Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting
Hospital Boardroom
Chair: Prof. Sir Christopher Edwards
Date: 12 July 2012 Time: 4.00pm

Agenda

		Lead	Time
1	**GENERAL BUSINESS**	**CE**	4.00
1.1	Welcome & Apologies	CE	
1.2	Declaration of Interests	CE	
1.3	Minutes of Previous Meeting held on 3 May 2012 draft (attached)	CE	
1.4	Matters Arising (attached)	CE	
1.5	Chairman's Report (oral)	CE	4.10
2	**ITEMS FOR DISCUSSION/DECISION/APPROVAL**		
	GOVERNANCE		
2.1	Presentation of Annual Accounts & Annual Report 2011/12 (attached)	LB/CE	4.15
2.2	External Auditors' Report on the Annual Accounts 2011/12 (attached)	HB	4.25
2.3	Report on the external assurance audit of the Quality Report year ended 31.03.2012 (attached)	HB	4.35
2.4	Audit Committee Annual Report 2011/12 (attached)	JB	4.45
2.5	Shaping a Healthier Future – consultation update (oral)	MA	4.55
2.6	Shaping a Healthier Future – communication and engagement plan (attached)	MAk	
2.7	Health and Social Care Act 2012 – briefing and review of constitution (attached)	CE/CM	
2.8	Membership Recruitment, Engagement and Communications Strategy 2012/13 (attached)	MAk/TP	
2.9	Council of Governors Quality Sub-Committee Terms of Reference* (attached)	CM	
2.10	Annual Members' Meeting Proposal (attached)	MAk	
	COUNCIL OF GOVERNORS		
2.11	Governors' Questions (attached)		
	- Are there are any plans to redecorate some of the clinics and corridors? (ML)	MA	
	- May we please have a report explaining in simple terms and relating specifically to our Foundation Trust the system described under the heading "Accountability and Governors" in the Paper "Accountability in Action" recently circulated?(ACle)	CE	
2.12	Report on Senior Nurse/Governor Rounds (attached)	TP	6.05
2.13	Council of Governors Funding Report (attached)	CM	6.10
2.14	The tenth FTGA National Development Day - 14 March 2012 & FTGA Mental Health Network Event – 23 May & 27 June 2012 – feedback* (attached)	SM/ACle	
	QUALITY		
2.15	Quality Sub-Committee report* (draft minutes of 15 June 2012 meeting attached)	MA	
	MEMBERSHIP		
2.16	Membership Sub-Committee report* (draft minutes of 1 June 2012 meeting attached)	ML	
2.17	Membership Engagement and Communication – update* (attached)	MAk	
2.18	Membership Report* (attached)	TP	
2.19	Open Day 12 May 2012 – Evaluation Report (attached)	MAk	6.20

3	**ITEMS FOR INFORMATION**		
3.1	Finance Report – May 2012 (attached)	LB	
3.2	Performance Report – May 2012 (attached)	DR	
3.3	Monitor Code of Governance – compliance (attached)	CM	
3.4	Wayfinding Project Update (attached)	TD	
3.5	Director–Governor interaction in NHS Foundation Trust (attached)	CE	
4	**ANY OTHER BUSINESS**		6.25
5	**DATE OF THE NEXT MEETING – 13 September 2012**		

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

HB - Heather Bygraves Deloitte

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 12 July 2012

AGENDA ITEM NO.	1.3/Jul/12
PAPER	Draft Minutes of Council of Governors Meeting – 3 May 2012
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper outlines a record of proceedings at the previous meeting.
DECISION/ ACTION	1. To agree the minutes as a correct record. 2. The Chairman to sign the minutes.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting Minutes, 3 May 2012
Draft

Prof. Sir Christopher	Edwards	Chairman		CE
Chris	Birch	Patient		CBir
Christine	Blewett	Public	Hammersmith and Fulham 2	CBle
Nicky	Brown	Appointed	The Royal Marsden NHS Foundation Trust	NB
Anthony	Cadman	Patient		ACad
Fergus	Cass	Appointed	NHS Kensington &Chelsea	FC
Cass. J	Cass-Horne	Patient		CC-H
Alan	Cleary	Patient		ACle
Brian	Gazzard	Staff	Medical and Dental	BG
Rosie	Glazebrook	Appointed	Hammersmith and Fulham PCT	RG
Jenny	Higham	Appointed	Imperial College	JH
Melvyn	Jeremiah	Public	Westminster 2	MJ
Jacinto	Jesus	Staff	Contracted	JJ
Martin	Lewis	Public	Westminster 1	ML
Kathryn	Mangold	Staff	Nursing and Midwifery	KM
William	Marrash	Patient		WM
Susan	Maxwell	Patient		SM
Wendie	McWatters	Patient		
Henry	Morgan	Public	Wandsworth 1	HM
Sandra	Smith-Gordon	Public	Kensington and Chelsea 2	SS-G
Frances	Taylor	Appointed	Royal Borough of Kensington and Chelsea	FT
Maddy	Than	Staff	Support, Admin & Clerical	MT

IN ATTENDANCE:

Sir John Baker	Non-executive Director	JB
Jeremy Loyd	Non-executive Director	JL
Sir Geoffrey Mulcahy	Non-executive Director	GM
Heather Lawrence	Chief Executive	HL
Dr Mike Anderson	Medical Director	MA
David Radbourne	Interim Chief Operating Officer	DR
Mark Gammage	Director of HR	MG
Catherine Mooney	Director of Governance and Corporate Affairs	CM
Matt Akid	Head of Communications	MAk
Renae McBride	Communications Manager	RMB
Axel Heitmueller	Director of Strategy and Business	AH

	Development	
Anthony Pritchard	Deputy Chief Nurse	AP
Ganesh Sathyamoorthy	Collaboration for Leadership in Applied Health Research and Care - for item 2.15	GS
Dr Paul Sullivan	Collaboration for Leadership in Applied Health Research and Care - for item 2.15	PS
Vida Djelic	Foundation Trust Secretary	VD
Patricia Gani	LINk representative	PG

2.1 Chief Executive Appointment **CE**

CE asked that those present who were not members of the Council of Governors or involved in the appointment to leave the room for discussion on this item.

CE requested that the governors treat any information about the candidate who is to be recommended as highly confidential and to not disclose it to any members outside the meeting at the present time.

CE outlined the appointment process. The Appointments Committee interviewed three candidates, not four as stated in the paper, due to the fact that one candidate withdrew.

All three candidates were very strong and are Chief Executives of very successful hospitals in the country. Each candidate met members of the executive team and were asked about patient experience, strategy and leadership. Comments on each candidate were passed to the Appointments Committee.

After careful consideration of all of three candidates the Appointments Committee agreed to propose Tony Bell, currently Chief Executive of Royal Liverpool and Broadgreen Hospital since 2007 as the new Chief Executive.

CE provided some background information including some highlights from Tony Bell's referees.

In response to questions, CE said that Tony Bell is a nurse by background and is 54 years old. He has been Chief Executive of Royal Liverpool & Broadgreen University Hospitals NHS Trust, a major university teaching hospital, since 2007 and was previously Chief Executive of Alder Hey Children's Hospital in Liverpool. He has an MBA from Liverpool.

Royal Liverpool & Broadgreen University Hospitals NHS Trust is not a Foundation Trust. Monitor introduced a new requirement, assessment against the Board Governance Assurance Framework, several weeks before the Board to Board with Monitor and this was not sufficient time to meet such a requirement.

Tony Bell's notice period is 6 months but this will be negotiated.

CE confirmed that the timeline for advertising was adequate.

BG, who was involved in meeting the candidates said he was very impressed with

all three candidates that were interviewed.

The Council of Governors unanimously approved the proposal to appoint Tony Bell as the new Chief Executive.

1 GENERAL BUSINESS

1.1 Welcome & Apologies — CE

CE welcomed two members of the public to the Council meeting, Andrew Roche and Carol Joseph.

CE welcomed David Radbourne, Interim Chief Operating Officer to his first Council of Governors meeting.

Apologies were received from: Edward Coolen, Carol Dale, Anna Hodson-Pressinger and Cyril Nemeth.

1.2 Declaration of Interests — CE

None.

1.3 Minutes of Previous Meeting held on 9 February 2012 — CE

Minutes of the previous meeting were accepted as a true and accurate record of the meeting with the following change:
- Amanda Pritchard was in attendance
- item 2.8, p.8 the funding part to be reworded to confirm that the Council did not approve the request for funding of the quality account development.
- reinstate matter arising re governors' chelwest email account as there has been no progress. **VD to reinstate.** — **VD**

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

ACle said that regarding the Junior Doctors – Your Life in their Hands programme (p.3 of minutes) that there was a breach of data protection law shown and felt strongly that this section should have been cut out. He considers that the junior doctor concerned was acting in good faith and this may affect his job prospects.

ACle said he wanted to raise a few points under any other business and tabled a paper copy for VD to circulate to the governors for information instead.

1.4 Matters Arising — CE

<u>2.5/Feb/12 Council of Governors Performance Evaluation Report – response to questionnaire</u>
It was noted that the work on governors communicating on what the Trust is doing for the local community, for patients services and trust membership is on the Membership Sub-Committee agenda 1 June meeting.

To address induction and training
CM spoke on behalf of CD who was unable to attend. CD had provided a paper on supporting governors development which will be sent to governors via email.

CM said the plan is to undertake a Training Needs Analysis (TNA) for the governors, to include some items as mandatory e.g. roles and responsibilities and some as optional e.g. the Quality Account. This will then provide us with training gaps. Regular reports will be produced. CD would like to set up a small group of governors to agree survey questions to help identify training needs, interpret the results, develop a training plan, and help set up training events for the coming year.

Governors are invited to send expressions of interest to Vida Djelic by 18 May 2012. **All**

NB noted that it might useful for the governors to have training on the implications of the Health and Social Care Act 2012. This was agreed.

2.6/Feb/12 Report on Senior Nurse/Governor Rounds
TP said that this has been reviewed and some visits were organised recently.

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

The Chairman confirmed that there was no further report from him.

2 ITEMS FOR DISCUSSION/DECISION/APPROVAL

2.2 Re-appointment of Non-executive Directors **CE**

CE introduced the paper on the reappointment of Professor Richard Kitney and Karin Norman whose terms of office were due to expire on 31 October 2012. CE suggested that the terms of office are extended for both Non-executive Directors. He highlighted the important involvement of Richard Kitney in the Electronic Document Management project and the IT strategy. Karin Norman is the Chair of the Assurance Committee and her strong financial background is very beneficial at this time.

There was also the issue of maintaining stability in the Board, as three NEDs were relatively new and there would be a new Chief Executive in due course.

SM asked for clarification on her belief that when one NED stepped down in 2010 we approved three new NEDs on the basis that KN and RK would be stepping down in 2012. CE said that this was not the case and that the NEDs they were actually replacing were Andrew Havery and Charlie Wilson.

RG queried what the exceptional circumstances were to keep RK and KN as stipulated by Monitor and whether we will keep extending the term of office for both NEDs again next year. CE responded that this is an exceptional situation as previously outlined and the extension was one year only.

The Council of Governors agreed that the term of office of Richard Kitney be extended for a further year.

The Council of Governors agreed that the term of office of Karin Norman be extended for a further year.

2.3 Business Planning 2012/13 – update **HL**

HL introduced the paper and updated the Council of Governors on the objectives and development of the business plan for 2012/13.

She outlined the strategic priorities and confirmed that the corporate objectives remain the same as for the last year. She outlined the Academic Health Sciences Partnership and noted that we had won an important musculoskeletal contract covering Kensington and Chelsea, Hammersmith and Fulham and Westminster.

She noted that there were few opportunities for growth and the importance of lifting the private patient cap. This year there is a cost improvement programme to deliver 7% savings.

WM referred to a TV programme about Great Ormond Street Hospital (GOSH) which was broadcasted a day ago for 1hr which in his view was horrific. HL replied that they provide excellent medical services and that GOSH has some problems of particular nature.

ML queried if the Trust has developed a marketing strategy in relation to the recent changes to the healthcare services. HL responded that it is too early to develop this but there will be one following the completion of the consultation process on whether we will be the major A&E services provider.

ML queried if we charge EU patients for treatment in the A&E. HL responded that we do not but any other treatments are charged.

WMW asked if there is a plan to upgrade the areas of the hospital for private patients. HL said that some upgrading has already been done and there are some finances in the capital programme which would allow us to do a further upgrade depending on the private patient demand.

MA suggested that our A&E needs to expand and modernise in order to be able to cope with the demand.

2.4 Shaping a healthier future **MA**

MA gave a presentation on the proposed reconfiguration of the health services in North West London (NWL) and highlighted the main points. There will be four types of hospital and NWL is currently considering options. All hospitals will have an Urgent Care Centre. The key question is which the major hospitals will be.

The evaluation criteria agreed by clinicians and stakeholders is based on quality of care, access to care, affordability, deliverability and research and education.

MA highlighted the potential impact on the Chelsea and Westminster Hospital with three scenarios:

- If Charing Cross loses A&E services
- If we lose A&E services

- Possibility of one less obstetric unit in NWL

ML asked if having a paediatric A&E was positive and MA confirmed that this was the case and that another positive feature was our estate.

HL said that the plans for consultation will be discussed at a clinician and public/patient involvement event which will be held on 15 May. She invited governors to attend. SM said that those interested in attending will need a ticket. HL responded that that transport will be organised by the Estates and Facilities Department for those interested in attending.

MAk will be doing a plan for stakeholder involvement.

2.5 It's who we are – our values **TD/MG**

MAk presented the paper and highlighted the wide range of responses outlined in the table 3 on p.2 with patient-focused getting the highest number of votes by staff.

MAk said that the Board at its meeting on 29 March agreed the four core values which are respectful, safe, kind and excellent and these will be launched publically at the hospital Open Day on 12 May. He emphasised the importance of applying these values in the organisation and this will be the responsibility of each individual staff member. These values will be embedded in everything we do e.g. recruitment processes, induction.

CBir expressed his disappointment with the Board decision to remove the patient-focused value and also that compassionate was changed. MAk clarified that the Board felt that 'patient-focused' is at the centre of everything we do as a hospital and as an individual member of staff. Jeremy Loyd (JL) added that as we progress with applying the agreed values patient focused will be emphasized. He said that it was felt that compassion is part of kindness.

ML commented that he was happy that Student Nurses were involved in the consultation process.

CE thanked JL who leads on values and has put a lot of work into this. CE also thanked MAk and CD for their hard work.

2.6 Governors' Questions **HL**

Trust's plans re lifting the Private Patient Cap (BG)

HL outlined the current private patient cap and highlighted the fact that with the new Health and Social Care Act it can be increased up to 49%. Under this provision trusts are allowed up to 5% without governors' approval. Up until now the private patient cap was 3.7% with no flexibility to increase.

Axel Heitmueller, Director of Strategy and Business Development is working on a private patient strategy. We have to consider which services we would want to expand depending on the market and impact on space.

NB suggested that AH could meet with the private patient lead at the Royal Marsden Hospital. MA commented that our greatest strength compared with private hospitals is that we are staffed out of hours.

Hospital plans for expansion (MJ)

HL said that MA had covered this to some extent as we will be affected by the NWL reconfiguration. We do however have plans including a midwifery led unit, moving pediatrics burns to the first floor and sexual health expanding outwith the hospital.

2.7 Report on Senior Nurse/Governor Rounds **TP**

This item was taken as read.

2.8 Open Day 12 May 2012 – update **RMB**

RMB said that an update on the Open Day planning was provided in the paper.

CE commented that the Open Day is an excellent event and invited all governors to attend.

2.9 Council of Governors Funding Report **VD**

CE highlighted that the Council of Governors budget for 2012/13 financial year has been affected by the CIP.

CBir said that the Membership sub-committee at its last meeting at the end of March had been under the impression that our budget for 2012-2013 would remain at £95,000, but are now being told that it had been reduced to £80,000 in January, two months previously and he questioned why the governors had not been told earlier.

