Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting

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

Agenda

	4pm group photo shooting	**Lead**	**Time**
1	**GENERAL BUSINESS**		
1.1	Welcome & Apologies	CE	4.30
1.2	Announcement of results of elections (oral)	CE	
1.3	Declaration of Interests	CE	
1.4	Minutes of Previous Meeting held on 21 April 2010 (attached)	CE	
1.5	Matters Arising (attached)	CE	
1.6	Chairman's Report (oral)	CE	
2	**ITEMS FOR DISCUSSION/DECISION/APPROVAL**		
	STRATEGY		
2.1	Strategy Update (attached)	HL	4.40
2.2	CIP Strategy Update (attached)	HL	4.50
2.3	Council of Governors/Board of Directors Away Day (oral)	CE	5.00
	QUALITY		
2.4	Quality Sub-Committee report (draft minutes of 19 May & 9 July 2010 meetings attached)	CM	5.10
2.5	Patient Experience (attached)	HL	
	MEMBERSHIP		
2.6	Membership Sub-Committee report (draft minutes of 13 May & 8 July 2010 meetings attached)	CB	5.20
2.7	StartHere – Piloting Patient Information System	LH	5.25
2.8	Membership and Engagement Strategy/Work Plan update (attached)	SN	5.35
2.9	Membership Report (attached)	SN	5.45
	GOVERNANCE		
2.10	New Code of Governance and Trust Position (attached)	CM	5.50
2.11	Funding Report (attached)	CM	6.00
2.12	Annual Members' Meeting - Proposal 2010 Report (attached)	MA	6.05
2.13	Council of Governors Performance Evaluation Report (attached)	CE	6.10
2.14	Appraisal of the Chair and NEDs* (attached)	CE	6.20
	OTHER		
2.15	Open Day Evaluation Report (attached)	MA	6.20
2.16	Western Extension of congestion charge zone (attached)	HL	6.25

3	**ITEMS FOR INFORMATION**		
3.1	Finance Report – May 2010 (attached)	LB	
3.2	Performance Report – May 2010 (attached)	LB	
3.3	Annual Report including Quality Report (Account) (attached)	MA	
4	**ANY OTHER BUSINESS**		6.30
5	**DATE OF THE NEXT MEETING – 16 September 2010 at 3pm**		

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 21 July 2010

AGENDA ITEM NO.	1.4/Jul/10
PAPER	Draft minutes of the meeting of the Council of Governors meeting held on 21 April 2010
AUTHOR	Vida Djelic, Interim Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper outlines a record of proceedings at the previous meeting.
DECISION/ ACTION	1. To agree the minutes as a correct record. 2. The Chairman to sign the minutes.

Council of Governors Meeting Minutes, 21 April 2010
DRAFT

Prof. Sir Christopher	Edwards	Chairman		CE
Lucy	Ball	Staff	Allied Health Professionals, Scientific and Technical	LB
Walter	Balmford	Patient		WB
Christine	Blewett	Public	Hammersmith and Fulham 2	CBle
Nicky	Browne	Appointed	The Royal Marsden NHS Foundation Trust	NB
Alan	Cleary	Patient		AC
Edward	Coolen	Patient		EC
Carol	Dale	Staff	Management	CD
David	Finch	Appointed	NHS Wandsworth	DF
Brian	Gazzard	Staff	Medical and Dental	BG
Jacinto	Jesus	Staff	Contracted	JJ
Martin	Lewis	Public	Westminster 2	
Catherine	Longworth	Appointed	Westminster PCT	CL
Susan	Maxwell	Patient		SM
Ann	Mills-Duggan	Public	Westminster 1	AMD
Jim	Smith	Patient		JS
Sue	Smith	Staff	Nursing and Midwifery	SS
Sandra	Smith Gordon	Public	Kensington and Chelsea 2	SSG
Frances	Taylor	Appointed	Royal Borough of Ken & Chelsea	FT
Alison	While	Major Education Provider	King's College	AW
Taryn	Youngstein	Patient		TY

IN ATTENDANCE:

Heather Lawrence	Chief Executive	HL
Catherine Mooney	Director of Governance and Corporate Affairs	CM
Mike Anderson	Medical Director	MA
Vida Djelic	Interim FT Secretary	VD
Amit Khutti	Director of Strategy & Service Planning	AK
Richard Kitney	Non-Executive Director	RK

Greg Hewitt attended for item 2.8

1 GENERAL BUSINESS

1.1 Welcome & Apologies — CE

CE noted the apologies tendered: Andrew MacCallum, Sian Nelson, Chris Birch, Cass Cass-Horne, Cyril Nemeth and Wendie McWatters.

CE informed the Council that AMC was leaving to join Thames Valley University for a prominent academic position, that of pro vice chancellor. He wanted to publicly thank AMC for his contributions to the Trust and wished him well for the future.

CE also congratulated Amit Khutti on his new job in the private sector and thanked him for his contribution, in particular with the HIEC (Health Innovation and Education Cluster) and wished him well for the future.

1.2 Declaration of Interests — CE

CE invited declarations of interest. None were tendered.

1.3 Minutes of Previous Meeting held on 3 February 2010 — CE

The minutes of the previous meeting held on 3 February 2010 were agreed as a correct record of proceedings with the following change:

- p.4, item 1.5, 3rd para should read 'Lady Rhys Williams, the Chairman of the Chelsea and Westminster Charity Trust'

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

1.4 Matters Arising — CE

2.5.2/Feb/10 Membership Report
This was included in the membership report.

2.7/Feb/10 Funding Report
VD said that the project for the Directory of Adult Services is at the information collection stage. No money has been spent yet and it is planned that it will be used for design and printing, which will commence once the information collection stage is complete.

1.5 Chairman's Report (oral) — CE

The Chairman said that the governors were aware that we are undertaking a big capital programme, that of the paediatric expansion.

We had held interviews to recruit a consultant for the paediatric High Dependency Unit but did not make an appointment. We have had to make arrangements for temporary cover. This is a challenging area in which to attract staff.

HL said that NHS London is currently reviewing how many paediatric intensive care units there should be. There will probably be two working in partnership. Our temporary HDU is up and running.

2 ITEMS FOR DISCUSSION/DECISION/APPROVAL

2.1 Chief Executive Update

2.1.1 Contracting implications 2010/11 linking to strategy

HL said that a search is underway to replace the Director of Strategy and someone will start next week to cover some aspects of the job. She said that she is changing the post. AK worked closely with HL but reported to the Director of Finance. The new post will report to the CEO.

There are three divisions now and responsibility is being devolved. Performance will now be covered by the Deputy Chief Executive.

She added that a search for a Director of Nursing also underway and she is looking for an interim solution.

She said we have to make 10% efficiencies. We are looking at using technology e.g. electronic document management, which will have a number of benefits including reducing the number of missing notes. We are also looking at transcription voice recognition, carbon savings and sustainability.

There are challenging strategic issues. The NW sector PCTs have been asked to re-do their strategy and we need to engage with that work. We know that we need to grow but also make 10% efficiencies this year and 10% next year.

She said that when we had discussed acquisitions some of the governors were unsure about community services; this needs to be kept under review.

The Trust was approached by Richmond and Hounslow PCT provider arm re provision of outpatient services and we will take this to the Board to consider bidding. NHS London and the PCTs want 55-60% outpatient services to move into the community.

West Middlesex Hospital will look for a partner in September and we may bid for this in partnership with others, in particular the Royal Marsden Hospital. Cally Palmer, the Chief Executive of The Royal Marsden NHS Foundation Trust, was supportive of the idea and the strategy needs to be developed.

Kensington and Chelsea are tendering dermatology services which accounts for about 30% of our outpatients. We have to bid in a way that is attractive in terms of the clinical model offered to PCTs. If we do not win this bid, we will have to reduce services. She noted that PCTs are tendering different services at different times.

We are progressing with the Netherton Grove extension. We won the bid on the facilities that we had and the extension is not related but is being done to improve services. The building is changing internally and we have had to move some services. We need to make sure we are administratively smart and we need to use our facilities effectively.

AK circulated a paper 'Contract Summary' and presented the main points. He said that we needed to agree the contract by 15th March and lots of organisations did not meet their deadlines.

The main four areas where we will need to improve our ability to operationally deliver agreed contractual terms were:

- How many new patients versus follow up appointments. Ratios were set in the past to decrease follow up appointments. The rationale is that it is better not to bring patients back e.g. do not bring patients in simply to give them information. We can look at other ways of doing this e.g. texting information. This is more convenient for patients and more efficient for the NHS.
- Ensuring that we are not undertaking low priority procedures unless these procedures meet specific clinical criteria.
- Being able to take cost out of certain services e.g. dermatology. If PCTs' ambitious plans to shift care out of hospitals are delivered, we do not bring patients back.
- Working with PCTs to control emergency admissions to the hospital so that we minimise the impact of the new national marginal rate of 30% payment for emergency admissions above 2008/09 activity levels.

CE expressed concern that adherence to ratios would translate into poor long term care. CL asked for clarification on follow up appointments. HL responded that if we exceed the ratio the PCT will not pay. AK said that specialities are being asked to come up with exceptions and we argued for some clinical exclusions. AK said on p.3 there is a list of clinical exclusions we put forward such as bariatrics. There has been a discussion on a care pathway and the reasonable ratio of follow-up appointments

WB said that he felt that this was a counter to patient care. However, SM said that she had come in recently simply to be told that her last result was alright. AC said he was dubious about performance indicators and their validity.

CE said that skilled negotiations were necessary. In response to CBlew's question about the status of the contract, HL responded that we have agreed the contract and the PCTs are under a mandate from NHS London. She said that MA and clinical leads have met with the PCTs and our negotiating team is very good.

BG said he can help with plans to mitigate risks. In the HIV directorate they are doing texts already and it is very popular with patients. There are ways to reduce visits and it needs to be thought through how we could improve communication with patients.

AK said that with respect to low priority procedures it was described as 'interventions not normally funded'. It is an initiative put forward by all PCTs and has not been monitored or enforced up until now. An example is varicose veins where the PCT will only pay 50%. It is rather arbitrary and so it has been agreed that clinicians will review in year and undertake audit.

CE said that it is a question of degree, some patients have severe conditions. MA said the challenge is to deal with individuals and their concerns e.g. there are some ways of treating veins problems rather than having a surgery.

AC asked if there was any benefit in early intervention? CE said that there was benefit in prevention and this principle would be fine if we had a good general practice but in London there were still a lot of single handed GPs. It was very important how this hospital got involved in polysystems.

CBlew asked how much we work in partnership with GPs and whether it is a joint decision with GPs. MA responded that GPs initially make the referral. There

would be an assessment by the hospital then a joint decision with the GP. He noted that GPs may be under pressure to refer.

AK said the point about shifting care out of hospitals had already been discussed but to note that it was more ambitious this year. With respect to controlling admissions to A and E there were schemes nationally to try and stop the rise in attendances year on year. To ensure Trusts are fully engaged the tariff has been changed so that above a certain ceiling Trusts will only get a third of the tariff.

HL noted that we have been communicating strategic direction and contract requirements widely through 'Fit for the Future' briefings with staff.

2.1.2 Lower Ground Floor Outpatient Plans

HL introduced Hannah Coffey who is the Operations Director for Medicine and Surgery and she is leading on the outpatient project.

HC said that we are relocating the current outpatients 1 area on the second floor which is diabetes, pain, general surgery and urology. This will move to the lower ground floor between lift bank C and D.

The new outpatients is due to open in February 2011 so the deadline is quite tight. This is a good opportunity to re-design as the hospital was designed 20 years ago and we need to make it more accommodating to the current needs e.g. there is more diagnostic testing now. She said that we have reflected the feedback from patients e.g. communication, waiting time and the facilities. We have been focusing on patient flow as the current arrangements are quite confusing. There is not enough space for comfortable waiting. We are planning to provide phlebotomy and diagnostics downstairs.

We are looking at booking on line and at patient letters e.g. the content of letters. We are due to sign off the plans in 2 weeks time.

FT asked if the waiting rooms would have windows. HC said that we were looking at the atrium as the waiting area and the coffee area. Most of the consulting rooms will have natural light.

SS-G said she had a concern about how patients would get down to the lower ground floor. HL said we plan to have escalators but she did not like the plans so far. Escalators are very expensive. HL agreed with the comments about the lifts and said she had met with the contractors on this issue. SM commented that it had got worse since the stairs had been closed. CE explained the reasoning behind the closed stairwells. He said that there had been three people who had jumped since the hospital had opened and we cannot have another one. He explained that the handrails on the upper floors had also been taken away.

NB said that these plans would have a huge impact and there had been little time to absorb the information. She said papers were needed in advance so that issues can be considered in advance. CE agreed.

To AMD's question HC confirmed that the plans will be ready for the Open Day on 8 May 2010.

CE said it was important to understand clinicians and patient concerns. HL confirmed that there were defined areas but a common waiting area. BG said that the presentation was superb and he believed the patient journey will

improve.

HL said the administrative arrangements needed to improve and IT was a very important part of making this work. She had a vision that the hospital will run similar to an airport, where patients will book in early themselves and know where to go. The clinicians would be like pilots working to their own brand but following governance rules like pilots do with the airport security.

FT asked about plans for the Netherton Grove Extension Project. HL responded that they would be available on the open day and we were meeting with the neighbours tonight. The main focus is on the staff who are being displaced and finding suitable offsite accommodation. The long term strategy is to buy Doughty House to accommodate 200 staff who would need to be onsite.

Regarding communication, the governors said that they were not getting the newsletter that goes to staff.
CM to follow up. **CM**

2.2 Quality CM

2.2.1 Quality Accounts Update

CM gave an update on the Quality Account. She said that the final draft would go to the Board next week. She said an important element is what our stakeholders want and she outlined the process that had been undertaken and how the issues were prioritised.

In order to get feedback we initiated a staff survey and CM thanked CD for leading on this on behalf of the staff governors. She pointed out that although not many responses were received, the comments were very useful and included issues that we were aware of and some new issues. She hoped that staff feedback using the survey approach would be an ongoing process.

CM said she was confident that the quality account will be of a good standard as governors had read it and she was very grateful for their time.

CM said that the next step was that PCTs would receive the draft quality account to comment on.

The Council had no further comments on the engagement process.

2.2.2 Quality Sub-Committee Report

CM said that she had covered most of this already but wanted to draw attention to the minutes of the Quality Sub-Committee, item 6 on p.5 relating to feedback from governors on patient experience. Each governor will ask five friends/contacts for feedback on their experience. She thought this would be a useful way of using individuals' experience to get feedback.

2.2.3 Patient Experience

CE introduced AMC's paper about phase I and II of the implementation of the Patient Experience Tracker (PET).

We set a target of achieving an 80% response rate and 40% response rate was agreed with Kensington and Chelsea PCT as a CQUIN with a value of £110,000.

CE said that patients should be made aware that the PET is anonymous.

SS said she wanted to reassure governors that as an outpatient sister that the PET is completely anonymous. Sometimes when it is busy it is difficult to focus on making sure that all outpatients have given their comments. She said that patients are not put under any pressure to complete them. HL suggested using volunteers to help. JS said that he does not think there is pressure put on patients to complete the trackers and it is obvious that it is anonymous.

ML suggested that the PET is used at the Open Day on 8 May 2010. HL confirmed that it was in the plan.

ML asked how we managed if the patients did not speak English. CD said we now have overlays in the major languages. AW asked if it was possible to know the different settings and to look at this data with complaints from the same area. CE suggested a geographical correlation so that bad areas do not get 'lost' and agreed it would be good to correlate with complaints.

HL said that there has been an excellent response in the Maternity Unit. However, in some areas there are no responses at all.

CD said we should celebrate the information gathered via the PET which helps wards improve the level of service they provide.

CE referred to fig 18 of the patient experience paper regarding booking appointments. HL said that this should improve.

AC queried fig 8 and fig 10 and the way questions were worded. HL said most of questions were taken from the national survey.

To CL's question on how many people took part in the survey, CD responded that this is illustrated in point 2.4.

HL agreed with AW's point that it would be a worthwhile exercise to analyse responses by age group. However the age is not recorded but this could be done by ward.

TY joined the meeting.

2.3 MEMBERSHIP **CE**

2.3.1 Membership Sub-Committee report

JS said that he had received a copy of the main discussion points that CBir had drafted and had asked JS to present them to the Council of Governors. The main points covered the following:
- In total there were 27 items on the agenda of the Council of Governors meeting and they weighed 1 lb 13 oz.
- At the Membership Sub-Committee we usually had about 13 or 14 items, but at the April's meeting we cleared the decks so that we could have a full of membership development and engagement discussion. The membership has declined and a new approach is needed. The sub-committee discussed schools and participation in the Nothing Hill Carnival and that the community mobile health clinic bus could be taken elsewhere.
- JS also noted that there was a new membership leaflet.

FT said she did not think that the Notting Hill Carnival would be as productive as we would hope as it is very crowded. She suggested instead going to the Portobello Market. ML said that we need to ensure that the black minority community get involved. FT suggested that the Mobile Health Clinic get taken to Kensington and Chelsea Town Hall.

CE said that with respect to the papers at this meeting there is an agenda sub-committee so this is in our hands. It was agreed previously that we would reduce the finance and performance report.

NB felt that we still had not addressed why patients and the public should get involved. We had not used the newsletter appropriately and a section on 'what was covered at the last meeting' would be a good idea. BG suggested we could write one page on what has been achieved e.g. 'you do make a difference, the following things have been done....'

Ideas to be considered by the Executive. **CM/AMC**

2.3.2 Membership and Engagement Strategy

This will be covered in more detail at the next Council of Governors meeting.

2.3.3 Membership Report

This was noted. CE said we need to be careful as we need active members not just numbers.

2.4 Funding Report* **CE**

This item was taken as read.

2.5 Remuneration of Non Executive Directors (NEDs) and the Chairman **CE**

CE said that the Council is required to consider the remuneration of the NEDs and the Chairman at least every three years. Considering the current financial climate he suggested that there should not be any change to the remuneration of NEDs and the Chairman. He noted that a very thorough benchmarking exercise had been taken at the time the remuneration was agreed, when the Trust became a Foundation Trust. The governors supported the Chairman's view.

2.6 FTGA/FTN Development Day 12 February & 23 March 2010 – feedback **SS-G/WB**

SS-G said that she would recommend the FTGA/FTN Development Day events to other governors having attended one on 12 February.

WB agreed that the day was worthwhile and informative.

2.7 Proposed questionnaire for Council of Governors performance evaluation **VD**

VD said the proposed questionnaire was an update on the questionnaire previously used for the evaluation of the Council of Governors performance. Changes included grouping of questions and an additional question relating to the Quality Account. The aim of the questionnaire is to evaluate and improve the performance of the Council of Governors.

Governors discussed the proposed questionnaire and the following questions

were agreed to be added to the questionnaire:

- How would you rate the level of support provided by the Foundation Trust to discharge your responsibilities as a governor?
- How would you rate your communication with the Trust?
- How would you rate the idea of having a chelwest e-mail account?

VD to update the questionnaire. **VD**

VD invited the governors to agree the proposed timetable:

- Questionnaires to be distributed to Governors by e-mail on 26 April 2010;
- Questionnaires to be completed and returned to the Trust Secretary by 10 May 2010;
- Summary report, including any recommended developmental actions, to be prepared and presented by the Chair to the Council of Governors meeting on 21 July 2010.

Governors agreed the proposed timetable.

2.8 Governors chelwest e-mail account arrangements **CE/GH**

CE said some governors expressed strong views about having a chelwest e-mail account so that members of their constituency could contact them.

Gregory Hewitt of the IT Department attended the meeting and briefly outlined the arrangements for the governors to have an e-mail account with the Trust. The e-mail address would be then published on the website.

It was agreed that VD would circulate an e-mail request form and the Acceptable Use Policy to the governors. **Those governors who are willing to have the e-mail account would send back to VD completed e-mail application form and signed Acceptable Use Policy.** **All**

2.9 Council of Governors group photo

One governor proposed that a group photograph be taken for the purposes of publishing it in the next Trust News. **It was agreed that it would be a good idea to gather together at 4pm on 21 July 2010.** **All**

2.10 Open Day – 8 May 2010 – update

CE said that the arrangements are in the place for the Open Day. VD said that copies of flyers for the Open Day were available for the governors.

3 ITEMS FOR INFORMATION

3.1 Finance Report – February 2010 **LB**

This item was taken as read.

3.2 Performance Report – February 2010 **LB**

This item was taken as read.

3.3 Foundation Trust Staff Governor Study **CE**

This item was taken as read.

3.4 Appraisal of Chair and NEDs – FTGA publication

This item was taken as read.

4 ANY OTHER BUSINESS **CE**

CE said that EC wanted to raise a few points under any other business.

EC said that he objected to not having time for AOB. He also said that the governors should be allowed to make unannounced visits to hospital wards so to be able to judge everyday standards. He said that he had personal experience as an outpatient, day patient, in patient and private patient. He found excellent nurse care as an outpatient and day patient while doctors were present. However, not the same standard of care was provided when doctors were not present.

CE responded that any personal views should not be generalised.

EC said he felt that the Trust News was mainly aimed at staff and felt that money spent on circulating it to members was not essential. He thought it should have been spent on other more essential areas e.g. nurse training. He said that the amount of paper generated appears excessive and that it could be reduced and some savings made.

NB said that she had not been contacted by anyone about the agenda and the agenda sub-committee should be seeking members' views. CE said that the dates of the agenda sub-committee meetings would be circulated so everyone was aware and could forward their views.

Vida to circulate a list of agenda sub-committee meeting dates to all governors. **VD**

5 DATE OF THE NEXT MEETING

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

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 21 July 2010

AGENDA ITEM NO.	1.5/July/10
PAPER	Matters Arising from the meeting of the Council of Governors meetings held on 21 April 2010
AUTHOR	Vida Djelic, Interim FT Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper lists matters arising from previous meeting and the action taken or subsequent outcomes.
DECISION/ ACTION	The Council of Governors is asked to note the matters arising and the updates.

MATTERS ARISING
Council of Governors Meeting
Hospital Boardroom
Chair: Prof. Sir Christopher Edwards
Date: 21 April 2010
Time: 4:30 – 6:30 pm

Ref	Description	Lead	Subsequent Actions or Outcomes
1.3/Apr/10	**Minutes of Previous Meeting held on 3 February 2010**		
	VD to amend minutes in line with comments received.	**VD**	Completed
2.1.2/Apr/10	**Lower Ground Floor Outpatient Plans**		
	The governors said that they were not getting the newsletter that goes to staff. **CM to follow up.**	**CM**	Matt Akid confirmed that the staff newsletter is circulated to all governors and individual governors who do not receive a copy should let Matt know.
2.3.1	**Membership Sub-Committee report**		
	We had not used the newsletter appropriately and a section on 'what was covered at the last meeting' would be a good idea. BG suggested we could write one page on what has been achieved e.g. 'you do make a difference, the following things have been done....' **Ideas to be considered by the Executive.**	**CM/AMC**	
2.7/Apr/10	**Proposed questionnaire for Council of Governors performance evaluation**		
	Governors discussed the proposed questionnaire and the		

	following questions were agreed to be added to the questionnaire: • How would you rate the level of support provided by the Foundation Trust to discharge your responsibilities as a governor? • How would you rate your communication with the Trust? • How would you rate the idea of having a chelwest e-mail account? **VD to update the questionnaire.**	**VD**	Completed
2.8/Apr/10	**Governors chelwest e-mail account arrangements** **Those governors who are willing to have the e-mail account would send back to VD completed e-mail application form and signed Acceptable Use Policy.**	**All**	In progress
2.9/Apr/10	**Council of Governors group photo** One governor proposed that a group photograph be taken for the purposes of publishing it in the next Trust News. **It was agreed that it would be a good idea to gather together at 4pm on 21 July 2010.**	**All**	
4/Apr/10	**Any other business** **Vida to circulate a list of agenda sub-committee meeting dates to all governors.**	**VD**	Completed

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 21 July 2010

AGENDA ITEM NO.	2.1/Jul/10
PAPER	Strategy Update
AUTHOR	Lucy Hadfield
LEAD	Heather Lawrence
SUMMARY	Following the Council of Governors' strategy day on 11th September 2009, the views of governors on the Trust's strategic direction were taken forward into the three year Corporate Plan, 2010-13, approved by the Board of Directors in May 2010. This high-level update outlines changes since then, particularly the new Government's policies in the White Paper 'Liberating the NHS' and their implications for our strategic plans.
DECISION/ ACTION	For information

Chelsea and Westminster Hospital NHS Foundation Trust

Council of Governors' strategic up-date

July 2010

Where we are now in mid 2010

- Our vision *'to provide high quality patient-centred care for our local population and those using our specialist services, delivered by a modern workforce in a range of settings along integrated pathways of care'*
- Continued success as a Trust (evidenced across most KPIs)
- Strengthened clinical leadership
- Netherton Grove project – expanding and modernising the hospital
- Becoming 'Fit for the Future' by reducing cost base by 10%
- Seeking and winning work in new markets, e.g, specialist children's services, dermatology out of hospital

However, we cannot stay as we are in future

What is changing?

