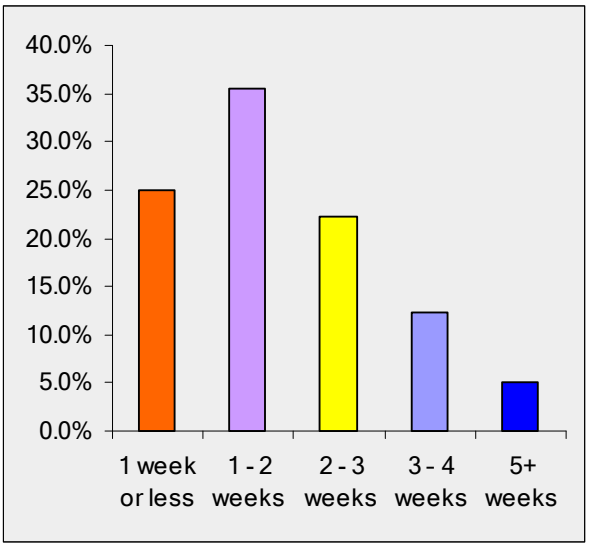
2009-2010 Action Points	Progress in 2010/2011
Ensure that physiotherapists use language that patients understand	**Achieved - 97.9%** of patients reported that they understood all the words their physiotherapist used within their physiotherapy sessions. This has improved from 92% in 2009/2010.
Continue to emphasise goal setting with patients.	**81.1%** of patients stated that they had set goals with their individual physiotherapist. This percentage remains largely unchanged from 2009 and therefore will form part of 2010-2011 action plan.
Ensure that 95% of patients are seen within 5 weeks of referral	**Achieved**. **94.9%** of all responders had been given an appointment within the service target of 5 weeks. This has improved from 89% in 2009/2010.
Ensure that there are equal waiting times across all physiotherapy sites	**Achieved.** The management of all MSK referrals through one centralised booking system has facilitated this improvement.
Improve the ease of contacting the physiotherapy department	**Achieved. 98%** of patients reported that they felt the service communicated well with them.
Improve telephone communication between patients and their therapist	**Achieved. 97.9%** of responders reported that they felt it was easy to contact their individual physiotherapist. This had improved significantly from 77% in 2009, possibly facilitated by one centralised contact system.

By acting on patient feedback, the 2010-2011 results now show high levels of overall satisfaction:

- **97.9%** of all responders reported that they were satisfied with the physiotherapy service that they received with **69.1%** of responders indicated that they were ***"definitely* satisfied"** with the service provided.
- **97.7%** of all responders reported that they would recommend the physiotherapy service to friends and family.

The results of the survey have also helped design services around the needs of patients. Local commissioners have agreed to include patient self-referral to physiotherapy within a new MSK care pathways for patients in Kensington and Chelsea as **67%** of patients in our survey rated self-referral as **very** important to them.

Waiting times to access Physiotherapy



Over the last 3 years we have significantly improved and shortened the waiting times to access physiotherapy.

Waiting Times from referral to 1st appointment:

- **24.9%** of all responders waited a maximum of 1 week.
- **60.4%** of all responders waited a maximum of 2 weeks.
- **82.7%** of all responders waited a maximum of 3 weeks.
- **94.9%** of all responders had been given an appointment within the service target of 5 weeks.

In 2011, we plan to drive down waiting times even further as **over 80% of patients** report that short waiting times are very important to them.

To further enhance our service, an action plan shaped upon patient feedback has been created**.** Following a team discussion, methods to achieve the action points were finalised and include:

2011 Action Points	Methods to achieve
Ensure that all patients are aware that they offered a choice of appointment dates and times for their first appointment.	Discuss with the administration team methods to ensure that patients are in informed of a choice of appointment times when making their initial appointment. **Achieved**
Continue to emphasise the importance of involving patients in decisions regarding their treatment plan.	Feedback to staff and reinforce in regular caseload reviews / supervision. **Achieved**
Continue to emphasise goal setting with patients.	Feedback to staff and reinforce in regular caseload reviews / supervision. Goal setting to be linked to patient-reported outcome measures**. Achieved**
Improve the awareness that patients have the right to decline treatment.	33.3% of responders reported they did not feel they were informed of their right to decline treatment despite the following measures in place. 1. All patients receive an information leaflet explaining their right to decline treatment at

	any time. 2. Patient consent is gained at the start of each treatment session which is one of many *CSP / HPC standards that are audited by the* department. 3. For future questionnaires, the wording of this question will be altered to better reflect the words commonly used by physiotherapists when making patients aware of their right to decline treatment. 'Did you feel able to opt out of a particular treatment?' **Achieved**
Investigate self-referral to MSK physiotherapy.	Discuss with GPs and GP Commissioning Consortia.
Improve access to the service from 4.30-6pm.	Discuss with MSK clinical team re: extended hours and flexible working to achieve this. **Achieved**
Improve directions given to patients to access GP locations	Provide maps of the GP locations at reception including nearest Tube stations / Bus stops so that reception staff can inform patients in an improved manner.

- Drive down waiting times to ensure 95% of patients are seen within a target of 4 weeks from referral. **Achieved** – targets are now set that all patients are seen within a target of 2 weeks from referral
- Produce an assessment pack to include: contract of attendance, right to decline / opt out of treatments, outcome measures / goals. This is currently in process and pending a tender specification
- Feedback results to GPs and patients:
    - Discuss with GP relationship Manager to disseminate information to GPs. **Achieved**
    - Produce posters for waiting area to display results for current patients**. Achieved**
- Investigate the possibility of translating the questionnaire to other languages to try and capture a greater variation of ethnic groups. The next steps include uploading the questionnaire onto the department website.

For future questionnaires it was proposed that patients will be given the option to request feedback. **Achieved**

The lessons have been learnt from this initiative which could be applied elsewhere in the Trust or the NHS is to be able to:

- Devise local solutions where national guidance do not exist
- Use patient feedback and experience to shape future services
- Use technology to enhance communication with patients
- Ask patients what matters to them

Over the last 3 years the team has significantly improved and shortened the waiting times to access physiotherapy.

The patient waiting times from referral to 1st appointment are as follows:

- 24.9% of all responders waited a maximum of 1 week.
- 60.4% of all responders waited a maximum of 2 weeks.
- 82.7% of all responders waited a maximum of 3 weeks.
- 94.9% of all responders had been given an appointment within the service target of 5 weeks.

As a future objective the team highlights that over 80% of patients report that short waiting times are important to them, in 2011, the department plans to reduce waiting times further.

3.2.3 The Plastic Surgery Team

This application was received from Dr Beryl de Souza and Dr Shivali Patel on behalf of the Plastic Surgery Team for their work for safety and patient effectiveness for a project addressing venous thrombo-embolism (VTE). This award work was achieved by assessing all operative and non-operative patients in the Plastic Surgery Department over a six month period.

The project addressed venous thromboembolism (VTE) which is a significant international patient safety issue and cause of morbidity and mortality in the UK. An estimated 25,000 people die from VTE in England and Wales each year. 1 in 3 patients having an operation in hospital can develop VTE if no preventative measures are taken. The first step to preventing death and disability is identifying those at greatest risk and initiating appropriate prophylaxis.

The Department of Health (DH) from June 2010 has made compulsory for all providers of NHS funded acute hospital care to provide data on VTE risk assessment, partly as a way to further embed VTE risk assessment and encourage appropriate prophylaxis for those at risk. The aim of the VTE project was to ensure the Plastic Surgery department complied with the Trust and DH guidelines on Thromboprophylaxis for admitted patients.

The plan was to identify reasons for inadequate compliance issues and to implement the necessary changes. All operative and non-operative patient cases within the Plastic Surgery Department over a 6mth time period were assessed with regards to VTE risk.

Having identified inadequate compliance the results were discussed at the Plastic surgery departmental audit meeting. Changes were implemented and this was followed by a re-audit to complete the audit cycle.

The first audit demonstrated poor adherence to VTE risk assessments with an average of 14% compliance across the department. After changes were implemented a further assessment was carried out which demonstrated an average of 97% compliance.

The lessons that have been learnt from this initiative which could be applied elsewhere in the Trust or the NHS are the benefits of patient education in the form of leaflets, and departmental staff education, including doctors of all levels, nurses in preadmission clinics, day surgery and on the ward, on VTE and local and national guidelines for risk assessment.

The department has also introduced a VTE question as part of the formal written and verbal handover system to increase awareness of those not assessed. The Trust electronic VTE risk assessment tool introduced a further reminder for those not risk assessed as well as highlighting those at risk after assessment was complete.

These changes have made VTE risk assessment easier to comply with and as a result have highlighted those at risk of VTE. It was noted that to ensure compliance with guidelines, the process should be first understood.

In this case the department was able to increase awareness by using the trust provided patient information leaflets identify obstacles to the process such as the handover from Emergency Department admissions and theatres not incorporating VTE prophylaxis and remedy these as appropriate by engaging the department as a whole. The Trust's

electronic VTE risk assessment tool was essential in providing compliance. The team reported that compliance to national guidelines begins at Trust level and the use of IT methods to improve compliance is and has been an important innovation.

By identifying inadequate compliance and acting on gaps the team implemented changes to facilitate improvement, using a variety of strategies. This good practice has been presented as a paper at the International Forum of Quality and Safety in Healthcare 2010 in Amsterdam.

3.2.4 Other Quality Award applicants

Other notable applications from those received and reported at the November Council of Governors Quality Sub Committee other notable applications were recognised as:

The Infection Control Team

Nominated by other Trust staff, the Infection Control Team led by Ros Wallis Consultant Nurse Infection Prevention and Control were recognised for their high quality and significant work for the Hand Hygiene Week. This work to raise awareness of hand hygiene was described as 'innovative work' in the submission.

The Volunteer Service

This team has received excellent patient feedback led by Charlotte Mackenzie Crooks and Serena Venticonti for the 'Request a Volunteer' Service. This service from purely volunteer led project has demonstrated a notable change to care in the clinical areas with a revolutionary approach of different initiatives.

The Heart Failure Exercise Programme project

This is a CLAHRC (Collaboration for Leadership in Applied Health Research and Care) funded project and was Heart Failure Nurse Specialist, Claire Copeland and Fiona Milligan Cardiac Rehabilitation Nurse Specialist. This project provides a structured exercise programme for cardiac patients beginning in hospital and extending out into the community.

4.0 Summary

The Quality Awards led by the Council of Governors Quality Sub Committee are awarded for Patient Safety, Patient Experience and Clinical Effectiveness and criteria is in place to determine the successful winners. The awards have been in place since January 2011.

The award winners were agreed at the November Council of Governors Quality Sub Committee Meeting. Three winners were chosen and their work will be highlighted at the Council of Governors Meeting on February 9th 2012 when the winners will be invited to attend.

5.0 Decision/action required

The Council is asked to note the content of this paper to gain an overview of the objectives and deliverables of the Council of Governors Quality Award and the most recent winners.

Melanie van Limborgh
Head of Quality and Assurance
January 2012

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 9 February 2012

AGENDA ITEM NO.	2.10/Feb/12
PAPER	Chelsea and Westminster Star Awards 2012
AUTHOR	Matt Akid, Head of Communications
LEAD	Mark Gammage, Director of HR
EXECUTIVE SUMMARY	This paper outlines the launch of the inaugural Chelsea and Westminster Star Awards, a new annual staff awards scheme which culminates in an awards dinner at Chelsea Football Club on 14 May. A Patient Choice Award and a Council of Governors Special Award are proposed as two of the award categories.
DECISION / ACTION	Governors are invited to give their feedback on the new staff awards scheme and, in particular, the proposed Patient Choice Award and Council of Governors Special Award – and are invited to put themselves forward to be involved in the judging panels for these 2 particular award categories.

CHELSEA AND WESTMINSTER STAR AWARDS 2012

1.0 Introduction

A grant of £17,160 from Chelsea and Westminster Health Charity will fund a new annual staff awards scheme. The Chelsea and Westminster Star Awards will complement existing staff recognition schemes including the Christmas Cheer Awards, Council of Governors Quality Awards, and Employee and Team of the Month awards.