CM explained that the process started in January 2012 and a series of budget setting meetings were held. We tried to avoid any reduction to the Council of Governors budget, however, all departments and divisions across the hospital have been affected by the CIP and the decision was eventually made that the Council of Governors budget had to be reduced as well.

CBir queried when the decision was made. CM responded that it was made in March 2012 although the budget setting process started in January.

The governors discussed the budget allocations for 2012/13 and suggested that the Council should be more strict when approving bids. WMW suggested there were more regular reports on progress with the projects approved by the Council of Governors. **This was agreed – reports will be provided to the sub committees when they meet**. **VD**

WMW introduced the item and said that she had already raised £10,520 for the Giggle Doctors and added that some funding is needed to be able to plan more sessions on the paediatric wards.

SS-G said this is a good idea but was not sure if the governors should fund this as the main purpose is membership and engagement; she suggested WMW approaches the health charity or the Friends.

The Council of Governors discussed the proposal and on the basis that the funding is needed for the 2013/14 financial year agreed that a fresh proposal be made to the Council at some point in the future and that in the meantime WMW explores other options.

CE expressed his thanks to WMW for her work.

Letter box drop
RMB said that the Membership Sub-Committee at its last meeting commented that the Open Day event had not been advertised as much as it should have been and they supported a funding proposal for a letterbox drop. RMB also proposed that the event is publicised in the local press as outlined in the paper. The request for funding totaled £4,793.

The governors discussed the proposal and agreed to approve the funding of the Open Day event to be publicised via the letterbox drop and in the local press on the condition that a survey is conducted on how many people visited the event as a result of the Open Day event being advertised this way vs the local press.
RMB to conduct the survey. **RMB**

2.10 The tenth FTGA National Development Day - 14 March 2012 & FTGA Mental Health Network Event – 24 April 2012 – feedback **MT/ACad**

This item was taken as read.

2.11 Chelsea and Westminster Star Awards 2012 **MG**

MA noted that an update regarding the Chelsea and Westminster Star Awards 2012 has been provided in the paper. He highlighted that a judging panel of governors agreed a shortlist of three staff and teams for the Council of Governors Special Award. He added that the Chief Executive will select the recipient for the Chief Executive Special Award.

HL said that the Star Awards will be presented at an awards evening at the Chelsea Football Club on 14 May.

2.12 Quality Account Update **CM**

CM outlined the key points in the paper and asked for comments. ACle queried why we had just started checking x-ray reports in July for clots. CM thanked him for this feedback – this refers to using this method to start following up on cases and agreed this was not clear and will be amended.

Otherwise the priorities were agreed.

2.13 Quality Sub-Committee report **MA**

This item was taken as read.

2.14 Staff Survey – Summary **MG**

MG said that according to research there is a link between a satisfied workforce and high quality patient care.

He highlighted that on the question regarding whether staff would recommend the Trust as a place to be treated and as a place to work we scored in the top 20% of acute Trusts nationally.

CE commented on the response rate of 61% and how we can encourage 39% of staff who did not participate in the survey to do so and compared it with the Care Quality Commission which bases its report on a 10% sample of staff as opposed to asking for everyone's views.

CE said one of the areas of concern is the percentage of staff experiencing discrimination at work. We will need to understand why this is the case and to address it appropriately.

CBir commented on the 17 pages of meaningless figures. MG apologised and said that the results will be resent.

2.15 Introduction to the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) – presentation **GS/PS**

Ganesh Sathyamoorthy, CLAHRC Head of Operations and Delivery and Dr Paul Sullivan, Senior Improvement Fellow gave a presentation on CLAHRC work and explained that is it nationally funded collaborative research improvement programme that will accelerate health research into patient care.

GS highlighted the CLAHRC approach and highlighted benefits for the Chelsea and Westminster Hospital.

GS tabled a paper outlining the CLAHRC work and invited governors to join the project meetings. Information will be provided in due course via VD.

2.16 Membership Sub-Committee report **ML**

This item was taken as read.

2.17 Membership Engagement and communication – update **MAk**

This item was taken as read.

2.18 Membership Report* **TP**

This item was starred and therefore taken as read.

3 ITEMS FOR INFORMATION

3.1 Finance Report – March 2012 **LB**

This item was taken as read.

3.2 Performance Report – March 2012 **DR**

This item was taken as read.

4 ANY OTHER BUSINESS **CE**

None.

5 DATE OF THE NEXT MEETING

The next meeting of the Council of Governors will be held on 12 July 2012.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 12 July 2012

AGENDA ITEM NO.	1.4/Jul/12
PAPER	Matters Arising from the meeting of the Council of Governors meetings held on 3 May 2012
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper lists matters arising from previous meeting and the action taken or subsequent outcomes.
DECISION/ ACTION	The Council of Governors is asked to note the matters arising and the updates.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

MATTERS ARISING
Council of Governors Meeting
Hospital Boardroom
Chair: Prof. Sir Christopher Edwards
Date: 3 May 2012
Time: 4:00 – 6:30 pm

Ref	Description	Lead	Subsequent Actions or Outcomes
1.3/May/12	**Minutes of Previous Meeting held on 9 February 2012**		
	Minutes of the previous meeting were accepted as a true and accurate record of the meeting with the following change: - Amanda Pritchard was in attendance - item 2.8, p.8 the funding part to be reworded to confirm that the Council did not approve the request for funding of the quality account development. - reinstate matter arising re governors' chelwest email account as there has been no progress. **VD to reinstate.**	**VD**	Completed
	VD to amend minutes in line with comments received.	**VD**	Completed
1.4/May/12	**Matters Arising**		
	To address induction and training **Governors are invited to send expressions of interest to Vida Djelic by 18 May 2012.**	**All**	Governors interested in joining are: Susan Maxwell, Maddy Than, Anna Hodson-Pressinger, Chris Birch, Sandra Smith-Gordon and Brian Gazzard.
	Governors' chelwest email account **Governors to be invited to test the new solution.**	**VD**	
2.9/May/12	**Council of Governors Funding Report**		
	The governors discussed the budget allocations for 2012/13		

and suggested that the Council should be more strict when approving bids. WMW suggested there were more regular reports on progress with the projects approved by the Council of Governors. **This was agreed – reports will be provided to the sub committees when they meet**. **VD**

Letter box drop

The governors discussed the proposal and agreed to approve the funding of the Open Day event to be publicised via the letterbox drop and in the local press on the condition that a survey is conducted on how many people visited the event as a result of the Open Day event being advertised this way vs the local press. **RMB**

RMB to conduct the survey.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 12 July 2012

AGENDA ITEM NO.	2.1/Jul/12
PAPER	Presentation of Annual Accounts & Annual Report 2011/12
AUTHOR	Lorraine Bewes, Director of Finance
LEAD	Lorraine Bewes, Director of Finance Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	The Trust had a successful financial year, ending the year with a surplus of £13.6m, a similar level to last year. Operating income was up just over 3% to £342.8m. As last year, this delivered the highest level Monitor Financial Risk Rating of 5, which is the equivalent of an excellent rating for use of resources by the Care Quality Commission. The delivery was underpinned by the successful achievement of the Trust's Cost Improvement Programme delivery, which was £20.9m against a target of £19.7m (9% of controllable expenditure). The Trust met its private patient cap of 3.7% and did not exceed any of its prudential borrowing limit ratios, which is a requirement of its Authorisation. The balance sheet position remained strong, with positive net current assets and cash holdings of £41m. This was after investment of nearly £33m (£25.5m 2010/11) on capital schemes which included: • Completion of the Netherton Grove 2 floor extension for paediatric theatres on 1st floor and the new Ron Johnson ward and oncology day care on the 2nd floor • Completion of the Plant Infrastructure project which has moved the hospital onto a Combined Heating and Cooling Power system. • Medical equipment including a new MRI scanner

	• IT systems development and infrastructure As a Foundation Trust, Chelsea and Westminster can use its cash surpluses to invest in the hospital's future developments and this is being fully committed on it service developments which requires a forward capital programme of £90m over the next 3 years. A copy of the Annual Report and Accounts 2011/12 is attached.
DECISION/ ACTION	To note.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 12 July 2012

AGENDA ITEM NO.	2.2/Jul/12
PAPER	External Auditors' Report on the Annual Accounts 2011/12
AUTHOR	Heather Bygrave, Partner Deloitte LLP
LEAD	Heather Bygrave, Partner Deloitte LLP
EXECUTIVE SUMMARY	This report presents the external auditor's key findings on audit risk and other matters arising from the audit of the accounts for the year ended 31 March 2012
DECISION/ ACTION	For information.

Deloitte.

Chelsea and Westminster NHS Foundation Trust

Year ended 31 March 2012

External audit report to the Council of Governors

5 July 2012

Contents

Executive summary

Introduction

We have now completed our external audit for the year 2011/12 and this is a report to you summarising the findings of our audit of the Trust's 2011/12 financial statements. We also performed certain procedures in 2011/12 in respect of the Trust's 2011/12 Quality Report and, in accordance with guidance published by Monitor. Our findings from that work are set out in a separate report to you.

We have issued a clean or unqualified opinion on the Trust's 2011/12 financial statements

We provided detailed reports, on both our audit of the Trust's financial statements and our work on the Trust's Quality report, to the Trust's Audit Committee on 18 May 2012 and the Board on 28 May 2012. We also signed our audit opinion on the Trust's financial statements on 29 May 2012. Our opinion on the financial statements was as follows:

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2012 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Our audit report includes a clean 'report by exception'

As well as providing an opinion on the Trust's financial statements, in accordance with Monitor's Code of Audit Practice ("the Code") we are also required to perform other procedures and sign a 'report by exception' on certain other matters. In respect of this requirement, we included the following statement in our audit report on the Trust's financial statements:

We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls;
- proper practices have not been observed in the compilation of the financial statements; or
- the NHS foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

1. Our approach

Procedures for auditing the Trust's financial statements

In summary, the audit of the Trust's financial statements included:

- developing an understanding of the Trust, including its systems, processes, risks, challenges and opportunities and then using this understanding to focus audit procedures on areas where we consider there to be a higher risk of misstatement in the Trust's financial statements;
- interviewing members of the Trust's management team and reviewing documentation to test the design and implementation of the Trust's internal controls in certain key areas relevant to the financial statements; and
- performing sample tests on balances in the Trust's financial statements to supporting documentary evidence, as well as analytical procedures, to test the validity, accuracy and completeness of those balances.

We have included further details of our audit approach in Appendix 1.

How we delivered the audit

Our responsibilities as external auditors are prescribed in Monitor's Code of Audit Practice ("the Code") but our approach to delivering the Trust's external audit, and where we focus our attention, is specifically tailored to the Trust.

This year, we performed audit planning procedures and audit testing in February and then completed our audit procedures in May. During our planning procedures in October we performed an audit risk assessment to identify those areas where we would focus our work. Further details of those areas are set out in Section 2.

Performing audit procedures during the year enabled us to:

- develop a deep understanding of the Trust well in advance of the end of the financial year;
- proactively work with the Trust to identify timely improvements to internal controls, systems and processes; and
- reduce the time needed by the Trust's finance team in the busy period following the end of the financial year.

2. The focus of our work

Our focus on items in the financial statements which had a higher risk of misstatement

When auditing the Trust's financial statements, we focused our work on significant balances and where we considered there to be a higher risk of misstatement. We refer to these areas as significant audit risks.

We assessed the significant audit risks of the Trust through our procedures in October 2011. We provided a detailed audit plan to the Trust's Audit Committee in November 2011 setting out what we considered to be the significant audit risks for the Trust, together with our planned approach to addressing those risks. We have provided a summary of each of the significant audit risks in the table below.

Based on our procedures, we concluded that the Trust's financial statements were not materially misstated in any of these significant audit risk areas.

We did identify some adjustments to the accounts, some of which were corrected by management. Those adjustments that were uncorrected in the final version of the financial statements were immaterial.

Significant audit risk	Description of risk
Recoverability of NHS receivables	At 31 March 2012, the Trust's financial statements showed that it was owed £7.4m by other NHS bodies. Typically, Trusts do not expect to receive the full amount of debt they are owed and therefore estimate a provision against that debt in the financial statements. The Trust has provided for £4.5m of bad debt against receivables and £4.4m for repayment of queried and disputed charges at year-end. These estimates are based on management judgements and assumptions. As auditors we focus our attention on estimates like this because, due to their nature, they are more susceptible to management bias.
Recording revenue through Payment by Results	The majority of Trust operating income is recognised under the Payment by Results (PbR) framework whereby each patient episode has a set fee to be charged to the relevant commissioning body. Information obtained from the PbR data flow forms the basis on which the Trust charges commissioners for healthcare services performed. The PbR systems and processes are typically complex with both automated and manual controls, and therefore we identified there could be a significant risk around the completeness of revenue recognised through the system.
Private Patient revenue recognition	The private patient income cap ("the cap") limits the amount of private patient work that NHS Foundation Trusts can carry out in proportion to their total patient related activity. The level of the cap is defined in each NHS Foundation Trust's terms of authorisation as agreed with Monitor, and, despite planned changes, remained in force at 31 March 2012. Private patient income in 2011/12 is at the cap level of 3.7%. We identified a significant risk around private patient revenue recognition as there is a risk of an incentive to understate this revenue in order to not breach the private patient income cap.
Revenue recognition from grants	International Standards on Audit include a presumption that there is a significant risk in relation to revenue recognition. In 2010/11 the Trust recognised £4,153k of research and development income and £25,286k of education and training income as part of other operating income. Accounting for grant income can be complex as the timing for recognising income in the accounts will depend on the scheme rules for each grant. This has been identified as a risk area due to the material value of income, the complexity of grant contracts, and the level of judgement required to determine whether grant conditions have been met.

2. The focus of our work (continued)

Significant audit risk	Description of risk
Valuation of property	The Trust used an external Valuer to value its estate in 2011/12. The valuation of assets is based on a number of assumptions and judgements made by the Trust and its Valuer. The revaluation resulted in a revaluation loss of £6.2m in the year. We identified this as a risk area, as valuations are by their nature estimates driven by the assumptions used, and with changes in the economic environment and property markets, the assets being valued can be subject to material changes in value.
Accounting for donated assets	In 2011/12 there was a change in the accounting rules that apply to Trusts in respect of donated assets. Because this was a change in accounting requirement and therefore a change in the Trust's relevant accounting policy, this required a restatement of the comparative balances in the financial statements. We identified this as a risk area because the implementation of new requirements, particularly where some judgement is needed in their application, can be susceptible to error.
Management override of controls	International Standards on Auditing require us to have a presumed significant risk in relation to management override of controls. Our audit procedures to address this risk included tests of journals and consideration of estimates and judgements in the financial statements.

Our recommendations to the Trust

We have made a number of recommendations for the improvement of the Trust's policies, procedures and internal controls throughout the year. We did not identify any recommendations that we consider to be a high priority.

3. Analysis of audit fees

The professional fees earned by Deloitte in the period from 1 April 2011 to 31 March 2012, which were in accordance with our contract, were as follows:

	Current year £000	Prior year £000
Audit services and Audit related assurance services		
Financial statement audit *	**82**	**79**
Quality Account work	**19**	**19**
Whole of Government Accounts work	**2**	**2**
Total fees	103	100

* Our contract allows for an inflationary increase to be applied to our fee after 2011. The Health Service Cost Index (HSCI) showed a 5% inflation rate, however this was capped at 3.8% for the 2011/12 audit.

Note 3 to the financial statements includes fees for the year ended 31 March 2012 of £124,000 and for the year ended 31 March 2011 of £138,000. The differences between these disclosures are:

- we have not have not included VAT in our fee in the table above;
- due to the timing of 2009/10 Quality Accounts work, the fee for that year's work of £20,000 was reported as within the 2010/11 financial statements (which therefore showed two year's costs for this work).