- New Government white paper
- Public sector spending cuts
- Integrated pathways of care – commissioners and patients want more convenience + quality outside hospital and greater specialisation for some services
- Increased competition from other providers in west London – there are too many hospitals

Also,

- There is uncertainty around the structural transitions ahead

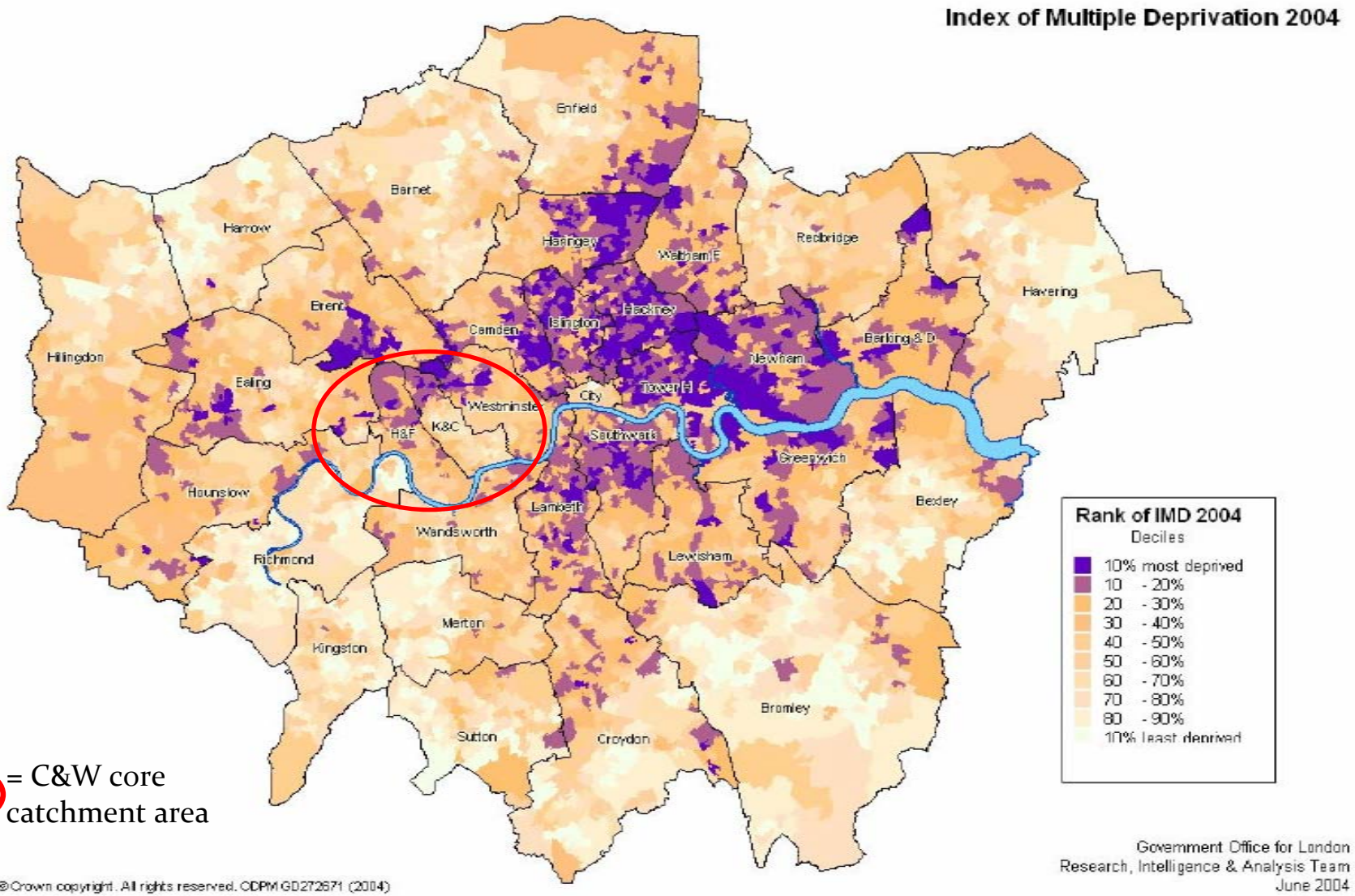
White Paper - Equity and excellence: Liberating the NHS

- NHS core principles upheld
- More information, choice and voice for patients
- Whole system dedicated to improving quality and outcomes, with ring-fencing for public health
- More autonomy, accountability and legitimacy of commissioning at local level by GP consortia and local authorities
- SHAs and PCTs will go
- Less bureaucracy and top-down micro-management
- All trusts and their clinicians to have greater freedoms as social enterprises within a more open, but clearly regulated, NHS market system e.g. remove cap on private patients

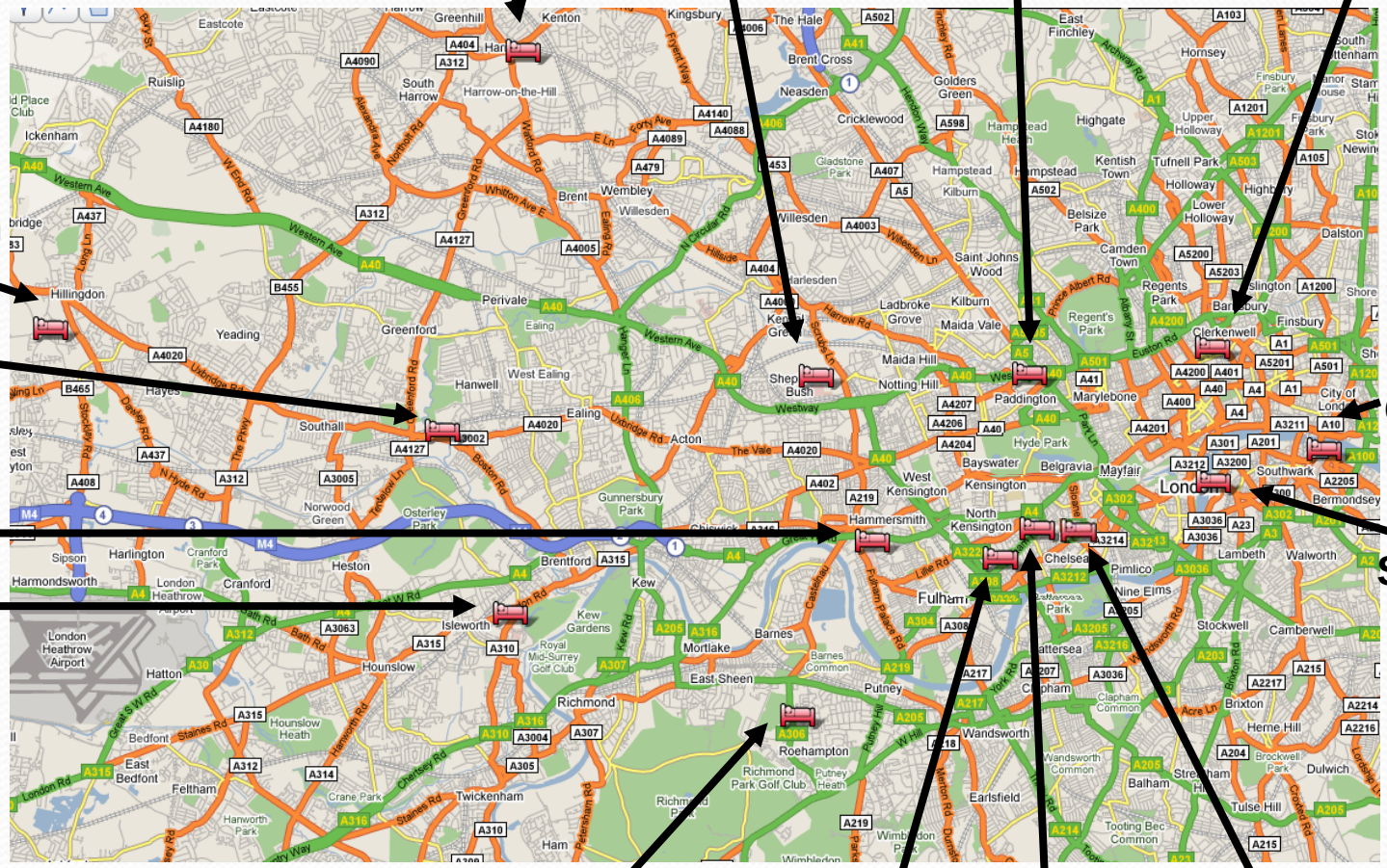
Long-term conditions case study– Kishore is 45 and overweight with type II diabetes

Current	Future
• Diagnosed with diabetes two years ago; went to see GP after wife nagging him for three years; • Under hospital care but misses specialist appointments as too busy at work; • Does little exercise; • Misses hospital appointments for eye and kidney checks; • Suffers from breathlessness, cannot walk up stairs, gets pains in legs if walks too far. Ends up being admitted to hospital for breathlessness as emergency.	• Diagnosed five years ago during routine health check, after sent weekly reminders and booked 10am Saturday appointment • Under care diabetic nurse who sees him monthly at local venue at a time convenient to him, checks his diet, exercise and treatment; • Prescribed exercise vouchers for local recreation centre; • Has eye and kidney checks close to home; • Successfully loses some weight and suffers no complications of diabetes

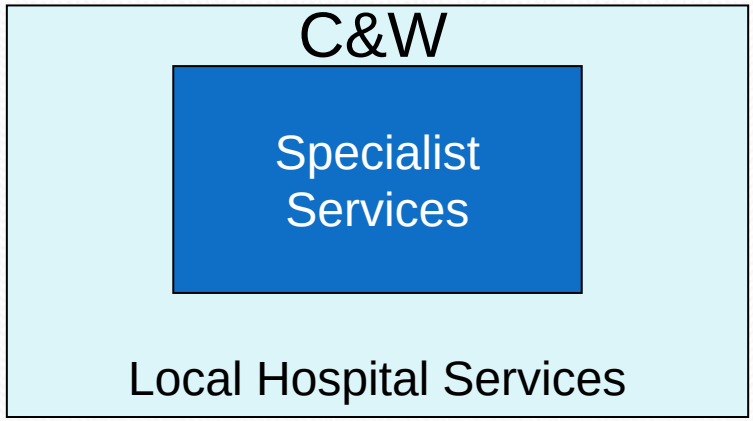
We serve a population of ~400,000



But there a number of hospitals in the vicinity



Potential strategic options



Collaboration with RBH and RMH

Out of hospital care – polysystems or more Dean Streets

Out of hospital care - community services

Acquisition – of another local hospital

Implications of Changes for C&W's Strategic Direction

No radical changes are needed to our 3 year corporate objectives at present, but greater priority will also be needed for:

- Growing clinician-driven management and leadership skills and systems to enable service lines to succeed or fail in more competitive markets, whilst the Trust grows as a whole
- Focus on engaging with customers i.e. patients **and** GPs, and on innovating to deliver what they ask for and would like
- Robust responsiveness to the ongoing volatility of the healthcare environment in London and uncertainties around structural transition

Next Steps

- Review mid-year progress against our 2010/11 corporate and financial plan
- Assess the external context for individual service lines, divisions and the trust overall ready to start business planning for next year in September
- Action plan to increase engagement with GPs
- Be alert to all opportunities to exploit identified potential strategic options to grow market share, within available capacity and capability

Council of Governors Meeting, 21 July 2010

AGENDA ITEM NO.	2.2/Jul/10
PAPER	Progress Report on CIPs Savings Strategy
AUTHOR	Heather Lawrence, CEO
LEAD	Heather Lawrence, CEO
SUMMARY	This paper details the Board of Directors approved approach to CIPs (cost improvement programmes) and seeks to assure the Council that patient care and quality are not being compromised.
DECISION/ ACTION	The Council is asked to note this report.

PROGRESS REPORT ON CIPs SAVINGS STRATEGY

1. INTRODUCTION

1.1. The Board agreed at the October 2009 meeting that a more strategic approach to CIPs (cost improvement programmes) was required in order to meet the challenges of the financial downturn. It was agreed that a higher level of CIP would be needed, somewhere in the region of 10%.

1.2. Our subsequent 3 year financial plan confirmed the need for a CIP of 10.5% in 2010/11, with 10% required in 2010/11. However, we have subsequently revised the 2011/12 figure down to 7% having revised our proposed capital spend.

1.3. The approach to achieving these savings had three streams:

- Strategic Opportunities
- Fulham Road Collaboration
- Internal Opportunities

1.4. This paper informs the Council as to our progress and aims to assure the Council that clinical care has not been compromised by this high level of unprecedented savings at the Trust.

2. NATIONAL PERSPECTIVE

2.1. The last Government set in train the QIPP (Quality, Innovation Productivity and Prevention) agenda. This approach is continuing under the new coalition Government and is consistent with our internal approach to savings.

3. STRATEGIC OPPORTUNTIES

3.1. Expanding strategic opportunities has the positive impact of generating more income and increasing market share which can offset savings.

3.2. The Trust has won new business in Westminster and Hammersmith & Fulham. The specialities concerned are sexual health, women's health and dermatology.

3.3. We have been shortlisted by Richmond to provide rheumatology, neurology and ophthalmology.

3.4. We made a joint bid with the Royal Marsden Hospital for Hounslow and Richmond Community Services but this process has now been placed on hold.

3.5. Most notable, is the success of the Dean Street Clinic which is now the busiest clinic in London and in the UK.

4. FULHAM ROAD COLLABORATION

4.1. This work has involving working with our Fulham Road partners, the Royal Marsden and Royal Brompton and Harefield Hospital Foundation Trusts, to consider areas where savings may be made from working together. External benchmarking has been undertaken to underpin this work.. The areas that are being explored together are:

- Soft facilities management
- Hard facilities management
- Finance
- Procurement
- Pathology
- HR
- ICT
- Telecoms
- Payroll

4.2. Separately we are consulting with staff on the option of the Royal Marsden Hospital managing our Occupational Health Services and if this is agreed the current service on site will remain the same, although we expect to see benefits in cross cover, greater specialisation and an increased ability to cope with peaks in demand.

4.3. Whilst there may be some savings in year from this partnership approach, we will realise the benefit in the next financial year, giving us a head start on the 2011/12 savings.

5. INTERNAL OPPORTUNITIES

5.1. As well as all the local initiatives we are undertaking, we have 13 Trust-wide schemes (Appendix 1) where the benefits of taking a collective approach was seen as advantageous. Each scheme has a lead manager/director. Some of these schemes are already releasing savings and others will take longer to see the benefits but are part of making us more efficient administratively.

6. PROGRESS TO DATE

6.1. We have identified 89% of the £22.5m required. The savings fall into the following categories:

- Pay 30%
- Non-pay 37%
- Income 22%

6.2. A cautious approach has been taken to allow additional income to be included. Each of these areas has been reviewed by the Director of Finance and she has assured the Board that they are robust.

7. IS PATIENT CARE BEING COMPROMISED?

7.1. Our aim has been to improve efficiency throughout the hospital thereby making working lives easier for staff, providing even better services for patients and reducing cost.

Example – Theatre Improvement Project
Ensuring theatres are utilised to their maximum capacity is a key workstream of the Theatre Improvement Project. Historically some theatres have been poorly utilised due to poor administrative processes, lists starting late or finishing early and patients and lists being cancelled and their slots not being filled.

A number of improvements have been implemented in this area including reassessing timings of operations and case mix to ensure continuity, monitoring and adhering to list start and finish times, and developing a clear policy relating to cancellation of lists. Work is also underway to ensure lists are scheduled well in advance to allow sufficient time for amendments and more attention to confirming appointments to identify any unexpected cancellations by patients.

This has provided a better quality of service for patients with fewer cancellations and shorter lengths of stay, a better working environment for staff with less frustration and more time spent treating patients and greater value for money.

These combined with other theatre projects such as improved stock control should generate savings of £260k.

7.2. Mark Gammage, Deputy CEO/ Director of HR has been through each of the CIPs with the relevant Director of Operations. Whilst pay accounts for 30% or £6.687m of our savings, not all of those are in clinical areas.

7.3. The Trust has held a number of consultations with staff and staff side to ensure there is understanding of the changes that we are making and individuals are involved in issues which directly affect them.

7.4. The Medical and Surgical Division proposed the creation of a combined medical and surgical admission ward and the co-location of medical and surgical level 1 patients. This is proposed because:

- Surgical admission often requires input from the physicians.
- Acute Coronary Care Patients now go to the Royal Brompton Hospital or St Mary's Hospital, creating spare capacity in CCU and under utilisation of staff skills.
- Centralisation of level 1 patients is generally believed to be better for patients, as it ensures a consistent and available skill set from nurses and doctors in the delivery of care.
- Due to a reduction in length of stay we are able to close a ward and redeploy the staff.

7.5. This proposal was agreed by the Board and the Acute Assessment Unit (AAU) opened to patients on 5 July.

7.6. In relation to scheme 3, some of this saving comes from a reduction in outpatient prescribing resulting from the national advice that patients should return to their GPs for the vast majority of new and repeat prescriptions other than medication required urgently or medication excluded from primary care e.g. medication for HIV, oncology, antivirals. The Board discussed this as it could impact on patient's perception of the

hospital and it was agreed that the Trust would look at employing an IT-based solution to link with GPs and therefore minimise impact on patients.

8. TRUST APPROACH AND RESPONSE TO SAVINGS TARGET

8.1. The approach the Trust has taken is to communicate widely with staff on why we need to make savings and to encourage their active involvement. This process has been ongoing since September last year.

8.2. We have two Trust-wide communications specifically designed to communicate with staff – the '*Fit for the Future'* and *'Putting Patients First'* campaigns. In addition, regular open sessions are held with the CEO which are open to all staff with regular updates published on the intranet.

8.3. The success that we have had to date is due to the early involvement of staff and staffside, our strategic approach, putting the savings in context for staff and the structured approach that we have taken, led initially by Amanda Pritchard, Deputy CEO. This approach generated many ideas that have subsequently been taken forward by Mark Gammage who is covering for Amanda's in her absence and translated into the 13 Trust-wide schemes (initially there were 14 schemes but two of the pharmacy schemes have been merged together).

8.4. Separately, the CEO has asked Mark Gammage to take forward an innovation, our own version of '*Dragon's Den'* to create energy and drive in making sustainable development. Employee circles are also being set up to give staff their own forum and encourage staff involvement in our future.

9. CONCLUSION

9.1. The Council of Governors are asked to note the progress to date in achieving the CIPs and to be assured that patient care is not being compromised.

Analysis of Trust Productivity Themes

	Initial Estimated Savings	Currently in Directorate CIP Plans 2010/11			Currently in Directorate CIP Plans Recurrent
		Achieved	Planned	Total	
Theme	£000's	£000's	£000's	£000's	£000's
Consultant job plan review	-	342	0	342	342
Medical secretaries / Digital Dictation	850	105	15	120	127
Drug savings	440	29	500	529	432
Restructure OPD Nurse & Admin	861	9	0	9	15
Nursing skill mix (to incorporate Specialist Nurse job plan review)	125	2,078	413	2,491	2,755
Energy consumption reduction due to changes in practise	52	75	0	75	75
Pathology	-	0	1,250	1,250	1,250
Length of Stay	1,500	680	0	680	1,000
Review of Overheads		171	129	300	336
Managed Print Service	300			-	-
Consolidation of performance functions	-			-	-
Centralisation of appointments and admissions	-			-	-
Theatre Improvement Project	50			-	-
HP10 (HP) Prescriptions (now part of theme 3)				-	-
Total	**4,178**	**3,489**	**2,307**	**5,796**	**6,331**

Note: Consultant Job Plan Review; although this scheme was originally planned to not release any savings during 2010/11 some Services have been able to identify efficiencies which can be released this year.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 21 July 2010

AGENDA ITEM NO.	2.4/Jul/10
PAPER	Minutes if the Council of Governors Quality Sub-Committee meetings held on 9 July (draft) and 19 May 2010 (approved).
AUTHOR	Vida Djelic, Interim Foundation Trust Secretary
LEAD	Catherine Mooney, Director of Governance and Corporate Affairs
EXECUTIVE SUMMARY	Minutes are enclosed.
ACTION	To note.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Quality Sub-Committee meeting, 9 July 2010

Draft Minutes

Attendees	Carol Dale	CD	Staff Governor – Management
	Susan Maxwell	SM	Patient Governor
	Wendie McWatters	WMW	Patient Governor
	Sandra Smith Gordon	SSG	Public Governor – Kensington & Chelsea 2
	Mike Anderson	MA	Medical Director, Chairman
	Renae McBride	RMB	Communications Manager
	Catherine Mooney	CM	Director of Governance and corporate Affairs
	Vida Djelic	VD	Interim Foundation Trust Secretary

1 Welcome and Apologies

Apologies were received from Rosie Glazebrook, Martin Lewis and Therese Davis, Interim Director of Nursing.

2 Minutes of previous meeting 19 May 2010

The minutes were approved as a true and accurate record of the previous meeting.

3 Matters arising

5/Mar/10 Quality Accounts Briefing- Discharge Group
CM said that the terms of reference are in draft awaiting sign off by Hannah Coffey. There is the intention to have one to two governors represented on the Discharge Group and for governors to comment on the terms of reference.

Action: to circulate terms of reference of the Discharge Group **CM to arrange**

4/May/10 Quality Account progress and next steps
A copy of the Quality Account 2009/10 which was published on the NHS Choices website was tabled at the meeting.

5.3/May/10 VTE prevention
A copy of the VTE leaflet was distributed to the sub-committee together with the papers prior to the meeting.

MA asked the sub-committee for their views. The governors thought it was very good. One governor suggested that the message about deep vein thrombosis (DVT) with a picture appears at the front as it has a lot of impact. CM suggested that an invitation about membership is added to the section on M-PALS. RMB said that the M-PALs section was

standard on all leaflets where there was space and CM commented that would mean even wider coverage.

CD felt that 'eat a balanced diet' in the section 'what can I do when I go home…' does not fit as there is no mention of this being important. CM said perhaps it should be together with 'keep a healthy weight'. The committee wondered if smoking was a risk factor and if there should be advice on giving up smoking.

Action: pass comments to Helen Yarranton to consider for the next revision **CM**

6/May/10 Feedback from governors on patient experience

SM said at the PEAT meeting there was mention of a blanket to be available on chairs and the problems with porters using the correct lift was raised.

MA said the problems with the lifts related to the number if people using them and the volume should go down when escalators are in place to the lower ground floor. RMB added that we try to encourage staff not to use lifts.

4 Promoting quality – an award **CM**

CM said that Helen Yarranton suggested that we should have a quality award at a meeting recently and this was also discussed with the Trust Executive. It was similar in concept to individual and team of the month sponsored by the Westminster Health Charity.

CM had discussed it with Matt Akid and he was concerned about the amount of work involved and suggested it being done annually but the executive team felt it should be more often. Quarterly was suggested as a compromise.

CM said that she would like it to be an educational event with a high profile e.g. led by the Chairman and with winners giving a short presentation but perhaps the quarterly award should be the first step.

CM said that people who have contributed to quality should be awarded as a way of recognising and promoting it and that it would be an excellent idea if submissions could be linked to the Trust's corporate objectives.

CM invited the sub-committee to comment.

CD agreed that the award should be annually, possibly at the end of year as an exhibition so we have several submissions and one award.

RMB suggested it could be linked to the Annual Members' Meeting (AMM) and have a poster display at the AMM.

RMB asked how all staff could contribute to quality as this may be more directed at clinical staff. CM responded that somebody can indirectly contribute e.g. by making the patient experience a bit better and it would be good to have an award given to someone 'in the back room' to emphasise that everyone does have a role.

CD said she thought most submissions would be from teams and it

needed to be a reasonable amount. It was thought that money would not be the greatest driver. The suggestion was to use a similar amount as the Charity which would be about £500 per quarter.

CM thanked everyone for their helpful suggestions and said that this proposal will be taken to the Council of Governors meeting on 21 July.
CM to take it to the Council of Governors for approval that awards get funded from their budget. **CM**

5 Communication of quality objectives **RMB**

RMB said that at the Membership Sub-Committee meeting we agreed that there will be an article on the quality objectives.

RMB said that Matt Akid had suggested an article giving some examples of governors working with the Trust.

CD tabled a cartoon on quality objectives.

One governor said when she accessed the Chelsea and Westminster Hospital NHS Foundation Trust website to find quality objectives they were not there. CM responded that there is link to the NHS Choices where the Quality Account was published but she agrees that there needs to be a section on quality objectives and how we are going to achieve them. She suggested that the group that is going to look at the website that was agreed this week should consider this.

There was a suggestion that an article is published in the Trust News and posters are put around the hospital. The idea of using cartoons for publicising the quality objectives was discussed. SM suggested that they could be linked to the patient experience. CM said she liked the idea of linking quality objectives to the patient journey. She said that this might work as there were objectives about admissions and appointments, being an in-patient (the general experience) and having surgery, both having it in time and not getting a VTE. The theme could be followed through to discharge. CD suggested a use of a story board so that both staff and public would remember these objectives. WMW suggested this should be published on the Trust's website.

CM was concerned whether the communications department has resources to get this done and asked if there was a need to ask the governors for funding. WMW said she had a cartoonist contact which we might like to consider but it would be helpful to know if he was a member.

VD to check membership of WMW's contact. **VD**

RMB to discuss resources with Matt Akid **RMB**

CM said that it would be good to have quality linked to a theme such as 'Fit for the Future' which had been successful in engaging staff in the Trust's strategy.

RMB said that we need to find out how this could be structured on the website. RMB to check with Matt Akid and George Vasilopoulos.
RMB to check. **RMB**

6 Staff Survey **CM/CD**

CM said that we conducted a survey to find out what staff felt were the issues, so that we could use this information in the quality account. This was run by CD on behalf of the govenors and we wanted to continue with this.

CD said that she would like some input into the questions for next time. How should we structure the questions and what sort of information do we want? We want to know how well we are doing this year as well as ideas for next year. Therese Davis is drafting a Patient Experience Strategy and this could be another strand of how we find about patient experience.

CM suggested that we put the definition of quality at the top of survey. SSG added that the quality objectives should be listed and to ask staff how they contribute. CM said we will have the survey quarterly. CD suggested that the prize for the quiz should appear in the Trust News.

CD to arrange another staff survey **CD**

7 Feedback from governors on patient experience **All**

SSG asked about an issue that was raised in an earlier sub-committee meeting re dressing gowns not being of the appropriate size. MA said that he was aware that some work was going on and he will check this with Therese Davis. **MA to find out from Therese Davis.** **MA**

SSG said she observed that some floors in the hospital have holes but it looks like they are not being cleaned properly, but they actually need repaired and there is a programme of repairs. She suggested it might be a good idea to publish this on the website that the Trust is aware of this and will do something about it. MA said that he will find out from Helen Elkington what we do about this. **MA to check with Helen Elkington.** **MA**

SM feels that the PEAT work needs more publicity. There is information on the website but it is hidden. RMC said she thought that this had been moved now to the patients and visitors section. She added that there was an article in Trust news in August.