Most award categories will be for staff nominated by other staff but the intention is to have a Patient Choice Award – for staff to be nominated by Foundation Trust members and other patients – and a Council of Governors Special Award for staff to be nominated by Governors.

2.0 Aim

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

As part of the Trust's corporate objective to improve the patient experience, we aim to be in the top 20% of acute trusts nationally for staff engagement. The Trust achieved this aim in the 2010 NHS Staff Survey (for the second consecutive year) and early indications are that our performance in this area has improved further in the 2011 survey to be published in March.

The Trust was also shortlisted in the 'Best Internal Communications' category of the *HR Excellence Awards 2011* and rated among the top 20% of acute trusts nationally for good communication between senior management and staff in the 2010 NHS Staff Survey.

Why does this matter? Evidence from the NHS and other areas of both the public and private sectors shows that organisations with higher levels of staff engagement perform better – in simplistic terms, happier staff mean happier patients.

Celebrating staff achievements is an important part of staff engagement and communication.

The Chelsea and Westminster Star Awards aim to reward and recognise the efforts of both clinical and non-clinical staff. They will culminate in an awards dinner at Chelsea Football Club on 14 May – all staff shortlisted will be invited to attend.

3.0 Progress to date

A small organising committee has been set up, chaired by Mark Gammage (Director of HR) with representatives from HR, Communications, Staffside, and the consultant body (Dr Roger Chinn). Progress to date includes:

- **Name and branding agreed**
- **Date, time and venue for awards dinner and prizegiving ceremony agreed** – Monday 14 May from 6.30pm onwards at Chelsea Football Club
- **VIP secured** - BBC presenter Sophie Raworth has agreed to present the awards
- **Award categories** – a shortlist of c.20 categories has been drawn up to be agreed at the next meeting of the organising committee on Monday 6 February
- **Sponsorship** – staff in HR have been identified to lead on seeking sponsorship for prizes from local businesses and Trust contractors
- **Publicity** – a communications plan has been agreed (see below under 6.0)

4.0 Next steps

A number of areas in which some progress has been made require further attention:

- Agreeing a list of **award categories**
- Securing **sponsorship** for prizes
- Designing **publicity materials** including online and paper-based nomination forms

In addition, a number of other areas need to be progressed including:

- **Compere and event management company** - to organise awards dinner and prizegiving ceremony
- **Trophies/certificates** – for award winners
- **Invite list** – for awards dinner and prizegiving ceremony
- **Dress code and timings** – for awards dinner and prizegiving ceremony
- **Judging panel** – composition of the judging panel to agree a shortlist of 3 staff in each category including the Patient Choice Award and Council of Governors Special Award
- **Timeline** – see below under 5.0, including dates for launch of call for nominations, deadline for nominations, judging panel, announcement of shortlist, deadline for RSVPs for awards dinner and prizegiving ceremony

5.0 Timeline

6 Feb	Meeting of organising committee to agree next steps
w/c 27 Feb	Launch of call for nominations – publicity starts
w/c 19 or 26 Mar	Deadline for nominations
w/c 26 Mar or 2 Apr	Judging panel
13 Apr	Shortlist announced – all invited to awards dinner/prizegiving ceremony
30 Apr	Deadline for RSVPs for awards dinner/prizegiving ceremony
14 May	Awards dinner/prizegiving ceremony

6.0 Communications plan – publicity

6.1 Internal

The Chelsea and Westminster Star Awards will be publicised to staff as follows:

- ***Trust News*** – launch of call for nominations (March), announcement of shortlist (joint April/May edition), announcement of winners (June)
- **Team Briefing** – launch of call for nominations (March), announcement of shortlist (April & May), announcement of winners (June)
- **Daily Noticeboard email bulletin** – from w/c 27 Feb onwards
- **PC desktop icon** - from w/c 27 Feb onwards
- **Posters/flyers/paper-based nomination forms** – to be distributed via line managers and displayed in the hospital from w/c 27 Feb
- **Online nomination form** – SurveyMonkey to be linked to from Team Briefing, Daily Noticeboard etc from w/c 27 Feb onwards

Directors and Divisional management teams will be asked to help publicise the awards to staff by making them a main agenda item at meetings and forums including:

- **Senior Operational Group** - General Managers and other senior managers
- **Joint Management and Trade Union Committee (JMTUC)** – Staffside reps

- **Local Negotiating Committee (LNC)** – consultants
- **Grand Round** – doctors (consultants and junior doctors)
- **Teaching sessions** – junior doctors
- **Nursing and Midwifery Advisory Committee (NMAC)** – senior nurses and midwives
- **Team meetings** – all staff
- **Designated Directors** – Directors to encourage staff to get involved
- **Equality & Diversity Steering Group**
- **Research Strategy Board**

6.2 External

The Patient Choice award of the Chelsea and Westminster Star Awards will be publicised to Foundation Trust members and other patients as follows:

- **Online nomination form** – SurveyMonkey to be linked to from Trust website Homepage and Latest News pages, also a dedicated webpage www.chelwest.nhs.uk/starawards from w/c 27 Feb onwards
- **Local media** – press releases to encourage nominations (w/c 27 Feb), announce shortlist (13 Apr) and announce winners (15 May)
- **Posters/flyers/paper-based nomination forms** - to be available at main reception, M-PALS, Information Zone and in clinical areas from w/c 27 Feb
- **Council of Governors** – agenda item at Council of Governors meeting 9 Feb
- **Trust News** – announcement of shortlist (joint April/May edition – this is sent to all patient and public Foundation Trust members as well as distributed in the hospital)
- **Members' News** – main news item in our new monthly email newsletter for Foundation Trust members to encourage nominations (2 Mar), announce shortlist (4 May) and announce winners (1 June)
- **Kensington and Chelsea LINk** – we will ask the LINk to publicise the awards to their members from w/c 27 Feb onwards
- **Patient support groups** – we will ask staff who look after existing patient support groups to publicise the awards to their members from w/c 27 Feb onwards
- **Charities** – we will ask the Friends, Chelsea and Westminster Health Charity, Volunteers, St Stephen's Volunteers, St Stephen's AIDS Trust etc to publicise the awards to people involved with their organisations

7.0 For action

a) Governors are invited to give their feedback on the new staff awards, in particular the proposed Patient Choice Award and Council of Governors Special Award.

b) In relation to the judging of the Patient Choice Award, the Trust would like 1 representative from the Council of Governors to be on the judging panel for this specific award – Governors are encouraged to put their names forward.

c) In relation to the Council of Governors Special Award, all Governors are invited to nominate staff for the award and the Trust would like 3 representatives from the Council of Governors to form a small judging panel for this specific award – Governors are encouraged to submit their nominations to Vida Djelic (Foundation Trust Secretary) via email vida.djelic@chelwest.nhs.uk or by post, and to put their names forward for the judging panel.

Matt Akid
Head of Communications
February 2012

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 9 February 2012

AGENDA ITEM NO.	2.12/Feb/12
PAPER	Draft Minutes of the Council of Governors Quality Sub-Committee meeting held on 24 January 2012*
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Mike Anderson, Chairman of the Quality Sub-Committee
EXECUTIVE SUMMARY	Draft minutes are enclosed.
ACTION	To note.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Quality Sub-Committee meeting, 24 January 2012

Draft Minutes

Attendees	Carol Dale		Staff Governor –Management	Apologies
	Melvyn Jeremiah	MJ	Public Governor – Westminster 2	
	Martin Lewis	ML	Public Governor – Westminster 21	Apologies
	Susan Maxwell	SM	Patient Governor	
	Wendie McWatters	WMW		
	Sandra Smith-Gordon	SS-G	Public Governor – Kensington & Chelsea 2	
	Mike Anderson	MA	Medical Director, Chairman	
	Cathy Mooney		Director of Governance and Corporate Affairs	
	Tony Pritchard	TP	Interim Deputy Chief Nurse	
	Christopher Collister	CC	PALS Manager	Apologies
	Patricia Gani	PG	LINk representative	
	Melanie van Limborgh	MvL	Head of Quality and Assurance	
	Vida Djelic	VD	Foundation Trust Secretary	

1 Welcome and Apologies **MA**

Apologies were received as noted above.

2 Minutes of previous meeting **MA**

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

- Add Wendie McWatters and Martin Lewis to the list of attendees.

The sub-committee agreed that a full list of members appears under attendees and any apologies will be indicated on the list.
VD to amend minutes in line with the comments received. **VD**

3 Matters arising **MA**

CM provided an update from Helen Elkington regarding the main reception. The issue of staff chewing has been raised with the Head of Security and HE noted that there are no plans for refurbishment of the main reception.

There was a discussion on how it could be made to be more prominent and inviting e.g. to be called reception and enquiries, and the use of banners to direct patients to reception.

It was suggested that the signage group could look at this. **CM to raise with Andy Denton/Helen Elkington for the signage group to consider.**

WMW suggested a 'meet a governor' banner be placed by the reception with the dates of governors' sessions in the Information Zone. The sub-committee suggested to pilot this and see if it works. **TP to discuss with PALS.**

Regarding the request around retired doctors this was clarified. **CM to discuss with BG.**

CM said that she had contacted DL and she will respond. It is up to individual prescribers to inform patients about the side effects.
Post meeting update from DL: this has been discussed with the Surgery and Care of the Elderly pharmacists. Pharmacy can confirm that there is guidance on prescribing for acute pain in the elderly (reduced doses) and the Lead Directorate Pharmacists also monitor tramadol usage as a drug of potential misuse.

Re classes for patients with osteoporosis, CM reported that physio thought this was a good idea and have contacted the enquirer directly.

CM to ask for an update for the next meeting.

The sub-committee noted that all other actions were completed.

4 Feedback from governors on patient experience

WMW said she had feedback from a friend re the follow up appointments in the pain clinic. The case identified gaps in the appointments of acute pains.

WMW to check with the patient the current state of the appointments arranged and to inform TP. TP to raise with PALS.

MJ reported on a visitor he met while being in the Information Zone. Her sister was on the Chelsea Wing with restricted hand movement and she was not being helped enough with meals, answering the phone and reaching the call bell. The importance of nursing staff considering individual patients needs was noted.

A bell check is undertaken as part of the senior nurse ward rounds which includes checking response times. This is fine during the day but not so good at night.

WMW thanked TP for being proactive re the patient mentioned at the last meeting who was very happy with the result of the investigation and who wrote a thank you letter to the Chief Executive.

5 Quality Account – report from the Quality Account Planning Group

The Quality Account Planning Group met on 18 January to discuss the readability and presentation of the quality report.

The Quality Account Planning Group Terms of Reference were agreed.

MvL highlighted the main points agreed. A copy of the notes are attached.

Suggestions included:

- look at the presentation of the Account and how to attract patients

to read it;
- Include a short leaflet to explain what the Quality Account is
- Boxes to explain terminology

Other suggestions included:
- Short pre audit of the current Quality Account
- Use Capita, the membership company to ask patients for opinions
- Volunteers or governors to help by taking it to patients on wards for comments
- Offer a costa coffee voucher to those giving feedback on the Quality Account
- Use a style that stands out
- Small quotes from patients about their care
- Contribution re comments from stakeholder to be in the same style

MvL will get a quote for a designer to explore a different layout of the Quality Account to make it look more interesting. **A paper requesting funding for the ideas to be circulated.**

The Quality Sub-Committee agreed to support the funding request.

6 Quality Award Certificate – ideas

All of the groups had visits from CM and governors. They are delighted by the recognition received.

MvL is considering how to develop the award further and will discuss at the next meeting. The next award is planned for February.

WMW said that the physiotherapy are pitching to get a community contract and they need some good comments. WMW asked CM to provide her with the details of contact in the physiotherapy.

SM suggested that CB is also asked to submit his comments as he has recently visited the physiotherapy department.

CM to follow up as above.

MvL presented three different Quality Award Certificate templates for the Quality Award Certificate.

Quality Awards winners will be invited to the Council of Governors meeting on 9 February 2012.

The sub-committee agreed on the template to be used and the proposal to have the certificates framed.

The sub-committee agreed that a governor who visited the area sign it as well as the Chairman.

7 Transparency section of Trust website

MAk provided an update on the design of the transparency section.

The main area for development is about consultants and we are considering how to introduce this.