4. Responsibility statement

This report should be read in conjunction with the "Briefing on audit matters" included in Appendix 1 of this report. This report sets out matters of interest which came to our attention during the audit. Our audit was not designed to identify all matters that may be relevant to the Trust and this report is not necessarily a comprehensive statement of all deficiencies which may exist in internal control or of all improvements which may be made.

This report has been prepared for the Council of Governors and we therefore accept responsibility to you alone for its contents. We accept no duty, responsibility or liability to any other parties, since this report has not been prepared, and is not intended, for any other purpose. Except where required by law or regulation, it should not be made available to any other parties without our prior written consent.

Deloitte LLP

Chartered Accountants

St Albans

5 July 2012

Appendix 1: Briefing on audit matters

Published for those charged with governance

This document is intended to assist those charged with governance to understand the major aspects of our audit approach, including explaining the key concepts behind the Deloitte Audit methodology including audit objectives and materiality.

Further, it describes the safeguards developed by Deloitte to counter threats to our independence and objectivity.

This document will only be reissued if significant changes to any of those matters highlighted above occur.

We will usually communicate our audit planning information and the findings from the audit separately. Where we issue separate reports these should be read in conjunction with this "Briefing on audit matters".

Approach and scope of the audit

Primary audit objectives

We conduct our audit in accordance with International Standards on Auditing (UK & Ireland) as adopted by the UK Auditing Practices Board ("APB"). Our statutory audit objectives are:

- to express an opinion in true and fair view terms to the members on the financial statements;
- to express an opinion as to whether the accounts have been properly prepared in accordance with the relevant Financial Reporting Manual;
- for certain disclosures relating to directors' remuneration to form an opinion as to whether they are made in accordance with the relevant Financial Reporting Manual; and
- to express an opinion as to whether the directors' report, including the business review, is consistent with the financial statements.

Other reporting objectives

Our reporting objectives are to:

- present significant reporting findings to those charged with governance. This will highlight key judgements, important accounting policies and estimates and the application of new reporting requirements, as well as significant control observations; and
- provide timely and constructive letters of recommendation to management. This will include key business process improvements and significant controls weaknesses identified during our audit.

Materiality

The concept of materiality is fundamental to the preparation of the financial statements and the audit process and applies not only to monetary misstatements but also to disclosure requirements and adherence to appropriate accounting principles and statutory requirements.

"Materiality" is defined in the International Accounting Standards Board's "Framework for the Preparation and Presentation of Financial Statements" in the following terms:

Appendix 1: Briefing on audit matters (continued)

Approach and scope of the audit (continued)

Materiality (cont'd)

"Information is material if its omission or misstatement could influence the economic decisions of users taken on the basis of the financial statements. Materiality depends on the size of the item or error judged in the particular circumstances of its omission or misstatement. Thus, materiality provides a threshold or cut-off point rather than being a primary qualitative characteristic which information must have if it is to be useful."

We determine materiality based on professional judgment in the context of our knowledge of the audited entity, including consideration of factors such as shareholder expectations, industry developments, financial stability and reporting requirements for the financial statements.

We determine materiality to:

- determine the nature, timing and extent of audit procedures; and
- evaluate the effect of misstatements.

The extent of our procedures is not based on materiality alone but also the quality of systems and controls in preventing material misstatement in the financial statements, and the level at which known and likely misstatements are tolerated by you in the preparation of the financial statements.

Uncorrected misstatements

In accordance with International Standards on Auditing (UK and Ireland) ("ISAs (UK and Ireland)") we will communicate to you all uncorrected misstatements (including disclosure deficiencies) identified during our audit, other than those which we believe are clearly trivial.

ISAs (UK and Ireland) do not place numeric limits on the meaning of 'clearly trivial'. The Audit Engagement Partner, management and those charged with governance will agree an appropriate limit for 'clearly trivial'. In our report we will report all individual identified uncorrected misstatements in excess of this limit and other identified errors in aggregate.

We will consider identified misstatements in qualitative as well as quantitative terms.

Audit methodology

Our audit methodology takes into account the changing requirements of auditing standards and adopts a risk based approach. We utilise technology in an efficient way to provide maximum value to members and create value for management and the Board whilst minimising a "box ticking" approach.

Our audit methodology is designed to give directors and members the confidence that they deserve.

For controls considered to be 'relevant to the audit' we evaluate the design of the controls and determine whether they have been implemented ("D & I"). The controls that are determined to be relevant to the audit will include those:

- where we plan to obtain assurance through the testing of operating effectiveness;
- relating to identified risks (including the risk of fraud in revenue recognition, unless rebutted and the risk of management override of controls);
- where we consider we are unable to obtain sufficient audit assurance through substantive procedures alone; and
- to enable us to identify and assess the risks of material misstatement of the financial statements and design and perform further audit procedures.

Appendix 1: Briefing on audit matters (continued)

Other requirements of International Standards on Auditing (UK and Ireland)

ISAs (UK and Ireland) require we communicate the following additional matters:

ISA (UK & Ireland)	Matter
ISQC 1	Quality control for firms that perform audits and review of financial statements, and other assurance and related services engagements
240	The auditor's responsibilities to consider fraud in an audit of financial statements
250	Consideration of laws and regulations in an audit of financial statements
265	Communicating deficiencies in internal control to those charged with governance and management
450	Evaluation of misstatements identified during the audit
505	External confirmations
510	Initial audit engagements – opening balances
550	Related parties
560	Subsequent events
570	Going concern
600	Special considerations – audits of group financial statements (including the work of component auditors)
705	Modifications to the opinion in the independent auditor's report
706	Emphasis of matter paragraphs and other matter paragraphs in the independent auditor's report
710	Comparative information – corresponding figures and comparative financial statements
720	Section A: The auditor's responsibilities related to other information in documents containing audited financial statements

Independence policies and procedures

Important safeguards and procedures have been developed by Deloitte to counter threats or perceived threats to our objectivity, which include the items set out below.

Safeguards and procedures

- Every opinion (not just statutory audit opinions) issued by Deloitte is subject to technical review by a member of our independent Professional Standards Review unit.
- Where appropriate, review and challenge takes place of key decisions by the Second Partner and by the Independent Review Partner, which goes beyond ISAs (UK and Ireland), and ensures the objectivity of our judgement is maintained.
- We report annually to those charged with governance our assessment of objectivity and independence. This report includes a summary of non-audit services provided together with fees receivable.
- There is formal consideration and review of the appropriateness of continuing the audit engagement before accepting reappointment.
- Periodic rotation takes place of the audit engagement partner, the independent review partner and key partners involved in the audit in accordance with our policies and professional and regulatory requirements.
- In accordance with the Revised Ethical Standards issued by the APB, there is an assessment of the level of threat to objectivity and potential safeguards to combat these threats prior to acceptance of any non-audit engagement. This would include particular focus on threats arising from self-interest, self-review, management, advocacy, over-familiarity and intimidation.
- The Firm's policies and procedures are subject to external monitoring by both the Audit Inspection Unit (AIU), which is a division of POB, and the ICAEW's Quality Assurance Directorate (QAD).

Appendix 1: Briefing on audit matters (continued)

Safeguards and procedures (cont'd)

- In the UK, statutory oversight and regulation of auditors is carried out by the Professional Oversight Board (POB) which is an operating body of the Financial Reporting Council. The Firm's policies and procedures are subject to external monitoring by both the Audit Inspection Unit (AIU), which is a division of POB, and the ICAEW's Quality Assurance Department (QAD). The AIU is charged with monitoring the quality of audits of economically significant entities and the QAD with monitoring statutory compliance of audits for all other entities. Both report to the ICAEW's Audit Registration Committee. The AIU also reports to POB and can inform the Financial Reporting Review Panel of concerns it has with the accounts of individual companies.

Independence policies

Our detailed ethical policies' standards and independence policies are issued to all partners and employees who are required to confirm their compliance annually. We are also required to comply with the policies of other relevant professional and regulatory bodies.

Amongst other things, these policies:

- state that no Deloitte partner (or any closely-related person) is allowed to hold a financial interest in any of our UK audited entities;
- require that professional staff may not work on assignments if they (or any closely-related person) have a financial interest in the audited entity or a party to the transaction or if they have a beneficial interest in a trust holding a financial position in the audited entity;
- state that no person in a position to influence the conduct and outcome of the audit (or any closely related persons) should enter into business relationships with UK audited entities or their affiliates;
- prohibit any professional employee from obtaining gifts from audited entities unless the value is clearly insignificant; and
- provide safeguards against potential conflicts of interest.

Remuneration and evaluation policies

Partners are evaluated on roles and responsibilities they take within the firm including their technical ability and their ability to manage risk.

APB Revised Ethical Standards

The Auditing Practices Board (APB) has issued five ethical standards for auditors that apply a 'threats' and 'safeguards' approach.

The five standards cover:

- maintaining integrity, objectivity and independence;
- financial, business, employment and personal relationships between auditors and their audited entities;
- long association of audit partners and other audit team members with audit engagements;
- audit fees, remuneration and evaluation of the audit team, litigation between auditors and their audited entities, and gifts and hospitality received from audited entities; and
- non-audit services provided to audited entities.

Our policies and procedures comply with these standards.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 12 July 2012

AGENDA ITEM NO.	2.3/Jul/12
PAPER	Report on the external assurance audit of the Quality Report year ended 31.03.2012
AUTHOR	Heather Bygrave, Partner Deloitte LLP
LEAD	Heather Bygrave, Partner Deloitte LLP
EXECUTIVE SUMMARY	The attached paper outlines the external assurance review of the 2011/12 Quality Report. This includes a review the content of the Quality Report to test that it complies with Monitor's published guidance and to ensure that it is not inconsistent with other specified information. It also includes testing two performance indicators, one mandated by Monitor and the locally agreed performance indicator chosen by the Council of Governors. Governors should note that the Quality Account and Quality Report are essentially the same document. Monitor requires that it is called the Quality Report when it is published within the Annual Report (and require some additional information) and the Department of Heath require it to be called the Quality Account when published on NHS Choices.
DECISION/ ACTION	For information. Progress against recommendations will be monitored by the Trust through the Information Governance Committee and reported to the Audit Committee.

Deloitte.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Chelsea and Westminster Hospital NHS Foundation Trust

Findings and Recommendations from the 2011/12 NHS Quality Report External Assurance Review

30 May 2012

Statement of Responsibility

We take responsibility for this report which is prepared on the basis of the limitations set out below. The matters raised in this report are only those which came to our attention during the course of our work and are not necessarily a comprehensive statement of all the weaknesses that may exist or all improvements that might be made. Any recommendations made for improvements should be assessed by you for their full impact before they are implemented.

This document is confidential and prepared solely for the purpose set out in our engagement letter dated 10 October 2011. You should not, without our prior written consent, refer to or use our name on this document for any other purpose, disclose them or refer to them in any prospectus or other document, or make them available or communicate them to any other party. No other party is entitled to rely on our document for any purpose whatsoever and thus we accept no liability to any other party who is shown or gains access to this document. We agree that a copy of our report may be provided to Monitor for their information in connection with this purpose but, as made clear in our engagement letter dated 10 October 2011, only on the basis that we accept no duty, liability or responsibility to Monitor in relation to our Deliverables.

Deloitte LLP
Chartered Accountants
St Albans Office
30 May 2012

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Executive Summary

Executive Summary

Assurance report conclusion

Based on the results of our procedures, which is based on the Quality Report 2011/12 28 May 2012, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2012:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Statement of directors' responsibilities in respect of the quality report; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

Our procedures have been based on the finalised Quality Report 2011/12 of 30 May 2012, and we have signed our limited assurance report which is included within your 2011/12 Annual Report.

Approach

Our external assurance review of the 2011/12 Quality Report is in three sections.

Firstly we have examined the content of the Quality Report to ensure that it complies with Monitor's published guidance (as set out in the NHS Foundation Trust Annual Reporting Manual) and to ensure that it is not inconsistent with other specified information.

Secondly, we have undertaken a programme of work to test two performance indicators mandated by Monitor, upon which we will publically report our limited assurance opinion.

Lastly, we have undertaken a programme of work to test the locally agreed performance indicator chosen by the Governors which we report privately here to the Council of Governors and a copy will be required to be sent by the Trust to Monitor.

Executive Summary (contd)

Section A: Content & Consistency

We have found the structure of the 2011/12 Quality Report , and in particular the "About this report" section, to be user-friendly.

We reviewed the content of the 2011/12 Quality Report against the criteria specified within Monitor's 2011/12 Annual Reporting Manual (Chapter 7) to assess whether the content was consistent. Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2012 the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual; the Quality Report is not consistent in all material respects with the sources specified in the Statement of Directors' Responsibilities in respect of the quality report.

Our procedures have been based on the finalised Quality Report 2011/12 at 30 May 2012 and we have signed our limited assurance opinion which is included within your 2011/12 Annual Report.

Section B: Performance Indicators

We have undertaken detailed data testing of C.Difficile and 62 day cancer data on a sample basis. Based on the results of our testing to date, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2012, the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports. A draft of our limited assurance opinion can be found in Appendix 1 and our signed limited assurance opinion is included within your 2011/12 Annual Report.

Our key findings are:

- C.Difficile
  - Our sample testing of 25 cases identified no errors affecting reported performance against the target indicator.
  - In a small number of cases we noted that the system data provided for testing was inaccurate. However, we were able to agree that the C.difficile monitoring spreadsheet used by the Trust for the purpose of reporting had correctly recorded the details of the case.
  - Our recommendations from last year had been implemented.

Executive Summary (contd)

Section B: Performance Indicators

- 62 day cancer
  - Our initial sample size was 25 cases; however, we extended this by a further 11 cases to give a total sample size of 36 cases. This included the total population of cases with waiting time adjustments.
  - There was 1 case where the start date (date referral received) was incorrect by one day. There is no impact on the Trust's performance as this case had already been reported as a breach.
  - There was 1 case where we were unable to conclude on the accuracy of the pathway stop date as the Stop Date recorded on the Inter-Trust Transfer Form provided by another Trust did not match the stop date recorded by the Trust on Open Exeter.
  - There were 2 cases where the wait period had been adjusted but there was no supporting documentation. Both cases had been recorded in an adjustments log but there was no evidence of independent review. We reviewed the total population of adjusted waiting times and found that, even where there was no supporting documentation, the adjustment did not affect whether the patient breached the waiting time target or not.
  - In the absence of appropriate supporting documentation for all relevant stages of the care pathway we were unable to conclude on the breach classification of 3 of the 36 cases (these being the case where the stop date could not be concluded and the two cases where the adjusted waiting time could not be concluded); however, we did not find any evidence that any cases had been mis-classified for the purpose of calculating the breach target indicator.
  - As noted in our approach, we extended our original sample but did not find any further errors.
  - Three of our recommendations from last year had not been implemented and we have made further recommendations for improvement.

The approach to our work and our detailed findings can be found within Section B of this report.

Executive Summary

Section B: Performance Indicators (contd)

Local Indicator Performance Testing:

We have also undertaken detailed data testing of the emergency surgery waiting targets, which was determined as a local performance indicator by the Council of Governors. Due to process changes, the indicator population has been extended to any patient recorded as requiring an immediate, urgent or expedited surgery on the PICIS system. Our testing identified that the Trust could not determine the start time for Hand Management Unit patients (Treatment Code 07). It was therefore agreed with the Trust to exclude these patients from the population for the Quality Report.

Our key findings are:

- In comparison to our testing last year, we found that the number of issues had improved.
- From our sample of 25 patients, there were 2 Hand Management Unit patients that were removed from the sample after testing.
- Whilst there were some data input errors for the start and end times, the differences did not mean that the cases breached the time standards set for the category. Given the size of the differences, it would be reasonable to agree time thresholds for data accuracy, dependent on the category of patient.
- On review of the categories, Dr Fauvel indicated that 10 patients had been incorrectly categorised. Of these 4 patients were elective and should not have been included within the indicator, and 6 patients had been categorised as "Urgent" (surgery within 24 hours) instead of "Expedited" (surgery within 96 hours). This means that the Trust has set itself a more challenging target than necessary and has achieved this target, bringing a benefit to the patient by being treated more quickly.
- Our recommendations from the prior year have been implemented; however, we have made further recommendations for improvement.