WMW said that some people are concerned about infections they may acquire while in hospital. RMB said there is an article in July edition of news on this.

WMW said she talked to a couple of mums one of which had her second baby at the Chelsea and Westminster Hospital. She said that they reported that the care on the pre natal ward was very good and during the delivery. However, they were disappointed with care provided in the post natal ward. MA responded that the reason for this might be if other wards are short of staff they take nurses from the post natal ward.

CM said that the Trust aims to achieve 90% on PET for 2010/11 specifically in the post natal wards so the Trust did recognise that this was a problem.

8 Any other business

None.

9 Date of next meeting – 3 September 2010

The next meeting of the Quality Sub-Committee will be held on 3 September 2010 at 3pm.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Quality Sub-Committee, 19 May 2010

Minutes

Attendees	Carol Dale	CD	Staff Governor – Management
	Martin Lewis	ML	Public Governor – Westminster 2
	Susan Maxwell	SM	Patient Governor
	Wendie McWatters	WMW	Patient Governor
	Sandra Smith Gordon	SSG	Public Governor – Kensington & Chelsea 2
	Mike Anderson	MA	Medical Director, Chairman
	Andrew MacCallum	AMC	Director of Nursing
	Catherine Mooney	CM	Director of Governance and corporate Affairs
	Vida Djelic	VD	Interim Foundation Trust Secretary

1 Welcome and Apologies

MA said that AMC was leaving the Trust at the end of the month and that Therese Davis will be the Interim Director of Nursing.

MA said he was very sorry to note the death of Jim Smith and he acknowledged Jim's extensive and valuable contribution to the sub-committee.

MA informed the sub-committee that Chris Birch had resigned from the Quality Sub-Committee. However, he will remain active on the Council of Governors and the Membership Sub-Committee.

Apologies were received from Cyril Nemeth.

2 Minutes of previous meeting 26.3.10

Minutes were approved as a true and accurate record of the previous meeting with the following changes:
- p.2 delete 'the' before draft 3
- p.4 re indicators: SM was actioning indictors 1&6, not indicator 2
- p.4, 2nd para: add an action relating to JS requesting the discharge summary to be an indicator for the next year, and the suggestion that a governor is involved in a discharge group.

3 Matters arising

5/Mar/10 Quality Accounts Briefing
CM said that HC had advised her that the Discharge Group is to be refocused and terms of reference to be revised. This will be done in June. CM said she will speak with HC how to best approach this. It was

suggested that the sub-committee look at the draft Terms of Reference and send any comments to HC. **CM to circulate draft Terms of Reference for the Discharge Group.** **CM**

6/Mar/10 Feedback from Governors on patient experience
This will be discussed later in the meeting.

4 Quality Account progress and next steps

CM said that the Quality Account has been finalised and thanked the sub-committee for their valuable input. The Quality Account has been sent to the PCT for comments and the deadline for response is Friday, 21 May 2010. It will go to the Board next week for approval. It was suggested that CM sends the final quality account to the sub-committee. **CM to send the final Quality Account to the sub-committee.** **CM**

Part of the quality account process required us to do a quality improvement plan which was approved by the Board at the last meeting.

CM said that the Quality Report will be sent to Monitor on 6 June 2010 and needs to be published on the NHS Choices website before 30 June 2010.

AMC suggested that we produce an easy read version or executive summary to share with staff and patients. CM added that this was discussed before and CD had suggested a cartoon approach like the productive ward. CM suggested that we invite Matt Akid to help with a communication strategy at the next meeting. **CM to invite Matt Akid to the next meeting of the quality sub-committee to assist with a communication strategy for the Quality Account.** **CM**

5 Quality priorities – governors input

MA said that the quality priorities were divided into three sub-headings of safety, effectiveness and experience. He added that it would be useful to get some help from governors with implementing the objectives.

5.1 Patient Experience

AMC outlined the key areas in the patient experience paper. It provides an update on the Trust's position regarding the Patient Experience Tracker (PET) and the results of the inpatient survey.

AMC drew attention to section 3 and the National CQUIN questions. The main issues are patient involvement in decisions about treatment and being able to talk about condition, side effect of medicines and who to contact when leaving the hospital.

CM said that the Trust aims to be above the national average on the three questions in the inpatient survey and clarified that the lower the score the better the Trust performance.

AMC said he had seen the results of the inpatient survey and the main points picked up were noise at night from patients and lack of information throughout the hospital about washing hands. He said that we were offering ear plugs and eye masks. The capital programme contains provision for putting glass partitions in.

AMC concluded that some more work needs to be done on this.

CM invited the sub-committee to discuss the medication question and how we might tell patients about medication they are about to take.

The sub-committee discussed some ideas and the main points included:

- A pharmacist could highlight side effects on the patient information leaflet (PIL) before giving medication to patient
- Patients attention needs to be drawn to read the PIL
- Patients to be provided with a card which would contain details of where to report, if there are any side effects
- Texting facility e.g. 'do you need further information about your drugs'
- The label on the box to say 'read leaflet inside'

ML asked if we could look at areas which do well e.g. the Royal Marsden Hospital (RMH). CM pointed out that side effects of chemotherapy were very significant and it would be expected that there would be focus in this area. AMC added that we are going to be assessed on this over the next two months as the survey is undertaken in September.

5.2 Falls

CM outlined the Trusts' priority to reduce the incidence of falls resulting in moderate or major harm by 25% in 2010/11. We decided not go for a reduction in total numbers of falls as we do not want to discourage people from reporting and AMC felt that serious falls are reported.

AMC said that the caveat is that every fall is significant to the reputation of the hospital and to patients. CM said we had analysed falls and approx 10%-30% result in harm to the patient of which 1 in 10 injury is moderate or serious. In the Mid Staffordshire Report it was identified that there were no preventable measures on falls.

ML asked if the Trust has a falls coordinator. AMC responded that there is a Falls Group and we have changed the reporting lines to give the group a higher profile.

CD commented that moderate and major harm has been static over the last five years.

CM said we recognise that falls are the most reported safety incident nationally. We will be setting up a standing panel for the investigation of falls which will allow consistency in investigation and ensure that learning is embedded. MA added that falls are age related so older patients are more likely to fall. AMC added that there is a connection between going to the toilet quickly and falls. Most of falls occur over the day time between 8am and 10am. Some wards have a footprint of the ward showing where falls occur.

5.3 VTE prevention

CM said that governors can help by advising us on how to get the importance of this across to patients. She suggested a message being

displayed on the screens in the hospital. WMW suggested that information about VTE should be given out to patient at the point of discharge. MA said that we are looking at preventing VTE and treating it when it does happen.

SM asked for clarification of term 'preventable'. MA responded that some VTEs are not preventable e.g. a blood disorder. CM added that if there is a VTE we will undertake a root cause analysis to help us identify areas where we can make improvements to prevent VTE in other patients.

SSG commented that 25,000 death rate from preventable VTE contracted in hospitals seemed a huge number.

SM suggested we produce a leaflet which would request patients to advise GPs if they experience any symptoms of VTE. MA said that in the new pre-operation assessment area they use a leaflet. WMW said that the leaflet should be simple and easy to understand so that we get the message across to patient. MA said there are a number of things to get through and it is a challenge.

CD commented that the rate of 83% of patients who were offered an information leaflet on DVT and PE at the pre-assessment clinic needed to increase.

MA said we have also designed an electronic VTE risk assessment for use with adult inpatients which highlights what preventable treatment may be required, supported by an electronic prescribing alert which appears if an at risk patient has not been prescribed preventative therapy.

CM concluded that the Trust will monitor cases of preventable VTE bi-monthly and rates of VTE risk assessment completion for all adult patients monthly. We will audit on a regular basis whether appropriate preventable treatment is being provided.

CM to circulate leaflet. **CM**

6 Feedback from governors on patient experience

The sub-committee discussed feedback collated and the main points raised were:

- Long waits for the porter, and patients can get cold. Blankets would be helpful
- Nurses being not very helpful and being off hand
- Night noise
- Lifts not working
- Porters using main lifts and not lift by A&E
- Wonderful food
- Discharge waiting time and no notice as to how long it takes
- Waiting time for drugs

AMC said we will do something about the porter, lift and blankets and these issues will be discussed at the PEAT meeting the next day. **AMC**

CD reported that she has not been close to any patients recently and that she will report at the next meeting. AMC suggested that this could

be a standing item.

CM asked how we monitor response times of porters. AMC responded that it could be at the PEAT inspections as it is specific department.

ML reported that he received a positive feedback from a friend who said that the hospital care was very good. However, she had to make her own way home after having an operation on her shoulder.

SM said she thinks there is a problem about empowering patients to complain. They feel that complaining may affect their care.

7 Any other business

None.

8 Date of next meeting – 9 July 2010

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting 21 July 2010

AGENDA ITEM NO.	2.5/Jul/10
PAPER	Patient Experience
AUTHOR	Jane Tippett, Acting Assistant Director of Nursing
LEAD	Therese Davis, Interim Director of Nursing
EXECUTIVE SUMMARY	All NHS Trusts are required to undertake an annual Inpatient Survey. Elements of the survey are used by the Care Quality Commission as part of its annual assessment of NHS Trusts. The annual Inpatient survey 2009 was undertaken in September 2009. A total of 850 questionnaires were sent to patients at home following their stay in Hospital in August 2009. The survey had a response rate of 42% (average 48%). 90% of respondents rated their overall care they received as good, very good or excellent. In comparison to the other 73 Trusts surveyed by the Picker Institute the survey showed that Chelsea and Westminster Hospital is: Significantly BETTER than average on 18 questions Significantly WORSE than average on 10 questions The scores were average on 64 questions For 2010/11 our objectives will focus on improving responsiveness to the personal needs of patients. Our target is to be above the national average on five questions from the inpatient survey. These have been chosen as national indicators as part of the Commissioning for Quality and Innovation (CQUIN) payment framework.
DECISION / ACTION	For information

Council of Governors Report on the 2009 Inpatient Survey

1.0 Introduction

1.1 All NHS Trusts are required to undertake an annual Inpatient Survey. Elements of the survey are used by the Care Quality Commission as part of its annual assessment of NHS Trusts.

1.2 A key objective for the Trust in 2009-10 was to achieve a progressive improvement in key issues identified in the annual NHS patient's survey relating to communication, information and customer service.

1.3 The 2009 Inpatient Survey shows that the Trusts position has improved in relation to the 2008 survey however it remains average for most questions asked in the survey.

1.4 90% of respondents rated their overall care they received as good, very good or excellent.

2.0 2009 Inpatients Survey Overview

2.1 Picker Institute Europe was commissioned to conduct the Trust's 2008 Inpatient Survey. The survey is based on a sample of patients discharged from the Trust between June and August 2009.

2.2 A total of **850** patients were sent a questionnaire in September 2009 of which **345** patients returned completed questionnaires; a response rate of **42%**. The average response rate for Trusts surveyed by Picker Institute Europe was **48%.**

2.3 The questionnaire contained 92 questions in 9 sections:

1. Admission to Hospital
2. The Hospital and Ward
3. Doctors
4. Nurses
5. Your Care and Treatment
6. Operations and Procedures
7. Leaving Hospital
8. Overall (view of hospital admission)
9. About You

3.0 How Do We Compare To The Other 73 Trusts Surveyed By The Picker Institute?

3.1 The survey showed that Chelsea and Westminster is:

Significantly BETTER than average on	18 questions
Significantly WORSE than average on	10 questions
The scores were average on	64 questions

3.2 The questions we are significantly better than the national average are shown in Table 1. **Lower scores reflect better performance.** Comparisons, with previous results in 2008 are included.

Ref	Question	2009	Avg	2008
A10	A&E Department: not enough/too much information about condition or treatment	16%	22%	18%
A11	A&E Department: not given enough privacy when being examined or treated	14%	22%	23%
A13	Planned admission: not offered a choice of hospitals	53%	61%	
A17	Planned admission: not given choice of admission date	46%	60%	48%
A22	Admission: had to wait a long time to get to a bed on ward	25%	30%	29%
B2	Hospital: shared sleeping area with opposite sex	13%	18%	20%
B14+	Hospital: nowhere to keep belongings safely	53%	63%	62%
C1+	Doctors: did not always get clear answers to questions	23%	31%	29%
C2	Doctors: did not always have confidence and trust	15%	19%	20%
C3	Doctors: some/none knew enough about condition/treatment	7%	11%	12%
E2	Care: wanted to be more involved in decisions	40%	46%	49%
E4+	Care: not enough opportunity for family to talk to doctor	46%	55%	53%
E7	Care: not always enough privacy when being examined or treated	8%	11%	13%
G1	Discharge: did not feel involved in decisions about discharge from hospital	33%	39%	39%
G5	Discharge: not given completely clear written/printed information about medicines	21%	30%	32%
G13	Discharge: did not receive copies of letters sent between hospital doctors and GP	31%	42%	36%
G14	Discharge: letters not written in a way that could be understood	17%	26%	
H3	Overall rating of care fair or poor	5%	7%	6%

Table 1: Questions where the Trust is significantly better than average for 2009

3.4 The questions we are significantly worse than average are shown in Table 2. The Trust scored significantly worse in only 10 questions compared to 25 in the 2008 survey. Again comparisons with 2008 are shown.

Ref	Question	2009	Avg	2008
B7+	Hospital: patients using the bath or shower who shared it with the opposite sex	27%	21%	34%
B9	Hospital: bothered by noise at night from other patients	46%	39%	47%
B12+	Hospital: toilets not very or not at all clean	11%	7%	12%
B15	Hospital: no posters or leaflets asking patients to wash their hands or use hand-wash gels	8%	4%	
B16	Hospital: bothered by other patients' visitors	19%	13%	
B18+	Hospital: food was fair or poor	51%	44%	53%
B21+	Hospital: patients did not get the food they ordered	33%	26%	
D2	Nurses: did not always have confidence and trust	35%	27%	40%
D5	Nurses: some/none knew enough about condition or	24%	18%	26%

	treatment			
G2	Discharge: was delayed	47%	39%	47%

Table 2: Questions *where the Trust is significantly worse than average for 2009*

A number of these questions relate to work overseen by both the Nursing and Midwifery Advisory Committee (NMAC) and the Patient Environment and Action Team (PEAT) Committee. In 2010 we:

- Undertook a survey (March 2010) of 134 adult inpatients and found that only 8% of patients had used a bathroom/ shower used by a member of the opposite sex
- Are installing glass panelling on 12 wards to reduce noise and improve privacy and dignity (August 2010)
- Are reminding staff to offer eye masks and ear plugs to patients on admission to the ward

4.0 Have we improved since the 2008 Survey?

4.1 A total of 79 questions were used in both the 2008 and 2009 surveys. Compared to the 2008 survey Chelsea and Westminster is:

Significantly BETTER on	16 questions
Significantly WORSE on	0 questions
The scores show no significant difference on	63 questions

4.2 The questions we improved significantly on compared to the 2008 results are shown in Table 3.

Ref	Question	2009	2008
A11	A&E: not given enough privacy when being examined or treated	14%	23%
A19	Planned admission: not given printed information about the hospital	23%	36%
A20	Planned admission: not given printed information about condition or treatment	26%	36%
B2	Hospital: shared sleeping area with opposite sex	13%	20%
B3	Hospital: patients using bath or shower area who shared it with opposite sex	27%	34%
B14+	Hospital: nowhere to keep belongings safely	53%	62%
B20	Hospital : not offered a choice of food	19%	26%
C1+	Doctors: did not always get clear answers to questions	23%	29%
C2	Doctors: did not always have confidence and trust	15%	20%
C5	Doctors: some/none knew enough about condition/treatment	7%	12%
D1+	Nurses: did not always get clear answers to questions	38%	45%
D3	Nurses: talked in front of patients as if they were not there	25%	33%
E2	Care: wanted to be more involved in decisions	40%	49%
E7	Care: not always enough privacy when being examined or treated	8%	13%
H14	Overall: worried about security of personal information held by the hospital	6%	11%
H7	Overall: no posters/leaflets seen explaining how to	37%	46%

	complain about care		

Table 3: Questions where the Trust has improved significantly since 2008

4.3 In response to the overall care and Treatment, 75.9% of respondents said they had always been treated with respect and dignity while 90% of respondents rated their overall care they received as good, very good or excellent.

5.0 Action that has been taken since the 2008 Survey

5.1 During 2009 the Trust introduced real time patient surveying to complement the inpatient survey. Information and communication with patients were identified as issues in six of the ten questions in the Inpatient Survey 2008. As such, it was decided that the five questions on the Patient Experience Tracker (PET) for the adult wards would focus on questions relating to communication including seeking the views of patients on the overall quality of care they have received.

5.2 Whilst the introduction of the PET only started in June 2009 it is encouraging to see that the Trust scored well in terms of involving patients in decisions about their care as well as being asked to give their views on the quality of their care in the 2009 survey. These results are shown in Table 4.

PET	Ref	Question	2009	Avg	2008
1.	E3	How much information about your condition or treatment was given to you?	18%	21%	18%
2.	E2	Were you involved as much as you wanted to be in decisions about your care and treatment?	40%*	46%	49%
3.	C1+	When you had important questions to ask a doctor, did you get answers you could understand?	23%*	31%	29%
	D1+	When you had important questions to ask a nurse did you get answers that you could understand?	38%	35%	45%
4.	C3	Did doctors talk in front of you as if you were not there?	24%	27%	29%
	D3	Did nurses talk in front of you as if you were not there?	25%	23%	33%
5.	H3	Overall, how would you rate the care you received?	5%*	7%	6%
	H6	During your hospital stay, were you ever asked to give your views on the quality of your care?	75%	79%	77%

Table 4: Improvements on information and communication

5.3 In all the above areas we either performed above the national average or made improvements on the 2008 result. For the questions (*) we are statistically significantly better than the national average.

6.0 Commissioning for Quality and Innovation (CQUIN)

6.1 A proportion of the Trust's income is conditional upon achieving quality goals agreed with our host commissioner, NHS Kensington and Chelsea, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

6.2 In May 2010 five questions from the Inpatient survey were chosen as national CQUIN indicators for 2010-11, as detailed in Table 5.

1.	Have you felt involved as you wanted to be in decisions about your care and treatment?	Yes definitely	Yes to some extent	No	
2.	Have you had the opportunity to talk to someone about any worries or fears?	Yes definitely	Yes to some extent	No	I have no worries or fears
3.	Have you been given enough privacy when discussing your condition or treatment?	Yes always	Yes sometimes	No	
4.	Have you been told about medication side effects to watch out for after you leave hospital?	Yes completely	Yes to some extent	No	I did not need an explanation
5.	Have you been told who to contact if you are worried about your condition after you leave hospital?	Yes	No		

Table 5: National CQUIN indicators 2010-11

6.3 Currently, only the first question is on the Inpatient PET device. However between April-June 2010, 1785 patients have given feedback on this question recording an overall satisfaction score of 85%.

6.4 In order to improve on our results from the 2009 survey we are changing the questions on thirteen of the PET devices in the adult inpatient wards to match the five selected questions.

6.5 These results will be fed back weekly to all ward staff to monitor progress towards improving our results in the 2010 Inpatient survey.

7.0 Next Steps

7.1 The Interim Director of Nursing will review the results with both the Patient Experience Steering Group (PESG) and the Patient Experience Improvement Group (PEIG) to track progress against the improvement plan (Appendix I).

NB. The full report of the Inpatient Survey 2009 can be requested from both Sian Nelson Membership and Engagement Manager at sian.nelson@chelwest.nhs.nhs.uk or Jane Tippett, Acting Assistant Director of Nursing at Jane.tippett@chelwest.nhs.uk

Appendix I

CQUIN Patient Experience Improvement Plan 2010-11

CQUIN: To improve our inpatient survey results in five key areas of care focusing on responsiveness to personal needs
(*note the lower score the better the result)
Our composite score for 2009 is 66.2% for the five questions. Our aim for 2010-11 will be to achieve a maximum score of 67.9%.

From July 2010 five questions will be placed on the Patient Experience Trackers (PETS) in the Adult Inpatient Ward areas

Aim	Trust score 2009*	National Average 2009*	PET satisfaction score (Target 90%)	Actions	Lead(s)	When
1. Patients are involved in decisions about treatment and care	40%	46%	April-June 2010 85%	1. Ward Sisters/Charge Nurses to continue to receive weekly feedback results from Dr Foster and discuss with team 2. Weekly and Monthly reports discussed at Divisional meetings and Quality Committee	Lead Nurses Divisional Directors/Clinical Leads	Weekly reports Monthly
2. Patients are able to find someone to talk about their worries and concerns	59%	57%	From July 2010	1. Lead Nurses and Clinicians to advocate the need for all staff to ask patients about worries or concerns 2. Actions 1& 2 for Question 1 to be implemented from July 2010	Lead Nurses and Matrons /Clinical Leads	Daily rounds
3. Patients are given enough privacy when discussing their condition or treatment	27%	29%	From July 2010	1. Effectively communicate positive feedback from Inpatient results at Ward and departmental Level meetings and sustain through positive role modelling	Lead Nurses/ Clinical Leads	Daily rounds

				2. Staff are aware of and use the Trust Privacy and Dignity Guidance 3. Actions 1& 2 for Question 1 to be implemented from July 2010		
4. Patients are told about medication side effects to watch out for when they go home	48%	47%	From July 2010	1. Medicines Management Technicians discuss side effects with patients on admission 2. Adapt pharmacy medicines information card to include questions about side effects and contact number 3. Actions 1& 2 for Question 1 to be implemented from July 2010	Vanessa Marvin	Daily June 2010
5.Patients are informed who to contact if they are worried about their condition once they leave hospital	24%	22%	From July 2010	1. Nursing staff to clarify with patient before they leave hospital that they know who to contact if worried or concerned 2. Review of Leaving Hospital/Discharge booklet to include space for contact details 3. Actions 1& 2 for Question 1 to be implemented from July 2010	Lead Nurses Paul Morris	Monthly October 2010

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 21 July 2010

AGENDA ITEM NO.	2.6/Jul/10
PAPER	Minutes of the Council of Governors Membership Sub-Committee meetings held on 8 July (draft) and 13 May 2010 (approved).
AUTHOR	Vida Djelic, Interim FT Secretary
LEAD	Chris Birch, Chairman
EXECUTIVE SUMMARY	Minutes are enclosed.
DECISION/ ACTION	To note.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Membership Sub-Committee, 8 July 2010

Draft Minutes

Attendees	Chris Birch	CB	Chairman
	Susan Maxwell	SM	Patient Governor
	Charlotte Mackenizie Crooks	CMC	Staff Governor
	Wendie McWatters	WMW	Patient Governor
	Sandra Smith-Gordon	SS-G	Public Governor – Kensington & Chelsea 2
In attendance	Renae McBride	RM	Editor of Trust News/Communications Manager
	Sian Nelson	SN	Membership and Engagement Manager
	Cathy Mooney	CM	Director of Governance and Corporate Affairs
	Jane Tippett	JT	Acting Director of Nursing
	Vida Djelic	VD	Interim FT Secretary

1 Welcome and Apologies **CB**

Apologies received: Matt Akid, Therese Davis, Interim Director of Nursing and Martin Lewis.

2 Minutes of previous meeting held on 13 May 2010 **CB**

Minutes of the previous meeting were accepted as a true and accurate record of the meeting with the following changes:
- add CM to the list of apologies
- p.3 remove sentence that starts: 'WMW said that she had asked a friend ….'
- p.4 should read 'Westminster School' instead of 'West Boys School'
- p.6 should read a 'Red Cross official' instead of 'friend'
- p.7 remove sentence that starts: 'SN this feeds…'
- p.8 insert correct number of attendees at the Open Day to read '1,500'

3 Matters Arising **CB**

4/Apr/10 Membership Development and Communications Strategy
SN said that this action has been completed. The second part of the action which refers to publishing a list of patient forums on the website is not completed yet but will be done once the patient experience site has been developed.

SN said that she has updated the Membership Development and Communications Strategy.

5/Apr/10 Membership Development Work Plan Review
1.Information Zone

SN said she has circulated to governors the timetable for joining the sessions in the Information Zone.

2. Seasonal Working Conference
SN said that the Seasonal Working Conference was postponed till November and that as soon as the date has been set up she will let governors know.

3. Patients Forums
SN to recircualte a list of patient forum dates.

4. Recruitment Campaign
SN said that she has received details of a Red Cross official from SM and will get in touch.

4 Foundation Trust Membership communications **RMB**

WMW drafted a paper with some ideas on communications which was circulated at the start of the meeting.

RMB introduced the paper on the Foundation Trust membership communications which was drafted by Matt Akid and outlined the main functions of the Communications Department.

She said that they try to link their activities to support the main corporate objectives.

Membership communication activity include:
- Annual Members' Meeting
- Open Day
- Membership mailings
- Ad hoc mailings
- Website
- Leaflets

In terms of budget the Council of Governors supports a number of projects i.e. Trust News (£6,000), Membership Recruitment Leaflet (£1,275), Open Day (15,000), etc.

RMB invited governors views on future communications activities.

SM noted that the members' mailings are sent to governors by 1st class post and they should be sent by 2nd class in order to save some money. RMB to ensure that the future mails are sent by 2nd class post.

WMW congratulated Matt Akid, George Vasilopoulos and RMB for working hard on the communications. She said she had a concern about trying to raise the profile of hospital in media. She felt that the next time the mobile clinic goes out we would need a good media coverage and promote what we do.

WMW said the Open Day is an excellent event and it deserves lot of media coverage.

RMB said that the projects and stories which are big get publicised. She

said that Jonathan Street PR provides out of hours help and deals with queries.

CM added that this was a sample list and that the Council of Governors also supports other initiatives e.g. the directory of services.