Axel Heitmueller, Director of Strategy and Business Development will meet with designers next week to explore options for presentation of the transparency section on the website.

MT said she did some research and liked the site of the Presbyterian Hospital in New York which included a short video clip, and sections on consultants overview and what they do.

MJ commented that the current information is very good. However, some information is difficult to find.

Suggestions included that the main introduction explained the relationship between the Quality Account and Quality Report, and that the transparency section is used to update people on progress with the Quality Account objectives and priorities. We would need to be assured on the quality of data but we could begin to put data on as we get assurance.

Charts which are updated monthly should say latest audited figures.

Re the content of the transparency section the following have been suggested:

- waiting time in the A&E;
- never events – agreed not to include or change the title slightly.
- publish what we are good at and where we do not perform well and how to improve performance
- publish annual medical legal costs
- incident reporting rate to put on the web; we can add link to the NPSA for more info.
- Outpatients waiting time (time waiting in clinics to be seen); **CM suggested that MD is asked to report on that at the next meeting.**
- local indicators
- length of stay here;
- day case procedures;
- patient leaflets
- CQC report (including explanation of the report)

13 Any other business

None.

14 Date of next meeting – 10 April 1012 at 10am

Quality Account Planning Group Meeting Notes

1.0 Introduction

The Quality Account Planning Group is a dedicated committee that has been established from members of the Council of Governors Quality sub-committee. The group was established after consultation with the members present at the November Council of Governors' Quality Sub Committee to provide input and view to the development presentation, readability, appropriateness of written information of the Quality Account and also to consider the modes of distribution of the Quality Account to relevant groups, but most appropriately the users of the Trust's services.

2.0 Background

The Quality Account is a report that is required by NHS Trusts by the Department of Health (DH) that should represent the quality of services provided by an NHS healthcare service. The report is published annually by each NHS healthcare provider and should be made available to the public and the users of the Trust's services. The quality of services provided are defined by Healthcare providers having measured the quality of the services they provide by looking at:

- patient safety
- the effectiveness of treatments that patients receive
- patient feedback about the care provided

The information that can be found in the Quality Account should be in relation to the quality of healthcare that is provided in the Trust and should contain a detailed statement about the quality of their services. Although there are mandatory sections to a Quality Account, there is also a section for the Trust to be able to highlight the areas of Quality and the objectives achieved in the Trust to provide quality care.

The role of the Head of Quality in conjunction with the Director of Governance and Corporate Affairs is to compile the Quality Report to the requirements and timescales of the Department of Health.

The quality account currently under development will represent the year 2011-2012 and will be required by the 3rd week of April 2012. The report in its final form will be submitted to and laid before Parliament in June 2012.

The Council of Governors' Quality Sub Group and the newly formed Quality Account Planning Group will hold an important role in ensuring the presentation of the account will be suitable for the intended recipients of the final document.

3.0 Composition of the Group

Representation has been taken from the Governors of the Council of Governors Quality Sub Committee Meeting and key Trust members and is chaired by the Head of Quality and Assurance. Matt Akid and George Vasilopoulos provided specialist communications advice. Patricia Gani provided representation from LINk.

4.0 Terms of Reference

The Terms of Reference of this group were agreed at the first meeting of the Quality Account Planning Group with following themes:

1. This is a fixed term task group to plan the readability and presentation of the quality account for the patients and other stakeholder groups.

2. The membership will be a sub-group of the Council of Governors Quality Sub Committee (CoG QSC) and will report to the CoG QSC.

3. Meetings will be chaired and led by the Head of Quality and Assurance and in the post-holder's absence, by the Director of Governance and Corporate Affairs.

4. Members will be required to attend meetings to review the Quality Account on a monthly basis, or as determined by the chair and the group itself, to ensure adequate appraisal of the document. Follow-up and correspondence will also be required to be addressed via email/telephone conferences in-between meetings.

5. Members will be required to provide timely review and comment to the versions of the Quality Account document throughout its development. In particular to assess document suitability and suggest on-going improvement to the:

    - presentation
    - readability
    - appropriateness of written information
    - issue of demonstrating making the document to patients and other stakeholders valuable

6. The group will be asked to provide view regarding the distribution and circulation of the final quality account in order to plan for the most effective exposure of the quality account to the Trust's patient groups and other stakeholders.

7. The work of the group will be concluded and evaluated when the final draft of the Quality Account is available for circulation.

5.0 Actions agreed at the first meeting

The provision of a brief and easy to read overview of the report for quick assimilation of the key points was suggested.

It was agreed a 1 to 2 page leaflet (or similar form), is made available to accompany the Quality Account to allow the important points of the account to be available, but also with clear indication of the reference to accountability.

A key suggestion was to ask patients their views on the current report and how the information could be presented in the most interesting and relevant way for the patient audience. To support this suggestion the concept of offering a refreshment voucher to patients who are approached, in return for their time to agree to briefly read through the 2010-2011 Quality Account and to offer their suggestions. In order to make this achievable it was suggested this would only need to be from a small sample of patients in the Outpatient area.

Other stakeholders who would provide additional comment for further enhancement for the document were suggested to come from LINk and the Overview and Scrutiny Committee.

The use of Capita and linking in with members was suggested and it was agreed further exploration of this would be taken forward.

In terms of presentations the following factors were highlighted as important:

- The use of varying types of headings and boxes complying with Trust 'house style'
- To consider the quality of paper for the final document in printed form
- A glossary at the back of the document
- To consider including small quotes from patients regarding the care they have received to support the Trust quality objectives
- To ensure the text takes on a clear and non-crowded form in terms of text

The communications team highlighted the value of the support of a copywriter who could assist the development of the document to a clear readable form for patients. It was suggested that there may be an opportunity to submit a business case to the Quality Sub Group and in turn the Council of Governors to establish if this initiative would be possible. An additional advantage was highlighted to provide a 'mock up' of a preferred style before a final document is agreed. As this would also incur a cost the suggestion was to seek specialist services and this could be included in a request for funding alongside a copywriter.

The DH guidance on the purpose of a Quality Account and the audience to be reviewed by the group to ensure that the Quality Account meets the objectives of the DH and any additional objectives agreed by the group.

6.0 Summary

The Quality Account is a report that is required by NHS Trusts by the Department of Heath that should represent the quality of services provided by an NHS healthcare service**.**

The Quality Account Planning group will provide an overview of the presentation of the document to ensure its value for the users of the Trust services.

Future work will consider the continuous development of the document's presentation and it was agreed a request in the form of a business case to the Council of Governors would be presented to the February Council of Governors Meeting.

7.0 Decision/action required

The Council of Governors Quality Sub Committee members are asked to note the content of this paper to gain an overview of the work of the Quality Account Planning Group. Support for a business case to be compiled for presentation to the Council of Governors to assist the enhancement of the 2011-2012 Quality Account would be valued.

Further information or clarification can be provided by the Head of Quality and Assurance and the Director of Governance or Corporate Affairs.

Melanie van Limborgh
Head of Quality and Assurance
January 24th 2012

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 9 February 2012

AGENDA ITEM NO.	2.14/Feb/12
PAPER	Membership engagement and communication update
AUTHOR	Matt Akid, Head of Communications
LEAD	Therese Davis, Chief Nurse and Director of Patient Experience and Flow
EXECUTIVE SUMMARY	This paper is an update on progress in establishing an enhanced calendar of membership engagement events and improved communication in 2012 – following the approval of funding at the Council of Governors meeting on 1 December 2011. Appendix 1 ('Calendar of events 2012 UPDATED') should be read in conjunction with this paper.
DECISION / ACTION	Governors are invited to note this update and to provide their feedback on the proposed activity and future plans.

MEMBERSHIP ENGAGEMENT AND COMMUNICATION UPDATE

1.0 Introduction

An application for funding of an enhanced calendar of membership engagement and communication in 2012 was approved at the Council of Governors meeting on 1 December 2011. The bid for funding was broken down by financial years. Full details are below – please note that 2011-12 funding has been reduced by £210 because the first monthly email to members will be sent in February, not January, and 2012-13 funding has been reduced by £5,000 because the budget for Open Day is £15,000 and not £20,000.

2.0 Funding

2011-12

1 extra membership mailing (Jan 2012)	£10,000	new activity
2 monthly emails (Feb & March 2012)	£420	new activity
1 'Medicine for Members' event (Feb 2012)	£1,000	new activity
TOTAL	**£11,420 (all new activity)**	

2012-13

1 extra membership mailing (Jan 2013)	£10,000	new activity
12 monthly emails (April 2012-March 2013)	£2,520	new activity
Open Day	£15,000	existing activity
Annual Members' Meeting (+ 2 associated events)	£5,000	existing activity
5 'Medicine for Members' events	£5,000	new activity
Christmas event	£5,000	new activity
TOTAL	**£42,520 (£22,520 new activity)**	

3.0 Update on progress

- **Extra membership mailing** – sent to all patient and public members w/c 23 January
- **Members' News** – first edition of new monthly email newsletter sent to all patient and public members with email addresses Friday 3 February
- **Medicine for Members** – first event to be held on Wednesday 22 February
- **Values focus groups** – Tuesday 21, Thursday 23 and Wednesday 29 February
- **Open Day** – Saturday 12 May from 11am-3pm
- **Annual Members' Meeting** – Thursday 13 September at 5.30pm

See Appendix 1 ('calendar of events 2012 UPDATED') for full details.

4.0 Next steps

Governors are invited to note this update and to provide their feedback on progress.

Matt Akid
Head of Communications
February 2012

Membership Engagement & Communication Calendar of Events 2012 (UPDATED FEB 2012)

Date/Month	Event/Activity	Existing or new activity?	Lead	Cost/Funding source
January				
w/c Mon 23 Jan	Membership mailing for all public and patient members (including covering letter from Chairman, Trust News and A5 flyers about details of Medicine for Members seminar and Values focus groups in February)	New activity	Communications Manager	£10,000 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
February				
Fri 3 Feb	Members' News Issue 1 (monthly email newsletter for c. 3,200 patient and public members who have provided us with their email addresses)	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
Wed 22 Feb	Medicine for Members 1st event – Bowel Cancer Awareness seminar	New activity	Communications Manager	£1,000 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
Tue 21 Feb Thu 23 Feb Weds 29 Feb	'Who do you think WE are?' Values focus groups for all patient and public members	New activity	Communications Dept	TBC (not from Council of Governors budget)
March				
Fri 2 Mar	Members' News Issue 2	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
April				
Fri 13 Apr (not Fri 6 Apr – Bank Holiday)	Members' News Issue 3	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
w/c Mon 16 Apr	Membership mailing for all public and patient members (including covering letter from Chairman, Trust News and A5 flyers about future events for members)	Existing activity	Communications Manager	£10,000 (Foundation Trust budget) - funding already budgeted for in Trust budget as part of our membership 'offer' of 2 mailings/year

Date/Month	Event/Activity	Existing or new activity?	Lead	Cost/Funding source
Date TBC	Medicine for Members 2nd event (seminar/talk or behind the scenes tour)	New activity	Communications Dept	£1,000 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
May				
Fri 4 May	Members' News Issue 4	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
Sat 12 May	Open Day	Existing activity	Communications Manager	£15,000 (Council of Governors) – funding approved at Council of Governors meeting 1 Dec 2011
June				
Fri 1 Jun	Members' News Issue 5	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
Date TBC	Medicine for Members 3rd event (seminar/talk or behind the scenes tour)	New activity	Communications Dept	£1,000 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
July				
Fri 6 Jul	Members' News Issue 6	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
August				
Fri 3 Aug	Members' News Issue 7	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
w/c Mon 13 or 20 Aug	Membership mailing (including covering letter from Chairman, Trust News, Annual Members' Meeting invitation and A5 flyers about future events for members)	Existing activity	Communications Manager	£10,000 (Foundation Trust budget) - funding already budgeted for in Trust budget as part of our membership 'offer' of 2 mailings/year

Date/Month	Event/Activity	Existing or new activity?	Lead	Cost/Funding source
September				
Fri 7 Sep	Members' News Issue 8	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
Thu 13 Sep	Annual Members' Meeting + 2 other engagement events for groups of members who do not traditionally attend the Meeting (eg Maternity, Paediatrics, HIV/GUM)	Existing activity	Head of Communications	£5,000 to cover costs of Annual Members' Meeting + 2 other events (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
Date TBC	Medicine for Members 4th event (seminar/talk or behind the scenes tour)	New activity	Communications Dept	£1,000 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
October				
Fri 5 Oct	Members' News Issue 9	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
November				
Fri 2 Nov	Members' News Issue 10	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
Date TBC	Medicine for Members 5th event (seminar/talk or behind the scenes tour)	New activity	Communications Dept	£1,000 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
December				
Fri 7 Dec	Members' News Issue 11	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011

Date/Month	Event/Activity	Existing or new activity?	Lead	Cost/Funding source
Date TBC (possibly to be co-ordinated with Friends of Chelsea & Westminster Hospital Christmas Fair)	Christmas event (mini Open Day)	New activity	Communications Dept	£5,000 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011

Other activity not included in calendar

'Meet a Governor' sessions – dates for Jan-March 2012 confirmed and on website at http://www.chelwest.nhs.uk/get-involved/meet-a-governor

Council of Governors Meeting, 9 February 2012

AGENDA ITEM NO.	2.15/Feb/12
PAPER	Council of Governors Membership Report*
AUTHOR	Tony Pritchard, Interim Deputy Chief Nurse
LEAD	Therese Davis, Chief Nurse and Director of Patient Experience and Flow
EXECUTIVE SUMMARY	This paper presents an overview of Foundation Trust membership and provides an analysis of trends for the period November 2011 to January 2012. The report shows an overall reduction of 242 members during the 3 month period. There were 258 patient and public members who left whilst 16 new members joined. During the year to date, there has been overall gain of 289 members, mainly due to 2 recruitment campaigns in June and September 2011.
DECISION/ ACTION	For information.