The approach to our work and our detailed findings can be found within Section B of this report.

Overall Scope

Scope

Under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010, providers of NHS care are required to prepare and publish Quality Accounts for each financial year from 2009/10. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) along with additional reporting requirements outlined within Monitor's annual reporting guidance

The external assurance engagements that will be undertaken on Quality Reports from 2011/12 will require NHS foundation trusts to:

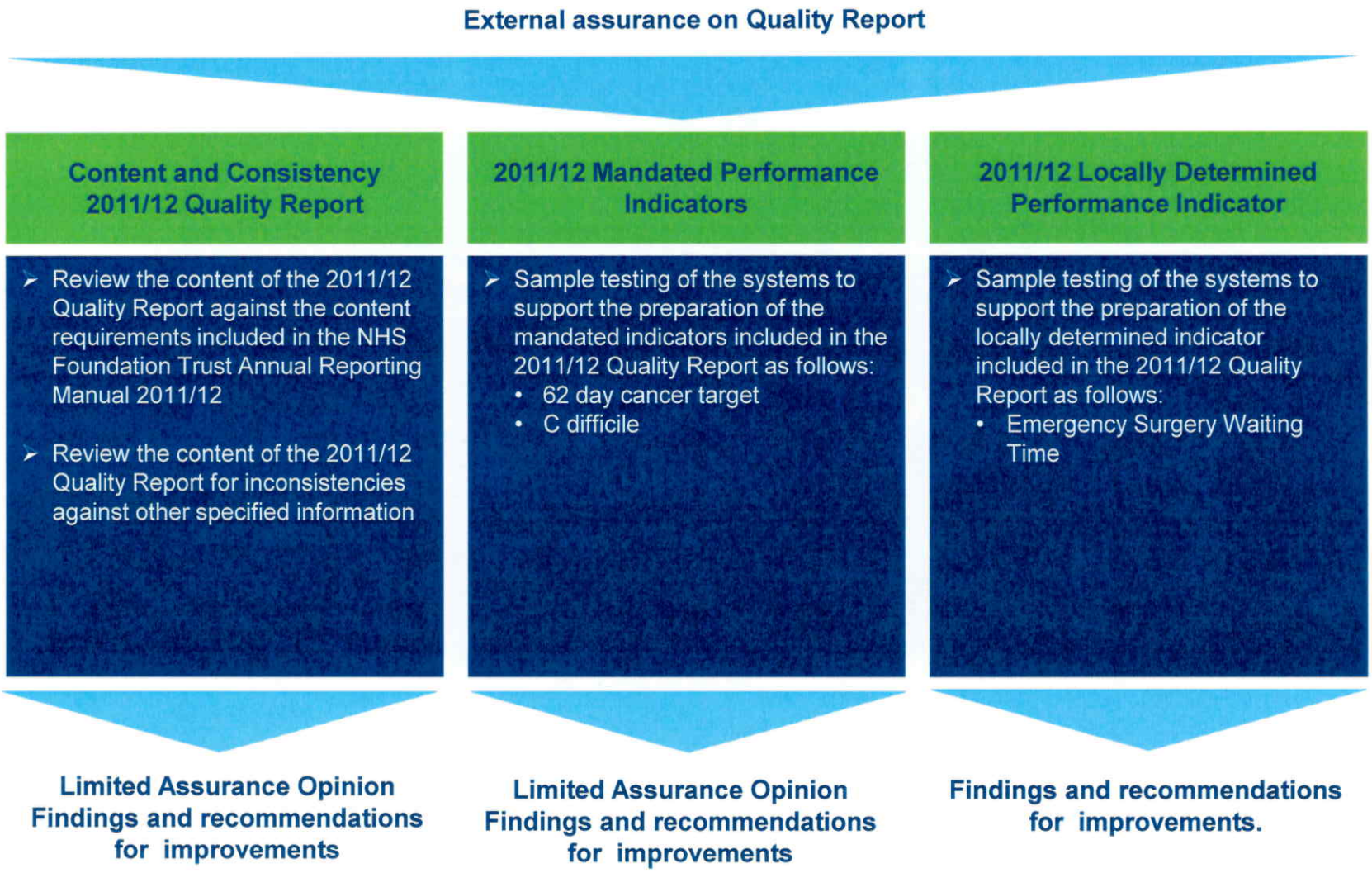
- include a brief description of the key controls in place to prepare and publish a Quality Report in the Annual Governance Statement in the published accounts;
- sign a Statement of Directors" Responsibilities in respect of the content of the Quality Report and mandated indicators for inclusion in the annual report;
- sign a Statement of Directors" Responsibilities in respect of all other indicators included within the Quality Report to provide to their auditors (this does not need to be published in the Quality Report);
- include the signed limited assurance report provided by their auditors on the content of the Quality Report and the mandated indicators in the annual report; and
- submit a copy of their auditors" report on the outcome of the external work performed on the content of the Quality Report, and the mandated and local indicators, to Monitor and to the NHS foundation trust's council of governors.

The external assurance engagements that will be undertaken on the Quality Reports from 2011/12 will require NHS foundation trust auditors to:

- review the content of the Quality Report against the requirements set out in the 2011/12 *NHS Foundation Trust Annual Reporting Manual;*
- review the content of the Quality Report for consistency against the other information sources detailed in section 2.1 of the detailed guidance;
- provide a signed limited assurance report in the Quality Report on whether anything has come to the attention of the auditor that leads them to believe that the Quality Report has not been prepared in line with the requirements set out in the *NHS Foundation Trust Annual Reporting Manual* and is not consistent with the other information sources detailed in section 2.1 of the guidance;
- undertake substantive sample testing of two mandated performance indicators and one locally selected indicator (to include, but not necessarily be limited to, an evaluation of the key processes and controls for managing and reporting the indicators and sample testing of the data used to calculate the indicator back to supporting documentation);
- provide a signed limited assurance report in the Quality Report on whether there is evidence to suggest that mandated indicators have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual; and*
- provide a report (the "governors report") to the NHS foundation trust council of governors of their findings and recommendations for improvements concerning the content of the Quality Report, the mandated indicators and the local indicator.

Further details on the scope (including the mandated KPIs) and the approach of our work is set out in the following pages.

Scope



Section A – Content & Consistency

Our Approach

Review content
Review the content of the 2011/12 Quality Report against the content requirement detailed in national guidance.

Document review
Conducting a desk based review of relevant documentation including: Board and committee minutes and papers relating to the Quality Report, feedback from partners, staff and patient survey results and Care Quality Commission quality and risk profiles and compare against the content of the Quality Report to ensure it is not inconsistent.

Form an opinion
We will assess the evidence from our documentation review and our interviews and form our limited assurance opinion that the content of the 2011/12 Quality Report is not inconsistent with any of the documentation listed in Appendix 2. Where appropriate we will also identify recommendations to address any areas for improvement.

Interviews
Interviews and discussions with a selection of Board Members and Trust staff, including those involved in the production of the Quality Report.

Detailed Findings

Following our agreed approach, we reviewed the content of the 2011/12 Quality Report against the criteria specified within Monitor's 2011/12 Annual Reporting Manual (Chapter 7) to ensure that the content was consistent.

We interviewed key staff involved in the production of the 2011/12 Quality Report (Appendix 2) and reviewed the documentation provided by the Trust (Appendix 2) to ensure that the 2011/12 Quality Report was not inconsistent with other information available.

Based on our work on the final Quality Report as at 30 May 2012, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2012, the content of the Quality Report is not in accordance with the 2011/12 NHS Foundation Trust Annual Reporting Manual and is not inconsistent with the sources specified in the detailed guidance.

We have signed our limited assurance report which is included within your 2011/12 Annual Report and a draft of our limited assurance opinion can be found in Appendix 1.

Section B: Performance Indicators

Our Approach

Interviews
Interviews and discussions with a selection of Trust staff, including those involved in the production of the specific performance indicators to be tested, to be able to document the relevant systems. We will also meet with the internal audit function as part of this process and review appropriate reports to inform our planning process.

Identify potential risk areas
Understand the key processes and controls for managing and reporting the selected indicators. For those performance indicators that were tested during the 2010/11 external assurance, we will follow up on any recommendations and subsequent action taken.

Identify improvement areas
From our work, we will identify recommendations to address any areas for improvement (where appropriate) for the 2012/13 Quality Report and our limited assurance opinion.

Detailed data testing
Determine a sample of the performance indicators to be tested, based on known areas of risk, including areas identified during the 2010/11 external assurance. The sample will be tested back to supporting documentation to gain assurance.

Detailed Findings: Sample Testing for the 2011/12 Quality Report

Following our agreed approach, we have undertaken detailed data testing of C.Difficile and 62 day cancer targets data on a sample basis. Based on our work, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2012, the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detialed Guidance for External Assurnace on Quality Reports. **Our draft limited assurance opinion can be found in Appendix 1 and is included within your 2011/12 Annual Report.**

We have also undertaken detailed data testing of the emergency surgery waiting time, which was determined as a local performance indicator by the Council of Governors.

The following pages show detailed findings for each of the Monitor mandated performance indicators and the locally determined indicator against the six dimensions of data quality (shown below). The assessment includes key strengths, perceived gaps and detailed recommendation that should be implemented. The summary of our recommendations and management responses can be found at the end of our report.

Monitor Six dimensions of Data Quality

- Accuracy – Is data recorded correctly and is it in line with the methodology.
- Validity – Has the data been produced in compliance with relevant requirements.
- Reliability – Has data been collected using a stable process in a consistent manner over a period of time.
- Timeliness – Is data captured as close to the associated event as possible and available for use within a reasonable time period.
- Relevance – Does all data used generate the indicator meet eligibility requirements as defined by guidance.
- Completeness – Is all relevant information, as specified in the methodology, included in the calculation.

Monitor six dimensions of data quality

Based on our detailed data testing, we have issued an unqualified opinion on the mandatory indicators.

	C.Difficile	62 day cancer wait	Emergency Surgery Wait
Accuracy – Is data recorded correctly and is it in line with the methodology.			
Validity – Has the data been produced in compliance with relevant requirements.			
Reliability – Has data been collected using a stable process in a consistent manner over a period of time.			
Timeliness – Is data captured as close to the associated event as possible and available for use within a reasonable time period.			
Relevance – Does all data used generate the indicator meet eligability requirements as defined by guidance.			
Completeness – Is all relevant information, as specifiec in the methodology, included in the calculation.			
Overall Conclusion			

We have assigned a rating for each dimension to give an indication of the relative level of urgency and need for action by the Trust.

No issues

Satisfactory – minor issues only

Requires improvement

Significant improvement required

Mandatory Indicator: Clostridium Difficile

Clostridium Difficile, often referred to as C. difficile or C-diff, is a bacterium that is present naturally in the gut of around two thirds of children and 3% of adults. C. difficile does not cause any problems in healthy people but some antibiotics that are used to treat other health conditions can interfere and cause the C. difficile bacteria to multiply and produce toxins. At this point, a person is said to be infected with C. difficile.

The national target is a 30% reduction in 2011/12 compared with the 2007/8 baselines figure. The Trust has a target of 31 cases and in the Quality Report the Trust has reported that this has been achieved with only 17 cases being reported.

Approach	Results	Recommendations
• We met with the Trust's lead for C.difficile to understand if there have been any changes during the year to the process from the initial symptoms being identified to the result being included in the Quality Report. • The main change is that a more sensitive test for C.Difficile has been introduced, which has significantly increased the number of positive test results above target. As agreed with the PCT the Trust have therefore put a process in place to assess the clinical significance of each case to determine whether it should be included in the reported indicator. • We have reviewed progress against our recommendations for last year. • We selected a sample of 25 patients from 1 April 2011 to 31 March 2012 including in our sample of mixture of cases attributable and not attributable to the Trust. • We agreed our sample of 25 patients to supporting documentation.	**Prior Year Recommendations** • Our recommendations have been implemented. **Testing** • Our sample testing identified no errors affecting reported performance against the target indicator. • In a small number of cases we noted that the system data provided for testing was inaccurate. However, we were able to agree that the C.difficile monitoring spreadsheet used by the Trust for the purpose of reporting had correctly recorded the details of the case. It was also noted that the Clinical Significance Assessment Forms are not signed by the Senior Clinicians discussing the case. • The results of our testing indicated that the Trust had correctly recorded the C.difficile result in the Quality Report. • We understand that from April 2012 C.Difficile is nationally defined and that there will be no requirement for the Trust to have Clinical Significance Assessment Forms in place. Given this change and in discussion with the Trust's lead, we have not made any recommendations for improvement in this area.	• None noted given that Clinical Significance Assessment Forms will no longer be required from April 2012.

Mandatory Indicator: Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

The NHS Cancer Plan set the goal that no patient should wait longer than two months (62 days) from a GP urgent referral for suspected cancer to the beginning of treatment, except for good clinical reasons. The target is that treatment should start within 62 days for 85% of patients receiving first definitive treatment. In the Quality Report the Trust has reported that it has achieved this target.

Approach	Results	Recommendations
• We met with the Trust's lead for the 62 day cancer wait to understand if there have been any changes during the year to the process from the urgent referral being received by the Trust to the result being included in the Quality Report. • We have reviewed progress against our recommendations for last year. • We selected a sample of 25 patients from 1 April 2011 to 31 March 2012 focusing on the patient pathways which appear to be most at risk of error e.g. pathways with manual adjustments, and pathways close to the 62 day breach date. • Following identification of some issues, we extended our original sample by a further 11 cases, which included all patients with an adjusted waiting time. • We tested the agreement of our population data back to the reported indicator in the Quality Report.	**Prior Year Recommendations** We have agreed that prior year recommendations have been satisfactorily implemented with the following exceptions: • Although a log has been created to record the details of wait-time adjustments there was no evidence that the entries in this log had been independently reviewed. Sample testing found that appropriate documentation was not available to support the timing or validity of 2 of the 4 adjustments made in the year. • The Trust decided not to involve internal audit to review the detailed patient data during the year. This is consistent with the small number of issues identified during audit testing • There were no patients with multiple-pathways during the year, therefore a detailed review was not required.	• Re-commit to implementing the adjustments log control with independent review to ensure validity supported by appropriate documentation. • Implement a single shared record of Inter Trust Transfer forms to record outstanding information, progress to date, and final documentation obtained to ensure supporting documentation to evidence pathway end-dates.

Mandatory Indicator: Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers (contd)

Results (contd)
Testing • **Start Date** There was one case where the start date (date referral received) was incorrect by one day. There is no impact on the Trust's performance as this case had already been reported as a breach. • **Stop Date** There was one case where we were unable to conclude on the accuracy of the pathway stop date as the Stop Date recorded on the Inter-Trust Transfer Form provided by another Trust did not match the stop date recorded by the Trust on Open Exeter. • **Adjustments** There were two cases where the wait period had been adjusted but there was no supporting documentation. Both cases had been recorded in an adjustments log but there was no evidence of independent review. We reviewed the total population of adjusted waiting times and found that, even where there was no supporting documentation, the adjustment did not affect whether the patient breached the waiting time target or not. • **Breach Testing** In the absence of appropriate supporting documentation for all relevant stages of the care pathway we were unable to conclude on the breach classification of 3 of the 36 cases (these being the case where the stop date could not be concluded and the two cases where the adjusted waiting time could not be concluded); however, we did not find any evidence that any cases had been mis-classified for the purpose of calculating the breach target indicator. As noted in our approach, we extended our original sample but did not find any further errors.