5 Chelsea and Westminster Hospital NHS Foundation Trust Website

CM said the Trust's website needs to be reviewed formally and suggested we form a small sub-group to go through the information on the website and what we include.

One reason for doing this was as we had a complaint from a lady who was keen to stand for elections and become a member of the Trust but claimed she could not find relevant information on our website. CM felt that there was some validity in her concerns and wanted to see them addressed.

SS-G, SM and CB volunteered to be a part of a sub-group which will look at the website.

CM to set up a meeting. **CM**

6 August/September Trust News – ideas **RMB**

RMB said that we want to make the Trust News more public and patient focused than staff oriented. It will contain 16 pages with the special 8 –page Year in Review – highlights and key stories.

Key stories would be as follows:
- AMM – come and join us
- an article focused on the Council of Governors, who they are and what they do
- 60 sec interview with one governor
- Desert Island disks - chairman
- An article on research and development being carried out in the Trust
- Putting patients first (outpatient development and RBKC streetscape improvement
- Meet the team Norland (services they provide for the Trust)

CB suggested a couple of articles about governors i.e. what they like, what surprise them and their personal experience as a governor.

SM suggested an article about empowering patients.

RMB invited some governors to volunteer and write articles.

WMW suggested that we take a photo of governors in the info zone while doing governor's surgery.

VD said that she has organised with George Vasilopoulos a group photo of the Council of Governors to be taken prior to the meeting on 21 July.

There was also a suggestion to have a title 'ask the governor' and 'tell the governor'.

CM said we need an article on the Trust's objectives and try to target this towards patients. RMB said she thought this was already covered.

SS-G suggested a mini profile of governors to be included. However, this would need to be styled slightly differently from what we already have published on the website. She volunteered to help with this.

CB and SM offered to write an article for the August/September issue on empowering patients.

7 Membership Development and Communications Strategy Work Plan Review **SN**

1. Information Zone
SN said that this item was discussed earlier in the meeting. She needs to put forward to the Council of Governors request for funding. CB said that the Membership Sub-Committee would like to see this before going to the Council. **SN to send the costing to the sub-committee by e-mail.**

2. Seasonal Working Conference
CB said we mentioned earlier in the meeting that the Seasonal Working conference has been delayed till November and SN will be in touch with the date.

3. Patient Forums
SN has circulated dates to governors and will recirculate them as some governors have not received them. The dates will also be published on the patient experience website when it gets created.
SN to recirculate patient forums dates.

4. Recruitment campaign
CB said there was no need to put scarce resources into recruiting in the two areas (K&C 2 and H&F 2) where Trust membership is already more than 1% of the population and that we should focus on one or two of the other public areas and on patients. CB said that it should not be very difficult to recruit patients as all patients would get a membership leaflet with their discharge leaflet. CB commented that when he got discharged from the hospital recently he did not get the discharge leaflet. SN said we need to raise this with staff on the wards. **JT to raise it with staff on the wards.** **JT**

WMW said that also the PET should be offered to all patients as she was not offered it when she recently stayed in the hospital.

5. Bi-annual membership mailing
This item was discussed earlier in the meeting.

6. Email communication with members
SN said we consulted members on the abolition of the congestion charge zone via e-mail.

7. Website
This item was discussed earlier in the meeting.

8. Council of Governors Elections
This item was discussed earlier in the meeting.

9. Staff Constituency
CB said Carol Dale is the only staff governor who organised a meeting with members of her constituency.

We also had a survey which worked very well. We will ask the Quality Sub-Committee to promote quality. JT suggested we could have an article in the Trust News regarding governors contribution to quality.

10. Reaching underrepresented groups in the membership
SN said that during the Notting Hill Carnival, we would have the mobile health clinic at Lighthouse West London to offer screening services. It costs £450 to use the mobile bus for the half of day and we will need to put a request to the Council of Governors for funding.

SN said she received some suggestions from governors as to which areas the mobile bus should be taken to and these were: Portobello Road in North Kensington, Battersea High Street Market, the North End Road Market in Fulham, etc.

11. Young Persons Membership Group
SN said the Human Resources department tried to encourage a group of students to contribute to their local Trust and invited them to assist the HR department. They were given a brief regarding the membership of Trust and asked them to think how they can contribute to the membership and potentially come up with a case for lowering the age.

A second group of young people were taken to the paediatric outpatient area. They were given a report from one of the PETs and asked to look at it. They have not completed it yet but they will get back in September and meet with the matron in the paediatric department. Maralyn Kay will facilitate how to improve the patient experience.

CM said it would be very helpful to know how Foundation Trusts like Great Ormond Street Hospital and Birmingham Children's Hospital deal with young patients and we should do this in parallel with the engagement work with young people.

SN

SN to follow up on young people membership.

12. Quality Accounts
SN said she will be meeting with LINKS tomorrow.

13. Members with Learning Disability
SN said that Learning Disability membership leaflet has been published on the website.

14. Service Development
SN said that all members have been consulted on the abolition of the congestion charge zone.

The sub-committee agreed that Brian Gazzard should be removed from the list of named personnel as he is not named in the document. **SN to update the list of named personnel.** **SN**

8 Meet the Governors information booklet – ideas **RMB**

RMB said that there have been some discussions around developing a governors' booklet.

CM suggested that we consult governors about information they would want to be included i.e. tel number, contact details, profile, etc.

RMB to contact governors. **RMB**

9 New Governors elections report and induction **VD**

VD said that the purpose of the paper was to update the sub-committee on results of elections held for the Council of Governors on 28 June 2010. She noted that there are still 4 vacancies on the Council of Governors, out of which 3 are elected governors and 1 appointed.

She said that she will be organising induction for new governors on 12 July and had provided a copy of the induction programme delivered in November 2009. She also provided the results of feedback she received following induction and said that the overall comments were very positive and that some governors felt the induction was long and there were some suggestions to spit it in two or thee parts. VD confirmed that this has been considered for induction in July.

CM said that we had provided a copy of the previous programme with annotations and minutes from a sub-group meeting which was held in order to devise a programme for induction in November 2009 so that the sub-committee can be reassured we delivered what we were asked and what we promised.

WMW suggested the idea of having a 'mentor' who would be a governor from the same constituency as a way of an experienced governor guiding a new governor. SS-G said she would be happy to mentor Eddie Adams, the new governor for Kensington and Chelsea Area 1, and CB said he would be happy to mentor Paul Baverstock, the new patient governor if Paul wanted to be mentored.

SS-G also suggested that an audit of governors' skills would be a useful addition to the Council's ability to function effectively. This might also show gaps in governors' knowledge that could benefit from some training.

VD to arrange mentoring. **VD**

VD to look into a skills audit. **VD**

10 Any Other Business

None.

11 Date of next meeting

The next meeting will be held on 2 September 2010 at 4pm.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Membership Sub-Committee, 13 May 2010

Minutes

Attendees	Chris Birch	CB	Chairman
	Martin Lewis	ML	Public Governor – Westminster 2
	Susan Maxwell	SM	Patient Governor
	Wendie McWatters	WMW	Patient Governor
	Sandra Smith-Gordon	SS-G	Public Governor – Kensington & Chelsea 2
In attendance	Renae McBride	RM	Editor of Trust News/Communications Manager
	Sian Nelson	SN	Membership and Engagement Manager
	Andrew MacCallum	AMC	Director of Nursing
	Vida Djelic	VD	Interim FT Secretary

1 Welcome and Apologies **CB**

CB said that his term of office as a governor had expired but that he was standing for re-election and asked the sub-committee if it was happy that he should chair the meeting. The sub-committee agreed that he should.

Apologies were received from Matt Akid, Priti Bhatt, Jane Tippett, Cathy Mooney and Matthew Whiting.

CB said that Jim Smith sadly died. The sub-committee paid tribute to Jim's valuable contributions to the membership sub-committee.

2 Minutes of previous meeting held on 8 April 2010 **CB**

Minutes of the previous meeting were accepted as a true and accurate record of the meeting. SS-G suggested that in the section regarding any other business instead of reading 'running elections' it should read 'announce elections'. **VD to amend the minutes in line with the comment received.** **VD**

3 Matters Arising **CB**

4.2/Jan/10 Welcome Pack Letter
SN handed out to the sub-committee an updated version of welcome pack letter and invited any comments.

4/Apr/10 Membership Engagement
SN said that she will circulate a copy of patient forums timetable to the sub-committee.

SN said that the updated development work plan is on the agenda and it will be discussed later in the meeting.

4 Membership Development and Communications Strategy **SN**

SN said that the Membership Strategy was originally written in June 2008 and it was revised in June 2009. She outlined the main points of the strategy plan and said that the strategy was updated following the last meeting of the sub-committee on 8 April 2010. It encompasses the size of membership, aiming to maintain the size and focuses mainly on the engagement.

WMW queried p.4 of the draft sub-committee minutes stating that there is steady decline in the membership figures and SN now saying that we do not necessarily need any new members. AMC responded that the overall membership numbers were boosted last year because of opt-out system for staff members. We will have to keep the membership number steady in terms of joiners and leavers.

SN said we are underrepresented in the public constituency Wandsworth Area 1. The most important point to work out is how to encourage people to join. She said that one way of achieving this would be by using the community mobile bus extensively.

SN said we had also previously discussed young persons' membership as an area of underrepresentation. This is described on p.4 of the strategy under age profiles and we need to explore the possibilities of how to engage with them.

On p.6 point 5.3 regarding maintaining membership communications strategy we need to further engage with members. We need to do some additional work so that public governors work with their members and encourage patient governors to join patient forums. SN will be sending timetable and invite governors to join. SS-G suggested that this should also be published on the website so that those members who are interested can attend. **SN to circulate.**

SN we should be getting results of the e-mail update via trust news from Capita (a membership company). This is included in the work plan.

SN

CB said that this is the third version of the membership strategy. The first version was huge and Catherine Mooney succeeded in cutting it down significantly.

CB said maintaining membership is the key. We lost 749 members in just two years. He concluded that in order to keep the membership numbers steady we need to recruit new members. Monitor does not set a target but the general view is 1% of the general population.

CB compared the previous version of the strategy with the current one and said that from page 3 onwards the new version was identical with the old version except where it should not be the same, e.g. on page 5 PALS should be M-PALS, on page 6 it should be Annual Members' Meeting not AGM, on page 7 it should be Council of Governors not Members' Council and Membership Sub-committee not Communications Sub-committee.

CB further suggested that 'June 2009' be deleted from the cover page and 'April 2010' be changed to 'May 2010'. He also pointed out that something

had gone wrong with the printing of the document and that appendices 1, 2, 3 and 10 were missing as were all of the diagrams.

CB asked the sub-committee to approve the above changes. The sub-committee agreed. **SN to update the current strategy.**

SS-G suggested a date in the footer section should be inserted so that it is easier to keep the track of any changes.

SN

WMW had a view that in order to encourage young people we need to think of an incentive. We will also need to be imaginative as it is likely that they are not interested in the Annual Members Meeting and the Council of Governors meetings. They are media aware and we all together need to think how to attract them to become members while they are young.

SN added that the mobile bus in terms of publicising the hospital might be a possibility. We can organise a mini Notting Hill carnival and WMW could help with getting some ethnic minority musicians to it. We would also need a good media coverage.

SN responded that we have booked the mobile bus for the carnival where there will be sexual health screening offered and also the plan to recruit some members but it will not be the main focus. ML said that he has been expressing his views on the lack of black minority representation over the long period of time and that the carnival might be an opportunity.

WMW queried whether we will target general or specific social groups. She said that the Carnival is too big to achieve what we want and suggested going to the housing estate or Portobello Road might be better idea.

CB said he gathered from the draft minutes of the Council of Governors meeting held on 21 April, which he did not attend as he was admitted to the hospital, that Frances Taylor opposed to the idea of our participation in the Notting Hill Carnival. SN said that the mobile bus will go to the Carnival and that we will offer health services and recruit at the same time which will be in tune with the event. SN suggested we have tables and chairs around the mobile bus so that we can have an informal chat with those interested in services and also provide information. CB and ML said that they would be attending to help.

WMW suggested considering that we have a huge paediatric development we may want to publicise it and possibly get a tea party for media spotlight.

SN we have project with the Westminster School. If it was successful, it could be taken to other schools.

CB invited any general points. None were raised.

5. Membership Development Work Plan Review **SN**

CB introduced the work plan and pointed out that the sub-committee agreed with its objectives. He said that in the previous version the action column was weak and it needed more substance.

AMC said all the actions will need to be delivered and it is also important to capture any important points raised by the governors. We need the governors to complete the patient survey to contribute to the engagement plan. We collate some ideas from the sub-committee and we will then action them.

SN outlined the work plan.

AMC asked for feedback from the Open Day and how governors found the Information Zone. SS-G responded that some governors did not seem as open to visitors as she would hope. There was a view that some governors were very helpful.

WMW asked some friends to attend in order to collate some feedback. Generally the music was excellent and one friend was marginally disappointed. She was invited to join the Trust. SSG said that she finds that people do not know what the Trust is. There is also Friends Office and there were some representatives from LINKs. The view was the people find it confusing who does what. Membership forms were distributed and only 4 returned.

1. Information Zone

SN said that we plan to develop drop in sessions for the current and potential members to meet Governors in the Information Zone. CB suggested a board in the Information Zone with the times that governors would be there and SN to identify the times suitable to governors. AMC suggested that the surgery dates could be linked to the patient forum in order to get more people attending. **SN to liaise with governors regarding the timetable and to publish information in the Information Zone.** **SN**

There was a discussion about targeting diabetes, rheumatism, the arts, getting a lecturer and having 15 mins presentation on the chosen subject to governors with the possibility to advertise it to other members.

2. Seasonal Working Conference

It was suggested that 1 to 2 governors could be present at the stand at the Seasonal Working Conference for Hospital Staff to discuss the membership and help staff link in the issues raised at patient forums.

AMC welcomed the idea and said the next conference will be held in July 2010. It was agreed that SN will invite governors to attend the conference and confirm the date.

SN to invite governors to the Seasonal Working Conference and confirm the date. **SN**

AMC said considering that we are the Foundation Trust we could invite our members to the staff seasonal conference once a year and invite all staff members to attend as it is the most popular conference. SSG felt that it might attract some people to join if they can come to the conference.

3. Patient Forums

SN said that the Trust has 9 patient forums and she will circulate a list of these to the governors. **SN to circulate a list of patient forums to governors.** **SN**

SN said that some forums are held regularly, some yearly or quarterly. AMC suggested that we monitor attendance at these forums and any forums which are not well attended/popular to be removed from the list.

4. Recruitment campaign
CB said it is important to increase % of representation in the membership from the local boroughs, especially in Hammersmith and Fulham 1, Kensington and Chelsea 1, Westminster 1 and 2, and Wandsworth 1 and 2, in all of which we have less than 1% of the local population.

WMW said that she had asked a friend at the Kensington and Chelsea Council to distribute the membership application form to colleagues and friends. However, there was not much interest in it.

CB said that the mobile bus would be of use there and asked SN to add it to the actions list.

SM referred to the last meeting and a discussion regarding local schools and said that a Red Cross official could help with this. She suggested that we invite them to visit the hospital and to attend a meeting of the Council of Governors as this might help them get an insight into what we do and what we would like to achieve. It was suggested that this should be followed up.
SN to follow up. **SN**

5. Bi-annual membership mailing
SN reminded the sub-committee that we currently have two mail shots per year. In the most recent mailing we asked the members to update us on their contact details.

ML suggested that we publish a photo and e-mail addresses of governors in the next edition of the Trust Newsletter.

SN said that we need to discuss ideas regarding contents for the next membership mail out. SM suggested we should ask about feedback from members. RMB responded that we enclosed a request for feedback and information about patient forums in the covering letter sent with the April Trust News. WMW said that the Trust News should be used to include as much information as possible about the membership involvement.

CB said he felt that the hospital staff need to learn more about the Council of Governors and what their role involves.

6. Email communication with members
Email addresses will be updated following the Trust News Letter as discussed earlier in the meeting.

7. Website
SN said that governors will be involved in redesigning of the Trust's website via the Website Steering Committee. SN said that she will work with Mat Akid and RMB to get the patient experience feedback results, surveys, patient forums and the patient experience tracker (PET) on the website.

SSG suggested that whilst refreshing the website we should have a membership page.

8. Council of Governors Elections
SN said that we have an action plan for the elections. We have a couple of Capita representatives who are in the Hospital this week and who are aiming to encourage people to stand for elections as well as to recruit some new members.

9. Staff Constituency
SN said we need to encourage staff to agree an annual programme of events with staff members and she needs to work more closely with the staff governors. Carol Dale recently held a meeting with the staff and this should be a regular event.

ML queried if there was any enthusiasm for elections at that meeting. SN responded that there was not much interest.

SM queried if any new members who registered in May would be able to stand for elections. SN responded that she would immediately process those applications if we had new joiner's contact details.

10. Reaching underrepresented groups in the membership
CB said that this item was already discussed and we would want to focus on which areas we want to target. CB we have already identified underrepresented groups and we need to work on this.

11. Young Persons Membership Group
CB said that this item was discussed as well and SN will keep members updated on progress.

ML said he liked the idea of a young persons champion.

12. Quality Accounts
SN said that she will contact CM and VD regarding the Quality Account to get their view on how to involve community members and the possibility of involving LINKS.

13. Members with Learning Disability
SN said we have recently developed learning disability leaflet and the passport which will contain the vital information on the passport i.e. eating, hygiene and will give these to any disabled patient. Council of Governors approved the learning disability leaflet at its meeting in January. The leaflet will give people with learning disabilities an easy access to the membership. This will also be reflected on the website.

14. Service Development

CB thanked SN and asked her to incorporate ideas in the action plan.

6 Elections to the Council of Governors – engagement plan **CB**

CB outlined that the Trust has particular difficulty in getting nominations in the following public areas:

- Hammersmith and Fulham 1
- Kensington and Chelsea 1
- Wandsworth 2

- Westminster 1

CB informed the sub-committee that he approached a friend who lived in the in the Kensington and Chelsea Area 1 regarding elections and gave him a copy of the nomination form. However, he has not received any response as yet.

He suggested that other governors could write to their friends and provide them with a nomination form so that we increase the chances of receiving some nominations in the public constituencies.

CB said on p.3 SN outlined the arrangements which are in place regarding promotion of elections, e.g. posters in the hospital, promotion during the Open Day, promotion and recruitment week with the Campaign Company and all Governors to engage with their local constituencies to promote the elections and offer their support to those who wish to nominate oneself, etc.

SS-G said that targeting all members of the Foundation Trust would be best place e.g. an e-mail a nomination form to all members should produce a good result.

VD said that the latest information she received from the OPT2VOTE was that there are 4 patient nominations, 1 staff and none in the public constituencies. She said considering that there are more patient nominations received, two more than needed, she and SN will speak on Monday to explore the possibility of switching over patients to the public constituency.

7 Open Day feedback

RMB said that we had a good PET feedback following the Open Day. We asked four questions and in general we have positive scores. On overall the music choice was excellent and we had about the same number of attendees as the last year (1,500), etc.

RMB invited the sub-committee to give their feedback on the Open Day.

SS-G said that we need more advanced notice on the website about the Open Day and posters should be published in the hospital in more prominent positions and on all floors.

WMW said that the distribution of posters in community is important. She felt that if all governors got involved in promoting it would help enormously. She said she had put the Open Day poster in 5 to 6 prominent positions in her area and suggested that other governors should have helped as well. CB and SM said they did it, too.

RMB said that governors would be more likely to engage more with members by coming out of the Information Zone and that when a visitor who is interested in joining appears then to be taken inside the Zone. CB agreed and had a view that 2 governors could encourage people to come inside the Info Zone and give feedback.

The sub-committee said that the overall view was that the Open Day was an enjoyable event.

8 Membership Newsletter feedback and ideas for next newsletter **RMB**

RMB said the trust newsletter was already covered earlier in the meeting. She asked the sub-committee for any ideas on articles to be included in the next edition of the trust news which would be published in August.

ML suggested that we publicise that the Council of Governors meetings are open to public and that all members are invited to attend. Some members expressed the concern over the size of the boardroom and whether it will get overcrowded.

CB thanked MA and RMB for continuing to do a great job on organising the Open Day.

9 Any Other Business

None.

10 Date of next meeting

The next meeting will be held on 8 July 2010.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 21 July 2010

AGENDA ITEM NO.	2.7/Jul/10
PAPER	StartHere – Piloting a Patient Information Service
AUTHOR	Lucy Hadfield, Interim Director of Strategy and Service Planning
LEAD	Lucy Hadfield
SUMMARY	The executive directors have agreed in principle for C & W to enter into a partnership with the Chiswick-based national charity, StartHere, which has a development contract with NHS Choices. This is to pilot their technology-based information service that acts as a single starting point from where people choose to access the information and services they need in times of crisis, distress or important life decisions. The vision for the service is to become a household name as the best way for individuals or their advocates to navigate information systems for help from health or other public services for their particular problem or need. This in turn should help achievement of NHS and hospital strategic objectives for helping the public access the right services for them in the right time at the right place. It will become available to local partner organisations serving the public to purchase at an economic cost. It provides information on a wide range of health, care-related and other social issues. It quickly and simply directs users to the most relevant organisations and services that can help, whether statutory or voluntary, both nationally and in their local area. It is particularly suitable for socially disadvantaged and digitally excluded groups. The service runs on a number of platforms including the internet, digital TV, touch-screen kiosks, stand-alone PCs and mobile phones. It is based on four key principles: • Signposting to local and national organisations • Simple to use and highly accessible • Reliable, up-to-date information • Complementary to existing services such as Directgov and NHS Choices

	More information about the service can be found at www.starthere.org, including a demonstration and video. A C & W project has been established and the service will be started in the urgent care centre, ante-natal clinic, medical day unit, and on discharge in the first instance. It is not anticipated that any significant costs of the project will fall to C & W. An invitation has been given to apply to NW London CLAHRC for research and development support. A presentation will be made to the Membership Sub-Committee meeting on 2nd September. Governors will be requested to nominate one or two people to join the project steering group.
DECISION/ ACTION	For information and to be referred to the Membership Sub-Committee on 2nd September for nomination of Governors to join the project steering group.

Council of Governors Meeting, 21 July 2010

AGENDA ITEM NO.	2.9/Jul/10
PAPER	Council of Governors Membership Report
AUTHOR	Sian Nelson, Membership and Engagement Manager
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper reports on the membership numbers for the Trust which currently has a total membership of 15, 212.
DECISION/ ACTION	For information

Council of Governors Membership Report

1. Introduction

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

2. Member Constituencies

There are three Member Constituencies, Patient, Public and Staff. Membership for each constituency is illustrated in Table 1. The information in this report was updated 15 July 2010.

Staff	**3,047**		20%
Patient	**6,113**		40.20%
Public	**6,052**		39.80%
Total	**15, 212**		

Table 1: Membership

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

2.1 Patient Constituency

Patient members for 2010/11 are currently at 6,113. The number of patient members who have left from 1st April 2010 currently stands at 150. The reasons for members leaving is generally either because of movement of address outside of the eligible constituency, or death. A total of 253 new members have joined since April 2010.

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

Age (years)	
0-16	0
17-21	66
22+	3,250

Table 2: Patient membership by age range

2.2 Public Constituency

The Trust's target is to maintain the size of membership in the public constituency in 2010/11. Currently we have 6,052 public members, against 6,131 in 2009/10. To date there have been 100 new members since April 2010, with 179 members leaving membership.

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

Ethnicity:	
White	4,292
Mixed	244
Asian	342
Black	290
Other	298
Socio-economic groupings:	
ABC1	5,225
C2	4
D	0
E	807
Gender analysis:	
Male	2,396
Female	3,612
Age (years):	
0-16	0
17-21	60
22+	5,169

Table 3: Analysis of Public membership

2.3 Staff Constituency

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

Staff constituency	
As at start April 1st 2010	**3,046**
New Members	1
Members leaving including (Opt Out)	0
May 2010	3,047

Table 4: Staff constituency figures.

* The report demonstrates a gap between data sent from work force and Capita. This does not reflect recent Trust starters and leavers.

3.0 Membership Recruitment and Engagement

Despite 185 public and 300 patient members joining in 2009-10 the total membership decreased by 242 in the public constituency and 126 in the patient constituency

Since April 2010 a total of 512 members have left membership and 458 have joined. Membership recruitment is just managing to maintain numbers.

Reasons for the decrease remain with patients dying and people moving outside of the eligible membership boroughs.

The Membership Development Sub-Committee of the Council of Governors develops and reviews the Membership Development and Communications Strategy.

A Membership Action Plan 2010-11 has been circulated to the Council of Governors. This provides direction and feasible actions for Governors to increase membership for the forthcoming year. The Action Plan 2010-11 emphasises engagement between the Governors and Trust with Members

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

A member's email database has recently been updated with over 3000 emails registered. The first mailing for member's email involved consultation of members, entitled 'support your hospital – have your say on the proposed abolition of the Western Extension of the Congestion Charging zone'. This form of communication saves on costs and allows fast access to members.

A discharge booklet, funded by the Council of Governors is given to patients on admission and includes a membership application form.

4.0 Developing a Representative Membership

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:

A Learning Disability Membership Application form: this provides accessibility for patients and the public with a learning disability to apply for membership through an easy read version of the main application form. A learning disability patient forum and other engagement activities will be developed once members are identified in this group.

Recruitment campaigns within the hospital prior to the Open Day and Governor elections.

The Trust has purchased a community mobile health clinic. This was set up with the aim of membership development and engagement in the community. The services from the mobile health clinic aim to target 'hard to reach' groups in the community. For example, a recent project to engage with men under the age of 45 years was carried out at Chelsea Football Club. Health screening was offered and membership recruitment took place alongside. Future projects will mirror this approach. The Membership and Engagement Manager will work closely with the Governors in 2010-11 to look at areas in the community with low membership representation and decide on appropriate outreach services for these areas.