Membership Report

1.0 Membership size and movements

Table 1 below shows the size and movement of membership for the year 2011- 2012 and for the current year to December by cumulative totals and by membership type.

Table 1. Size and movement of membership

OVERALL MEMBERSHIP OVERVIEW	Last Year 1 Apr 10 – 31 Mar 11	2011/12 Year to Date 1st April – 31st January
As at start	**15,187**	**14,501**
New Members	2,008	1,519
Members leaving or changing constituency	2,694	1,230
TOTAL	**14,501**	**14,840**
PUBLIC MEMBERSHIP OVERVIEW	**Last Year 1 Apr 10 – 31 Mar 11**	**2011/12 Year to Date 1st April – 31st January**
As at start	**6,131**	**5,737**
New Members	257	542
Members leaving or changing constituency	651	386
TOTAL	**5,737**	**5,893**
PATIENT MEMBERSHIP	**Last Year 1 Apr 10 – 31 Mar 11**	**2011/12 Year to Date 1st April – 31st January**
As at start	**6,010**	**5,591**
New Members	396	469
Members leaving or changing constituency	815	344
TOTAL	**5,591**	**5,716**
STAFF MEMBERSHIP	**Last Year 1 Apr 10 – 31 Mar 11**	**2011/12 Year to Date 1st April – 31st January**
As at start	**3,046**	**3,173**
New Members	1,355	508
Members leaving or changing constituency	1,228	450
TOTAL	**3,173**	**3,231**

2.0 Membership Joiners and Leavers November 2011 – January 2012

2.1 Public Membership

Table 2 below shows public membership joiners and leaves between November 2011 and January 12. There were 12 public who joined as members and 124 who left membership during this period

Month	November	December	January	Total
Joiners	3	5	4	12
Leavers	0	104	20	124

Table 2. Public Membership joiners and leavers November 2011 – January 2012

2.2 Patient Membership

Table 3 below shows patient membership joiners and leavers between November 2011 and January 2012. There were 4 public who joined as members. There were 134 individuals who left patient membership during this period

Month	November	December	January	Total
Joiners	0	1	3	4
Leavers	2	2	130	134

Table 3. Patient membership joiners and leavers November 2011 – January 2012

3. Membership Demographics

3.1. Public Membership Ethnicity January 2012

Within the public membership, the highest proportion is within the white category of ethnicity, whilst the lowest representation remains within the black and mixed ethnic categories. Figure 1 below shows the analysis of public membership by categories of ethnicity.

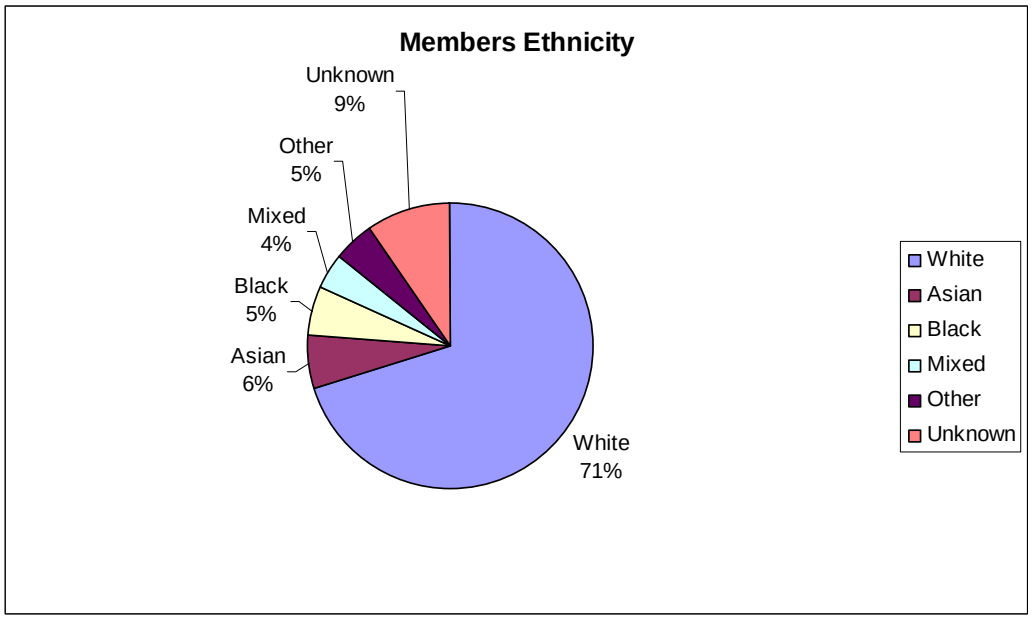
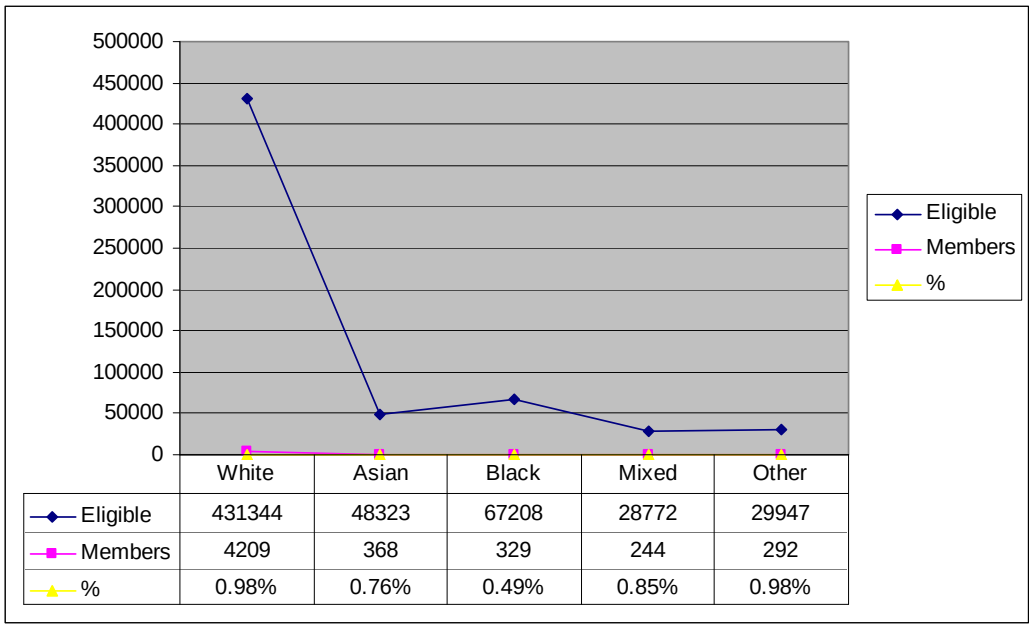


Figure1. Public Membership Ethnicity

3.2. Public Membership Ethnicity – comparison against local eligible population

Figure 2 shows the public membership comparison against the local eligible population. Representation is also highest in the white population and lowest in the black ethnic group.



	White	Asian	Black	Mixed	Other
Eligible	431344	48323	67208	28772	29947
Members	4209	368	329	244	292
%	0.98%	0.76%	0.49%	0.85%	0.98%

Figure 2. Public Membership comparison against local eligible population

3.3. Public Membership Age

Figure 3 shows a profile of public membership by age. The lowest age group is those within the 16-19 age group and the highest within the 40-49 age group

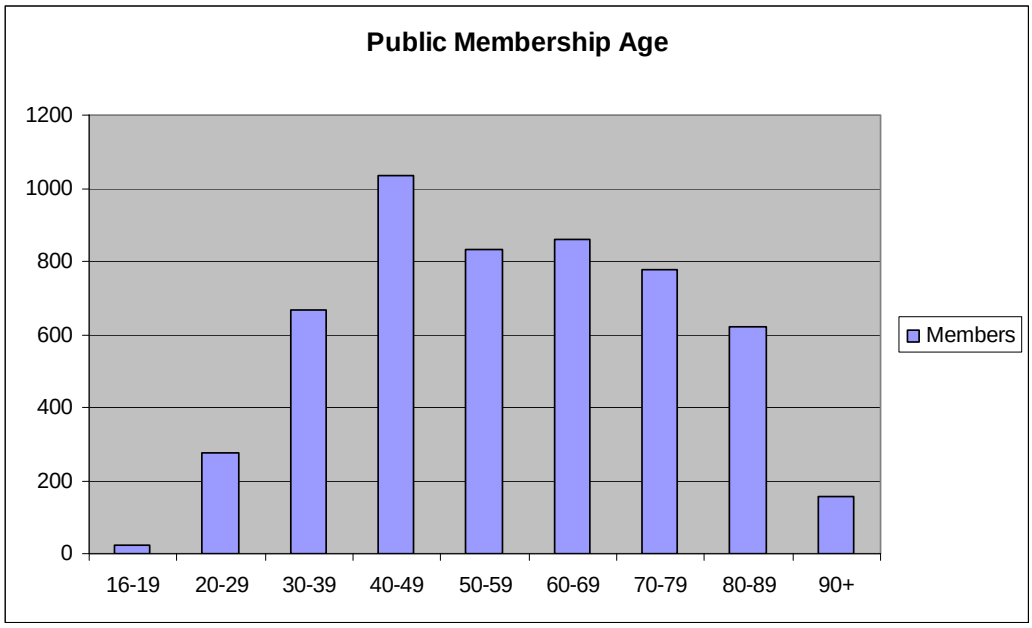
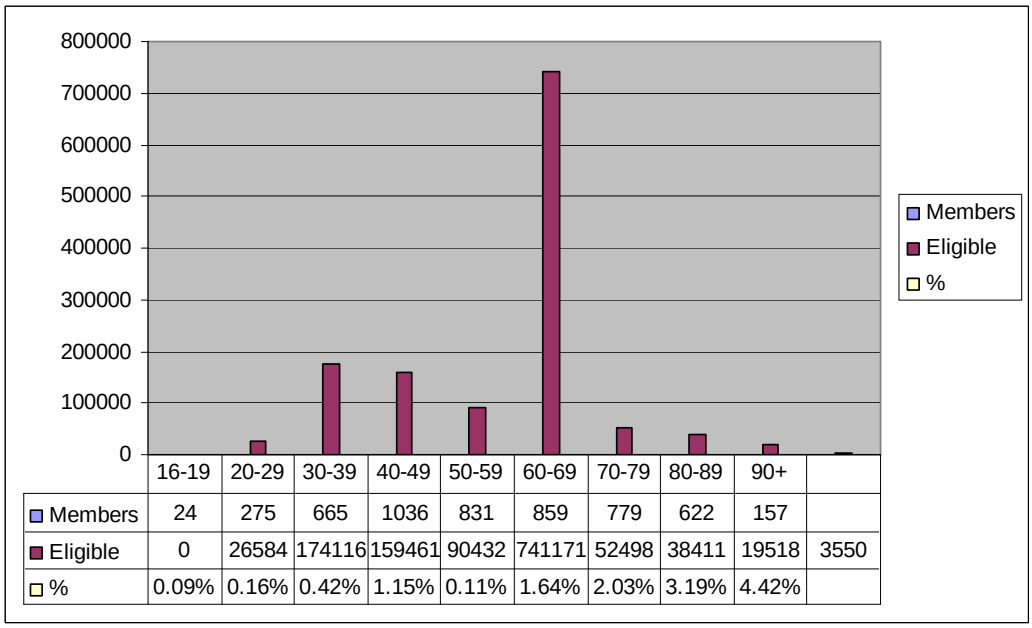


Figure 3. Public Membership Age

3.4. Public Membership Age – Comparison against local eligible population

Figure 4 shows the public membership profile in comparison to the local eligible population. The representation rises from 50 years to 90 years plus.