Local Indicator: Emergency surgery waiting time

In the 2009/10 Quality Report the Trust included a priority for 2010/11 in relation to clinical effectiveness which introduced a requirement to monitor the time it took for the Trust to undertake emergency surgery. There are three categories of emergency surgery: immediate; urgent; and expedited. The categories apply to the time within which patients should receive their emergency surgery. As part of our external assurance review of the 2010/11 Quality Report we undertook sample data testing and reported our findings and recommendations to the Board. The Trust decided that this continued to be a priority for the Trust in 2011/12 to reduce waiting times further and to improve other aspects of the patient experience in emergency surgery. The Trust set itself a target for 2011/12 of 90% for each category. The actual performance within the Quality Report is: Urgent 95%; and Expedited 99%.

Approach	Results	Recommendations

• We met with the Trust's lead for this indicator to understand if there had been any changes to the process of recording the emergency surgery results in the Quality Report identified last year.
• We have reviewed progress against our recommendations for last year.
• We selected a sample of 25 patients from 1 April 2011 to 31 March 2012 including in our sample a mixture of categorisations (immediate, urgent and expedited).
• We agreed our sample of 25 patients to supporting documentation. Specifically we:
  • Compared the case booking time as recorded on the paper surgery booking form with the booking form recorded in PICIS;
  • Compared the anesthesia start time recorded in theatre ledgers with the anesthesia start time recorded in PICIS; and
  • Corroborated the PICIS record validated categorisation by case record review with the Trust's lead.
	Prior Year Recommendations
	• Our recommendations have been implemented.
	Testing
	• Our reconciliation of the overall result recorded in the Quality Report back to the population data identified that:
	  • Q2 "intermediate" had missed 1 patient bringing the total to 4 patients, all seen within the standard; and
	  • Q3 "intermediate" had overstated 1 patient out of 9 patients seen within the standard.
	• These figures have now been corrected in the draft Quality Report.
	• Due to process changes, the indicator population has been extended to any patient recorded as requiring an immediate, urgent or expedited surgery on the PICIS system.
	• Our testing identified that the Trust could not determine the start time for Hand Management Unit patients (Treatment Code 07). It was therefore agreed with the Trust to exclude these patients from the population for the Quality Report.
		• Consider whether to improve starting time data collection for Hand Management Unit cases in order to include within the Quality Report next year.
		• Implement training or other controls to ensure that times recorded on PICIS are correct according to the 24 hour clock.
		• Ensure documentation such as surgery booking forms and medical notes can be accessed at a later date for the purpose of data testing.
		• Implement strategies to ensure that classifications are correctly assessed and recorded in the PICIS system.
		• Ensure that the surgery-wait data extracted from PICIS and used to prepare the Quality Report is fully up to date before it is sent for clinical validation at the year end.
		• Consider the use of data accuracy thresholds for the start and end time, specific to each category.

Local Indicator: Emergency surgery waiting time (contd)

Results

- From our sample of 25 patients, there were 2 Hand Management Unit patients that were removed from the sample after testing. Our detailed testing of the remaining 23 patient s identified:

  Wait Start

  - We found 10 errors where the surgery wait time as per the emergency surgery booking form had been incorrectly recorded in the PICIS system. Of these, there were 6 errors of less than 1 hour and 4 errors which appeared to related to the mis-interpretation of the 24-hour clock: e.g. 21.00 being recorded as 09.00. None of these time errors made the cases become breaches against their category standard time;
  - We were unable to conclude on the wait start time of 10 cases due to lack of supporting evidence;

  Wait End

  - We identified 3 cases where there were errors with the anaesthetic start time on the PICIS system. None of these time errors made the cases become breaches against their category standard time.

  Categorisation

  - On review of the categories, Dr Fauvel indicated that 10 patients had been incorrectly categorised. Of these 4 patients were elective and should not have been included within the indicator, and 6 patients had been categorised as "Urgent" instead of "Expedited". This means that the Trust has set itself a more challenging target than necessary and has achieved this target, bringing a benefit to the patient by being treated more quickly.
- In comparison to our testing last year, we found that the number of issues had improved.
- Whilst there were some data input errors for the start and end times, the differences did not mean that the cases breached the time standards set for the category. Given the size of the differences, it would be reasonable to agree time thresholds for data accuracy, dependent on the category of patient.

Action plan and management response

Action plan and management response

Pg	Recommendation	Agreed	Priority Rating (H/M/L)	Management response	Responsible Person	Time-scale
Mandatory Indicator: Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers						
20	Re-commit to implementing the adjustments log control with independent review to ensure validity supported by appropriate documentation.	Yes	H	Agree with regard to adjustments made within the Chelsea and Westminster component of the pathway. Adjustments made by another provider more difficult to evidence	Clinical Cancer Services Manager/ Macmillan Lead Nurse	End Q1
20	Implement a single shared record of Inter Trust Transfer forms to record outstanding information, progress to date, and final documentation obtained to ensure supporting documentation to evidence pathway end-dates.	Yes	H	Agreed	Clinical Cancer Services Manager/ Macmillan Lead Nurse	End Q2

Draft action plan and management response (contd)

Pg	Recommendation	Agreed	Priority Rating (H/M/L)	Management response	Responsible Person	Time-scale
Local Indicator: Emergency surgery waiting time						
22	Consider whether to improve starting time data collection for Hand Management Unit cases in order to include within the Quality Report next year.		M	We will explore the possibility of including this data if robust processes can be developed.	Mike Weston	End Q1
22	Implement training or other controls to ensure that times recorded on PICIS are correct according to the 24 hour clock.		H	We will work with relevant staff groups to improve the accuracy of data entry/transcription in PICIS. We will consider the cost-effectiveness of manual rechecking of data transcription from surgery booking forms into PICIS.	Odette Ferrao	End Q 3
22	Ensure that documentation such as surgery booking forms and medical notes can be accessed at a later date for the purpose of data testing.		M	We will improve the monthly retention of surgery booking forms, which was poor during Q1 of 2011-12. The Trust continues its efforts to move from paper-based to electronic patient records and would appreciate written guidance to ensure that any future data systems relevant to this indicator will meet the Auditors' requirements for data testing.	Odette Ferrao	End Q1

Action plan and management response (contd)

Pg	Recommendation	Agreed	Priority Rating (H/M/L)	Management response	Responsible Person	Time-scale
22	Implement strategies to ensure that classifications are correctly assessed and recorded in the PICIS system.		H	We have decided to make our classification system more complex, thereby better to reflect clinical reality. We will provide more detailed guidance for clinical staff in the use of our new classification system. We will remove responsibility for assigning the classification from junior surgical staff, making it a joint clinical responsibility of the anaesthesia and surgical teams.	Dr N Fauvel	Q2 onwards
22	Ensure that the surgery-wait data extracted from PICIS and used to prepare the Quality Report is fully up to date before it is sent for clinical validation at the year end.		M	Surgery-wait data is extracted on a monthly basis for validation of the clinical classification, rather than yearly. We will work to ensure that this monthly extraction of surgery-wait data accurately reflects the data held in the PICIS database.	Odette Ferrao	Q2 onwards
22	Consider the use of data accuracy thresholds for the start and end time, specific to each category.		M	To allow proper consideration, we would value discussion with the Auditors to ensure that we understand their recommendation.	Odette Ferrao	Q 3

Appendices

Appendix 1: Draft Independent Auditor's Assurance Report to the Council of Governors of Chelsea and Westminster Hospital NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Chelsea and Westminster Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Chelsea and Westminster Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2012 (the "Quality Report") and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the Council of Governors of Chelsea and Westminster Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting Chelsea and Westminster Hospital NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2012, to enable the Council of Governors to demonstrate that is has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Chelsea and Westminster Hospital NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- C.Difficile; and
- Maximum 62 day wait from urgent GP referral to treatment.

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that::

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual;*
- the Quality Report is not consistent in all material respects with the sources specified in section 2.1 of the Detailed Guidance for External Assurance and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports.*

We read the Quality Report and considered whether it addresses the content requirements of the *NHS Foundation Trust Annual Reporting Manual,* and considered the implications for our report if we became aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the documents specified within the detailed guidance. We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Appendix 1: Draft Independent Auditor's Assurance Report to the Council of Governors of Chelsea and Westminster Hospital NHS Foundation Trust on the Annual Quality Report (contd)

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – "Assurance Engagements other than Audits or Reviews of Historical Financial Information" issued by the International Auditing and Assurance Standards Board ("ISAE 3000"). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Testing key management controls;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual.*

The nature, form and content required of Quality Reports are determined by DH/Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts. In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Chelsea and Westminster Hospital NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2012:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual;*
- the Quality Report is not consistent in all material respects with the sources specified in the detailed guidance; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports.*

Deloitte LLP
Chartered Accountants
St Albans
30 May 2012

Appendix 2: List of Interviewees and Documentation

As part of our work, we met with the following individuals:

- Cathy Mooney (Director of Governance and Corporate Affairs);
- Catherine Gillespie (Macmillan Lead Nurse and Acting Cancer Manager);
- Doctor Nicholas Fauvel (Consultant Anaesthetist and Intensivist)
- Rosalind Wallis - Consultant Nurse (Infection Prevention and Control)
- Andrew Guilder – Information Lead (Information and Performance)

As part of our work, we reviewed the following documentation:

- Draft Quality Report dated 21 May 2012
- Care Quality Commission – Quality and Risk Profile dated March 2012
- The Trust's complaints and concerns annual report 2010/11;
- Overview of the 2011 Inpatient / Maternity / Paediatrics survey;
- 2011 NHS Staff Survey
- Board meeting minutes from April 2011 to Mar 2012
- Quality Sub Committee from April 2011 to Mar 2012
- Council of Governors Report September 2011
- Board papers specifically relating to the Quality Report;
- KPMG Head of Internal Audit Opinion dated 22 March 2012;
- Feedback from Governors dated 17 May 2012;
- Feedback from Kensington and Chelsea Local Involvement Network dated 11 May 2012.

Appendix 3: 2012/13 Quality Accounts Planned Changes

On 16 February 2012, the Department of Health and Monitor issued a joint letter to all NHS Chief Executives detailing the planned changes to the 2012/13 Quality Accounts.

The National Quality Board has recommended that mandatory reporting against a small, core set of quality indicators be introduced to improve readers' understanding of comparative performance whilst maintaining local ownership. It is likely that this new requirement will be introduced by amending the Quality Accounts regulations for the 2012/13 reporting period (i.e. the Quality Accounts that are due to be published in June 2013). Monitor will consult on these requirements as part of its consultation on the Annual Reporting Manual for NHS Foundation Trusts 2012/13.

The indicators are based on recommendations by the National Quality Board. They align closely with the NHS Outcomes Framework and are all based on data that the Trust already report on. The intention is that the Trust will be required to report:

- their performance against these indicators;
- the national average; and
- a supporting commentary, which may explain variation from the national average and any steps taken or planned to improve quality.

The Department of Health is currently exploring the feasibility of extending the proposed new reporting requirements to independent sector providers of NHS-funded care from 2014/15.

The joint letter also suggested, given the likely changes, that Trusts may wish to consider using the current 2011/12 Quality Accounts to report against the proposed core set of quality indicators and to feedback their experiences to the Department of Health.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 12 July 2012

AGENDA ITEM NO.	2.4/Jul/12
PAPER	Audit Committee Annual Report 2011/12
AUTHOR	Lorraine Bewes, Director of Finance
LEAD	Sir John Baker, Chairman Audit Committee
EXECUTIVE SUMMARY	This report outlines key Audit Committee activity for the financial year 2011/12 and provides evidence for the assurances that have been made to the Board with regard to the Trust's risk management, internal control and governance processes being adequate and effective. The report summarises the external assurance received during the year from internal audit, external audit and the local counter fraud specialist. The opinion of the Committee is that the Trust's risk management, control and governance processes are adequate and effective and may be relied upon by the Board.
DECISION/ ACTION	The Council of Governors is asked to note the report of the Audit Committee.

CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST

Audit Committee Annual Report for financial year 2011/12

1.0 Introduction

1.1 The Committee's chief function is to advise the Board on the adequacy and effectiveness of the Trust's systems of internal control and its arrangements for risk management, control and governance processes, and securing economy, efficiency and effectiveness (value for money).

1.2 In order to discharge this function the Audit Committee has prepared an annual report for the Board and Accounting Officer. This report includes information provided by Internal Audit, External Audit and other Assurance Providers, including the Assurance Committee. This report covers the financial year to 31st March 2012.

2.0 Audit Committee's Opinion

2.1 Members of the Board should recognise that assurance given can never be absolute. The highest level of assurance that can be provided to the Board is a reasonable assurance that there are no major weaknesses in the Trust's risk management, control and governance processes.

2.2 The opinion of the Committee, based on the issues set out in section 3 below, is that the Trust's risk management, control and governance processes are adequate and effective and may be relied upon by the Board.

3.0 Information supporting Opinion

3.1 Summarised below is the key information / sources of assurance that the Committee has relied upon when formulating our opinion.

3.2 Internal Audit

3.2.1 2011-12 represents the first full year of internal audit service provision by KPMG, following the appointment on 1 December 2010. KPMG have provided a substantial assurance Head of Internal Audit opinion for 2011-12 on the overall adequacy and effectiveness of the Trust's risk management, control and governance processes for the year ended 31 March 2012.

3.2.2 KPMG's opinion is that:

'Substantial assurance can be given that there is a generally sound system of internal control on key financial and management processes. These are designed to meet the Trust's objectives, and controls are generally being applied consistently.'

3.2.3 One high risk recommendation was raised by KPMG during the Freedom of Information Requests review:

- Delays were noted in responding to requests, with performance from April to July 2011 showing 59% of cases being closed within the mandatory 20 working day deadline. This compares to 95% reported for the same period in 2010/11., which was driven by delays in receiving the information from the relevant Directorate.

  It was recommended that the Information Governance Team (IGT) ensure that they agree deadlines for responding with the Directorate contact and chasing should always occur 3 days prior to the deadline.

  KPMG noted that the recommendation was implemented during the year.

3.2.4 KPMG has delivered 12 reviews. Of these, an 'adequate assurance' opinion was provided for financial management, financial reporting, strategy formation, information governance, quality governance, risk management and changing commissioners. Five 'requires improvement' opinions were provided for reviews on Board Assurance Framework, Medical Locums, Cost Improvement and QIPP, Freedom of Information Requests and Netherton Grove.

Within each review, areas of best practice have been highlighted by KPMG to enhance the current arrangements that are in place.

3.2.5 For the year to 31 March 2012, the Head of Internal Audit considered that there were no issues that needed to be brought to the attention of Trust Management that they considered relevant to the Statement of Internal Control.

3.3 External Audit

3.3.1 Deloitte LLP have continued to serve as external auditors.

3.3.2 The external auditors will be reporting to the Audit Committee on 23rd May 2012 on the accounts prepared for the year to 31st March 2012. It is anticipated that they will be issuing an unqualified audit opinion. The accounts will be approved at the Board on 28th May and will be signed to ensure they are delivered to Monitor within the required timescale (31st May).

3.3.3 Use of Resources: External audit are required to review the Trust's use of resources and to be satisfied that proper arrangements have been made for securing economy, efficiency and effectiveness in the use of resources. It is anticipated that their review will identify no matters that needed to be referred to in their audit report.

3.3.4 The Audit Committee will review the Quality Accounts on 23th May and consider how assurance over the data quality of the 2011/12 Quality Report is given to the Board when they adopt the accounts for submission on 28th May. This year external audit will provide a Limited Assurance opinion on the Quality Accounts and sample testing of two mandated indicators (C Diff and 62 day cancer waits) in the Annual Report, and a private report to the Board of Governors (and a copy given to Monitor) on one local indicator (Emergency Surgery target). The Quality Account requirements and the work required of the auditors are expected to be changed for 2012/13 to require reporting on indicators aligned with the NHS Outcomes Framework.

3.4 Other Committees

3.4.1 The Trust had two other assurance committees during the year. These are the Assurance Committee and the Finance and Investment Committee (FIC).