Membership under-representation continues in the following areas:

- Low penetration in the Public: Wandsworth 1 constituency
- Significantly lower membership in the under-40 age group
- Lower membership in the Black and Asian ethnic groups.

Council Members and Foundation Trust Members were invited to attend the Annual Members' Meeting in September 2009 to give their views on the Trust and will be invited to the Annual Members' Meeting in September 2010. Chelsea and Westminster Hospital held a successful Open Day on May 8th 2010 and invited all members.

5.0 Election Plan

Chelsea and Westminster Hospital Foundation Trust held Governor Elections in the following constituencies, and the following Governors were successfully elected.

Patient Governors seats	**Public Governor seats**	**Staff Governor seats**
Paul Baverstock	Hammersmith & Fulham Area 1 Samantha Culane	Support, Administrative & Clerical: Charlotte Mackenzie Crooks
Chris Birch	Kensington & Chelsea Area 1 Eddie Adams	
	Wandsworth Area 2	

	Del Husain	
	Westminster 1 No nominees	

Table 5: Election seats for nomination

Election results were published on 29th June 2010 on the Trust's website. Staff received Induction (part 1) on 12th July 2010.

Summary

Membership engagement is a priority for 2010-11. The Membership and Engagement Manager encourages Governors to engage further and more meaningfully with their constituencies. Increasing representation in all areas is important, and encouraging growth in hard to reach communities. The Membership Work Plan 2010-11 outlines direction for development.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors meeting, 21 July 2010

AGENDA ITEM NO.	2.10/Jul/10
PAPER	New Code of Governance and Trust Position
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Catherine Mooney, Director of Governance and Corporate Affairs
EXECUTIVE SUMMARY	This paper considers the Trust's position against the revised Code which applies for 2010/11.
DECISION/ ACTION	To note.

Monitor Code of Governance

1.0 Introduction

1.1 The Council is asked to note the Trust's position with the Monitor Code of Governance compliance 2010/11

1.2 Appendix 1 is an assessment of the position against the Code.

1.3 Appendix 2 lists the amendments.

2.0 Action

The Council is asked to note the Code. The governors are asked to particularly note the following and suggest any action that is required.

B.1.8 The Council of Governors should ensure its interaction and relationship with the board of directors is appropriate and effective, in particular, by agreeing the availability and timely communication of relevant information, discussion and the setting in advance of meeting agendas and use, where possible, of clear, unambiguous language.

D.1.5 Governors should canvass the opinion of their members, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors.

D.1.6 The board of directors should consider and take account of the views of the Council of Governors on the NHS foundation trust's forward plan. Where appropriate, the board of directors should communicate to the Council of Governors where their views have been incorporated in the NHS foundation trust's plans, and, if not, the reasons for this.

Appendix 1

CODE OF GOVERNANCE COMPLIANCE - STATUS MAY 2010

Monitor Reference	OK	Evidence/comment	Action	Lead
A Directors **A.1 The board of directors**				
A.1.1 The board of directors should meet sufficiently regularly to discharge its duties effectively.	√	Comprehensive Annual Cycle of Business Attendance Record of Directors		
There should be a formal schedule of matters specifically reserved for decision of the board of directors. The schedule of matters reserved for the board of directors should be complemented with a clear statement detailing the roles and responsibilities of the Council of Governors (as described in B.1.4). There should also be a statement explaining how any disagreements between the Council of Governors and the board of directors will be resolved.	√	Scheme of Delegation is due to be approved at the Audit Committee in May 2010 and this statement is included. For conflict resolution refer to roles paper 19.03.09; Council of Governors paper 2.8/March/09 p.4		
The annual report should include a statement of how the board of directors and the Council of Governors operate, including a high-level statement of which types of decisions are to be taken by each of the boards and which decisions are to be delegated to the executive management by the board of directors. The developmental nature of the Council of Governors role would suggest that any agreements should be kept under review as the role evolves.	√	Annual Report 08/09 p.31	To ensure included in the annual report for 09/10.	CM
A.1.2 The annual report should identify the chairman, the deputy chairman (where there is one), the chief executive, the senior independent director (see A.3.3) and the chairmen and members of the nomination, audit and remuneration committees. A record should be kept of the number of meetings of the board of directors and the attendance of individual directors, and it should be supplied to the Council of Governors on request.	√ √	Annual Report 08/09 p.29&30 Board Minutes include attendees. There is also a summary in the annual report.	To ensure included in the annual report for 09/10	CM

A.1.3 The chairman should hold meetings with the non-executive directors without the executives present. Led by the senior independent director, the non-executive directors should meet without the chairman at least annually to evaluate the chairman's performance, as part of a process, which should be agreed with the Council of Governors, for appraising the chair and on such other occasions as are deemed appropriate.	√	Chairman met with NEDs individually as part of performance evaluation. Appraisal process undertaken in September 2009. Council of Governors item 2.6/Sept/09 Report on Chair Appraisal.	Meeting with NEDs to be arranged on 24.6.10	CE
A.1.4 The board of directors should make available a statement of the objectives of the NHS foundation trust showing how it intends to balance the interests of patients, the local community and other stakeholders, and use this as the basis for its decision making and forward planning.	√	Corporate objectives are available and used for decision making and forward planning. Included in the Annual Plan 2009-10. (p.11 section 2.1.4)		
A.1.5 The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the NHS foundation trust's effectiveness, efficiency and economy as well as the quality of its healthcare delivery. The board should regularly review the performance of the NHS foundation trust in these areas against regulatory requirements and approved plans and objectives. The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance. Where appropriate, and in particular in high risk or complex areas, independent advice should be commissioned by the board of directors to provide an adequate and reliable level of assurance.	√	Monthly Perf. Report Monthly Finance Report CQC Declaration Nat. Patient Survey Corp. objectives progress report for Trust Board. Audit committee and Assurance Committee Board signs off the Monitor quarterly report and signs off the financial plan and budgets External Audit provide Value for Money opinion as part of their audit opinion. Quality Accounts in preparation Development of Board Dashboard Internal audit to report on performance management May 2010.		LB
A.1.6 The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in accordance with guidance set out by the Department of Health, the Healthcare Commission and Monitor.	√	Clinical Quality and Performance Report. Corporate objectives include quality and safety and are reported on quarterly. Trust Executive for Clinical Governance provides reports to the Assurance Committee. Quality objectives monitored quarterly by the		

		Assurance Committee. Quality Report 08/09 Quality Accounts 2009/10 in preparation		
A.1.7 Where the board or individual directors have concerns which remain unresolved, about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the board minutes.	√	Board Minutes Directors approve the minutes and have the opportunity to highlight if their concerns were not minuted.		
A.1.8 The chief executive, as the accounting officer, should follow the procedure set out by Monitor (NHS Foundation Trust Accounting Officer Memorandum, April 2005) for advising the board of directors and the Council of Governors, and for recording and submitting objections to decisions considered or taken by the boards in matters of propriety or regularity, and on issues relating to the wider responsibilities of the accounting officer for economy, efficiency and effectiveness.	√	Minutes of meetings.		
A.1.9 The board of directors should establish the values and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behaviour in public life, which include the principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership (The Nolan Principles).	√	Council of Governors and Board have Code of Conduct. Code of Conduct for staff included in starter pack. Induction presentation from CEO includes values. Feb 2009: NHS Constitution values adopted by the Board of Directors.		
A.1.10 The board of directors should operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility. The board of directors should follow a policy of openness and transparency in its proceedings and decision making unless this conflicts with a need to protect the wider interests of the public or the NHS foundation trust (including commercial-in-confidence matters) and make clear how potential conflicts of interests are dealt with.	√	Board Code of Conduct Board Etiquette paper Open Minutes Board of Directors Governance Arrangements		

A.1.11 The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors.	√	Reviewed by Director of Finance. Paper to Board July 2006		
A.2 Chairman and chief executive	**OK**	**Evidence**	**Action**	**Lead**
A.2.1 The division of responsibilities between the chairman and chief executive should be clearly established, set out in writing and agreed by the board of directors.	√	Statement on division of responsibilities approved at Jan 08 Board.		
A.2.2 The chairman should on appointment meet the independence criteria set out in A.3.1 below. A chief executive should not go on to be chairman of the same NHS foundation trust.	√	Chairman meets criteria.		
A.3 Balance and independence of the board if directors	**OK**	**Evidence**	**Action**	**Lead**
A.3.1 The board of directors should identify in the annual report each non-executive director it considers to be independent. The board should determine whether the director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgement. The board should state its reasons if it determines that a director is independent notwithstanding the existence of relationships or circumstances which may appear relevant to its determination, including if the director: ■ has been an employee of the NHS foundation trust within the last five years; ■ has, or has had within the last three years, a material business relationship with the NHS foundation trust either directly, or as a partner, shareholder, director or senior employee of a body that has such a relationship with the NHS foundation trust; ■ has received or receives additional remuneration from the NHS foundation trust apart from a director's fee, participates in the NHS foundation trust's performance-related pay scheme, or is a member of the NHS foundation trust's pension scheme; ■ has close family ties with any of the NHS foundation trust's advisers, directors or senior employees; ■ holds cross-directorships or has significant links with other directors through involvement in other companies or bodies;	√	Register of interests regularly updated. Balance of Board Membership and Independence - Annual Report 08/09 p.28.	To ensure included in the annual report for 09/10	CM

■ has served on the board for more than nine years from the date of their first election; ■ is an appointed representative of the NHS foundation trust's university medical or dental school.				
A.3.2 At least half the board, excluding the chairman, should comprise non-executive directors determined by the board to be independent.	√	Constitution		
A.3.3 The board of directors should appoint one of the independent non-executive directors to be the senior independent director, in consultation with the Council of Governors. The senior independent director should be available to members and governors if they have concerns which contact through the normal channels of chairman, chief executive or finance director has failed to resolve or for which such contact is inappropriate. The senior independent director could be the deputy chairman.	√	SID agreed Nov 06		
A.3.4 The board of directors should include in its annual report a description of each director's expertise and experience. Alongside this in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust. Both statements should also be available on the NHS foundation trust's website.	√	Annual Report 08/09 p.28&29 Website – section 'Board of Directors'	To ensure included in the annual report for 09/10	CM
A.3.5 No individual should hold, at the same time, positions of director and governor of NHS foundation trusts.	√	No person holds both. See register of interest.		
A.3.6 Non-executive directors should receive the necessary information and feel able to raise appropriate challenge of recommendations or decisions of the board, in particular making full use of their skills and experience gained both as a director of the trust and also in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of an NHS foundation trust as they would in other similar roles.	√	Board meetings		
B. Governors **B.1 The Council of Governors**	**OK**	**Evidence**	**Action**	**Lead**

B.1.1 The Council of Governors should meet sufficiently regularly to discharge its duties. Typically the Council of Governors would be expected to meet as a full board at least four times per year. Governors should where practicable make every effort to attend the meetings of the Council of Governors. The NHS foundation trust should take appropriate steps to facilitate attendance.	√	Meet at least 4 times per year. See Constitution. Have misc. travel budget. Attendance records.		
B.1.2 The Council of Governors should not be so large as to be unwieldy. The Council of Governors should be of sufficient size for the requirements of its duties. The roles, structure, composition, and procedures of the Council of Governors should be reviewed regularly as described in provision D.2.2.	√	Structure and composition is not reviewed regularly but as the need arises e.g. the composition of the Council of Governors has been changed to accommodate changes to the main education provider for nursing.	See D 2.2	
B.1.3 The annual report should identify the members of the Council of Governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor. A record should be kept of the number of meetings of the board and the attendance of individual governors and it should be made available to members on request.	√	Annual report 08/09 p.32 Included in the annual report for 09/10		CM
B.1.4 The roles and responsibilities of the Council of Governors should be set out in a written document. This statement should include a clear explanation of the responsibilities of the Council of Governors towards members and other stakeholders and how governors will seek their views and inform them.	√	Paper on roles and responsibilities included in welcome pack. Monitor guidance on the roles of governors circulated to all governors. For conflict resolution refer to roles paper 19.03.09; Council of Governors paper 2.8/March/09		
B.1.5 The Council of Governors should receive and consider other appropriate information required to enable it to discharge its duties, for example, clinical and operational data.	√	Council of Governors Agendas: Receive performance report, finance executive summary and other relevant service updates. Agenda Sub-Committee established to oversee information to Council.		
B.1.6 The chairman is responsible for leadership of both boards (A.2) but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive to their meetings and inviting attendance by other executives and non-executives as appropriate. In these meetings other Governors of the	√	Minutes: All directors and CE invited and attend Council of Governors meetings.		

Council of Governors may raise questions of the chairman or his deputy or any other director present at the meeting about the affairs of the NHS foundation trust.				
B.1.7 The Council of Governors should establish a policy for engagement with the board of directors for those circumstances when they have concerns about the performance of the board of directors, compliance with the terms of authorisation or other matters related to the general wellbeing of the NHS foundation trust. The Council of Governors should consider the advantages of there being a senior independent director on the board of directors (see A.3.3).	√	Directors attend all Council meetings. Have a SID. See paper with role. 02.11. 06. Board paper 3.4/Nov/06 Senior Independent Director For conflict resolution refer to roles paper 19.03.09; Council of Governors paper 2.8/March/09	Include conflict resolution in standing orders.	CM
B.1.8 The Council of Governors should ensure its interaction and relationship with the board of directors is appropriate and effective, in particular, by agreeing the availability and timely communication of relevant information, discussion and the setting in advance of meeting agendas and use, where possible, of clear, unambiguous language.	√	Council of Governors Agenda Sub-Committee	Outstanding actions to establish appropriate information.	CM
B.1.9 Governors should acknowledge the overall responsibility of the board of directors for running the NHS foundation trust and should not use the powers of the Council of Governors to veto the decisions of the board of directors or otherwise obstruct the implementation of agreed actions and strategies. Through the nominated lead governor, the Council of Governors should communicate directly with Monitor if the NHS foundation trust is at risk of significantly breaching the terms of its authorisation and if these concerns cannot be satisfactorily resolved.	√	Constitution Lead Governor – paper to the Council of Governors 3.12.09.		
B1.10 The Council of Governors should only exercise its power to remove the chairman or any non-executive directors after exhausting all other means of engagement with the board of directors.	√	Constitution		
C. Appointment, resignation and terms of office **C.1 Appointments to the board of directors**	**OK**	**Evidence**	**Action**	**Lead**
C.1.1 The nominations committee or committees, with external advice as appropriate, are responsible for the identification and nomination of	√	Nominations Committee for Executive Directors agreed at the Board meeting 25		

executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the NHS foundation trust and the skills and expertise required within the board of directors to meet them.		June 09. Board minutes 25 June 09.		
C.1.2 There may be one or two nominations committees. If there are two committees, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chairman). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and make recommendations for changes where appropriate. In particular, the nominations committee(s) should evaluate the balance of skills, knowledge and experience on the board of directors and, in the light of this evaluation, prepare a description of the role and capabilities required for appointment of both executive and non-executive directors, including the chairman.	√	Nominations Committee ToR agreed at the Board meeting 25 June 09. Paper outlining Chair and NED appointment process. Complimentary arrangements for Nominations and the TOR of new Nominations Committee for Executive Directors agreed at the Board meeting 25 June 09.		
C.1.3 The chairman or an independent non-executive director should chair the nominations committee(s).	√	ToRs Chairman chairs Nominations Committee.		
C.1.4 The governors are responsible at a general meeting for the appointment, re-appointment and removal of the chair and the other non-executive directors. They should agree with the nominations committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have been identified the nominations committee should make recommendations to the Council of Governors.	√	Constitution Council of Governors paper 2.5/Sep/09 Policy for Board Composition of NEDs Nominations Committee ToR.		
C.1.5 Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should consist of a majority of governors. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chairman or a deputy chairman, are being discussed, there should be a majority of	√	Chelsea and Westminster Hospital NHS Foundation Trust has two nominations committee and the one responsible for NEDs does consist of a majority of governors		

governors on the committee and also a majority governor representation on the interview panel.				
C.1.6 When considering the appointment of non-executive directors, the Council of Governors should take into account the views of the board of directors on the qualifications, skills and experience required for each position.	√	This is built into the process for appointment of a NED via the Nominations Committee,		
C.1.7 For the appointment of a chairman, the nominations committee should prepare a job specification defining the role and capabilities required including an assessment of the time commitment expected, recognising the need for availability in the event of emergencies. A chairman's other significant commitments should be disclosed to the Council of Governors before appointment and included in the annual report. Changes to such commitments should be reported to the Council of Governors as they arise, and included in the next annual report. No individual, simultaneously whilst being a chairman of an NHS foundation trust, should be the substantive chairman of another NHS foundation trust.	√	Process followed for appointment of chair. Significant commitments included in annual report 08/09 p.28	To ensure included in the annual report for 09/10	CM
C.1.8 The terms and conditions of appointment of non-executive directors should be made available for inspection. The letter of appointment should set out the expected time commitment. Non-executive directors should undertake that they will have sufficient time to meet what is expected of them. Their other significant commitments should be disclosed to the Council of Governors before appointment, with a broad indication of the time involved and the Council of Governors should be informed of subsequent changes.	√	Terms and conditions contained in recruitment pack. Letter of appointment sent out in June 2009. Time commitment included in NED appraisal.		
C.1.9 The annual report should describe the process followed by the Council of Governors in relation to appointments of the chairman and non-executive directors.	√	Annual Report 08/09 p.30	To ensure included in the annual report for 09/10	CM
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	√	Standing Orders 'the Board shall appoint a committee whose members shall be the chair, the non-executive directors and the chief executive whose function will be to appoint the executive directors of the Trust		

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.		other than the Chief Executive'. Complimentary arrangements for Nominations and the TOR of new Nominations Committee for Executive Directors agreed at the Board meeting 25.06.09.		
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.	√	Constitution		
C.1.12 An independent external adviser should not be a member of or have a vote on the nominations committee(s).	N	This is contrary to what our constitution which states that an external assessor should be invited to be on the Nominations Committee. The constitution takes precedent.		
C.1.13 The board of directors should not agree to a full-time executive director taking on more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity, nor the chairmanship of such an organisation.	√	Constitution Register of interests		
C.1.14 A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	√	Annual Report 08/09 p.30	To ensure included in the annual report for 09/10	CM
C.2 Re-appointment of directors and re-election of governors	**OK**	**Evidence**	**Action**	**Lead**
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.	√			
C.2.2 Non-executive directors, including the chairman, should be appointed by the Council of Governors for specified terms subject to re-appointment thereafter at intervals of no more than three years and to the 2006 Act provisions relating to the removal of a director. The	√	NED Appraisal Process Constitution		

chairman should confirm to governors that, following formal performance evaluation, the performance of the individual proposed for re-appointment continues to be effective and to demonstrate commitment to the role. Any term beyond six years (e.g. two three-year terms) for a non-executive director should be subject to particularly rigorous review, and should take into account the need for progressive refreshing of the board. Non-executive directors may serve longer than six years (e.g. two three-year terms), subject to annual re-election. Serving more than six years could be relevant to the determination of a non-executive director's independence (as set out in provision A.3.1).		Updated paper on NED appraisal process went to Board in June 2009.		
C.2.3 Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to take an informed decision on their election. This should include prior performance information such as attendance record at governor meetings and other relevant events organised by the NHS foundation trust for governors.	√	Ballot Papers Constitution October election completed. N.B We did not include prior performance information such as attendance record at governor meetings and other relevant events organised by the NHS foundation trust for governors.	Due May 10	CM
C.3 Resignation of directors				
C.3.1 The board of directors should not agree to an executive member of the board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/ or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment.	√	To be noted and considered when relevant.		
D. Information, development and evaluation **D.1 Information and professional development**	**OK**	**Evidence**	**Action**	**Lead**
D.1.1 The chairman should ensure that new directors and governors receive a full, formal and appropriate induction on joining their respective boards.	√	Council of Governors induction programme and slides 24.11.09 Induction evaluated		

		NED induction programme		
D.1.2 The board should ensure that directors, especially non-executive directors, have access to independent professional advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as directors. Directors should also have access, at the NHS foundation trust's expense, to training courses and/or materials that are consistent with their individual and collective development programme as described in provision D.2. Decisions to appoint an external adviser should be the collective decision of the majority of non-executive directors. The availability of independent external sources of advice should be made clear at the time of appointment. Committees should be provided with sufficient resources to undertake their duties. The board of directors should also ensure that the Council of Governors is provided with sufficient resources to undertake its duties, with such arrangements agreed in advance.	P	Individual development Joined Governors' Network. Governors informed about all training opportunities. Availability of external sources of advice. June 2009: As per Supplementary appointment letters.	Confirm there are individual professional development programmes for directors if applicable. Keep record of training opportunities available and uptake.	HL/CE CM
D.1.3 The board of directors and the Council of Governors should be provided with high quality information appropriate to the respective functions of the boards and relevant to the decisions they have to make. The board of directors and the Council of Governors should agree their respective information needs with the executive directors. The information for the boards should be concise, objective, accurate and timely, and it should be accompanied by clear explanations of complex issues. The board of directors should have complete access to any information about the NHS foundation trust that it deems necessary to discharge its duties, including access to senior management and other employees.	√	Board Papers Board of Directors Governance Arrangements Policy Performance Report		

D.1.4 The board of directors, and in particular non-executive directors, may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the board of directors, although they should wherever possible ensure that they have sufficient information and understanding to take decisions on an informed basis. When complex or high risk issues arise the first course of action should normally be to encourage further and deeper analysis to be carried out, in a timely manner, within the NHS foundation trust. On occasion, non-executives may reasonably decide that external assurance is appropriate.	√	Board considered Mid Staffordshire Report. Governance seminar scheduled in for May Board.		
D.1.5 Governors should canvass the opinion of their members, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors.	P			
D.1.6 The board of directors should consider and take account of the views of the Council of Governors on the NHS foundation trust's forward plan. Where appropriate, the board of directors should communicate to the Council of Governors where their views have been incorporated in the NHS foundation trust's plans, and, if not, the reasons for this.	√	Business planning and strategy meetings		
D.2 Performance evaluation	**OK**	**Evidence**	**Action**	**Lead**
D.2.1 The chairman, with the assistance of the secretary of the boards if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for directors relevant to their duties as board members.	P	Annual NED appraisals Updated NED appraisal process – June 09	Confirm that there are individual professional development programmes for directors if appropriate.	HL/CE
D.2.2 Led by the chairman, the Council of Governors should periodically assess their collective performance and they should	P	Council of Governors Self Evaluation Questionnaire and Report (Jul 08).	Review of Council of Governors	CM

regularly communicate to members details on how they have discharged their responsibilities, including their impact and effectiveness on: ■ contributing to the development of forward plans of the NHS foundation trust; and ■ communicating with their member constituencies and transmitting their views to the board of directors. The Council of Governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice.		Trust Newsletter April 2010 Council of Governors minutes 19.03.09 re roles and responsibilities of the Council of Governors Task & Finish Group 29.07.09	performance on the agenda for the Council 21.4.10	
D.2.3 There should be a clear policy and a fair process for the removal from the Council of any Governor who consistently and unjustifiably fails to attend the meetings of the Council of Governors or has an actual or potential conflict of interest which prevents the proper exercise of their duties. In addition removal from the Council of Governors may be appropriate where behaviours or actions by a governor or group of governors may be incompatible with the values and behaviours of the NHS foundation trust. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be requested to consider the evidence and conclude whether the proposed removal is reasonable or otherwise.	√	Constitution Meeting attendance monitored by the Foundation Trust Secretary.		
E. Director remuneration **E.1 The level and make-up of remuneration**	**OK**	**Evidence**	**Action**	**Lead**
Remuneration policy **E.1.1** Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should follow the following provisions: (i) The remuneration committee should consider whether the directors should be eligible for annual bonuses. If so, performance conditions should be relevant, stretching and designed to match the long term	√	Remuneration Committee TOR		

interests of the public and patients. (ii) Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the NHS foundation trust. Consideration should be given to criteria which reflect the performance of the NHS foundation trust relative to a group of comparator trusts in some key indicators, and the taking of independent and expert advice where appropriate. (iii) Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed. (iv) The remuneration committee should consider the pension consequences and associated costs to the NHS foundation trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement. In general, only basic salary should be pensionable.				
E.1.2 Levels of remuneration for the chairman and other non-executive directors should reflect the time commitment and responsibilities of their roles.	√	Minutes of Board re Updated Remuneration ToR and NED Remuneration levels		
E.1.3 Where an NHS foundation trust releases an executive director to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement on whether or not the director will retain such earnings.	NA	Ensure the remuneration disclosures of the annual report include a statement on whether or not the director will retain such earnings when moving to another trust, if applicable	.	
Service contracts and compensation **E.1.4** The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointment would entail in the event of early termination. The aim should be to avoid rewarding poor performance. They should take a robust line on reducing compensation to reflect departing directors' obligations to mitigate loss.	√	Ref. early termination in the Remuneration Committee TOR		
E.2 Procedure	**OK**	**Evidence**	**Action**	**Lead**
E.2.1 The board of directors must establish a remuneration committee composed of non-executive directors which should include at least three independent non-executive directors. The remuneration	√	Remuneration Committee ToR. It is available to all affected directors through the Board papers.		