	16-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90+	
Members	24	275	665	1036	831	859	779	622	157	
Eligible	0	26584	174116	159461	90432	741171	52498	38411	19518	3550
%	0.09%	0.16%	0.42%	1.15%	0.11%	1.64%	2.03%	3.19%	4.42%	

Figure 4. Public Membership Age – Comparison against local eligible population

3.5. Public Membership - Socio-economic grouping

Figure 5 shows the profile of public membership by socio – economic groups. The highest representation remains in the ABC1 category*

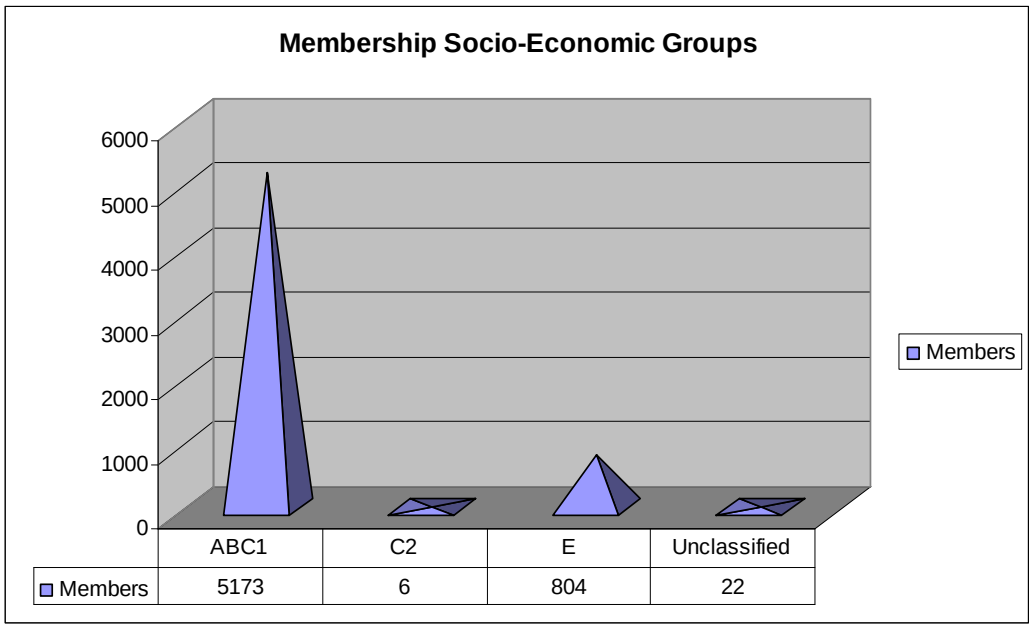


Figure 5. Public Membership - Socio-Economic Groups*

*Social economic grade: A-upper middle class (higher managerial, administrative or professional occupation, B-middle class (intermediate managerial, administrative or professional occupation), C1-lower middle class (supervisory or clerical, junior managerial, administrative or professional occupation), C2-skilled working class (skilled manual workers), D-working class (semi and unskilled manual workers) and E-those at the lowest level of sustenance (state pensioners or widows (no other earner), casual or lowest grade workers).

4.0 Membership Recruitment

4.1 Since April 2011 a total of 1519 members have joined and 1230 have left membership showing an overall gain of 289 members for the year to date.

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

4.3 The Membership Development Sub-Committee of the Council of Governors develops and reviews the Membership recruitment strategy. In November 2011, the Sub Committee proposed funding to support additional community recruitment activity. This provides 5 recruitment sessions between November 2011 and April 2012 including events hosted through the Health Bus.

4.4 In order to enhance future membership recruitment we intend to organise a number of recruitment activities within local general practitioner clinics.

4.5 The Membership – Patient Advice and Liaison Services support membership promotion. Any visitor to the M-PALS office is offered a membership

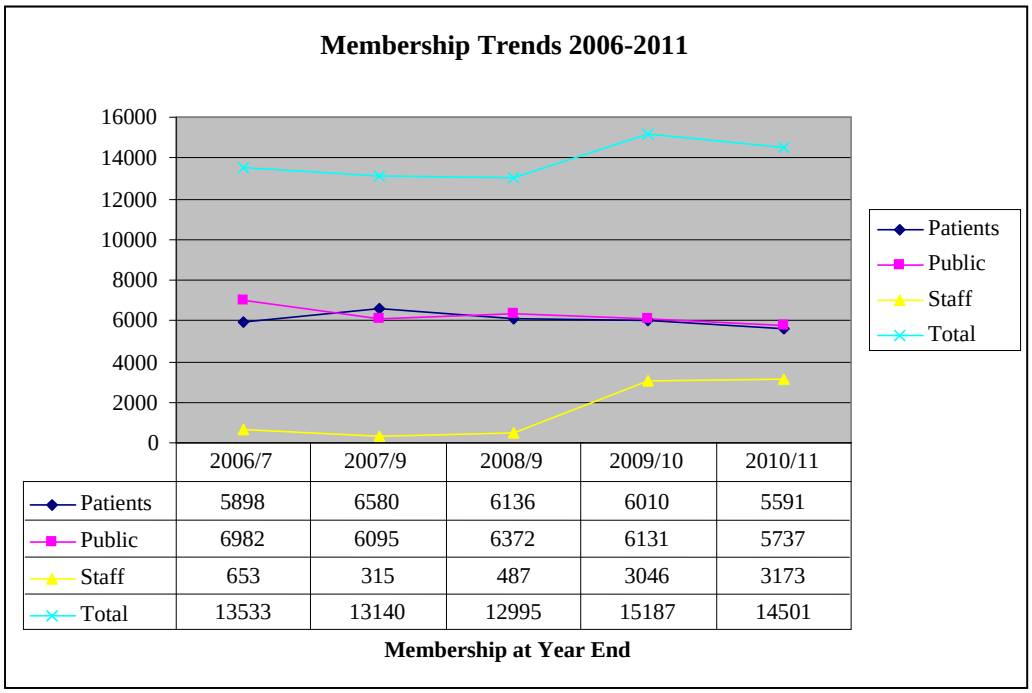
application form when appropriate. The forms are sent with all patient response letters from the M-PALS service and the team will continue to actively promote membership.

4.6 A member's email database has been updated with over 3,000 emails registered. This will be used for low cost, rapid response membership consultation.

4.7 A booklet for patients coming in for elective surgery, funded by the Council of Governors is currently being developed and will be given to patients on admission and includes a membership application form.

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

4.9. Figure 6 below shows the trends in Trust membership from 2006-2011.



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

Figure 6. Membership trends 2006-2011

5.0 Developing a Representative Membership

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

5.2 The community mobile health clinic continues its screening activities and when possible recruiters join the services to recruit new members alongside screening. The services from the mobile health clinic aim to target 'hard to reach' groups in the community. Dates are circulated to all Governors to encourage Governor Participation.

5.3 A Governor now attends the Mobile Health Steering Group. The group plan activities and decide how Governors can link with Trust activities in the community (especially where membership is underrepresented) and decide on appropriate outreach services for these areas.

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

5.5 To create equal representation, It is recognised that membership recruitment should focus on increasing its numbers and engagement with Black, Ethnic and Minority groups. Our recruitment strategy will continue to focus on activities which can encourage wider representation within our membership.

6.0 Summary

6.1. The hospital gained Foundation Trust status in 2006 and at year end 2006/07 totalled 13, 533 members. Membership numbers peaked in 2009 when staff members' status changed from 'opt in' to 'opt out'.

6.2. We need to continue our focus on recruitment to maintain our membership numbers whilst also seeking a representative membership. Beyond this, we are taking forward a range of initiatives to actively encourage the engagement of members in the work of our hospital. The Council of Governors Membership Sub Group has identified plans to enhance membership engagement and also reviews on going plans for membership recruitment

7. Membership Recruitment Achievements 2011/12

The below table summarises key recruitment events between April and January 2012

Month	Event	Total Recruited
April	No events	
May	Open Day	79
June	• Capita Recruitment Campaign H&F • Mobile clinic at Shepherds Bush Market • Meet a Governor Session	• 300 Public Members
September	• Capita recruitment campaign for patients and public members within the hospital	• 300

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 9 February 2012

AGENDA ITEM NO.	3.1/Feb/12
PAPER	Finance Report - December 2011
AUTHOR	Mike Fox, Chief Management Accountant
LEAD	Lorraine Bewes, Executive Director of Finance
EXECUTIVE SUMMARY	For the financial year to December 2011 the Trust achieved an EBITDA of £25.1m (£2.6m ahead of plan) and a net surplus of £9.8m (£2.8m ahead of plan). The Trust financial performance to date has been driven by contractual over-performance for NHS clinical activity which has been delivered at a lower cost than the income generated. The Trust has continued to monitor pay costs with a significant focus on the use of temporary staffing in Medical and Nursing groups. Weekly monitoring of these costs has led to better control of this spend so that increased costs are only incurred where required by increased levels of clinical activity. Year to date the Trust pay spend is in line with budget. Non pay costs were overspent by £2.6m year-to-date. The most significant element of this over-spend is the continuing costs of Pathology with a combination of increased activity and slippage on the implementation of demand management schemes. Other areas of significant over-spend are for clinical consumables as a direct result of clinical activity. The Trust has continued to perform well in both identifying and implementing Cost Improvement Plans (CIP) plans worth £20.3m and reserves release of £1.5m, totalling £21.8m (111% of the target) for 2011/12, with a recurrent value of £19.9m (100%). The year-to-date achievement is £14.2m. The Trust is currently forecasting a surplus of £11m for 2011/12 (£2.5m ahead of plan), the main driver of this performance is the increased clinical income being delivered at marginal costs and successful delivery of the Trust CIP target.
DECISION/ ACTION	The Council is asked to note the financial position for the financial year to December 2011.

Glossary of Terms

AAU: Acute Assessment Unit

BPPC: Better Payment Practice Code

CIP: Cost Improvement Programme

Clinical Contract Income: Income from Primary Care Trusts (PCTs) for activity carried out by the Trust under agreed contracts.

EBITDA: Earnings before Interest, Taxes, Depreciation and Amortisation.

Monitor: Regulatory body for NHS Foundation Trusts.

PBL: Prudential Borrowing Limit (established by Monitor)

PPI: Private Patients' Income

PDC: Public Dividend Capital

Working Capital: Assets available for use in the production of further assets, e.g. stock.