3.4.2 The Assurance Committee assures the Board on systems, processes and outcomes relating to quality (patient safety, effectiveness and patient experience), staff satisfaction and the environment including compliance with the Care Quality Commission Standards. In addition to the minutes being available to the Board from the Assurance Committee there is a monthly report which identifies key issues discussed and an assessment of assurance.

3.4.3 The FIC assures the Trust Board on financial and investment policy issues, including oversight of material capital investment business cases. All these committee minutes are made available to the Audit Committee.

3.5 Local Counter Fraud Service (LCFS)

3.5.1 Each NHS body is required to take necessary steps to counter fraud under instructions from the Secretary of State's Directions. As a Foundation Trust, this is one our contractual requirements with PCTs. The Trust has complied with these Directions by agreeing an Annual Service Level Agreement with Parkhill for the delivery of the Local Counter Fraud Service for 2011/12, which includes a proactive counter fraud programme to detect fraud as well as investigations in response to alleged frauds. The Audit Committee receives a regular report on progress against the agreed work plan and annual report.

3.5.2 NHS Protect, who were previously known as the Counter Fraud and Security management Service (CFSMS), carries out an annual Qualitative Assessment of the strengths and weaknesses of Local Counter Fraud arrangements within NHS bodies and bands NHS bodies into one of four rating levels. The ratings achievable are designated 1 – 4, 4 being the highest. The Trust scored a level 3 in 2011/12 (and also scored a level 3 in 2010/11 and 2009/10). A level 3 rating means that the 'organisation is performing well' and is defined within the Qualitative Assessment document as:

> 'To achieve a level 3 performance and assess the health body as performing well, the arrangements at level 2 should be embedded and operating effectively with clear outcomes. In addition to achieve level 3 assurances for work completed must clearly be evident and must clearly demonstrate qualitative outputs.'

3.5.3 During the year, the Trust tendered the contract for counter fraud services as part of a Fulham Road collaborative approach. Following the tender, the three year contract award was made to Parkhill.

3.5.4 Counter fraud arrangements are compliant with the Secretary of State's Directions.

4.0 <u>The Role and Operation of the Audit Committee</u>

4.1 Membership of the Committee

4.1.1 The members of the Committee during the period of the Report were as follows:

Andrew Havery (Chair of the Committee) until October 2011
Charlie Wilson until October 2011
Karin Norman until October 2011
Sir John Baker (Chair designate) from January 2012
Prof Richard Kitney from January 2012
Sir Geoff Mulcahy from January 2012

In addition the Chief Executive, Director of Finance, Deputy Chief Executive, External Auditors, Internal Auditors, Local Counterfraud Specialist and Director of Governance and Corporate Affairs are in attendance.

4.1.2 The members of the Committee disclosed their interests, which included the following, in the Trust's register of interests:-

Andrew Havery:
- Councillor, Westminster City Council
- Member of the Board of the CityWest Homes ALMO
- Vice Chair of Governors for Quintin Kynaston Specialist Technology College
- NHS Practice Management, Dr Lee's Surgery
- Finance Director, Mind Sports Olympiad

Karin Norman:
- Trustee, Nursing and Midwifery Council and Associated Employers Pension Scheme
- Chair, MyGeneration (registered charity)
- Director, Raglan Capital Ltd
- Audit Committee member, Parkinson's Disease Society of the UK

Charles Wilson
- Trustee of Addaction, currently vice-chairman. (Addaction is a leading drugs treatment charity)
- Non-Exec Director of the-racehorse.co.uk (a commercial online horseracing news site)
- Trustee Royal Naval Museum
- Member of the Board of the Countryside Alliance

Sir John Baker
- Director of Renewable Energy Holdings plc
- Director of Motac Holdings Ltd
- Chairman, Mayor of London's Fund for Young Musicians

Prof Richard Kitney
- Director of RJK Consultants Ltd
- Chairman and Director of Visbion Ltd

Sir Geoff Mulcahy
- Chairman, Javelin Group
- Non-executive Director, Sunderland ARC
- Trustee, Consumer Credit Counselling Service and FCC

4.1.3 The Committee was supported by Paulina Woodberry.

4.2 Operation of the Committee

4.2.1 Meetings and attendance

The Committee is required to meet quarterly in line with the terms of reference. Meetings took place during the period and were attended as follows:

	19th May 2011	24th May 2011	27th July 2011	20th Oct 2011	31st Jan 2012	22nd Mar 2012	TOTALS	
							No of meetings	%
Andrew Havery	*P*	*P*	*P*	*P*	*N/A*	*N/A*	*4/4*	*100%*
Karin Norman	*P*	*P*	*P*	*P*	*N/A*	*N/A*	*4/4*	*100%*
Charlie Wilson	*P*	*P*	*P*	*A*	*N/A*	*N/A*	*3/4*	*75%*
Sir John Baker	*P**	*P**	*A**	*P**	*P*	*P*	*2/2*	*100%*
Prof Richard Kitney	*N/A*	*N/A*	*N/A*	*N/A*	*P*	*P*	*2/2*	*100%*
Sir Geoff Mulcahy	*N/A*	*N/A*	*N/A*	*N/A*	*P*	*P*	*2/2*	*100%*
TOTAL	*100%*	*100%*	*100%*	*75%*	*100%*	*100%*	*17/18*	*96%*

Key – P (Present for meeting) A (Absent from meeting) N/A (Not applicable)

* In attendance

The quorum for meetings of the Committee was 67%. As the table above shows all meetings of the Committee during the period were quorate.

4.2.2 Committee Self-Assessment

The Committee undertook a self-assessment as to its performance using the template recommended in the Audit Committee handbook in September 2010. No material deficiencies were found.

4.2.3 Performance Indicators

The Committee has established performance indicators for External Audit, Local Counter Fraud Service and Internal Audit.

We consider there are no issues about their performance that affects their ability to support this Committee in discharging its duties.

5.0 Governance and risk management

5.1 The following information regarding Governance was presented and discussed at the Audit Committee meetings during the year:

5.2 Risk Management

5.2.1 The Trust's system of risk management including adequacy of the risk identification, recording, reporting and monitoring arrangements is outlined in the Annual Governance Statement. The Governance Statement is to be approved at the meeting of 23rd May.

5.2.2 The Audit Committee received a report on how well risk management was undertaken at local – divisional - level. There was adequate assurance and two moderate and one minor recommendation. In addition an approach to risks identified through Board papers was agreed.

5.3 Governance

The Audit Committee received an annual report on Information Governance in January 2012. Internal Audit undertook a review of Information Governance evidence for the IG Toolkit submission and noted adequate (green) assurance. The Committee endorsed the Toolkit submission of 95% rating.

It was noted that the Trust has achieved Level 2 and above in all requirements with the exception of Requirement 505 [A robust programme of internal and external data quality/clinical coding audit is in line with the requirements of the Audit Commission and NHS Connecting for Health is in place.]

The component that is non-compliant relates to the results of an internal data quality/clinical coding audit carried out in April 2011 as part of a programme of internal Information Governance audits designed to supplement the annual external Data Assurance Framework clinical coding audit.

NHS Connecting for Health sets the following percentage accuracy scores as targets;

	Level 2	**Level 3**
Primary Diagnosis	>=90%	>=95%
Secondary Diagnosis	>=80%	>=90%
Primary Procedure	>=90%	>=95%
Secondary Procedure	>=80%	>=90%

The Trust did not meet these accuracy scores and the Trust's overall percentage of correct coding achieved is documented in the table below.

	Correct%
Primary Diagnosis	88
Secondary Diagnosis	72.7
Primary Procedure	83.9
Secondary Procedure	85.2

Action to address:

The following actions will be taken to achieve Level 2:

• Implement a programme of regular, structured internal audit to include quarterly audits covering a minimum of 150 FCEs providing feedback and training to the coders as

required. This will require the identification of a suitable location for conducting the audits.

- Enrol one of the Clinical Coding Team managers to undertake the NHS CfH classification Service Clinical Coding Audit Workshop to provide support to the Head of Coding who is at present solely responsible for internal clinical coding audit.

- Deliver targeted training sessions to coders based on the findings of the coding audit report, with particular reference to the coding of mandatory co-morbidities, the coding of diagnostic imaging, method of approaches and the assignment of OPCS site codes.

- Review the location arrangements for coding personnel to determine and achieve, as far as practical, an optimum working environment to promote a productive and efficient coding service, where coders can concentrate without frequent interruption or distraction by staff from other areas and interact as a team.

- Extend use of the discharge summary template to other specialities to support complete information provision and good quality coding.

- Implement a process to ensure coders check all histopathology reports in a timely fashion and amend the coded clinical record accordingly to reflect the most accurate diagnosis.

- Ensure the clinical coding department has increased engagement with all specialties in order to validate the coded data, create a forum for dialogue and obtain clinician guidance on specific procedures.

- To support more coders to attain the Association of Clinical Coding qualification.

The Audit Committee considered the Trust position against the Monitor Quality Governance framework and agreed further actions. The policy for Governance Structures and Processes was agreed. The Audit Committee also agreed the new Trust anti-bribery policy and associated gifts, hospitality and sponsorship policy.

A paper outlining how the Trust meets the terms of authorisation and how this is assured was considered in Jan 2012.

The committee effectiveness was reviewed in October 2011 and reported to the Board

6.0 Conclusions

6.1. **The opinion of the Committee, based on the issues set out in the above report, is that the Trust's risk management, control and governance processes are adequate and effective and may be relied upon by the Board.**

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 12 July 2012

AGENDA ITEM NO.	2.6/Jul/12
PAPER	*Shaping a healthier future* – Communications & Engagement Plan
AUTHOR	Matt Akid, Head of Communications
LEAD	Therese Davis, Chief Nurse and Director of Patient Experience and Flow
EXECUTIVE SUMMARY	The *Shaping a healthier future* public consultation on major service change in North West London could have major strategic implications for the Trust, depending on the outcome of consultation and subsequent decisions made about service reconfiguration. This paper outlines a proposed approach to the Trust's communications and engagement with internal and external stakeholders during the consultation which runs for 14 weeks from 2 July-8 October. It includes a suggested programme of activity to engage Governors and Foundation Trust members in supporting the Trust and advocating on behalf of the Trust during the consultation process. The paper also proposes a 'brand' for this programme of activity – '*Safe in our hands' – keep A&E at Chelsea and Westminster*.
DECISION/ ACTION	The Council of Governors is invited to comment on this plan and to discuss its role in supporting and advocating for the Trust during the public consultation.

1.0 Introduction

Public consultation on NHS North West London's *Shaping a healthier future* service reconfiguration programme started on Monday 2 July and is due to last for 14 weeks until 8 October – information is available at www.healthiernorthwestlondon.nhs.uk.

The decision to go to public consultation was taken following approval at a meeting of the Joint Committee of Primary Care Trusts (JCPCT) for North West London on Monday 25 June and an NHS London Executive meeting on Thursday 28 June.

The outcome of the public consultation will have a major impact on the future of Chelsea and Westminster Hospital which is why a Communications & Engagement Plan is required.

2.0 Public consultation proposals

The most contentious element of the consultation is the proposal to reduce the number of full A&E departments in North West London, and as a consequence effectively 'downgrade' 3 acute hospitals to local hospitals.

3.0 Strategic implications of public consultation proposals

If A&E is retained at Chelsea and Westminster instead of Charing Cross
The future of Chelsea and Westminster as a 'major hospital' is safeguarded, we see increased A&E activity, more emergency admissions, and increased inpatient and operating theatre activity.

If A&E is retained at Charing Cross instead of Chelsea and Westminster
The future of the Trust is threatened because Chelsea and Westminster is downgraded to a 'local hospital', we lose income from 100,000+ A&E attendances per year, we lose more than 60% of current adult inpatient activity, and our status as a specialist centre for Paediatrics and Maternity is compromised by the lack of 24/7 emergency care in A&E

4.0 Why do we need a Communications & Engagement Plan?

The *Shaping a healthier future* consultation document recommends Chelsea and Westminster as the preferred option for a full A&E service, in preference to Charing Cross.

However, the public debate has started with local politicians expressing concern about the loss of A&E services at Charing Cross and Hammersmith hospitals.

"Removing all A&E services in my borough makes no sense when Hammersmith and Fulham is set for dramatic growth. For years I have warned that Charing Cross Hospital was being downgraded and facing closure by stealth."
Cllr Stephen Greenhalgh
Ex-Leader of Hammersmith & Fulham Council

"These crass proposals will pit Charing Cross against Chelsea and Westminster. With a growing population in this part of London, and heavily congested roads, we need Accident & Emergency at both hospitals."
Greg Hands MP
MP for Chelsea and Fulham

Some politicians have also publicly questioned whether Chelsea and Westminster would be able to absorb extra A&E and other activity.

A number of online petitions have been set up to 'Save Charing Cross Hospital' including one by Hammersmith & Fulham Council.

The biggest danger for Chelsea and Westminster is complacency because we are the preferred option. This is why we need a robust Communications & Engagement Plan to ensure that the voice of Chelsea and Westminster is heard in the consultation exercise and so that the Trust has a planned and consistent approach to its communications on this issue.

5.0 Communications and engagement activity to date

5.1 Chelsea and Westminster activity

During the pre-consultation period before 2 July, communications and engagement activities have been undertaken to raise awareness about the implications of the forthcoming public consultation for Chelsea and Westminster.

This included an article in April's *Trust News*, which was sent to all patient and public Foundation Trust members, an article in May's *Members' News* email newsletter for Foundation Trust members, an agenda item at the Council of Governors meeting on 3 May, and open forums for staff including the Grand Round for medical staff on 3 May.

Members of City of Westminster's Health Overview and Scrutiny Committee visited the Trust on 11 June for a factfinding visit during which they visited A&E, Maternity and Paediatrics and had an opportunity to talk to members of the Executive team and other staff.

During the first week of the public consultation, a series of 3 consultation events for staff and Governors were held on 5 July and the Acting Chief Executive Dr Mike Anderson met Governors and other key stakeholders on 3 July to brief them on the consultation and to inform them how they could support the Trust during the public consultation.

5.2 NHS North West London activity

NHS NW London ran 3 pre-consultation engagement events for staff and patient/public representatives in February, March and May – these were well-attended by Chelsea and Westminster clinicians, senior managers and Foundation Trust Governors.

Before the consultation started on 2 July, NHS NW London also held Clinical Implementation Groups (CIGs) with clinicians from Paediatrics, Maternity and A&E from acute hospitals in North West London to discuss the reconfiguration plans.

6.0 Future communications and engagement activity – aim and approach

The aim is to mobilise support for maintaining a full A&E service at Chelsea and Westminster by building on the success of 2 recent Trust communications and engagement exercises that used a strong, recognisable 'brand' to connect with patients, staff and other key stakeholders:

- The '**Who do you think WE are?' consultation** on the Trust's values led to more than 800 people voting for their values in an online and paper-based survey, with a further 130 people taking part in focus groups
- The **Chelsea and Westminster Star Awards** attracted almost 800 nominations

A simple strapline for all communications and engagement activity has been developed to encourage people to take part in the consultation – *'Safe in our hands' – keep A&E at Chelsea and Westminster*.

This is supported by a recognisable visual brand for use on posters, our website, printed publications like *Trust News* etc.

7.0 Target audiences

- **Internal** – All staff but especially in A&E

- **External** - Patients and visitors, Foundation Trust Governors and members, patients, local stakeholder groups such as Kensington & Chelsea LINk and Age UK Kensington & Chelsea, GPs (especially CCGs), local MPs, local Council leaders and other key politicians

8.0 Building a network of champions/advocates/spokespeople

The key to the success of any communications and engagement activity during a consultation is to build a network of champions or advocates who will not only support the Trust themselves but also encourage others to do so.

Our status as a Foundation Trust with active Governors and more than 10,000 patient and public members is a key advantage compared with Charing Cross. Governors are encouraged to mobilise support from our members and members of the local community.