committee should make available its terms of reference, explaining its role and the authority delegated to it by the board of directors. Where remuneration consultants are appointed, a statement should be made available of whether they have any other connection with the NHS foundation trust.				
E.2.2 The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The definition of 'senior management' for this purpose should be determined by the board but should normally include the first layer of management below board level.	√	Remuneration Committee ToR		
E.2.3 The Council of Governors is responsible for setting the remuneration of non executive directors and the chairman. The Council of Governors should consult external professional advisers to market-test the remuneration levels of the chairman and other non-executives at least once every three years and when they intend to make a large change to the remuneration of a non-executive.	√	Nominations Committee Minutes Council of Governors Minutes Council of Governors Agenda 21.04.10		
F. Accountability and audit **F.1 Financial, quality and operational reporting**	**OK**	**Evidence**	**Action**	**Lead**
F.1.1 The directors should explain in the annual report their responsibility for preparing the accounts and there should be a statement by the external auditors about their reporting responsibilities.	√	Annual Report 08/09	To ensure included in the annual report 09/10	LB
F.1.2 The directors should report that the NHS foundation trust is a going concern, with supporting assumptions or qualifications as necessary.	√			
F.1.3 (a) The board of directors must notify Monitor and the Council of Governors without delay, and should consider whether it is in the public interest to bring to the public attention, any major new developments in the NHS foundation trust's sphere of activity which	√	Quarterly reporting to Monitor. Ad hoc reporting of SUIs e.g. report to Information Commissioner on stolen laptops		

are not public knowledge which may lead, by virtue of its effect on its assets and liabilities or financial position or on the general course of its business, to a substantial change to the financial wellbeing, healthcare delivery performance or reputation and standing of the NHS foundation trust. (b) The board of directors must notify Monitor and the Council of Governors without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a material change: ■ in the NHS foundation trust's financial condition; ■ in the performance of its business; and/or ■ in the NHS foundation trust's expectations as to its performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, healthcare delivery performance or reputation and standing of the NHS foundation trust.				
F.1.4 At least annually, the board of directors should set out clearly its financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and operations, including clinical outcome data, to allow members and governors to evaluate its performance.	√	Annual Plan Quality Account		
F.2 Internal control	**OK**	**Evidence**	**Action**	**Lead**
F.2.1 The board should conduct, at least annually, a review of the effectiveness of the NHS foundation trust's system of internal control and should report to members that they have done so. The review should cover all material controls, including financial, clinical, operational and compliance controls and risk management systems.	√	Statement on Internal Control p.38 Annual Report 08/09 p.38 & p.39 Audit Committee annual report to the Board.	To ensure included in the annual report for 09/10	CM
F.3 Audit committee and auditors	**OK**	**Evidence**	**Action**	**Lead**
F.3.1 The board must establish an audit committee composed of non-executive directors which should include at least three independent non-executive directors. The board should satisfy itself that at least one member of the audit committee has recent and relevant financial experience.	√	Audit Committee ToR		

F.3.2 The main role and responsibilities of the audit committee should be set out in written terms of reference and should include details of how it will: ■ monitor the integrity of the financial statements of the NHS foundation trust, and any formal announcements relating to the trust's financial performance, reviewing significant financial reporting judgements contained in them; ■ review the NHS foundation trust's internal financial controls and, unless expressly addressed by a separate board risk committee composed of independent directors, or by the board itself, review the trust's internal control and risk management systems; ■ monitor and review the effectiveness of the NHS foundation trust's internal audit function; ■ review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements; ■ develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm; and ■ report to the Council of Governors , identifying any matters in respect of which it considers that action or improvement is needed and making recommendations as to the steps to be taken.	√	Audit Committee ToR Audit Committee Papers		
F.3.3 The terms of reference of the audit committee, including its role and the authority delegated to it by the board of directors and by the Council of Governors, should be made publicly available. A separate section of the annual report should describe the work of the committee in discharging those responsibilities.	√	Audit Committee ToR Annual Report 08/09	To ensure included in the annual report 09/10	CM
F.3.4 The Council of Governors should take the lead in agreeing with the audit committee the criteria for appointing, reappointing and removing external auditors.		Constitution		
F.3.5 The audit committee should make a report to the Council of Governors in relation to the performance of the external auditor, including detail such as the quality and value of the work, and the timeliness of reporting and fees, to enable the Council of Governors to	√	Audit Committee ToR		

consider whether or not to reappoint them. The audit committee should also make recommendations to the Council of Governors in relation to the appointment, re-appointment and removal of the external auditor and approve the remuneration and terms of engagement of the external auditor. If the Council of Governors does not accept the audit committee's recommendation, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why Council of Governors has taken a different position.				
F.3.6 The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust. The current best practice is for a three to five year period of appointment.	√			
F.3.7 When the Council of Governors ends an external auditor's appointment in disputed circumstances, the chairman should write to Monitor informing it of the reasons behind the decision.	N/A			
F.3.8 The annual report should explain to members how, if the external auditor provides non-audit services, auditor objectivity and independence is safeguarded.	√		To ensure included in the annual report for 10/11	LB
F.3.9 The audit committee should review arrangements by which staff of the NHS foundation trust may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The audit committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.	√		Audit Committee to undertake this at October meeting	LB
G Relations with stakeholders **G.1 Dialogue with members, patients and the local community**	**OK**	**Evidence**	**Action**	**Lead**
G.1.1 The board of directors should make available a public document that sets out its policy on the involvement of members, patients, and	√	Membership development and communication strategy including a policy on		

the local community at large, including a description of the kind of issues it will consult on.		engagement and reference to consultation will be updated following the Membership Sub-Committee meeting on 08.04.10 Council of Governors Minutes 18.06.09		
G.1.2 The board of directors should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums already in place (e.g. Local Involvement Networks, the Overview and Scrutiny Committee, the local League of Friends, and staff groups).	√	This will form a part of the new Membership and Engagement Strategy. Council of Governors Minutes 18.06.09		
G.1.3 The chairman should ensure that the views of governors and members are communicated to the board as a whole. The chairman should discuss the affairs of the NHS foundation trust with governors. Non-executive directors should be offered the opportunity to attend meetings with governors and should expect to attend them if requested by governors. The senior independent director should attend sufficient meetings with governors to listen to their views in order to help develop a balanced understanding of the issues and concerns of governors.	√	Good attendance at Council of Governors which is minuted. Away Day November 08 Planned Joint Away Day June 2010 Council of Governors report to the Board.		
G.1.4 The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	√	Trust News April and Sept 09 All Governors photos and bios on website and kiosks in Trust Website section – 'Meet the Governors' and Contact the Governors' FT Secretary contact details in the Annual Report.		
G.1.5 The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the Council of Governors,	√	Annual Report 08/09 p.31 Council of Governors Minutes Away Day November 08	To ensure included in the annual report for 09/10	CM

direct face-to-face contact, surveys of member opinion and consultations.				
G.1.6 The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement. This information should be used to review the trust's membership strategy, taking into account any emerging best practice from the sector.	√	Regular membership report goes to both Council of Governors and Board. The Council of Governors Membership Sub-Committee reviews progress quarterly and reports via minutes to the Board. The Chair of the Membership Sub-Committee present update at each Council of Governors meeting where Board is present. Membership action plan reviewed at the Membership Sub-Committee meeting in November 09. Minutes of the Membership Sub-committee meeting on 8 April 2010.		
G.2 Co-operation with third parties with roles in relation to NHS foundation trusts	**OK**	**Evidence**	**Action**	
G.2.1 The board of directors should maintain a schedule of the specific third party bodies in relation to which the NHS foundation trust has a duty to co-operate (refer to Monitor's *Compliance Framework* for a generic, non-exhaustive list of bodies). Directors should be clear of the form and scope of the co-operation required with each of these third party bodies in order to discharge their statutory duties.	√	Schedule of third party bodies and lead directors.		
G.2.2 The board of directors should ensure that effective mechanisms are in place to cooperate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each. Periodically, the board of directors should review the effectiveness of these processes and relationships and, where necessary, take proactive steps to improve them.	√	Board minutes March 2009 MOU with Royal Brompton Hospital.		

Appendix 2

The Code was amended in April 2010 and the main changes are as follows:

Section A: Directors

- Additional wording to reflect additional focus on board skills, the importance of appropriate external assurance, and the design and measurement of relevant indicators. A.1.5
- Additional supporting principle added regarding the requirement to ensure the trust exercises its functions effectively, efficiently and economically. A.3.6

Section B: Governors

- Requirement for the identification of a nominated lead governor. B.1.3
- Additional clarification regarding the relative and complementary roles of Council of Governors and boards of directors. B. 1.8, B.1.9 & B.1.10

Section C: Appointment, resignation and term of office

- Additional provision added where the trust operates two nominations committees. C.1.5 & C.1.6
- Additional provision regarding independent external advisors voting on the nominations committee. C.1.12
- A change to the terms of appointment length for non executive directors. C.2.2
- Recommendation that executive directors are re-appointed for a fixed period of no more than five years deleted.
- Additional provision regarding resignation of directors C.3.1

Section D: Information, development and evaluation

- Additional provision emphasising the need for assurance and challenge of information supplied to the board. D.1.4
- Additional provisions relating to governor and member involvement with the forward plan. D.1.5 & D.1.6
- Further clarification relating to the removal processes for a governor, including the use of an independent assessor. D.2.3

Section F: Accountability and audit

- Additional provisions relating to a report to the board of governors regarding:
- period of time which the external auditor is appointed. F.3.6
- external auditor performance. F.3.8 & F.3.9

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 21 July 2010

AGENDA ITEM NO.	2.11/Jul/10
PAPER	Council of Governors Funding Report
AUTHOR	Part A: Vida Djelic, Interim FT Secretary Part B: Sian Nelson, Membership and Engagement Manager Part: C: Cathy Mooney, Director of Governance and Corporate Affairs
LEAD	Cathy Mooney, Director of Governance and Corporate Affairs
EXECUTIVE SUMMARY	Part A: This paper provides an overview of the use of the Council of Governors budget to Month 3 of FY 10/11. Part B: This paper outlines a proposal for improvements to the Information Zone, to improve engagement between Governors and Members, patients and the public. Part C: Quality Award
DECISION/ ACTION	Part A: The Council of Governors is asked to note the report. Part B: The Council of Governors is asked to agree to funding for improvements to the Information Zone. Part C: The Council of Governors is asked to agree to funding of £2k per year for the quality award for 2010/11.

Part A

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.

The recurring budget was adjusted in the following financial year (2010/11) for the effect of inflation which is estimated at £500 bringing the total budget available in 2010/11 to £100,500.

2.0 Update

The Board of Directors agreed the budget for 2010/11 financial year at its meeting on 29 April 2010.

3.0 Funding Overview

Of the £100,500 circa £54k has been accrued for the activities listed in the table below which were approved by the Council of Governors.
It leaves circa £46k in the budget to be spent for the remainder of the 2010/11 FY.

4.0 Use of funds FY 10/11

TABLE 1

Activity 10/11	Estimate
Trust Open Day 2010	£15,000
Recruitment of new members via Campaign for pre-election	£4,000
Recruitment campaign for the Annual Members' Meeting	£2,000
Directory of Services	£19,817
Discharge Leaflets	£8,200
Learning Disability Membership Leaflet	£1,304
Membership recruitment via Mobile Health Clinic	£3, 539.10
TOTAL:	**£53,860**

Part B

Information Zone

1.0 Introduction

1.1 The Council of Governors funded the Information Zone, as a designated area for governors and members, patients and the public to engage regarding membership matters. The Zone currently has a bench, a membership leaflet stand, and an information screen.

1.2 The Council of Governors Membership Sub-Committee has created a schedule for Governor Sessions within the Information Zone. This creates an opportunity for members, patients and the public to meet a governor, and discuss membership or other matters.

1.3 The Information Zone does not display any governor information and is in need of apparatus to promote the work of governors and provide source of accessibility for members or potential members to contact a governor.

2.0 Aims

2.1 Improvements to the Information Zone

2.2 Aims of Improvements to the Information Zone are to:

- Increase engagement between governors and members or potential members
- Promote governor activities

2.2.1 Discussions have been held with governors who are members of the Membership Sub-Committee. Governors wish to further utilise the Information Zone to reach potential members and engage with members.

2.2.2 Improvements to the Information Zone will include:

1. Supply and installation of a picture board with maple frame. This will display all governors (and Chairman) pictures and contact details.
2. Supply and install an electronic message board. The text can be easily altered on a daily basis and display governor activities or messages.

The use of maple wood is advised so as to keep in theme with the maple wood bench and fencing, which has a smart appearance.

3. Funding

Funding is requested from the Council of Governors for a total of £2,158.48 inclusive of VAT.

The breakdown of costs is:

1. Supply and installation of a picture board with maple frame = £891.83
2. Supply and install an electronic message board = £1, 266.65

4. Action for the Council of Governors

The Council of Governors is invited to comment on the proposal and to support the Membership Sub-Committee request for funding of improvements to Information Zone.

Sian Nelson
Membership and Engagement Manager
July 2010

Part C

Quality Award

1.0 Introduction

It has been suggested that a quality award is created to increase awareness about our quality objectives, to recognise achievements and to encourage further work. This suggestion has met with a positive response from the executive and the Council of Governors quality sub committee.

Discussions have been held about whether this is a monthly, quarterly or annual award and the consensus is that this should be a quarterly award initially. This would run in parallel with the current member of staff/team of the month award run by the HR department ands sponsored by the Charity.

2.0 Aim

The Council is asked to fund this award and for governors to be involved in the judging. It was agreed at the Council of Governors quality sub-committee that the amount should be similar to the Charity awards which would be equivalent to £500 per quarter, divided over the three areas of quality (safety, clinical effectiveness and patient experience).

It is planned that the first awards will be invited in September so it is unlikely that this amount will be spent in year one. Apart from the publicity associated with winning an award, the information submitted will be used for the Trust News and for the website.

Further ideas will be explored e.g. having poster presentations of the awards at the annual members meeting and considering the awards being linked to an educational event around quality.

4.0 Action

The Council of Governors is asked to agree to funding of £2k per year for this award for 2010/11.

Cathy Mooney
Director of Governance and Corporate Affairs
July 2010

Council of Governors Meeting, 21 July 2010

AGENDA ITEM NO.	2.12./Jul/10
PAPER	Annual Members' Meeting 2010 - Proposal
AUTHOR	Matt Akid, Head of Communications
LEAD	Matt Akid, Head of Communications
EXECUTIVE SUMMARY	This is a proposal for the Annual Members' Meeting to be held on Thursday 16 September.
DECISION/ ACTION	The Council of Governors is invited to comment on this proposal to help shape plans for the Annual Members' Meeting.

ANNUAL MEMBERS' MEETING 2010 – PROPOSAL

1. Background

The Annual Members' Meeting is scheduled to be held at **5.30pm** on **Thursday 16 September** in the Restaurant on the lower ground floor of the hospital.

In previous years this has been a well-attended event with several hundred Foundation Trust members and hospital staff in attendance. This is in contrast to other neighbouring Trusts which struggle to attract patients and the public to their annual meetings.

Our Foundation Trust constitution sets the following requirements for the meeting:

- The Board of Directors shall present to Foundation Trust members the annual report and accounts; report of the external financial auditor (included in the annual report and accounts); forward planning information for the next financial year (ie 2010/11)
- The Council of Governors shall present to Foundation Trust members a report on steps taken to ensure that the membership of the Trust is representative of those eligible for membership of the public, patients and staff constituencies; progress on the membership strategy; results of Council of Governors elections; announcement of any Non-executive Directors appointed

Planning for this year's Annual Members' Meeting is at an early stage because the event is in 2 months' time. However, the Council of Governors is asked for its involvement in planning at this stage because the next full Council meeting will not be held until the day of the Annual Members' Meeting.

2. Specific issues surrounding this year's Annual Members' Meeting

The official opening of the new Hospital School in its new location in the hospital has been tentatively arranged to take place at 2pm on the day of the Annual Members' Meeting – Governors will be invited to attend this event, if it goes ahead as planned, before the meeting of the Council of Governors at 3pm in the Boardroom.

Redevelopment of the lower ground floor of the hospital for outpatient services is due to start on 16 August but assurance has been provided by the Head of Estates & Facilities that this will not impact on the Restaurant being a suitable location for the Annual Members' Meeting on 16 September.

The state of the public finances and the possible impact of funding cuts on the NHS is a key public concern at the present time and is likely to be equally high profile in September. Therefore we must consider how this issue is tackled at the meeting to ensure public concerns are addressed under the umbrella of the Trust's *Fit for the Future* campaign to make 10% cost savings in 2010/11.

The redevelopment of the hospital will be well underway by September and so the meeting is an excellent opportunity to inform Foundation Trust members and hospital staff about the *Putting Patients First* campaign to improve services for patients.

3. Aims and themes

3.1 Aims

The Annual Members' Meeting should be a positive event which enables the Board and the Council of Governors to set out the key achievements of the last financial year and plans for the current financial year.

The meeting should also aim to create a genuine dialogue with Foundation Trust members by providing them with an opportunity to ask questions of the Board of Directors and to provide their feedback on the Trust's performance and future plans.

3.2 Themes

It is proposed that the overarching theme of the Annual Members' Meeting should be 'Your hospital, your health, your say' to ensure consistency with the Open Day.

It is also proposed that *Fit for the Future* – how the Trust is making 10% cost savings without compromising the quality of patient care – and *Putting Patients First* – the first major redevelopment of the hospital since it opened in 1993 – should be unifying themes of presentations by speakers at the Annual Members' Meeting.

For decision

- The Council of Governors is invited to comment on the proposed aims and themes of the Annual Members' Meeting.
- The Council is also asked to note the proposed use of the Patient Experience Tracker devices to get feedback on the Annual Members' Meeting from those who attend – in the same way that they were used at the Open Day in May.

4. Format of the meeting

4.1 Statutory presentations (5-10 minutes maximum for each speaker):

1. Chairman
Outline our performance in 2009/10 and our plans for 2010/11 both operationally and strategically. Focus on key issues including quality of care, waiting times, infection control/cleaning, hospital food, administrative pathway etc.

Highlight examples of engagement with Foundation Trust members, the Council of Governors and others in the local community, for example the Open Day, Congestion Charge public consultation, and the mobile community health clinic at Chelsea FC.

2. Chief Executive
Introduce the *Fit for the Future* and *Putting Patients First* themes and explain how we are planning to survive the economic downturn without compromising the quality of care in the context of the current financial and political climate.

Set out the strategy for the Trust and include care pathways and the importance of working in partnership. Examples could include new community gynaecology and dermatology services, the Urgent Care Centre, paediatrics and stroke. This could be illustrated by a diagram demonstrating the pathways and links, with Chelsea and Westminster at the centre, emphasising a 'healthcare' rather than 'hospital' approach and setting this in the context of the White Paper published by the new Government in July.

3. Director of Finance
Presentation of accounts and brief overview of our financial position, in particular how we have used our Foundation Trust freedoms to invest our 2009/10 surplus in developments to improve patient care.

4. Council of Governors representative
Membership report to include an explanation of the role of the Council of Governors.

For decision

- The Council of Governors is invited to comment on the proposed content of the statutory presentations.
- Governors are invited to indicate if they are interested in presenting the membership report at the Annual Members' Meeting.

4.2 Video/DVD (10 minutes – to be shown after the Chairman's presentation):

Following the success of screening an ITN film about the hospital at the Annual Members' Meeting in 2008 and the Paediatric DVD at the Annual Members' Meeting in 2009, it is proposed to consider screening another video or DVD this year.

Possibilities currently being explored include edited versions of either the recent Channel 5 documentary about the Facing the World charity that many Trust staff are involved with or footage of the pioneering work done by Trust staff to care for Landina, a little girl rescued from the Haiti earthquake and brought to the UK for treatment.

For decision

- The Council of Governors is invited to comment on the proposal to screen a video/DVD.

4.3 Votes on proposed changes to the Foundation Trust constitution

If votes on proposed changes to the constitution are necessary, full details will be included in both the Foundation Trust membership mailing which is sent out to publicise the Annual Members' Meeting in August and also the agenda/programme provided at the meeting itself. The Director of Governance & Corporate Affairs will advise if any such votes are required.

4.4 Q&A

At least half of the meeting to be left for questions from the public to be answered by the Trust Board of Directors.

Matt Akid
Head of Communications
July 2010

Council of Governors Meeting, 21 July 2010

AGENDA ITEM NO.	2.13/Jul/10
PAPER	Council of Governors Performance Evaluation Report
AUTHOR	Vida Djelic, Interim Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper summarises the results of the individual self evaluation of the performance of the Council of Governors which was done in early May of this year.
DECISION/ ACTION	The Council of Governors is asked to note the report and discuss and agree any actions if appropriate.

11 responses were received **Each question has been graded from 1 to 11 according to the number of responses received from individual governors**								
No	**Question**	**Excellent**	**Good**	**Adequate**	**Weak**	**Do not know**	**Not applicable**	**Comments**
	Council of Governors meetings							
1.	How well balanced do you feel the agenda is in covering both procedural as well as strategic matters?	2	3	4	1			I have only attended 2 meetings but there seems to be a good mix – the last meeting clearly showing and involving Governors in strategic plans and thinking
2.	How would you rate your level of engagement during the debates held at the Council of Governors meetings?		6	4	1			There is sometimes more 'information giving' than debate and sometimes information is presented at the meeting and governors have to debate there and then, with little time to prepare
3.	How would you rate the meeting schedule and time of the meetings?	2	3	4	2			Sometimes agenda is too big to cope in allotted time. Scheduling OK but never enough time to fully discuss all issues Time is fine with me. The schedule? Agenda? Is very full despite the agenda sub-committee arrangements
4.	How would you rate the balance of discussion between clinical and business issues?	1	3	5	1			Unsure what 'clinical refers to in this context There is not much "discussion "– what takes place is information presentations
5.	How would you rate the balance of discussion between long-term vision and immediate needs?	1	3	3	3			A little one sided
6.	How would you rate the time given for discussion and decision-making at meetings?	1	1	4	5			Needs to be more focussed I am not always clear that a decision has been made on the basis of our discussions. But sub-group work is more likely to have clear decisions Too long is spent on oral presentations and the meeting often overruns as the discussions are not carefully chaired to promote debate – rather people are allowed to digress off the subject. Meetings of large numbers of people are hard to control and the layout of the Boardroom does not help

No	Question	Excellent	Good	Adequate	Weak	Do not know	Not applicable	Comments
7.	How would you rate Council meetings in terms of ensuring open communication, meaningful participation and timely resolution of issues?	1	5	4	1			Difficult to ensure meaningful participation by all when time is so limited I think some training for Governors on how to contribute usefully might be good, and not to only represent your personal views, but your constituent's
8.	How would you rate the Council of Governors papers in terms of receiving timely and accurate minutes; advance written agendas and meeting notices, and clear and concise background material prepared in advance of the meeting?	2	3	3	3			Papers too long, more concise executive summaries needed. At most generally received papers etc one week before the meeting. Often key issues are not given enough visibility in the agenda/papers. They are extensive and need some time for reading. The last set were delayed by internal post. But minutes are well written and accuracy checked I would like fewer oral presentations and more written papers to digest in advance. Minutes: it would be helpful to have the draft minutes soon after the meetings rather than with the following meeting's papers so that written comments could be sent and also as one has a clearer memory of what took place soon after the meeting.
9.	How would you rate the quality of the finance and performance reports?	5	3	2		1		Exception reporting as a cover sheet. Too much received too late. Finance report is too technical
	Council of Governors knowledge							
10.	How would you rate your knowledge and understanding of the Trust's aims and values?	2	6	1	2			I understand the business objectives better than the 'values' of the organisation. I am not even sure we have any – particularly not communicated
11.	How would you rate your understanding of the role of the Council of Governors?	2	6	1	2			I am building an understanding

No	Question	Excellent	Good	Adequate	Weak	Do not know	Not applicable	Comments
12.	How would you rate the information you receive about the required standards of performance from Monitor?	3	5	2	1			
13.	How would you rate your awareness of the number and nature of the Council of Governors sub-committees and their focus of work?	1	8	1	1			
	Council of Governors influence							
14.	How well do you feel the Council of Governors collectively discusses the strategy?	1		7	1	1		We receive the recommendations from the Board This relates to the lack of discussion time. The amount of discussion is sometimes curtailed due to the meeting running over and it takes us a long time to ensure we understand the complexities of the information being given. The separate strategy meeting was very good but there is not time in the general meetings to discuss strategy.
15.	How would you rate the Council's performance in discharging its governance responsibilities appropriately? E.g. approval of financial auditor, self-evaluation, reporting at the annual membership meeting	2	4	2		3		Not been through these processes as yet
16.	How would you rate the incorporation of Governor views into the business plan?	1	2	3	3	2		Was unavailable for the specific meeting regarding business planning, but minutes suggest involvement

No	Question	Excellent	Good	Adequate	Weak	Do not know	Not applicable	Comments
17.	How would you rate the incorporation of Governor views into the Quality Account?	3	2	1	2	2		Individual governors reviewed each draft quality indicator and gave feedback
18.	How would you rate your level of contact with your constituent members? **(Elected Governors)**		2	2	4		2	Without having access to a list of members it is impossible to reach out to my constituents First meeting called with all constituents invited by letter. Only 5 people attended. I think this could be developed more.
19.	How would you rate the impact of the Council of Governors on the overall performance of the organisation?	1	2	4	2	2		Cannot answer at this stage
20.	How would you rate the level of opportunity you have been given to implement and review the Trust's Membership Strategy?	2	4	2	2			I am not in the membership sub-group but this has been raised at full meeting This was done in the sub-committee but I do not think all the members had much input.
21.	How would you rate the opportunities you have had to serve the interests of the community or organisation that you represent?	2	2	4	2			Will be at open day, welcome and well administered meetings. At present they appear to be non-existent I think the public who are members make their own contacts with the hospital rather than going through governors. Governors representation of the public might be promoted by opportunities for them to meet the governors more often.