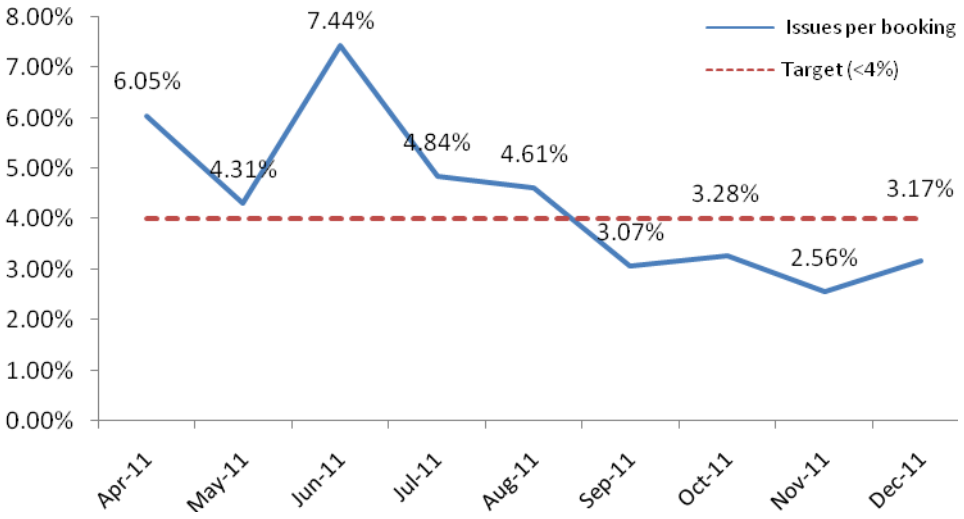
Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 9 February 2012

AGENDA ITEM NO.	3.2/Feb/12
PAPER	Performance Report Commentary – December 2011
AUTHOR	Helen Byrne, Interim Head of Performance Improvement
LEAD	Amanda Pritchard, Deputy Chief Executive
EXECUTIVE SUMMARY	Overall the Trust has performed well in month 9, achieving the required performance level in all Monitor indicators which could be measured. The 18 week referral to treatment RTT target remains a very high priority target for the Trust and compared to Trusts in London, we are regarded as a high performer. Our performance is 93.73% for admitted patients against the target of 90% and for non-admitted patients our performance is 98.87% against a target of 95%. As noted in the Chief Executive's update, we are undertaking additional activity between January and March 2012 as part of the London wide RTT access initiative, which will drive up our performance further and will help to improve the London position. Moving forward into 2012/13, there will be an additional target of 92% patients on the waiting list to be below 18 weeks at each month end. The ability to choose and book outpatient slots is a high priority for both GPs and patients. Although this target of no more than 4% Appointment Slot Issues (i.e. unsuccessful booking attempts) was met in December and has been met each month since September 2011, the Trust struggled to meet the target for the first few months of the year, resulting in a year to date performance of 4.3%. There is now good performance in the majority of specialties. There were 3 mixed sex breaches in December, with a total of 10 breaches year to date. The breaches the result of miscommunication between staff within A&E and the AAU. To prevent future occurrences, the Divisional Director of Operations and Divisional Nurse have met with staff to clarify the correct procedures. There has further improvement in discharge summary completion within 24 hours; however continued focus is required to achieve the required standard. On current performance, there are a number of other risks to achievement of internal, contractual and commissioner priorities. The actions being taken to improve performance in these areas are set out in the report. Back up data relating to the performance report can be found in Appendix 1.

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

1.1. Choose and Book – Slot Issues



18 Weeks

% Admitted Patients seen within 18 Weeks

% Non-Admitted Patients seen within 18 Weeks

The 18 week referral to treatment RTT target remains a very high priority target for the Trust and compared to Trusts in London, we are regarded as a high performer. Our performance is 93.73% for admitted patients against the target of 90% and for non admitted patients our performance is 98.87% against a target of 95%. As noted in the Chief Executive's update, we are undertaking additional activity between January and March 2012 as part of the London wide RTT access initiative, which will drive up our performance further and will help to improve the London position.

Moving forward into 2012/13, there will be an additional target of 92% patients on the waiting list to be below 18 weeks at each month end. This is a measure to avoid the build up of back logs of long waiting patients on hospital waiting lists. A plan will be developed to ensure that the new target is achieved.

Choose and Book

The ability to choose and book outpatient slots is a high priority for both GPs and patients. Although this target of no more than 4% Appointment Slot Issues (i.e. unsuccessful booking attempts) was met in December and has been met each month since September 2011, the Trust struggled to meet the target for the first few months of the year, resulting in a year to date performance of 4.3%. There is now good performance in the majority of specialties.

However, there is an on-going lack of capacity for paediatric cardiology and paediatric ophthalmology and there are seldom appointments available on C&B for these specialties. In paediatric cardiology, demand is also growing. The Directorate is reviewing the SLA with the Royal Brompton to increase clinics in the interim and for the future. In Paediatric Ophthalmology, there has been an in-year business case which has allowed the expansion of capacity and the Directorate has put forward a plan to increase activity in 2012/2013.

Single Sex Accommodation

There were 3 mixed sex breaches on the 13thDecember 2011 in the assessment area of the Acute Assessment Unit (AAU). Year to date there have been 10 breaches. A root cause analysis was undertaken and showed that the breaches were avoidable and were the result of miscommunication between staff within A&E and the AAU. To prevent future occurrences, the Divisional Director of Operations and Divisional Nurse have met with staff to clarify the correct procedures.

***Clostridium difficile*,** two Trust-attributable *Clostridium difficile* cases were recorded in December. The Trust is now forecasting that there is a low level of risk associated with the target of less than 31 cases for the financial year despite the potential impact of winter.

Monitor Compliance

NHSQuarter	Target	YTD	Apr-Jun 2011	Jul-Sep 2011	Oct-Dec 2011	Score YTD	Expected Score
Clostridium difficile cases	< 23	14	6	3	5	0	0
MRSA objective	<2	1	0	1	0	0	0
All cancers: 31-day wait from diagnosis to treatment	96.0%	100.0%	100.0%	100.0%	100.0%	0	0
All cancers: 31-day wait for second or subsequent treatment Surgery	94.0%	100.0%	-	100.0%	100.0%	0	0
All cancers: 31-day wait for second or subsequent treatment anti cancer drug treatments	98.0%	100.0%	-	100.0%	100.0%	0	0
All cancers:62-day wait for first treatment from urgent GP referral to treatment	85.0%	95.8%	94.4%	93.8%	98.5%	0	0
All cancers:62-day wait for first treatment from consultant screening referral	90.0%	94.7%	-	93.3%	100.0%	0	0
Cancer: Two Week Wait from referral to date first seen comprising all cancers	93.0%	96.2%	95.8%	95.0%	98.5%	0	0
Referral to treatment waiting times - Admitted (95th percentile)	<23 Wks	22.9	22.9	22.5	22.4	0	0
Referral to treatment waiting times - Non-Admitted (95th percentile)	< 18.3 Wks	16.1	11.9	11.5	16.1	0	0
A&E: Total time in A&E*	=> 95%	98.6%	98.5%	98.9%	98.5%	0	0
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability		Compliant	Compliant	Compliant	Compliant	0	0
						Green	Green

Quality KPIs

Clinical Effectiveness	Dec	Trend	YTD
Urinary Catheter Incidence			
Income lost to first to follow-up ratio			
Maternity Booking Access Target			
Breastfeeding initiation rates			
Caesarean section rate			
Cellulitis Admissions			
DVT Admissions			
Non-Elective avg. Length of stay			
Stroke: Treatment within 24 hours			
Category 3/4 pressure ulcers			
Stroke: Time spent on stroke unit			
Rapid access chest pain clinic wait			
Elective average length of stay			
Daycase rate (Basket 25 procedures)			

Process Effectiveness	Dec	Trend	YTD
Delayed transfers of care			
Referral to Treatment Non-admitted			
Referral to treatment incomplete pathways			
13 week outpatient waits			
Call Centre Hang Up %			
DNA Rate Treatment Centre			
26 week inpatient waits			
2 Week HIV Appointment wait			
Fracture Neck of Femur - Time to Theatr			

KPIs Under-development

Delay in offering patients ERPC within 12 hours, DNA Rates, Paeds turnover, Paeds & Neonatal occupancy % , Acu - Pregnancy rate per treatment cycle started , % of Colorectal Cancer resections performed laparoscopically

Safety	Dec	Trend	YTD
Hand Hygiene Completion			N/A
Hand Hygiene Compliance			N/A
Incident reporting			
Never events			
Patient falls resulting in moderate or major harm			
PEAT audit composite score (1mth behind)			N/A
Hospital Associated VTE			
Ratio of midwives to deliveries			
3/4th degree perineal tears			
1:1 care of women in established labour			
Emergency MRSA screening rate			
Elective MRSA screening rate			
NICU Nurse: Patient ratio vs. BAPM compliance			

Clinical Effectiveness	Dec	Trend	YTD
Formal complaints responded in 25 working days			
Breach of same sex accomodation			
Staff job satisfaction		-	
Slot issues on Choose and Book			
Access to GUM clinics			
Rebooking cancelled operations			
Six week diagnostic test wait			

Pathway Colour Code

- APPLIES TO ALL PATHWAYS
- OUTPATIENT PATHWAYS
- MATERNITY PATHWAYS
- EMERGENCY PATHWAYS
- PAEDIATRIC PATHWAYS
- ELECTIVE PATHWAYS
- LONG TERM PATHWAYS

Key:- = Better than plan = Within 5% of plan = More than 5% worse than plan

= >5% increase in performance : perf. improved same <5% decrease >5% decrease

-The proportion of acute and general patients with a urinary catheter was 16.37% against a target of less than 12.5%.Actions to improve performance include improved compliance with the 'saving lives' audit tool which is in place to ascertain that the presence of the catheter is clinically indicated and to ensure the timely removal of catheters. In December, a further 1 off audit was completed by the infection control team across 3 inpatient wards to ascertain if those catheters present were clinically indicated and this concluded that there was no evidence of inappropriate usage. The Deputy Chief Nurse is establishing a task group to review the areas with the highest incidence and to identify steps to reduce usage.

-£596k of follow up activity has been undertaken without payment year to date as a result of lack of adherence to new:follow-up ratios in Rheumatology, Diabetic Care, Paediatric Trauma And Orthopaedics and other specialities. The Divisions are reviewing activity plans and have already reduced the rate at which the volume of unfunded activity is undertaken.

--The percentage of A&E attendances for cellulitis which end in admission was 50.3% against national best practice of 10-40%. The medical team are developing ambulatory pathways to address this issue.

-The percentage of A&E attendances for DVT which end in admission was 0% against national best practice of 10%. The medical team are developing ambulatory pathways to address this issue.

-Elective Average Length of Stay (Target 3.0 against year to date actual 3.98) has been rolled forward. Targets are currently under-review to ensure that this target is appropriate.

-The basket day case rate (target of 95% against a year to date performance of 81.8%) is being reviewed with a focus on complexity of case mix, with the aim of achieving 100% day case for simple procedures and also on achieving the national upper quartile performance in orthopaedic procedures in particular. Work is underway in a number of paediatric specialties to improve day case rates.

-Delayed transfers of care. 'The medicine directorate has been managing a higher than usual number of Delayed Transfers of Care as there have been four patients with "extraordinarily complex" needs (housing, social care, refusing to leave and one requiring repatriation). All four patients have now been safely discharged to their planned destinations.

-The 2 week HIV Appointment target measures all newly diagnosed patients being offered counselling by a Heath Advisor within 2 weeks (target of 100% with year to date performance of 90%). There is work underway to quantify the percentage of patients identified as new positives who know their status and are having their HIV care elsewhere. Performance will be adjusted on the findings.

-Hand hygiene audit completion was 94.4% against a target of 100% although compliance in the audits which were undertaken was within target. The divisional representatives on the Infection Control Committee have been asked to address this issue with the support of the local infection control nurse leads.

-In December, there was 1 patient fall against the target of 0. A new falls risk assessment has been introduced which is linked to a care plan for those at risk and also 'Seven steps' prompts for staff have been introduced to minimise the risk of fall. Yellow wrist bands and falls alarms have been introduced for those patients assessed as having a high risk of falling and falls.

-The Deputy Chief Nurse is leading work to improve MRSA screening of elective and emergency patients. An analysis has been undertaken of each of the elective cases not screened in December and the reasons why. Actions have been agreed and include a pilot of self screening for bariatric patients who commonly breach the 3 month preoperative screening period and a particular focus on Trauma and Orthopaedic patients.

-Complaints, only 81% of Type 2 complaints have been responded to and resolved by the Directorates within 25 days this year. To address this issue, the complaints team update and send a log of current and reopened complaints to all the divisions weekly. The team also send a weekly report to the Deputy Chief Executive who follows-up with the Divisional Director of Operations and the General Manager.