It is also important to mobilise the support of our staff (especially in A&E) because they are key advocates to patients – our communication between senior management and staff, the best nationally in the NHS Staff Survey, is a key advantage compared with Charing Cross. Other potential advocates include:

- **Patients** - especially those who have had a positive experience of A&E
- **Charities and voluntary organisations that support the Trust** – Chelsea and Westminster Health Charity, Children's Hospital Trust Fund, Friends, Volunteers etc

Spokespeople for any media activity that we undertake during consultation could include:

- **Acting Chief Executive/Medical Director** - Dr Mike Anderson
- **Divisional Medical Director** – Mr Jeremy Thompson
- **A&E clinicians** – specifically the lead clinician, Dr Patrick Roberts
- **Governors**

9.0 Stakeholder contact programme

A specific contact programme is being developed to build support among key stakeholders – 1:1 meetings to be led by the Chairman and Acting Chief Executive/Medical Director with:

- MPs – especially Greg Hands (Chelsea & Fulham) and Sir Malcolm Rifkind (Kensington) but also other local MPs
- Council leaders – especially Sir Merrick Cockell (Kensington & Chelsea) and Nick Botterill (Hammersmith & Fulham)
- Kensington & Chelsea LINk
- GPs – especially CCG Chairs

10.0 Key messages

A set of key messages to be tailored to different target audiences are required to ensure consistency in our communication – these 6 key messages form the basis:

- Chelsea and Westminster is a modern, purpose-built hospital providing an excellent patient environment
- Our A&E Department provides an excellent standard of patient care and consistently meets the Government's target that 98% of patients should be treated and either discharged from hospital or admitted to an inpatient ward within 4 hours of arrival
- The Department includes a dedicated Children's A&E which is increasingly popular with parents and is a key element of the new Chelsea Children's Hospital at Chelsea and Westminster
- Chelsea and Westminster has the best mortality rates of any hospital in the country, according to the independent Dr Foster Hospital Guide 2011
- Chelsea and Westminster is a financially stable Foundation Trust with a track record of providing excellent patient care while delivering significant efficiency savings
- We enjoy strong community support from more than 10,000 Foundation Trust members and their elected representatives on our Council of Governors
- Chelsea and Westminster works closely with its partner hospitals on the Fulham Road, the Royal Marsden and Royal Brompton, to provide excellent care for patients

11.0 Tactics

11.1 Internal communications and engagement

- **Team Briefing** – information to be included on the first Friday of each month
- ***Trust News*** – published every month
- **Daily Noticeboard email bulletin** – information can be published as required
- **Chief Executive's Blog** – published every 2 weeks and emailed to all staff
- **Staff open forums** – can be organised as and when required
- **Ad hoc meetings with staff** – especially if staff are anxious about the implications of the proposed changes, Directors will make themselves available to attend staff meetings etc to discuss the implications for the Trust
- **Email Inbox and regularly updated Q&A on the Trust Intranet to answer staff queries and concerns** – to provide a point of contact and regularly updated information for staff
- **PC Desktop icon** – to raise awareness among staff

11.2 External communications and engagement

- **Trust website** – www.chelwest.nhs.uk now has more than 70,000 visits a month
- **Trust Twitter feed** - @ChelwestFT now has more than 1,300 followers who are potential supporters of the Trust during a consultation
- **Chief Executive's Blog** – emailed to all Governors and key external stakeholders
- ***Members' News*** – email newsletter for Foundation Trust members
- ***Trust News*** - August's *Trust News* is sent to all Foundation Trust members
- **Membership meetings** – to rally support among members
- **Annual Members' Meeting** – the annual meeting on 13 September is an opportunity to mobilise support during the public consultation period
- **Local newspaper advertising** – for example, a 'wrap' cover
- **Leaflet drop** – to encourage support for the hospital in the local community
- **Posters in public areas of the hospital** – to raise awareness among patients, visitors and staff
- **Hoarding** – to replace the current *Putting Patients First* hoarding next to A&E
- **GP newsletter** – to raise awareness among GPs and encourage their involvement
- **Press release** - to publicise the consultation in the local media

- **Communication with patient groups/forums in the Trust and organisations supportive of the Trust such as the Friends, Volunteers etc**– potentially a letter from the Chairman encouraging their support

12.0 Consultation events

12.1 Joint Health Overview and Scrutiny Committee (JHOSC)

A Joint Health Overview and Scrutiny Committee (JHOSC) for all the 8 boroughs in North West London, as well as neighbouring boroughs outside North West London whose residents will be affected by the changes proposed, has been set up to overview the consultation – the first meeting is being held on Thursday 12 July and a representative from the Trust will attend all meetings so we are aware of local politicians' views.

12.2 Public roadshows

The *Shaping a healthier future* programme has organised a roadshow event in Hammersmith and Fulham on Saturday 28 July – this will include a Q&A session. The venue and timings are still to be confirmed. It will be important for us to publicise this event to staff and other potential supporters to attend the roadshow, and especially the Q&A, to ensure that Chelsea and Westminster's voice is heard – details will be made available to Governors.

Similar public roadshows will be organised in Kensington and Chelsea, Wandsworth and Westminster – details will be publicised to Governors as and when they are available.

12.3 Events for Council of Governors and Foundation Trust members

The Trust has formally requested the *Shaping a healthier future* programme to organise 2 specific consultation events for the Council of Governors and Foundation Trust members:

- Presentation by Dr Mark Spencer, GP and Medical Director of the *Shaping a healthier future* programme, and opportunity for roundtable discussion and debate at the Council of Governors meeting on 13 September
- Meeting for Foundation Trust members with presentation by Dr Mark Spencer followed by a Q&A session to be held in September

12.4 Staff consultation events

The Trust has formally requested the *Shaping a healthier future* programme to repeat the staff consultation events being held in the hospital on 5 July – it is proposed that a further round of staff open forums (to which Governors will be invited) will be held in September.

13.0 Next steps

The Council of Governors is invited to comment on this plan and to discuss its role in supporting and advocating for the Trust during the public consultation.

Matt Akid
Head of Communications
June 2012

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 12 July 2012

AGENDA ITEM NO.	2.7/Jul/12
PAPER	Health and Social Care Act 2012 – briefing and review of constitution
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman Cathy Mooney, Director of Governance and Corporate Affairs
EXECUTIVE SUMMARY	A brief guide has been produced for governors by the FTGA which provides an overview of changes arising from the Health and Social Care Act 2012. The attached is an overview of changes arising from the Health and Social Care Act 2012 impacting on Foundation Trusts. A plan for addressing changes to the constitution is outlined.
DECISION/ ACTION	For information.

1.0 Introduction

The Health and Social Care Act 2012 amends the NHS Act 2006 and in particular, Schedule 7 of the NHS Act 2006 which affects the provisions which must be contained in all Foundation Trusts' Constitutions.

2.0 Background

The Health and Social Care Act 2012 (the 'Act') received Royal Assent on 27 March 2012. The Government's vision was to modernise the NHS by proposing to create an independent NHS Board, promote patient choice and to reduce NHS administration costs. The key areas of the Bill were:

- establishing an independent NHS Board to allocate resources and provide commissioning guidance
- increasing GPs' powers to commission services on behalf of their patients
- strengthening the role of the Care Quality Commission
- developing Monitor into an economic regulator to oversee aspects of access and competition in the NHS, and
- reducing the number of health bodies to help meet the Government's commitment to cut NHS administration costs by a third, including abolishing Primary Care Trusts and Strategic Health Authorities.

A Constitution Review Task Force met in January 2011 and identified a wide range of potential changes to the constitution. It also identified areas which could be included in Standing Orders. This was put on hold due to the impending Act.

3.0. Overview of Changes to Impact on FTs

The key reforms in relation to Foundation Trust governance and constitutional matters are outlined below.

<u>Provisions Relating to Governors</u> *(provision 151)*

- All boards of governors must be renamed 'Council of Governors' *(provision 151 (1))*
- There is no requirement for PCT appointed governors to sit on the Council of Governors (given that PCTs will be abolished). *(provision 151 (2))*
- Any organisation specified in the Constitution may appoint one or more governors (but no more than the number specified in the Constitution). *(provision 151 (3) (7))*
- Governors have two new general duties: *(provision 151 (4) 10A)*
    - to hold the Non-Executive Directors individually and collectively to account for the performance of the Board; and
    - to represent the interests of members as a whole and of the public.
- FTs must equip governors with the skills and knowledge they require to carry out the role. *(provision 151 (5) 10B)*
- Governors have a new power to require one or more directors to attend a meeting of the Council in order to obtain information on the performance of the FT or performance of directors. *(provision 151 (6) 10C)*

- FTs must hold an 'annual meeting of members', open to members of the public, to receive the annual accounts, any report of the auditor on them and the annual report. *(provision 157 (1) 27A)*
- Governors are also given powers to approve amendments to the Constitution, and to approve 'significant transactions', mergers, acquisitions, separations and dissolution. *(provision 168,169,170 and 171).*

- Monitor has a new power to establish a panel to advise governors in the event that the Council of Governors passes a resolution and complains to Monitor that the FT has failed or is failing to act in accordance with its constitution or with the provisions of Part 4 of the Act. The panel will have the power to decide whether or not to investigate and must publish a report on any investigation. *(provision 162)*

Provisions relation to Directors/Board *(provision 152)*

- There is a new duty on the board generally and directors individually to act with a view to promote the success of the FT and maximise the benefits for members and the public. *(provision 152 (1) 18A)*
- Directors have an explicit duty to avoid conflicts of interest and declare if any should arise. *(provision 152 (3) 18C)*
- Directors have an explicit duty not to accept benefits from a third party by reason of being a director or for doing or not doing anything in this regard. *(provision 152 (2) 18B)*
- The Constitution must make provision for Board meetings to be held in public but may also provide for members of the public to be excluded from a meeting for 'special reasons'. *(provision 152 (5) 18E)*
- Directors must send a copy of the board agenda to the Council of Governors prior to the meeting taking place and, as soon as practicable after, a copy of the minutes of the board meeting to the Council of Governors. *(provision 152 (4) 18B)*

FT Members *(provision 153)*

- FTs must ensure that membership is representative of those eligible (this amends the 2006 Act which placed the duty on the regulator). In addition, there is a new provision that when deciding on areas for public constituencies or deciding whether to have a patients' constituency, the FT must have regard to the need for those eligible for membership to be representative of those to whom services are provided. *(provision 153 (2) (2))*

Amendments to Constitution *(provision 161)*

- Monitor no longer has a role in approving FTs' constitutions. A majority of both the Board of Directors and Council of Governors voting must approve any amendments to the constitution. *(provision 161 (1) (1))*

- Furthermore, any amendments regarding the powers or duties of governors must be approved by the annual members' meeting. *(provision 157 (1) (4))*

Other Reforms

There is also a range of other administrative reforms included in the Act which will require amendments to be made to FT constitutions.

4.0 Proposed way forward

A detailed plan will be developed to work through the implications of the Act with respect to the constitution. The following outlines a

The changes have not yet come into force, but it is proposed that this is taken forward in 2012/13, so that the changes can be implemented as soon as possible. Until then the current model constitution and requirement for Monitor to approve changes remains in force.

As Monitor no longer checks constitutions it is the Trust's responsibility to ensure the constitution is legally compliant. This will be required as a final step.

Outline plan:

1. Review and refresh previous proposed amendments in light of the Act and revised Model Core Constitution.

2. Governors to review staff constituencies (this has previously been identified as an area for review)

3. Board/Council to review Council size and membership

4. Draft constitution agreed and approved by the Board of Directors and Council of Governors. *(provision 161 (1) (1))*

5. Final constitution agreed (legal review)

6. Approval by membership (this is currently in our constitution)

7. Constitution implemented

8. Standing Orders reviewed and agreed

It is proposed that the above issues are reviewed by small working groups, facilitated by the Director of Governance and Corporate Affairs with expert advice. The groups will report to the Board of Directors and the Council of Governors.

There are other key areas to be identified and discussed e.g. the meaning of significant transactions, the roles of governors and training which may be out with the constitution and a separate process will be identified.

The Council will also note the question under 2.11 on the agenda and the paper on 'Director–Governor interaction in NHS Foundation Trusts' under items for information. The Chairman will address a proposed way forward for this.

5.0 Action

The Council of Governors is asked to comment on the outline plan.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 12 July 2012

AGENDA ITEM NO.	2.8/Jul/12
PAPER	Membership Recruitment, Engagement and Communications Strategy 2012-13
AUTHOR	Matt Akid, Head of Communications
LEAD	Therese Davis, Chief Nurse and Director of Patient Experience and Flow
EXECUTIVE SUMMARY	This paper sets out a membership strategy for approval by the Council of Governors – it was drafted by the Head of Communications and has been amended following feedback at the Council of Governors Membership Sub-Committee meeting on 1 June. Once approved, the strategy will be published on the Trust website and will form the basis of membership activity for the next year, which comprises a membership recruitment calendar of events and a membership engagement and communications calendar of events. Enhanced membership recruitment, engagement and communications activity over the last 6-12 months has led to an increase in membership numbers, more meaningful and focused engagement with members, and more regular communication with members. This strategy focuses on the 2 key areas of the Trust's membership activity for the next 12 months: • Recruitment of new members and development of a representative membership • Engagement and communication with existing members Delivery of the strategy and associated activities is the responsibility of the Deputy Chief Nurse (recruitment and development of a representative membership) and the Head of Communications (engagement and communications) – it is overseen by the Council of Governors Membership Sub-Committee. The strategy summarises the principles that will govern the Trust's membership activity over the next 12 months.
DECISION/ ACTION	The Council of Governors is invited to comment on and approve this strategy.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

MEMBERSHIP RECRUITMENT, ENGAGEMENT AND COMMUNICATIONS STRATEGY 2012-13

1.0 Introduction

Since receiving authorisation as a Foundation Trust in October 2006, Chelsea and Westminster Hospital NHS Foundation Trust has made considerable efforts to build a membership that is vibrant and representative.

However, membership numbers steadily declined over a number of years since authorisation. This decline was masked by the decision post-authorisation to change staff membership from 'opt-in' (staff actively choosing to become members) to 'opt-out' (staff being members unless stating that they do not wish to be so) which artificially boosted membership numbers by c.2,500.

There was limited membership engagement and communication activity during this time – members received two membership mailings per year and were invited to the Open Day and Annual Members' Meeting.

However, there has been an enhanced programme of more focused membership recruitment, engagement and communication activity over the last 6-12 months:

- **Recruitment** - The number of members increased by 350 in 2011/12 compared with 2010/11
- **Engagement** - Members have been actively engaged in the development of the Trust's values and wayfinding strategy, they were invited to nominate staff for the first Chelsea and Westminster Star Awards, and a series of 'Medicine for Members' seminars are now being run as extra membership events
- **Communication** - An extra membership mailing and monthly email newsletters have been introduced

1.1 Who can be a member?

Patients - Any patient treated at the hospital in the last 3 years or the carer of any patient treated at the hospital in the last 3 years

Members of the public - Anyone living in the local boroughs of Kensington and Chelsea, Hammersmith and Fulham, City of Westminster, and Wandsworth (for Council of Governors elections, each borough is divided into 2 areas)

Staff - Staff automatically become members when starting employment with the Trust unless they 'opt out' (for Council of Governors elections, the staff constituency is divided into six staff groups: Allied Health Professionals, Scientific & Technical; Contracted; Management; Medical & Dental; Nursing & Midwifery; Support, Administrative & Clerical)

Volunteers – Anyone who is a volunteer at Chelsea and Westminster

1.2 What does this strategy cover?

This strategy focuses on the 2 key areas of membership activity:

- Recruitment of new members and development of a representative membership
- Engagement and communication with existing members

The 2 areas are clearly linked - if we do not provide existing members with good enough reasons to retain their membership and play an active part in the hospital, they will leave and we will have to expend more energy and resources on recruiting new members to replace them.