No	Question	Excellent	Good	Adequate	Weak	Do not know	Not applicable	Comments
	Miscellaneous							
22.	If you are on a sub-committee, how would you rate the membership of the committee in terms of appropriate skill set for the task at hand?	1	4				6	
23.	How would you rate your level of contact with the board of directors?		3	2	5		1	No contact
24.	If a conflict of view occurs, how would you rate the process for conflict resolution in terms of being dealt with in as an open, positive manner?	1	1	3	1	2	3	Have not really seen any conflict of views, but chairman keeps discussion to the agenda and is happy to intervene if we are off scope I am not aware of any conflict of view occurring

No	Question	Excellent	Good	Adequate	Weak	Do not know	Not applicable	Comments
25.	How would you rate your corporate induction which you should have received prior to your first Council meeting? Please use the space provided to suggest additional information/areas to be covered.	2	3	2	2		2	Regular updates should be given as the health care environment has changed radically My induction was less an hour of discussion with a small number of papers given to read. This may have been because I was the only new governor at the time and the then council secretary knew that I am a volunteer in the hospital and therefore aware of some of its functions. I think new governors need to be encouraged to take more part in sub-committees – perhaps they need more information about what the sub-committees are and what they do. New governors need to feel involved from the start – they need contact details of the other governors and information about them gathered from a skills audit. Apart from meeting the CEO, it is important to have a proper visit to the hospital, as many governors are only familiar with small parts of the workings.
26.	How would you rate the current form of the Annual Members' Meeting? Please use the space provided to make further suggestions for future meetings.	2	5	1		2	1	
27.	How would you rate the information your have received about future training sessions? E.g. FTGA	3	3	4			1	Information sent out by e-mail and attached to papers. Might be more robust in suggesting suitable programmes and ensuring all governors get access (bringing training in)
28.	How would you rate the level of support provided by the Foundation Trust to discharge your responsibilities as a governor?	1	6	3				Variable - excellent to poor depending on whom I have had contact with.

No	Question	Excellent	Good	Adequate	Weak	Do not know	Not applicable	Comments
29.	How would you rate your communication with the Trust?		8	2				Define word communication
30.	How would you rate the idea of having a chelwest e-mail account?	1	3			2	3	What would this involve and what format Require more information; what is advantage of having a chelwest e-mail account?

Additional comments:
I think that an audit of governors' skills would be a useful addition to the Council's ability to function effectively. This might also show gaps in governors' knowledge that could benefit from some training.
Note: a skills audit is not the same as the short biographies submitted by prospective governors on their nomination forms.

Results of Self Evaluation

Council of Governors Meetings, Participation and Engagement

- Overall governors feel that the agenda is balanced in covering both procedural and strategic matters but that sometimes it is long
- Overall governors are content with the level of engagement; there was a suggestion to train governors on how to represent their constituent's views rather than personal
- Some members feel there is not enough time for discussion
- Overall governors feels there is good balance of discussion between clinical and business issues
- Seem to be mixed feeling about the balance of discussion between long-term vision and immediate needs
- Overall governors feels there needs to be more time given for discussion and decision-making at meetings
- Overall governors are happy with meetings in terms of ensuring open communication, meaningful participation and timely resolution of issues
- Seem to be mixed feeling about the Council of Governors papers in terms of receiving timely and accurate minutes; advance written agendas and meeting notices, and clear and concise background material prepared in advance of the meeting
- Overall governors feel that the quality of the finance and performance reports is excellent

Council of Governors Knowledge

- Overall knowledge of the Trust's aims and values is good
- Overall understanding of the role of the Council of Governors is good
- Overall the information Governors receive about the required standards of performance from Monitor is good
- Most of governors are aware of the number and nature of the Council of Governors sub-committee and their focus work

Council of Governors Influence

- Overall governors feel that they adequately discuss the strategy, in particular there was a view that the separate strategy meeting was very good but there is not enough time in the general meetings to discuss strategy
- Overall governors are happy with the way they discharge their governance responsibilities
- Seemed to be mixed feeling about incorporation of governors views into the business plan
- Overall governors feel that their views are incorporated into the Quality Account
- Seem to be not very strong contact between governors and constituent members
- Overall governors feel there is adequate impact of the Council of Governors on the overall performance of the organisation
- Overall governors feel content with the level of opportunity given to review and implement the Trust's Membership Strategy
- Most of governors feel they have an adequate opportunity to serve the interests of the community/organisation they represent

Miscellaneous

- Most of Governors feel they are not involved in the sub-committees and those who are feel that the skill set is appropriate for the task
- Overall there is feeling that contact with the Board of Directors is not very strong

- Governors feel there is adequate to not applicable process for conflict resolution
- Overall governors are happy with their corporate induction. There was a suggestion of involving new governors in the sub-committees work as well as providing them with contact details of other governors. One governor suggested a visit to the hospital as a way of understanding the business
- Overall members seem happy with the annual members' meetings
- Governors feel that they receive adequate information about future training sessions
- Overall governors are happy with the level of communications with the Trust
- Seem to be mixed feeling about having a chelwest e-mail account; some governors do not understand the need for it and benefits

Council of Governors Meeting, 21 July 2010

AGENDA ITEM NO.	2.14/Jul/10
PAPER	Appraisal of the Chair and NEDs*
AUTHOR	Vida Djelic, Interim FT Secretary
LEAD	Christopher Edwards, Chairman
SUMMARY	This paper outlines the process for appraising the Chairman and NEDs which will be approved at the Board meeting on 29 July. It reflects the process undertaken at the last appraisal of the Chairman and NEDs. Attention is drawn to point 5 of section 2. The NEDs appraisal process is attached for information. The Council of Governors are not involved in the process but do confirm extension of term of office based on the appraisal process set out in section 6.
DECISION/ ACTION	The Council is asked to note the appraisal process for the Chair and NEDs and that the process will commence shortly. It should be noted that the term of office of the Chairman and the following NEDs expires in October 2010: Andrew Havery, Professor Richard Kitney and Charles Wilson, and that their appraisal will be linked to an extension of the terms of office. Colin Glass is not seeking a further term and therefore appraisal will not be undertaken.

Part A

Chairman Appraisal Process

1 The Role of the Chairman

The post of the Chairman has two different roles: chairmanship of the Foundation Trust Board of Directors and chairmanship of the Council of Governors. It is a statutory requirement that both roles are filled by the same person. The focus of the chairman's appraisal will be his performance as leader of the Board of Directors. The appraisal should carefully consider that performance against pre-defined objectives that support the design and delivery of the NHS foundation trust's priorities and strategy described in its forward plan.

1.1 Chairmanship of the Board of Directors

The main formal responsibility in this role is to provide leadership to the Board of Directors, ensuring its effectiveness in all aspects of its role and setting its agenda.

With the leadership of the Chairman, the Board is collectively responsible for exercising the powers and performance of the Trust. Specifically, these responsibilities include:

- Establishing and maintaining a framework of prudent and effective controls which enable risk to be assessed and managed.
- Ensuring compliance with all statutory and regulatory requirements.
- Setting the Trust's strategic aims, taking into account the views of the Council of Governors, and ensuring that financial and human resources are in place to meet the Trust's objectives.
- Ensuring the safety and quality of healthcare services, education, training and research delivered by the Trust.
- Setting the Trust's values and standards of conduct and ensuring that obligations to all stakeholders are met.

The chairman is also responsible for:

- Ensuring that the Board of Directors and the Council of Governors work together effectively.
- Ensuring that the directors receive accurate, timely and clear information appropriate for their duties.
- Ensure effective communication with stakeholders.
- Facilitate the effective contribution of executive and non-executive directors and constructive relationships between them.
- Performance review of the non-executive directors and the chief executive and advising on their development.

Beyond these formal responsibilities the chairman also needs to:

- Act as an ambassador for the Trust within the wider NHS, with relevant local authorities and partner institutions and to develop constructive relationships with each of these.

- Act as a sounding board and counsel for the chief executive.

- Encourage capitalising on the freedoms of being a foundation trust and the adoption of best commercial management disciplines.

- Be recognised, alongside the Chief Executive, as a leader within the Trust and the wider health community.

1.2 Chairmanship of the Council of Governors

The Chairman's role in relation to the Council is to:

- Ensure the effective joint working of the Council of Governors and the Board of Directors.

- Ensure that the Council of Governors receives accurate, timely and clear information to allow it to fulfil its role.

- Help members of the council individually and collectively to develop their understanding of the Trust and of the role they are required to fulfil.

2.0 The Appraisal Process

The evaluation of the Chairman in the execution of the above role should aim to show whether he continues to contribute effectively and to demonstrate commitment to the role (including commitment of time for board and committee meetings and any other duties).

The SID should lead the actual appraisal and preside at meetings of the Council of Governors for the purpose of seeking their views in relation to the appraisal or to report on the outcome of the appraisal.

The following appraisal process is to be followed:

1. The Chairman should prepare a written statement setting out his/her view of the extent to which the above responsibilities have been fulfilled.

2. The Senior Independent Director (SID) will discuss with the other Non-Executive Directors the Chairman's Performance against the responsibilities outlined above and the statement.

3. The SID will discuss with the Chief Executive the Chairman's Performance against the responsibilities outlined above and the statement.

4. The SID will seek the views of the Executive Directors, including the Director of Governance and Corporate Affairs as Secretary to the Board of Directors

and the Council of Governors, to evaluate the Chairman's Performance against the responsibilities outlined above and to review the statement.

5. The Deputy Chairman of the Council of Governors will seek the views of the Governors on the Chairman’s performance.

6. The SID will collate the feedback and then meet with the Chairman to review his performance, against the responsibilities as described above in relation to the Board of Directors and the Council of Governors, using the written statement and feedback gained, as a framework for discussion.

7. The SID will report to the Council of Governors on completion of the review, confirming whether or not the Chair continues to be effective and to demonstrate commitment to the role.

8. The SID will report to the Board of Directors on completion of the review, confirming whether or not the Chair continues to be effective and to demonstrate commitment to the role.

Part B

NEDs APPRAISAL PROCESS

1.0 Role of a Non-Executive Director - General

NEDs should scrutinise the performance of the management in meeting agreed goals and objectives and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and that financial and clinical quality controls and systems of risk management are robust and defensible. They are responsible for determining appropriate levels of remuneration of Executive Directors and have a prime role in appointing, and where necessary removing, Executive Directors, and in succession planning.

The key role of NEDs is to bring a "real world' (or at the very least an external) focus and influence to the board's discussions - particularly as regards the consideration of strategy and business development and its implementation.

There are a number of other aspects to the role such as:

1. acting as a confidant to and providing advice to Executive Directors and commenting on their ideas/plans
2. serving on board committees: Audit; Assurance; Remuneration; and Finance and Investment Committee
3. helping to maintain an ethical climate and encouraging probity in the conduct of the Trust's business

5.0 Selection Criteria

The following responsibilities and personal specification were used to support the Trust in recruiting its NEDs and they are listed below to provide some background for the appraisal process. These have been used to construct the formal paperwork.

5.1 Corporate responsibility

Shared with other directors, Non-Executive Directors' corporate responsibility includes:

- setting the corporate strategic aims, ensuring that the necessary financial and human resources and infrastructure are in place for the Trust to meet its objectives, and that performance is effectively monitored and reviewed;
- providing entrepreneurial leadership to the organisation within a framework of prudent and effective controls which enable risk to be assessed and managed;
- setting the Trust's values and standards and ensuring that its obligations to its stakeholders and the wider community are understood and met.

5.2 Specific responsibilities

Specific responsibilities of the Non-Executive Directors are to:

- constructively challenge and help develop the Trust's strategic direction and proposals on individual supporting strategies;

- scrutinise the performance of the organisation in meeting agreed goals and objectives and monitor the reporting of performance;
- satisfy themselves on the integrity of financial information and that financial controls and systems of risk management are robust and defensible;
- determine appropriate levels of remuneration and terms of appointment for Executive Directors; and
- take an active part in committees established by the Board of Directors to exercise delegated responsibility, taking part in at least one of these.

5.3 Person specification

Experience, as both an executive and a Non-Executive Director, of leadership and change in a complex commercial or service environment with a multidisciplinary workforce.

S/he will have a strong interpersonal style, able to empathise with and relate easily to people, both internally within the Trust and externally in the wider community.

Ability to:

- work at board level in a commercial environment and demonstrate an understanding of corporate governance requirements;
- contribute specific skills in one or more of a number of areas, including:
    - business development;
    - customer service;
    - marketing/PR;
    - finance; and
    - IT
- demonstrate a clear understanding of executive and non-executive roles and their boundaries;
- support the Executive Directors in their leadership of the organisation, while monitoring their conduct and seeking to uphold the highest ethical standards of integrity and probity;
- question intelligently, debate constructively, challenge rigorously and reach decisions dispassionately;
- listen sensitively to the views of others, inside and outside the Board, and gain the trust, respect and confidence of a wide range of audiences; and
- promote the highest standards of corporate governance and seek compliance with the Foundation Trust's Terms of Authorisation.

6.0 Appraisal Process

A standardised document has been prepared based on information given to NEDs on appointment and is intended to be the basis for appraisals of Non-Executive Directors.

A report and recommendation will be presented to the Council of Governors as part of the process of re-appointment.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 21 July 2010

AGENDA ITEM NO.	2.15/Jul/10
PAPER	Open Day 2010 – Evaluation Report
AUTHOR	Matt Akid, Head of Communications
LEAD	Matt Akid, Head of Communications
EXECUTIVE SUMMARY	This paper is an evaluation report of the hospital Open Day held on 8 May 2010.
DECISION/ ACTION	The Council of Governors is invited to comment on the evaluation report and to provide any further feedback on the Open Day.

1. Introduction

1.1 At its meeting on 2 December 2009 the Council of Governors agreed to fund Open Day 2010 at a cost of £15,000.

1.2 **Open Day 2010** was held from **11am-3pm** on **Saturday 9 May**. It was 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 The overall slogan of the Open Day was 'Your hospital, your health, your say'.

2. Aims and themes

2.1 **Aims** of Open Day 2010, as stated in the proposal for funding approved by the Council of Governors on 2 December 2009 were to:

- Market the Trust to Foundation Trust members and local residents
- Develop communication between Council of Governors elected representatives and Foundation Trust members
- Promote health and wellbeing
- Promote teaching and research
- Seek patient feedback
- Raise the profile of fundraising
- Address issues of public concern
- Foster partnership working
- Improve staff morale

Themes of Open Day 2010, in line with the corporate objectives agreed by the Trust Board for the 2010/11 financial year, were to:

- Improve patient safety and clinical effectiveness
- Improve the patient experience
- Deliver excellence in teaching and research
- Ensure financial and environmental sustainability

3. Implementation

3.1 An Open Day Steering Group provided high level oversight of the Open Day and an Operational Group managed its planning and implementation – Governors were involved in both groups.

3.2 The Head of Communications was responsible for project managing the Open Day including publicity, logistics, liaison with Trust teams, charities and partner organisations that took part in the Open Day, and organising the official opening of the revamped Assisted Conception Unit.

3.3 VIPs who attended the Open Day included 2 local MPs, Sir Malcolm Rifkind and Greg Hands, the Mayor of Kensington & Chelsea, the Deputy Lord Mayor of Westminster, and BBC presenter and newsreader Sophie Raworth who carried out the official opening of the Assisted Conception Unit.

3.5 More than 1,500 visitors attended the Open Day – see section 4 ('Evaluation and feedback') for details.

3.6 Pre-event publicity included:

- Membership mailing to all Foundation Trust members in April including a covering letter from the Chairman and a copy of *Trust News*
- Regularly updated information on the Trust website
- A prominent banner on the front of the hospital
- Flyers and posters distributed widely in the local community by the Communications Department and Governors
- Targeted mailings to GPs, schools, maternity support groups and others
- Pre-event editorial coverage in local newspapers

3.7 Post-event publicity included:

- Photo gallery on Trust website
- Full page of photos in June edition of *Trust News*
- Editorial coverage in local newspapers

4. Evaluation and feedback

More than 1,500 visitors attended the Open Day – feedback was sought from visitors, Open Day participants (both Trust staff and those representing charities and partner organisations), and Governors.

4.1 Visitors' feedback

Open Day visitors were invited to give their feedback by using the Patient Experience Trackers which are used to gather instant patient feedback from patients:

- 97% rated the Open Day as 'Excellent' or 'Good'
- 86% would recommend the Open Day to friends and family
- 93% said staff at the Open Day were friendly and approachable

4.2 Staff feedback

All staff involved in the Open Day – both those working for the Trust and those from charities and partner organisations that participated – were invited to give feedback either at the post-Open Day meeting on the following Monday or via email. Feedback was largely positive – this is a small representative sample:

Dot Davidson (Nurse Manager, Treatment Centre)
"It was a great day and we seemed to be busier than ever this year giving visitors tours of the operating theatres in the Treatment Centre."

Heather Lawrence (Chief Executive)
"We now put on a professional Open Day which is a credit to everyone concerned. Our partnership with ISS Mediclean stands out on such occasions and is recognised by external visitors."

Frank Johnson (Information Exchange Co-ordinator, St Stephen's Centre)
"The day seemed to have a very good atmosphere and the music was good. Everyone enjoyed themselves and I had a great team of volunteers on the Welcome Desk who provided an enthusiastic service."

Kim Crosby (Carers Network Westminster)
"Everyone involved with the Open Day should be very proud of their work. What a creative, interesting, vibrant event."

Catherine Sands (Emergency Planning Officer)

"It was my teenage daughter's first Open Day and she commented on how friendly everyone was and how genuinely impressed she was with the event – praise indeed!"

Lynne Frankland (Friends of Chelsea and Westminster Hospital)
"It was a lovely event with a great atmosphere and as far as the Friends were concerned it was a good day as we raised over £800 but I do wonder at the amount of resources, staff time and marketing publicity materials spent on the event given the visitor numbers."

We will analyse all feedback to learn lessons for future Open Days.

4.3 Governors' feedback

Governors were contacted in June and invited to give their feedback on the Open Day – the following responses were received:

Chris Birch
"I thought the Open Day was good. There seemed to be more music than in previous years and that helped to create a lively, enjoyable atmosphere. Our new mobile clinic, parked outside the main entrance, was a welcome addition to the Open Day, illustrating our outreach work.

"I got the impression there were slightly less visitors than last year and we still haven't got the Governors' stand quite right. We had a fairly wide table outside the Information Zone, with Governors standing in front of it, which allowed very little room for people to pass by. Next year I think we should use the inside of the Information Zone but with a banner and a couple of Governors outside the Zone to encourage people to come inside and learn about the Trust and membership."

Alan Cleary
"The event was a resounding success in my view and all the staff that supported the Open Day should be congratulated and thanked personally."

Sandra Smith-Gordon
"I thought it was an excellent day and very well organised, although maybe a bit more pre-publicity would have been good. I think we should continue to hold the Open Day every year."

5. Budget

The Council of Governors agreed to provide £15,000 funding for the Open Day – a checklist of costs paid from this budget are provided below:

Printing (publicity materials, programme etc)	£1,880.44
Furniture hire (tables, chairs etc)	£2,246.48
Balloons	£941.18
T-shirts	£1,857.23
Official photographer	£260
Facepainter	£200
Live music/children's puppet show	£1,380
ISS Mediclean (staff refreshment vouchers etc)	£3,369.12
Dr Foster (Patient Experience Tracker)	£526.50
Petty cash support for Trust teams (up to £25 each)	£188.64
Total	**£12,849.59** `

6. Actions for the Council of Governors

The Council of Governors is invited to comment on the evaluation report and to provide any further feedback on the Open Day.

Matt Akid
Head of Communications
July 2010

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 21 July 2010

AGENDA ITEM NO.	2.16/Jul/10
PAPER	Proposed Abolition of the Western Extension of the Congestion Charge Zone
AUTHOR	Matt Akid, Head of Communications
LEAD	Heather Lawrence, Chief Executive
EXECUTIVE SUMMARY	This report outlines the Trust's activities in relation to Transport for London's current consultation on proposed changes to the Western Extension of the central London Congestion Charging Zone. The paper sets out the background of this and describes the activities already taken to garner support for the abolition of the Western Extension of the Congestion Charge. The consultation ends on Monday 2 August 2010.
DECISION/ ACTION	The Council of Governors is asked to note the actions taken to engage with staff, Foundation Trust members and other key stakeholders on this issue and to consider whether the Council should respond to the consultation formally.

1. INTRODUCTION

1.1 The Mayor of London, Boris Johnson, has published his new Transport Strategy which states that, subject to consultation, he will make changes to the existing Congestion Charge arrangements including abolishing the Western Extension with effect from 24 December 2010.

1.2 The statutory consultation period is now open and the Trust Board confirmed its support for the proposed removal of the Western Extension at its meeting on 24 June 2010. The Trust has also encouraged staff, Governors and members to support its position and respond to the public consultation.

2.0 BACKGROUND

2.1 In February 2007, the Western Extension of the central London Congestion Charging Zone was introduced, placing Chelsea and Westminster Hospital within the zone and making the majority of our patients, staff and visitors liable for the £8 daily congestion charge.

2.2 At the time, the Trust lobbied strongly on behalf of staff and patients to both the previous Mayor of London and also our local MP to argue against its introduction, but this was unsuccessful.

2.3 In September 2008 the Chief Executive presented a paper to the Members' Council outlining the Trust's intention to respond to a non-statutory consultation carried out by Transport for London relating only to the future of the Western Extension. Stakeholders were asked for their views on whether the Western Extension should be kept, removed or changed.

2.4 The results of this informal consultation showed that the majority of stakeholders supported the removal of the Western Extension and it was recommended that the Mayor of London proceed to formal consultation with a view to removing the Western Extension.

3.0 RESPONSE TO CONSULTATION

3.1 The formal consultation period has opened and the Chief Executive will formally respond on behalf of the Trust to support the abolition of the Western Extension before the consultation ends on Monday 2 August.

3.2 The Chief Executive wrote to the Council of Governors and those Foundation Trust members who supplied their email addresses when joining the Trust , encouraging them to support the hospital by responding to the public consultation. The Trust provided some suggested wording which people can use if they wish to respond.

3.3 Chelsea and Westminster staff have also been asked to provide support. An email from the Chief Executive was sent to all staff explaining the consultation and asking for their support and further information was provided in July's Trust News and Team Briefing.

4.0 DECISION / ACTION REQUIRED

4.1 The Council of Governors is asked to note the Trust's activities and to confirm if they wish to submit a formal response to the public consultation.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 21 July 2010

AGENDA ITEM NO.	3.1/Jul/10
PAPER	Finance Report – May 2010
AUTHOR	Kelda Alleyne, Deputy Director of Finance
LEAD	Lorraine Bewes, Director of Finance and Information
EXECUTIVE SUMMARY	The Trust begins a new financial year with a full year planned income of £315m and profit measured by EBITDA (earnings before interest, depreciation & amortisation) of £30.9m and a planned net surplus of £12.4m after financing charges and depreciation. The Trust has achieved a net surplus to month 2 of £2.3m which is £0.9m (59.5%) ahead of budget. EBITDA was £5.1m which is £0.6m (13.5%) ahead of budget. However, within this position is a benefit of £0.9m related to prior year over-performance income. Therefore the underlying position is broadly on plan for the first 2 months but pressures in non pay are evident. Pay is £0.2m behind budget YTD, which includes unidentified Cost Improvement Programmes (CIPs) built into the budget phasing. After salary recharges, the pay position is broadly on target with budget (£27k behind budget) Non-Pay is £0.8m behind budget YTD, due to unidentified CIPs within budget position (£0.3m); over-performance on the baseline contract within Pathology SLA (£0.1m); and increase in bad debt provision (£0.3m) to recognise some specific potential debt challenges related to Month 12 freeze of SAFF income. For 2010/11 the Trust has a very challenging CIP target of £22.6m (10%) and has identified 80% so far, of which 48% is achieved or low risk and 32% medium and high risk. The main risk areas to achieving the overall CIP rest with Pathology SLA, Central Budgets relating to the Fulham Road Alliance and Surgery and Medicine. The key assumptions and risks to note are: • The Trust has just under £4m of income (1.5% of PCT income) which will only be paid if quality improvement targets are achieved under the Commissioning for Quality and Improvement scheme (CQUIN). At this stage it is assumed that 75% of CQUIN income is achieved as per budget. The risk remains that less than 75% of

	some CQUINS could be identified, which would affect the bottom line. • There are a number of low priority procedures that the Commissioners will not fund if they are not clinically indicated. The Trust has agreed that an audit to identify the activity related to low priority procedures will be carried out during the year and the PCTs will pay activity based on the outcome of the audit. Provisionally 50% has been assumed to be payable for month 2 in line with plan. • There are unresolved data challenges from the North West London Commissioning Partnership (NWLCP) which are still being quantified for consideration by the Directors of Finance. A provision for 09/10 data challenges has been built in which is expected to be more than sufficient. The responsibility for challenging data is planned to move from the NWLCP to a new organisation, CSL, who will eventually carry out data validation for all of London commissioners. Whilst £18m of the CIP target of £22.6m has been identified, only £10.9m is achieved or low risk and £3.5m of the identified is high risk. The Executive will continue to be working with Divisions to identify plans to recover the gap, with a weekly focus at Monday Executive meetings to discuss CIPs. A full forecast will be completed for month 3. Taking into account the challenge to identify and deliver against CIPs at this stage, there is a significant risk to delivering the full year planned EBITDA and net surplus despite the one off income benefit identified to date.
DECISION/ ACTION	The Council is asked to note the financial position for the 2 month period to 31st May 2010 and the updates in this report.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 21 July 2010

AGENDA ITEM NO.	3.2/Jul/10
PAPER	Performance Report – May 2010
AUTHOR	Sherryn Elsworth – Head of Performance Improvement
LEAD	Mark Gammage – Deputy Chief Executive
EXECUTIVE SUMMARY	The purpose of this report is to update the Council on the Trust's performance for the period ending 31st May 2010 and to highlight performance risks going forward. The CQC has yet to publish the indicators, thresholds and scoring methodology for this year's assessment so a continuation of the 2009/10 assessment framework is assumed for monitoring purposes. The Trust performed well year to date in nine of the eleven Monitor indicators and in twenty of the twenty six Care Quality Commission indicators which are measured at month two. There are some areas where improvement is needed including MRSA bacteraemia, clostridium difficile, outpatient slot availability through choose & book, use of the patient experience tracker and timeliness of discharge summaries.
DECISION/ ACTION	The Council is asked to note the report.

PERFORMANCE REPORT FOR THE PERIOD MAY 2010

1. PURPOSE

1.1. The purpose of this report is to provide information about the Trust's performance for the month of May 2010. The Council is asked to note the report and conclusions.