-Incident reporting rate per 100 admissions in December was 6.3 against the Trust target of 8.0 and YTD performance of 7.85. Performance should improve for the remainder of the year due to successful recruitment to a key post in Pathology.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Our patient experience strategy for 2011-12 aims to reduce complaints and concerns on: communication and information; discharge and care of the older person

Complaints and Concerns for Quarter 3 2011 by Campaign & Division

		Communication						Discharge						Concern Age 75 and Over					
		Type 1			Type 2			Type 1			Type 2			Type 1			Type 2		
Division	**Directorates**	**Q 1**	**Q 2**	**Q 3**	**Q 1**	**Q 2**	**Q 3**	**Q 1**	**Q 2**	**Q 3**	**Q 1**	**Q 2**	**Q 3**	**Q 1**	**Q 2**	**Q 3**	**Q 1**	**Q 2**	**Q 3**
Clinical Support Services		5	0	2	0	0	3	5	0	0	1	1	0	1	0	1	0	1	0
Women, Children, Young People & Neonates, HIV, GUM & Dermatology	HIV GUM Directorate	4	4	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0
	Women and Children Directorate	4	4	7	6	7	3	5	0	0	0	0	0	1	0	1	0	0	0
Medicine & Surgery	Medical Directorate	7	4	0	5	7	6	2	1	2	5	5	1	3	1	5	10	4	7
	Surgical Directorate	11	3	9	1	4	10	11	0	1	2	1	1	0	14	9	0	3	4
Central Outpatient Services		0	13	6	0	5	10	0	0	0	0	0	0	0	0	4	0	2	2
Non Clinical Support Services		3	0	1	1	0	1	0	0	0	0	0	0	5	0	0	0	0	1
Totals for Q1, Q2 and Q3		**34**	**28**	**25**	**13**	**23**	**34**	**23**	**1**	**3**	**8**	**7**	**2**	**10**	**15**	**21**	**10**	**10**	**14**
2011/12 YTD		**87**			**70**			**27**			**17**			**46**			**34**		
2010/11 Total		**177**			**83**			**94**			**14**			**-**			**-**		

N.B. Type 1 complaints are informal complaints which are dealt with by the M-PALS office. Type 2 complaints are formal complaints of a more serious nature which need to be escalated

	Communication	Discharge	Concern Age 75 and Over
Themes	Cancellation of appointments at very short notice; Content of letters unclear; Poor communication regarding waiting times; Patients unclear about treatment options; Next of kin not kept informed regarding future plans	Concern that patient discharged too early and needed to be readmitted for further inpatient stay; Information in discharge summary either incomplete or inaccurate; GP's do not always receive copy of summary	Administration of meds in terms of supervision and help offered; Lack of info to families regarding management of care; Attitude of staff towards elderly patients requesting help; Failure to answer call bells; Failure to monitor fluid intake
Actions	Pilot of new system for producing and despatching OP letters; New call management system / handling process in outpatients; Range of approaches to communicating outpatient waiting times; Initiation of cancer information prescription project; Implementation of a medicines information leaflet	Prioritisation of diagnostics to support discharge; Interventions to improve timeliness and quality of discharge summaries; Piloting of community re-enablement project and hospital role of community matron / increase in medihome input; Interventions to reduce readmission;	Identification on admission of dementia patients and initiation of pathway to enable the communication and coordination of care; Use of volunteers to support patients during mealtimes; 'Comfort rounds' have been initiated, and will be rolled out to further inpatient ward

Maternity Real Time Patient Feedback: In Q3 453 patients from 1076 discharges (42.1%) gave us feedback on the following questions.Our local target is to achieve an overall satisfaction score of ≥ 90%

I felt I was left alone when I didn't want to be, when I was in established labour	97.6%
Overall, how would you rate the care received during your pregnancy?	94.9%

Thinking about the care you have received in hospital after the birth of your baby, have you been treated with kindness and understanding?	96.8%
Do you feel the ward is clean enough?	93.9%

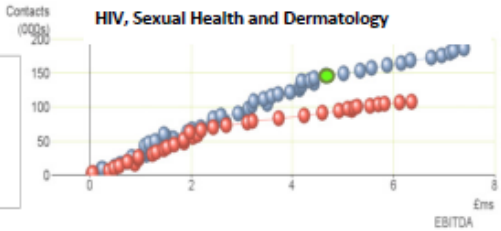
Paediatric Outpatient Department Real Time Patient Feedback: In Q3 446 patients from 9624 attendances (4.63%) gave us feedback. Since November patients have been giving us feedback on the following questions.Our local target is to achieve an overall satisfaction score of ≥ 90%

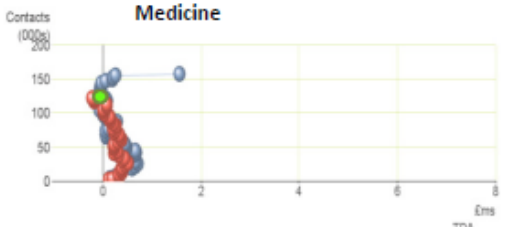
Were the reception staff friendly and approachable?	91.7%
How well organized was the outpatient department you visited?	81.3%
Approximately how long after your child's stated appointment time did their main appointment start?	67.6%

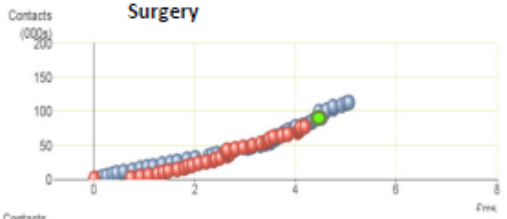
Was the amount of time between finding out that your child needed an outpatient appointment, to actually taking them to their appointment, acceptable to you?	80.2%
Before you arrived at the hospital, did you know what was going to happen to your child during their appointment?	67.2%

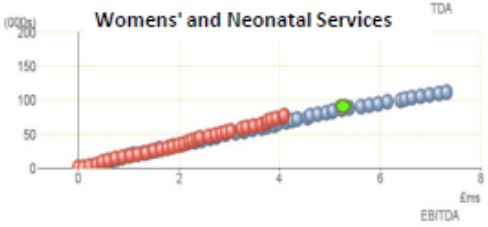
Finance / Efficiency KPIs

Know Your Chart:
Each blob is a week
Size of blob is average cost
Volume and EBITDA (profit) is cumulative for each week.
More recent weeks are in front of weeks at the beginning of the year.





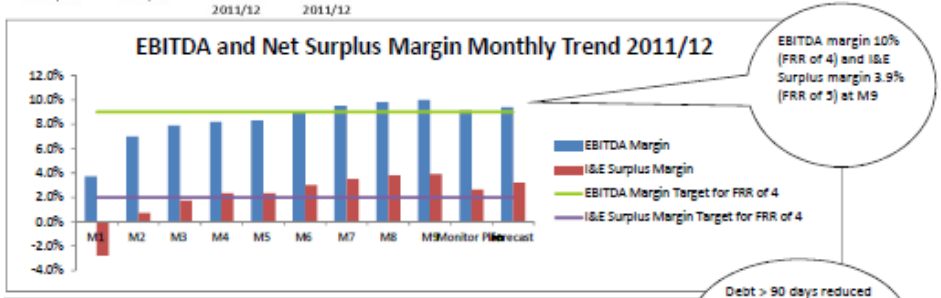


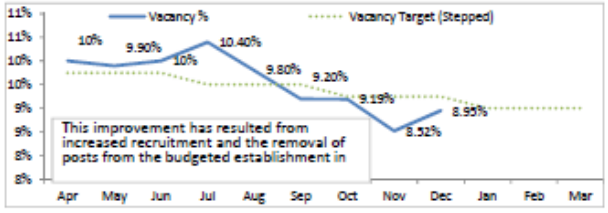


	M1	M2	M3	M4	M5	M6	M7	M8	M9	M12 Monitor Plan	M12 Forecast
EBITDA margin	3.7%	7.0%	7.9%	8.2%	8.3%	8.9%	9.5%	9.8%	10%	9.1%	9.4%
EBITDA , % plan achieved	75.1%	112.9%	109.6%	108.7%	110.0%	112.3%	106.2%	104.7%	111%	102.4%	106.9%
Return on assets	0.5%	3.8%	4.8%	5.1%	5.2%	5.8%	6.3%	6.7%	6.8%	5.6%	6.2%
I&E surplus margin	-2.8%	0.7%	1.7%	2.3%	2.3%	3.0%	3.5%	3.8%	3.9%	2.6%	3.2%
Liquidity days	26.4	26.6	22.0	21.5	19.9	17.0	28.7	28	26	16	19
Overall Financial Risk Rating	2	3	3	4	4	4	5	5	5	4	4

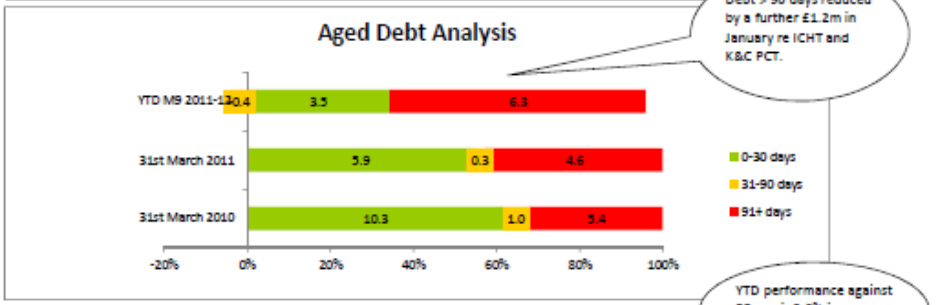
Capital Expenditure Plan vs Actual

EBITDA and Net Surplus Margin Monthly Trend 2011/12

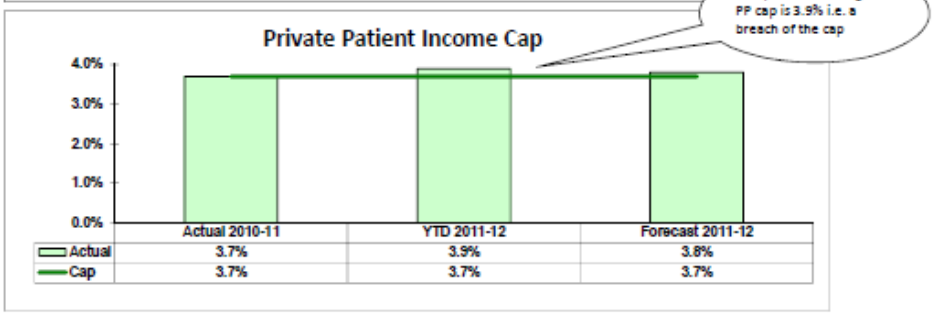




Aged Debt Analysis



Private Patient Income Cap



Commentary:

1) Key issue this month is breach of private patient cap - 3.9% YTD and forecast 3.8% compared to cap of 3.7%.

2) EBITDA and Net Surplus continue to be ahead of plan. YTD FRR 5 is ahead of plan. Forecast FRR 4 is on plan.

3) CIPs: £19.2m (105%) identified plus reserves release of £1.5m , forecast achievement is £19.6m (100% of target). Key slippage is in LOS, Pathology and reduction of Surgical Outliers.

4)Clinical income: Contract income over performed by £1.1m in M9 - elective and day case activity significantly ahead of plan but non elective activity behind plan bringing YTD position in line with plan. OP significantly ahead of plan due to Obstetrics and GUM. HIV Out of London income is behind plan ytd due to a tariff dispute re ytd activity - the M9 position reports the lower tariff but this is still under negotiation with the London SCG.

5) Expenditure: Pay budgets underspent by £0.5m in month (unidentified CIPs and pass through costs apart) - main drivers release of prior year provisions relating to disputed on-call payments and slippage on reserves. Non pay costs overspent £0.7m in month due to overspends in Pathology relating to CIP slippage and increased use of tests due to activity increases.

6) Capital expenditure: First Floor Paediatric Wards Project (budget £11.7m) is at detailed design stage, and Diagnostic Centre (budget £3.5m) is at development stage. Infrastructure Project on target and Netherton Grove Extension delayed by a month to mid January. Trust submitted high level 5 year capital plan to Monitor on 13th January 2012 following meetings with project leads.

7) Value of debt >90 days decreased by £1.4m due to post month-end cash received from Hillingdon and Ealing PCTs. >90 days debt has reduced further in January due to ICHT paying M1-8 SIFT invoices £(0.6m was >90 days) and £0.6m of cash from K&C PCT re invoices >90 days.

Last Printed: 17/01/2012

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

REGULATORY COMPLIANCE & KEY PRIORITIES

Key Priorities

	Performance Indicator	Trend	YTD Value	YTD	Forecast
Priorities	VTE Assessment (Target: > 90%)		91.9%		
	OP Letter Turnaround Times (Target: Less than 5 Days)		N/A		
	Discharge Summaries (Target: 100% Complete within 24 Hr		84.84%		
	Emergency Re-Admissions following Non-Elective spell (Target: < 2.8%)		2.84%		
	Emergency Re-Admissions following Elective spell (Target: 0%)		1.5%		
	NCE POD Recommendations (Target: 95% within waiting time)		96.8%		
	Mortality - HSMR (Target: < 87.34)		72.6		
	LAS Handover - HAS Data Quality (Target > 90%)		<80%		
	GP Referrals Recieved		Avg: 6,392 Last Month: 5,284		

Commentary

- Outpatient letter turnaround performance has decreased in December (7.95) from November (6.93). The main causes of this wereoperational problems associated with the roll out of BigHand into Surgery. Bighand has identified clearly where there are problems with backlog eg. in general medicine and divisions are taking action to address this.

- Discharge summary completion rate is improving month on month with December at 96%. The divisions will continue to focus on improvement in moving towards the 100% target.

-Emergency readmissions following an elective spell performance has remained constant throughout the year (1.5%). The performance, year to date, includes readmissions for unrelated conditions. Negotiations are scheduled with the commissioners to discuss this and to discuss procedures where a proportion of readmissions would be expected.

- LAS handover performance is within standard on a new electronic recording system (HAS) and our performance will be measured via this new system as soon as data quality issues are resolved, which relate primarily to non A&E ambulance handovers. Lack of access to LAS data is constraining the pace of improvement in this area.

- In A&E, although in overall terms the Trust is over 98% against the 4 hour waiting time target, there has been pressure on the target since late November 2011. The team in A&E continue to work hard to avoid breaches and to achieve 98% on a consistent basis.

-A&E time to initial assessment has improved and the standard is now being met consistently. Poor performance in the first quarter is distorting the year to date position. Work to reduce unplanned A&E attendances continues in parallel with work to reduce readmissions described above. An action plan is in place which includes internal initiatives such as the implementation of an Acute Review Card system in Paediatric A&E and working with external partners to better manage the care of patients who repeatedly attend A&E.

Monitor Indicators

	Performance Indicator	Trend	YTD Value	YTD	Forecast
Infection Control	MRSA (Less than 3 11/12)		1		
	Clostrium Difficile (Less than 31 11/12)		14		
Accident & Emergency	A&E: Initial Assessment (Target < 15mins)		15		
	A&E: Total Time (Less than 4 hours)		02:12		
	A&E: Time to Treatment (Less than 1 hr)		00:52		
	A&E: Left without being seen (Less than 5%)		3.90%		
	A&E: Unplanned Re-Attendances (Less than 5%)		6.8%		
Cancer Services (Quarters)	Cancer: 2-WW Ref to Seen (> 93%)		96.2%		
	Cancer: 62 Day Wait (Consultant Screening) (>85%)		94.7%		
	Cancer: 62 Day Wait (Ref to Treat) (>90%)		95.8%		
	Cancer: Diag to Treat (31 day) (>96%)		95.8%		
	Cancer: Subsequent Surg (31 Day) (>94%)		100.0%		
	Cancer: Subsequent Drugs (31 Day) (>98%)		100.0%		
Access	RTT Admitted (95% Percentile) (< 23wks)		22.41		
	RTT Non Admitted (95% Percentile) (<18.3 weeks)		16.10		
	Compliance with requirements regarding access to people with a learning disability (100%)		100%		

Appendix 1 - Quality Report Actuals

Clincial Effectiveness	Target	Nov	Dec	YTD	Trend
% General and acute patients with a urinary catheter	12.5%	17.20%	16.37%	16.88%	4.81%
Income lost due to first to follow-up ratio	£0.0	£-28k	£29k	£596k	-202.6%
Maternity Access 12 weeks + 6 Days	90.0%	91.0%	91.0%	91.6%	0.0%
Breastfeeding initiation rates	91.1%	92.0%	93.9%	92.3%	1.8%
Caesarean section rate	30.0%	25.1%	22.3%	27.5%	-2.8%
Percentage of A& E attendances for cellulitis that end in admission	40.0%	40.0%	50.8%	45.3%	10.8%
Percentage of A& E attendances for DVT that end in admission	10.0%	-	0.0%	36.7%	-
Non-Elective average length of stay	3.1	3.18	3.05	3.08	4.0%
Stroke: % High risk TIA patients assessed and treated within 24 hours	100.0%	100.0%	100.0%	98.2%	0
Incidence of newly-acquired category 3 and 4 pressure ulcers	4	4	2	18	350.0%
Stroke: Patients who had a stroke who spend at least 90% on a stroke unit	90.0%	100.0%	100.0%	97.0%	0.0%
% Rapid access chest pain clinic patients seen within 2 weeks	98.0%	100.0%	100.0%	100.0%	0
Elective average length of stay	3.0	4.14	3.94	4.00	5.0%
Daycase rate (Basket 25 procedures)	95.0%	84.2%	75.2%	81.6%	-8.9%

Process Effectiveness	Target	Nov	Dec	YTD	Trend
Delayed transfers of care (% Beds effected - snapshot)	3.5%	1.2%	2.1%	1.4%	0.9%
Referral to treatment: Non Admitted (Outpatient Median Weeks)	6.6	0.77	0.76	0.8	-21.6%
Referral to treatment: Incomplete Median (Weeks)	7.2	5.94	6.91	6.0	-16.4%
% Outpatients waiting longer than 13 weeks	0%...	0.00%	0.00%	0.01%	0.00%
Call Centre Hang Up %	9.5%	13.5%	8.7%	11.9%	4.8%
DNA Rate Treatment Centre	3.0%	2.7%	2.7%	3.3%	0.0%
Inpatients waiting longer than the 26 week standard	0.0%	0.0%	0.0%	0.0%	0
2 week wait for appointments for newly diagnosed HIV	100.0%	84.6%	88.6%	90.2%	4.0%
Fracture Neck of Time to Theatre for Medically Fit Patients	100.0%	75.0%	100.0%	90.1%	25.0%

Safety	Target	Nov	Dec	YTD	Trend
Hand Hygiene Completion	100%	93.6%	94.4%		0.8%
Hand Hygiene Compliance	100.0%	95.0%	95.0%		0.0%
Incident reporting rate per 100 discharges	8	7.9	6.4	7.9	-19.9%
Never events	0.0	0	1	4	-100.0%
Patient falls resulting in moderate or major harm	0.0	0	1	7	-100.0%
PEAT Audit (Composite score 1 month behind)	90.0%	95.51			0.4
Hospital Associated VTE	0.0	0	0	6	0.0%
Ratio of midwives to deliveries	TBC	32.01	32.58	34.80	-4.74%
3/4th degree perineal tears	3.0%	3.4%	4.6%	3.8%	-1.1%
1:1 care of women in established labour	100.0%	100.0%	100.0%	100.0%	0.0%
Emergency MRSA screening rate	100.0%	91.5%	93.5%	87.6%	2.0%
Elective MRSA screening rate	100.0%	94.2%	94.0%	88.3%	-0.2%
NICU Nurse: Patient ratio vs. BAPM compliance	86.0%	86.0%	92.0%	87.7%	6.0%

Clinical Effectiveness	Target	Nov	Dec	YTD	Trend
Formal complaints responded in 25 working days	90.0%		-		-11.1%
Breach of same sex accomodation	0.0%	0	3	10	-300.0%
Staff job satisfaction		Yearly Audit(2009 = 3.51, 2010 = 3.48)			
Slot issues on Choose and Book	4.0%	2.6%	3.2%	4.3%	-0.6%
Access to GUM clinics	100.0%	100.0%	100.0%	99.8%	0.0%
Rebooking cancelled operations	0%	0%	0%	0%	0%
Six week diagnostic test wait	0%...	0.0%	0.0%	0.0%	0.0%

Key Commissioner Priorities

MonthYear	YTD	Apr 2010	May 2010	Jun 2010	Jul 2010	Aug 2010	Sep 2010	Oct 2010	Nov 2010	Dec 2010	Jan 2011	Feb 2011	Mar 2011	Apr 2011	May 2011	Jun 2011	Jul 2011	Aug 2011	Sep 2011	Oct 2011	Nov 2011	Dec 2011
VTE Assessment	92.7%	-	-	-	-	-	-	94.8%	94.3%	94.3%	93.3%	93.6%	93.5%	92.9%	91.8%	91.5%	91.8%	94.5%	92.3%	91.0%	90.7%	90.9%
OP Letter Turnarounds	7.46	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	9.10	8.40	6.30	6.10	6.93	7.95
Discharge Summary Completion	84.8%	-	-	-	-	-	-	-	-	-	-	-	-	70.7%	76.8%	77.2%	78.6%	85.5%	91.3%	90.9%	94.7%	95.0%
Emergency Re-admissions Following a Non-elective spell	2.8%	-	-	-	-	-	-	-	-	-	-	-	-	3.4%	2.7%	2.8%	2.6%	2.8%	2.3%	2.8%	2.7%	3.0%
Emergency Re-admissions Following a Elective spell (Target 0)	1.5%	-	-	-	-	-	-	-	-	-	-	-	-	1.5%	1.2%	1.7%	1.7%	1.4%	1.4%	1.6%	1.3%	1.6%
NCE POD Recommendations (One month in arrears)	96.8%	-	-	-	-	-	-	-	-	-	-	-	-	-	96.6%	98.6%	93.7%	97.0%	98.6%	97.2%	96.3%	-
HSMR	81.34	104.10	79.18	87.08	58.82	108.97	71.01	71.23	85.96	71.72	97.05	107.84	83.80	66.25	73.17	61.62	69.08	84.25	85.81	81.48	-	-
LAS Handover - 90% HAS Data Completeness	-	-	-	-	-	-	-	-	-	-	-	-	-	66.0%	70.0%	79.0%	81.0%	82.0%	73.0%	72.0%	71.0%	77.0%
GP Referrals	136053	5626	5742	6023	6319	5871	6127	7438	7791	6035	7239	6820	7490	5919	7104	7261	6416	5923	6189	6609	6827	5284

Monitor Indicators

NHSQuarter	YTD	Apr-Jun 2011	Jul-Sep 2011	Oct-Dec 2011
Clostridium difficile cases	14	6	3	5
MRSA objective	1	0	1	0
All cancers: 31-day wait from diagnosis to treatment	100.0%	100.0%	100.0%	100.0%
All cancers: 31-day wait for second or subsequent treatment Surgery	100.0%	-	100.0%	100.0%
All cancers: 31-day wait for second or subsequent treatment anti cancer drug treatments	100.0%	-	100.0%	100.0%
All cancers: 31-day wait for second or subsequent treatment radiotherapy	N/A	N/A	N/A	N/A
All cancers:62-day wait for first treatment from urgent GP referral to treatment	95.8%	94.4%	93.8%	98.5%
All cancers:62-day wait for first treatment from consultant screening referral	94.7%	-	93.3%	100.0%
Cancer: Two Week Wait from referral to date first seen comprising all cancers	96.2%	95.8%	95.0%	98.5%
Cancer: Two Week Wait from referral to date first seen comprising symptomatic breast patients (cancer not initially suspected)	N/A	N/A	N/A	N/A
Referral to treatment waiting times - Admitted (95th percentile)	22.9	22.9	22.5	22.4
Referral to treatment waiting times - Non-Admitted (95th percentile)	16.1	11.9	11.5	16.1
A&E: Total time in A&E*	98.6%	98.5%	98.9%	98.5%
Stroke indicator	TBC	TBC	TBC	TBC
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability	Compliant	Compliant	Compliant	Compliant