2. CONTENT OF PERFORMANCE REPORT

2.1. The performance report comprises the following components:

- **Executive Summary**
- **Monitor Indicators**
- **Care Quality Commission Indicators**
- **18 week performance**
- **Discharge summary performance**
- **Choose and book performance**
- **Efficiency performance**
- **Commissioning for Quality and Innovation (CQUIN) targets**
- **Contract KPIs/penalties**
- **Stretch target performance**
- **Human Resources performance**
- **Performance dashboard**
- **Conclusion**

3. PERFORMANCE REPORT

3.1. EXECUTIVE SUMMARY

3.1.1 SUMMARY PERFORMANCE

The Trust has performed well year to date month 2, achieving the required performance level in nine out of eleven of the CQC indicators at month 2 and twenty out of the twenty six Monitor indicators which could be measured.

3.1.2 YEAR TO DATE PERFORMANCE ISSUES

The Trust has not achieved the required performance level in the following indictors year to date and action is required to improve the position going forward.

Target	Performance
C Diff	Year to date 18 cases against full year targets of 16.7 (CQC), 10.8 (local stretch target A), 5.8 (local stretch target B)
MRSA	Year to date 2 cases against full year targets of 3 (CQC), 6 (Monitor),10 (local stretch target A), 5 (local stretch target B)
Slot issues per Directly	31% against a target of less than 4%

Bookable Service booking	
Discharge Summaries within 24 hrs	Year to date 80.19% against a contractual target of 100%
Patient Experience Tracker	Year to date completion rate of 35.42% against a Quality Account target of 80% and satisfaction rate of 89% against a Quality Account target of 90%

3.1.3 OTHER AREAS OF CONCERN GOING FORWARD

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

Target	Issue
18 weeks admitted care performance	Some high volume specialties have been very close to a breach position (General Surgery, Urology, Trauma & Orthopaedics) and some low volume specialties have been very close to a breach position or have in fact breached the target, but not in that instance caused the overall low volume specialty aggregate to breach (Paediatric: Dental, Plastic Surgery, ENT, Surgery). The area of most concern going forward is Paediatric Dental where the directorate is predicting significant capacity problems from June onwards caused by a mismatch between capacity and the phasing and volume of demand and a plan is being implemented to address this issue.
18 weeks non admitted care performance	Some high volume specialties have been very close to a breach position (General Surgery, Urology, Trauma & Orthopaedics, Cardiology, Neurology) and some low volume specialties have been very close to a breach position or have in fact breached the target, but not in that instance caused the overall low volume specialty aggregate to breach (Pain management, Hepatitis Clinic, Paediatric: Surgery, Dental, Plastic Surgery, Gastroenterology) (as listed above).
Cancer performance	Total cancer patient numbers are low so any individual breach of the cancer target has a disproportionately high impact on overall cancer performance.
Elective MRSA Screening rates	The Trust's overall ratio of admissions to MRSA tests is acceptable but detailed analysis shows that some patients are tested more than once and some patients may not be screened at all.

MONITOR INDICATORS

3.2. There were no cases of MRSA bacteraemia in May. The Trust had 2 cases in April. The Trust objective for the full year 2010/11 is 3 cases, however Monitor applies a "de minimis" limit of 6 cases per year and the Trust will

therefore not be deemed to be in breach of this objective as long there are no more than 6 cases across the year.

3.3. The number of C Difficile cases in May was 9 and the Trust had 18 cases year to date against a threshold of 16.7 derived from our annual target of 100 cases. C Diff detection rates in 2010/11 are likely to be higher than 2009/10 due to a more accurate laboratory test introduced on 15th April 2010. This new test is 100% sensitive to detecting the C Diff toxin, whilst the previous test was approximately 60-70% sensitive. We therefore expect higher monthly C Diff detection rates in 2010/11 compared to 2009/10 (there were 32 cases in full year 2009/10) and at current performance levels are at risk of breaching our agreed target of 100 cases and of not achieving either of our stretch targets of 65 (worth £100k) or 35 (worth £150k). The infection control team are in the process of analysing the breaches which have occurred year to date to ascertain whether all of the increase in confirmed cases is as a result of the new test and discussions are taking place with Kensington & Chelsea PCT and the North West London Commissioning Partnership regarding the appropriateness of the current targets given the impact of the new test.

3.4. Our year to date performance on the 18 week target was 94.04% for admitted care (against a target of 90%) and for non-admitted care was 99.37% (against a target of 95%).

3.5. Our performance on the maximum waiting time of 31 days from diagnosis to treatment for all cancers up to May was 100% (against a target of 96%).

3.6. Our performance on the maximum waiting times of 31 days for second or subsequent treatment anti cancer drug treatments up to May was 100% (against a target of 98%).

3.7. Our performance on the 62-day wait for first treatment from urgent GP referral to treatment up to May was 96.23%(against a target of 85%).

3.8. Our performance to date for the 2 week wait for urgent referral cancer target was 94.43% (against a target of 93%).

3.9. Our year to date A&E performance was 99.01% which is above target.

3.10. Access to healthcare for people with a learning disability is a new target. The current Trust position is based on the 2009/10 assessment which was undertaken at 31st March 2010. A gap analysis has been undertaken and we are scored as partially met. A steering group has been convened to oversee the development of an action plan to ensure this indicator is fully met for the year 2010/11.

3.11. Where the Monitor indicators are also CQC indicators, the RAG rating used is as per the CQC defined methodology.

CARE QUALITY COMMISSION

The CQC has not yet published the first phase of the 2010/11 periodic review indicator constructions; this is expected at the end of June. Therefore, we will continue monitoring national and existing commitments indicators as per last year until details of the 2010/11 indictors are published.

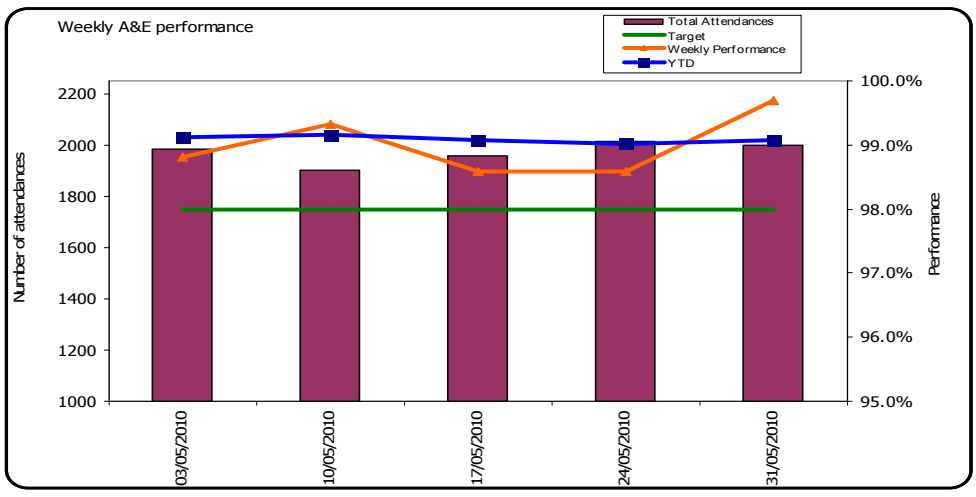
Existing commitments indicators

3.12. The Trust's performance for Access to Genito-Urinary Medicine (GUM) clinics year to date is 100%.

3.13. The Trust's performance for data quality for ethnicity for May was 93.66% and 95.53% year to date against an internal annual target of 95% (the CQC target is 85%). Performance will be reviewed and discussed and action plans implemented to ensure compliance. Performance reports are being sent to the Divisions for monitoring purposes.

3.14. The Trust continues to perform well on delayed transfers of care with performance year to date of 1.38% against an expected threshold of 3.5%.

3.15. Our performance for waiting times in A&E below the 4 hour wait was 98.84% for May and performance year to date was 99.01% against an expected target of 98%. A&E activity and 4 hour wait performance since the start of the year is illustrated in Graph 1 below.



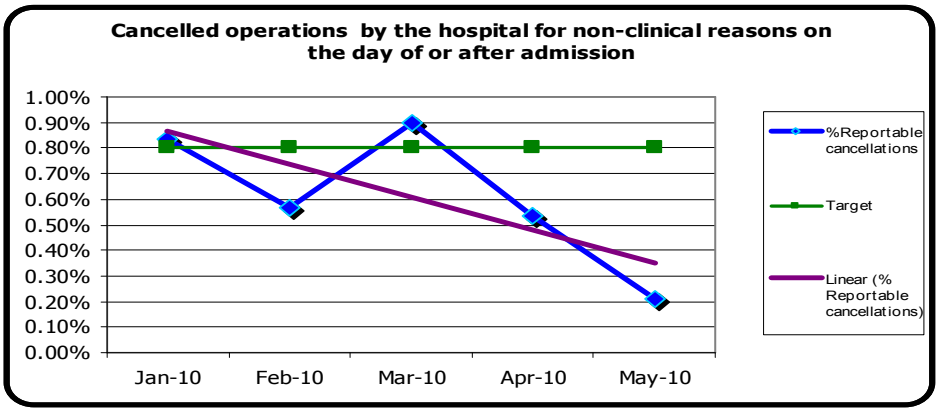
Graph 1 Accident & Emergency performance

3.16. Our Performance for the Rapid Access Chest Pain Clinics in May was 100% compared with an expected threshold of 98%.

RACPC				
Month	**Total number of patients**	**% Complete**	**Patients seen within the target**	**Target**
April	26	100.00%	26	**98%**
May	39	100.00%	39	**98%**
YTD	65	100.00%	65	**98%**

Table 1 *RAPC analysis*

3.17. Our performance against the guarantee for patients to be treated within 28 days following cancellation for non-clinical reasons is 0% (against a target of no more than 5%) and our performance to date for cancelled operations by the hospital for non-clinical reasons is 0.37% (against a target of no more than 0.8%).



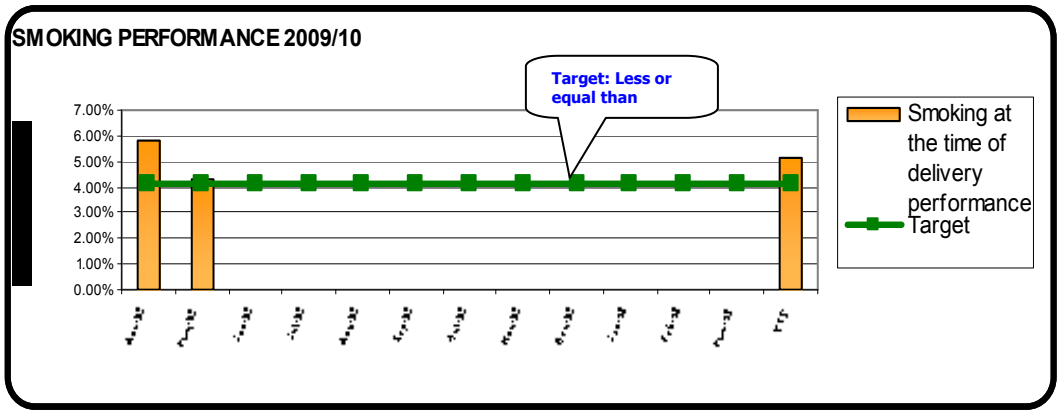
Graph 2 Cancelled operations

National Priority indicators

3.18. Our May performance on data completeness for breastfeeding initiation year to date is 99.63% (against a target of 95%) and data completeness for smoking during pregnancy was 99.88% (against a target of 95%).

3.19. Our performance regarding women known to be smokers at the time of delivery year to date is 5.11% (against a target of no more than 4.13%).

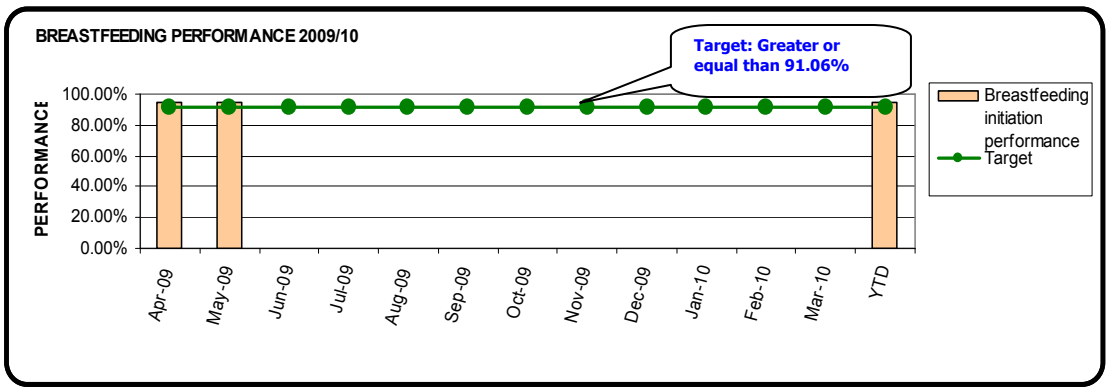
3.20. Our performance regarding women known to be smokers at the time of delivery for May was 4.34%.



Graph 3 Smoking performance

3.21. Our performance for breastfeeding initiation year to date was 94.65% (against a target of 91.06%).

3.22. Our performance for breastfeeding initiation in May was 94.90%.



Graph 4 Breastfeeding performance

3.23. The Stroke indicator looks at the percentage of stroke patients who are treated in the stroke unit. The Trust performance year to date for this indicator is 100% against a target of 80% as set in the Vital Sign's framework for PCTs.

The TIA assessment has been dropped from the CQC assessment. However, we continue to monitoring TIA performance. Most TIA patients are being seen within 24 hours. TIA performance for May was 100%.

3.24. RAG rating is as per the CQC defined methodology.

4. 18 WEEK ACTIVITY

4.1. 18 week performance for May 2010

	Treated within 18 weeks		**Not treated within 18 weeks**		**Total volume**	**Unknown clock start date Volume**	**Data Completeness** (Internal target 90-110%)
	%	Volume	%	Volume			
Admitted	**93.79%**	1072	6.21%	71	1143	0	**91.37%**
Non-admitted	**99.39%**	10664	0.61%	65	10729	0	**91.08%**

Table 2 *18 weeks performance May 2010*

4.2. The Trust achieved both the admitted and non-admitted target overall but there were some high volume specialties close to breach for the month (Admitted care: General Surgery and Urology; Non-admitted care: General Surgery, Urology, Trauma & Orthopaedics) and low volume specialties which breached (Admitted care: Paediatric Dental; Non-Admitted Care: Paediatric Dental, Paediatric Plastics, Paediatric Surgery) or were close to breach (Admitted care: Paediatric Plastics; Non-admitted care: Pain Management).

4.3. Predicted 18 week performance for June 2010

	Treated within 18 weeks		**Not treated within 18 weeks**		**Total volume**	**Unknown clock start date Volume**
	%	Volume	%	Volume		
Admitted	**90.71**	1083	9.29%	111	1194	0

Table 3 Predicted 18 week performance for June 2010

4.4. The Trust is currently predicted to achieve the overall admitted care target for June however there are risks around specific specialties. Urology and Plastics are currently predicting performance levels of 89.47% and 89.70% respectively, very close to the target of 90% and these specialties should achieve 90% following further validation and review of clock stops by the directorate. Predicted performance for the low volume specialty aggregate deteriorated in month and is now at 88.81%. This is predominantly driven by Paediatric Dental breaches and a smaller number of Paediatric Plastic and Paediatric Surgery breaches. General Managers have been asked to review administrative and clinical validations of breaches, identify any additional clock stops and maximise the volume of activity in specialties which fall within the low volume specialty aggregate in order to mitigate this performance risk. It is not yet known whether in month specialty breaches will continue to be allowable by the CQC in 2010/11.

4.5. Paediatric Dental has been highlighted as an 18 week performance risk going forward due to a mismatch between capacity and the volume and phasing of demand. This is a significant performance risk to the organisation as it will cause the 18 week performance in the low volume specialty aggregate to be at risk for Q2 and Q3 which would be likely to adversely affect our rating. The directorate is working on a plan to manage the short term risk and has been asked to develop and submit proposals for a longer term solution to the recurrent capacity gap as soon as possible.

DISCHARGE SUMMARY TARGET

4.6. The May 2010 Monthly Discharge Summary performance has dropped to 79.96% with performance year to date at 80.19% against a target of 100% within 24 hours. The divisions are assessing the reasons for the change in performance and are putting together action plans to rectify the problem.

5. CHOOSE AND BOOK

5.1. The slot issues per successful booking indicator is measured by the proportion of slot issues against the number of DBS bookings made successfully. Our contract target is to have no more than 4% slot issues. Our year to date rate is 31.91%.

5.2. At the Patient Access, Booking and Choice Steering Group in June an overall trajectory was proposed to reduce and then sustain appointment slot issues to below the target of 4% by December 2010. As the high rate of slot issues is due to a lack of consistent capacity available to Choose and Book, this will be achieved through demand and capacity work within all specialties experiencing slot issues. Initial demand and capacity meetings with the directorates will have been completed by the end of June and robust plans will ensure a reduction in slot issues month on month until the December target of 4% is achieved.

5.3. We are also measuring the average poll length as low average poll lengths tend to have an adverse impact on slot availability. This snapshot, taken at the end of the first week, shows the number of slots polled within each specialty over the coming 13 weeks.

Measure	Apr-10	May-10
1 - Slot issues	355	453
2 - DBS bookings	1231	1301
3 - Issues per booking	28.84%	34.82%
4 - Average slot poll	6.9	7.01

Table 4. *Choose and Book indicators*

5.4. We do not expect to be assessed by the CQC on our Choose & Book performance in 2010/11 but have continued to monitor as it is one of our contractual indicators. The Patient Access Booking and Choice Steering Group has been established to develop and oversee the implementation of a plan to resolve Choose and Book slot issues and deliver against a performance improvement trajectory to be agreed with the North West London Commissioning Partnership.

6. EFFICIENCY (AND OTHER TARGETS)

6.1. At the end of May 99.54% of clinical coding was being completed within the 7 day target. The internal target for the year is 98%.

6.2. Efficiency and Use of Resources

- The Trust's day case rate was 73.18% for the year to date ending May 2010.
- Elective average length of stay year to date is at 3.28 (against the existing target of 3.00) and non-elective average length of stay year to date is also ahead of plan at 3.10 (against the existing target of 4.00).
- The percentage of outcomes recorded in outpatients in May 2010 was 93.88%.

7. Commissioning for Quality and Innovation Targets (CQUINs)

7.1. CQUINs are quality targets associated with additional income over and above contract baseline values. In 2010/11 the CQUIN value is set at 1.5% of contract value. CQUINs are set at national, regional and local level. National and regional CQUINs have been set for 2010/11 and local CQUINs are in the process of being agreed.

7.2. The majority of the CQUIN targets have associated data collections due by close of quarter 1 in order to define baseline performance against which an improvement trajectory is to be agreed with commissioners for delivery across the remaining 3 quarters. In some cases the baseline performance assessment methodology will be provided by NHS London. An implementation plan with devolved responsibility for key milestones will be developed for each CQUIN and monitoring arrangements put in place to track delivery.

8. CONTRACT KPIs / PENALTIES

The contract contains a lengthy schedule of contractual KPIs (summary performance attached as appendix 7), some of which are associated with direct financial penalties for failure to achieve the required level of

performance, some KPIs are for monitoring without financial impact and some refer to clause 32 where the Trust will be required to produce an action plan if performance is off track and may incur financial penalties if the action plan is not delivered and if performance does not improve. Many of the KPIs in the contract schedule are also Monitor or CQC indicators and performance has already been discussed earlier in this report. The most significant additional area of performance concern relates to the KPI which outlines that less than 4% of bookings should be associated with a slot issue, i.e. less than 4% of people should have a problem trying to book at an appointment on Choose & Book. As highlighted in 3.2.1 the Trust's performance is currently at 31.91%. The Patient Access, Booking and Choice Steering Group has been established to oversee the delivery of this target. The group has developed an improvement trajectory which will be presented to the June Clinical Quality Group for agreement. The divisions are working up individual plans to meet the trajectory.

9. STRETCH TARGETS

Neither of the MRSA or C Difficile stretch targets were achieved in May, however these are annual targets so if performance improves across the rest of the year it will still be possible to achieve additional income in this area. The Trust achieved stretch target A in 2009/10 in both MRSA and C Difficile.

10. HUMAN RESOURCES PERFORMANCE

10.1. Performance against key HR Metric targets are outlined in the table below.

HR Metric	Target	2009/10	Year to Date
Turnover rates	14%	14.6%	**13.08%**
Stability rates	96%	95.9% (excluding Jnr Drs)	To be presented Quarterly
Vacancies: total active	 10% 4%	 14.98% 4.1%	 **14.1%** **3.1%**
Sickness absence rates	3.6%	3.70%	**3.24% (April 2010)**

Red - below target and below 2009/10
Amber – below target but above 2009/10
Green – above target and above 2009/10

10.2. In May, the Trust staff in post stood at 2741WTE with the substantively employed workforce increasing by 123 wte (4.7%) since May 2009.

Unplanned turnover (i.e.: resignations) increased in May 2010 to 1.31%

Projected turnover for the year 2010/11 currently stands at 13.08%, although we anticipate this will reduce further.

10.3. The Trust's vacancy rates are calculated using the budgeted wte (based on reconciliations with the Finance department), and the wte staff in post at the end of the month. This represents the 'total vacancy' position.

The full Trust vacancy rate for May 2010 increased to 14.1% .The 2009/2010 monthly average vacancy figure was 14.98%.

A truer measure of vacancies is those being actively recruited to, based on unique jobs being advertised through NHS jobs throughout May. The active vacancy rate is currently 3.1%

10.4. The Trust's sickness rate decreased in March 2010 with a rate of 3.24%. Although lower than the 2009/10 YTD average (3.48%) this was higher than the April 09 rate (2.85%)

The number of sickness days by department (cost centre) and short/long-term absence is available in the 'Monthly Sickness by Department' report.

All departments have been asked to focus on the management of sickness absence.

10.5. The Trust showed a decrease in Bank and Agency usage for May 2010, down by a total of 5.82 WTE on April. Agency usage continues to be significantly lower than last year (down 37%: 74 WTE).

11. TRUST DASHBOARD

The recently developed Trust dashboard provides a visual display of performance in key indicators. Not all the data required to fully populate the dashboard has been available for month two. It is hoped that additional data will be available to ensure that the vast majority of the dashboard can be populated for month three. Feedback on the content or composition of the dashboard is welcome. The RAG rating of the dashboard differs slightly from that on the CQC / Monitor pages where the indicators are RAG rated according to a CQC defined methodology. The dashboard is the key tool for the organisation to identify areas where action is required to improve performance so it has been decided to RAG rate as red all performance areas which are below target. The RAG rates will be updated to orange once there

has been Exec Lead confirmation that there is a low risk plan in place to deliver the required performance level. The RAG rating will be updated to green once performance is above the required threshold.

12. CONCLUSION

12.1. The Trust met all Monitor targets as at end May 2010 apart from those described above.

12.2. The CQC assessment framework should be confirmed in late June.

12.3. The key performance challenges in 2010/11 are likely to include:

- Achieving the 18 week wait targets on both an aggregate basis (each month) and by specialty (across the quarter)
- Achieving cancer targets since total numbers are low and each breach has a proportionately high impact on performance. Performance may also be adversely affected by patient choice in the diagnostic phase.

- Achieving the MRSA bacteraemia and C-difficile target.

- Ensuring timely production of discharge summaries.

- Increased use of the Patient Experience Tracker.

- Delivering the extensive programme of work required to achieve the CQUIN payments and perform well against contract KPIs.

- Responding to commissioner queries regarding performance variation.

APPENDIX 1 YEAR TO DATE PERFORMANCE ISSUES

The Trust has not achieved the required performance level in the following areas year to date and action is required to recover the position:

Target	Performance
MRSA	Year to date 2 cases against full year targets of 3 (CQC), 6 (Monitor),10 (local stretch target A), 5 (local stretch target B)
C Diff	Year to date 18 cases against full year targets of 16.7 (CQC), 10.8 (local stretch target A), 5.8 (local stretch target B)
Hand Hygiene	Year to date 84.05% completion and 68.97% compliance against Quality Account targets of 90%
% Women smoking at time of delivery	Year to date 5.11% against a CQC target of 4.13%
Discharge Summaries within 24 hrs	Year to date 80.19% against a contractual target of 100%
Patient Experience Tracker	Year to date completion rate of 35.42% against a Quality Account target of 80% and satisfaction rate of 89% against a Quality Account target of 90%
Complaints & Concerns re admissions and appointments	96 year to date against a Quality Account target of 36
Complaints responded within target time	86.96% against a Quality Account target of 90%
Outpatient encountering completion	95.86% against a contractual target of 100%
Vacancy rate	13.9% against an internal target of 10%
Day Case Rate (basket of procedures)	75.09% against a contractual target of 95%
18 week RTT completion	90.49% against an internal target of 100%
Diagnostic wait >6 weeks	0.29% against a contractual requirement of 0%
Slot issues per DBS booking	31.91% against an contractual requirement of < 4%
A&E minors seen within 4 hrs	99.71% against a contractual target of 100%
No A&E patient to wait for admission more than 4 hours from decision to admit	2.83% against a contractual target of 0%
Ethnicity Data Quality	93.53% year to date against a target of 95% (internal), 85% (CQC)

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 21 July 2010

AGENDA ITEM NO.	3.3/Jul/10
PAPER	Annual Report including Quality Report (Account)
AUTHOR	Matt Akid, Head of Communications
LEAD	Matt Akid, Head of Communications
EXECUTIVE SUMMARY	Enclosed is a link to the Annual Report & Accounts and the Quality Report. http://www.chelwest.nhs.uk/aboutus/annual-reports.html http://www.chelwest.nhs.uk/aboutus/qualityaccount.html Hard copy versions of the Annual Report & Accounts and Quality Account are currently being printed and will be available at the Council meeting.
DECISION/ ACTION	To note.