1.3 Which Trust staff are responsible for membership?

Due to the maternity leave of Sian Nelson (Membership and Engagement Manager), responsibility for membership is currently divided between Tony Pritchard (Deputy Chief Nurse – recruitment and developing a representative membership, working with the Equality & Diversity Manager Priti Bhatt) and Matt Akid (Head of Communications – engagement of and communication with members).

The Membership Sub-Committee of the Council of Governors, which is chaired by Public Governor Martin Lewis, oversees the membership strategy and commented on an earlier draft of this paper at a meeting on 1 June.

2.0 Recruitment

The Trust's membership at the end of the 2011/12 financial year was 14,858 – an increase of 350 members compared with 2010/11.

This is almost 1,000 more than the average Foundation Trust membership according to the recent Monitor report *Current practice in NHS foundation trust member recruitment and engagement.*

Constituency	31 Mar 2012	31 Mar 2011
Staff	3,231	3,173
Patients	5,685	5,591
Public	5,942	5,737
Total	**14,858**	**14,501**

Recruitment is an ongoing activity because we need to recruit new members just to maintain the current membership numbers – in order to replace members who move away from the area or who pass away.

2.1 Recruitment of new members

This strategy proposes that recruitment of new members should continue to focus on activities that are demonstrated to be effective and on activities that enable the Trust to develop a representative membership.

Recruitment should be systematic and evidence-based so that the Trust's limited budget for this activity is spent in a cost-effective way.

For example, in 2011/12 the Trust gained 600 new members through **hospital-based recruitment drives** in May and September 2011.

It is proposed to run these events again in 2012/13 because they have proven to be successful in not only recruiting new members but also helping to publicise the Trust's Open Day and Annual Members' Meeting.

In addition, the **Open Day** held in May each year is an opportunity for Governors to recruit new members – approximately 70 at each of the last 2 Open Days.

The **Membership and Patient Advice & Liaison Service (M-PALS)** promotes membership by giving membership application forms to visitors to the M-PALS office in the hospital and sending out membership application leaflets with letters responding to comments received by M-PALS.

Other potential opportunities for recruitment of new members include the **'Meet a Governor'** sessions in the hospital, **local community events** (eg open days, fairs, fetes etc) and ad hoc recruitment in **GP surgeries** but these should not replace the larger scale recruitment drives.

2.2 Development of a representative membership

Analysis of the membership database by age, gender and ethnicity is undertaken to help the Trust work towards developing a membership that is representative of the communities we serve.

It is recognised that membership recruitment should focus particularly on increasing the number of Black and Minority Ethnic (BME) members as well as other under-represented groups.

Targeted activities have included the recruitment of 30 new members from a **Somali women's group** at West London Centre for Sexual Health in March 2012 and the recruitment of new members at regular **Shepherd's Bush Market community mobile health clinic sessions**.

However, a coherent recruitment strategy is required to address areas where our membership is under-represented – not only BME groups but also younger people and also certain geographical areas.

This work will be led by the Deputy Chief Nurse and the Equality & Diversity Manager.

3.0 Engagement and communication

Membership numbers alone are meaningless unless we engage with our existing members to give them reasons to maintain their membership and to fulfil our role as a locally accountable organisation.

Limited engagement with members in the past may have been a contributory reason for declining membership numbers.

Certainly our membership engagement activity used to be limited compared with some other Foundation Trusts.

3.1 Enhanced programme of activity 2012/13

The Council of Governors approved a programme of proposals to improve membership engagement and communication at its meeting on 1 December 2011.

This programme is now being implemented – thanks to funding from the Council of Governors budget.

In 2012/13 the Council of Governors has provided funding of £42,592 to support the following activity:

- 3 *Trust News* membership mailings
- 12 *Members' News* monthly membership email newsletters
- 5 'Medicine for Members' seminars
- Open Day
- Annual Members' Meeting
- Christmas event

3.2 Campaigns to engage members in key issues

In addition, members have been involved in a number of engagement campaigns including the **'Who do you think WE are?'** consultation on the Trust's values in February 2012 and the **'Show us the way'** consultation on proposed improvements to wayfinding in the hospital.

In May 2012 the Trust Board approved a Communications & Engagement Plan for the ***Shaping a healthier future*** public consultation about proposed changes to NHS services in North West London – members and Governors are being encouraged to get involved in this consultation which runs for 14 weeks from Monday 2 July.

3.3 'Meet a Governor' sessions

These sessions are communicated to members in advance through the *Trust News* membership mailings, the monthly *Members' News* email newsletters, and via the 'Get Involved' section of the Trust website.

Currently 5 Governors hold 'Meet a Governor' sessions – other Governors are encouraged to do likewise.

4.0 For action

The Council of Governors is invited to comment on and approve this strategy.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 12 July 2012

AGENDA ITEM NO.	2.9/Jul/12
PAPER	Council of Governors Quality Sub-Committee Terms of Reference*
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Cathy Mooney, Director of Governance and Corporate Affairs
EXECUTIVE SUMMARY	The Council of Governor Quality Sub-Committee Terms of Reference have been updated by the Quality Sub-Committee at its meeting on 15 June 2012. There were discussions about the Chair and it was agreed to reconsider once implications of the Health and Social Care Act 2012 were known. (See minutes of Quality Sub-Committee for more information).
DECISION/ ACTION	For approval.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Quality Sub-Committee

Terms of Reference

1.0 Authority

1.1 The Council of Governors Quality Sub-Committee is constituted as a Sub-Committee of the Council of Governors to assist the Trust to develop and implement the Trust's quality programme.

1.2 Its terms of reference shall be as set out below and shall not be amended, revoked or replaced except by a resolution passed at a general meeting of the Council of Governors.

1.3 The Council of Governors shall not delegate any of its powers to the Sub-Committee and the Sub-Committee shall not exercise any of the powers of the Council of Governors.

2.0 Aim

This sub-committee will provide key stakeholder input into the development and implementation of the Trust's quality programme, including safety, effectiveness and patient experience.

3.0 Role

3.1 To identify priorities for quality improvement in line with national and local initiatives.

3.2 To contribute to the structure and content of the Quality Account within the required framework, including developing agreed metrics, to ensure it is clearly and well-presented and can be understood by all stakeholders.

3.3 To facilitate communication and feedback to the membership and the public on the Quality Account and quality issues e.g. through advice on the content of the website and participation in developments, Trust News and other means of communication.

3.5 To identify ways in which stakeholders can be involved in the quality programme e.g. safety walkabouts, advising on leaflets.

3.6 To champion the patient's experience and encourage and advise on patient involvement.

3.7 To identify areas where there is particular added value from stakeholders.

3.8 To ensure that there is input from all member constituencies.

3.9 To obtain the lay perspective on assurance of quality.

3.10 To support funding initiatives relevant to quality to the Council of Governors.

4.0 Membership of the Sub-Committee

4.1 The Sub-Committee shall comprise both elected and appointed governors with representatives from patients, the public, and staff

4.2 Representative from Chelsea and Westminster Local Involvement Network and representative from NHS London Cluster (Hammersmith and Fulham, Kensington and Chelsea and Westminster Primary Care Trusts).

4.3 Trust staff to include:

a) The Medical Director (Chair)
b) The Chief Nurse
c) The Director of Governance and Corporate Affairs
d) Membership and Engagement Manager
e) Head of Assurance and Quality

In addition, the Sub-Committee may invite other people to attend including those from an external organisation

5.0 Quorum

5.1 A quorum shall comprise at least one of: the Medical Director, Director of Governance and Corporate Affairs or Director of Nursing and three governors.

6.0 Frequency of Meetings

6.1 The Sub-Committee shall meet bi-monthly and report to the Council of Governors after each meeting.

7.0 Attendance requirements

Two thirds of the meetings.

8.0 Administration of the Meeting

8.1 This will be undertaken by the Foundation Trust Secretary.

9.0 Review

9.1 The terms of reference of the sub-committee shall be reviewed by the Council of Governors annually.

Approved by the Council of Governors 03 December 2009
Approved by the Council of Governors 14 July 2011

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 12 July 2012

AGENDA ITEM NO.	2.10/Jul/12
PAPER	Annual Members' Meeting proposal
AUTHOR	Matt Akid, Head of Communications
LEAD	Therese Davis, Chief Nurse and Director of Patient Experience and Flow
EXECUTIVE SUMMARY	This paper is intended to propose the format of this year's Annual Members' Meeting on Thursday 13 September and other events to be organised for Foundation Trust members and prospective members during September. The Annual Members' Meeting is a statutory requirement and must include presentations by the Chairman, Chief Executive, Director of Finance and a Governor – it is also proposed this year to include presentations by clinicians. A number of other events are proposed to be organised for members during September.
DECISION/ ACTION	Governors are invited to comment on this proposal and to put themselves forward to present the membership report on behalf of the Council of Governors.

ANNUAL MEMBERS' MEETING PROPOSAL

1. Background

The Annual Members' Meeting will be held at **5.30pm** on **Thursday 13 September** in the Restaurant on the Lower Ground Floor of the hospital.

All Board members – both Executive and Non-Executive Directors – are expected to attend.

The meeting is organised by the Head of Communications on behalf of the Chairman and Chief Executive.

In previous years this has been a well-attended event with several hundred Foundation Trust members and hospital staff in attendance.

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 2011/12; report of the external financial auditor (included in the annual report and accounts); forward planning information for 2012/13
- 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, patient and staff constituencies; progress on the membership strategy; results of Council of Governors elections; announcement of Non-Executive Directors appointed in 2011/12

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

This will be Tony Bell's first major public event after joining the Trust as our new Chief Executive on 3 September. It is therefore a key opportunity for him to introduce himself and his vision for the future of Chelsea and Westminster to Foundation Trust members and staff.

The meeting is being held during the *Shaping a healthier future* public consultation on service reconfiguration in North West London and therefore is an opportunity for the Trust to make its case to supporters and potential supporters. We can expect questions from the floor on this issue.

The state of the public finances and the possible impact of cuts on the NHS continues to be a key public concern and may also generate questions. This is an opportunity for us to discuss the success of the Trust's strategic approach to making cost improvements from 2010/11-2012/13 under the umbrella of the Trust's *Fit for the Future* campaign.

The redevelopment of the hospital is now well underway 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 – in particular, the opening of our new HIV & Cancer Unit and the development of the new Chelsea Children's Hospital.

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.

This year in particular it is an opportunity to engage members and staff in supporting Chelsea and Westminster in the *Shaping a healthier future* consultation.

3.2 Themes

It is proposed that the overarching theme of the Annual Members' Meeting should be 'It's who we are', which will build on the official launch of the values at the Open Day in May, with a focus on excellence in clinical care.

4. Proposed format of the meeting

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

1. Chairman
Content to be discussed nearer the time.

2. Chief Executive
Content to be discussed nearer the time.

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 surplus in developments to improve patient care.

4. Council of Governors representative
Membership report to include an explanation of the role of Governors with a particular focus on the *Shaping a healthier future* public consultation and the role of members and Governors in supporting the Trust.

4.2 Question & Answer session (30 minutes maximum)

Questions from the public to be answered by the Trust Board of Directors – this session will be chaired by the Chairman.

4.3 Presentations by clinicians

It is proposed to have 2 brief (10-15 minutes) presentations by frontline clinicians based on case studies in the Quality Account 2011/12 – to reinforce the importance of excellence in clinical care and to publicise the Quality Account.

The Chairman has suggested that the Medical Director introduce these presentations which would be followed by a Question & Answer session with the clinicians, chaired by the Medical Director.

Suggested topics for the presentations are the Trust's work to reduce preventable venous thromboembolism (VTE), to be presented by Consultant Haematologist Dr Helen Yarranton and Specialist Anticoagulant Pharmacist Sheena Patel, and the introduction of 'wellbeing rounds' on inpatient wards which have enhanced the care of older patients, especially those who suffer from dementia, to be presented by

Chief Nurse and Director of Patient Experience and Flow Therese Davis and David Erskine Ward Sister Lesley-Anne Marke.

4.4 Votes on proposed changes to the Foundation Trust constitution

If votes on proposed changes to the constitution are necessary, full details must be included in both the Foundation Trust membership mailing which is sent out to all patient and public Foundation Trust members in August to publicise the Annual Members' Meeting and the agenda/programme provided at the meeting itself.

The Director of Governance & Corporate Affairs is asked to advise if any votes on changes to the constitution are required.

5. Other events proposed to take place during the week of the Annual Members' Meeting

5.1 Paediatrics and Maternity events

Although the Annual Members' Meeting is well attended, it does not tend to attract younger people, parents (especially women) with young children, and others who use our Women's & Children's Services. These groups are also under-represented in our current Foundation Trust membership.

Therefore it is proposed to run 2 other events in September that are targeted specifically at Foundation Trust members and prospective members – focusing on Maternity and Children's Services.

These events will be planned in conjunction with the Divisional management team.

The Council of Governors has already provided funding of £5,000 to cover the cost of the Annual Members' Meeting (advertising in local press, catering, hire of PA system provided and run by an external company) and these 2 other events.

5.2 'Medicine for Members' seminars

It is proposed to organise 1 or possibly 2 'Medicine for Members' seminars during September – repeating the recent Dementia seminar which was over-subscribed and also potentially organising a seminar about musculoskeletal (MSK) problems to coincide with the launch of the Trust's new community MSK service in Kensington and Chelsea, provided jointly with Connect Physical Health.

These seminars would be introduced and chaired by the Chairman or another representative of the Council of Governors Membership Sub-committee to enhance the link between elected Governors and Foundation Trust members.

5.3 *Shaping a healthier future* consultation events

As part of the *Shaping a healthier future* public consultation which runs for 4 months from 2 July-8 October, the Trust has requested that 2 specific consultation events be organised for the Council of Governors and Foundation Trust members:

- Presentation by Dr Mark Spencer, GP and Medical Director of the *Shaping a healthier future* programme, and opportunity for roundtable discussion and debate at the Council of Governors meeting on 13 September
- Meeting for Foundation Trust members with presentation by Dr Mark Spencer followed by a Q&A session to be held in September

6. Next steps

Governors are invited to comment on this proposal and to put themselves forward to present the membership report on behalf of the Council of Governors.

Matt Akid
Head of Communications
June 2012

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 12 July 2012

AGENDA ITEM NO.	2.11/Jul/12
PAPER	Governors' Questions
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Dr Mike Anderson, Interim Chief Executive
EXECUTIVE SUMMARY	Two questions were received: 1.Trust plans to redecorate some of the clinics and corridors – Martin Lewis 2. Explain in simple terms '"Accountability and Governors" in the Paper "Accountability in Action' recently ciruclated – Alan Cleary
DECISION/ ACTION	The Council of Governors is asked to note that Dr Mike Anderson will provide response to the above questions.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 12 July 2012

AGENDA ITEM NO.	2.12/Jul/12
PAPER	Report on Senior Nurse/Governor Rounds
AUTHORS	Tony Pritchard, Deputy Chief Nurse
LEAD	Therese Davis, Chief Nurse and Director of Patient Experience and Flow
EXECUTIVE SUMMARY	This report provides a summary Governor rounds and visits that were conducted during February, March and April 2012. The paper provides details of forthcoming senior Nursing and Midwifery clinical rounds in which we assess the Care Quality Commission essential standards of quality and safety.
DECISION / ACTION	For information.

Report on Senior Nurse / Governor Rounds

1.0 Introduction

1.1. This report provides a summary of Governors rounds and visits during February, March and April 2012 and provides details of future Senior Nursing and Midwifery clinical rounds during the forthcoming months.

1.2. Governors are welcome to arrange individual visits or rounds to specific wards or services and to join the senior Nursing and Midwifery clinical rounds that take place on alternate Wednesday afternoons each month.

2. Individual Governor Visits

2.1. Governor Mr Harry Morgan visited on Friday March 23rd as part of a planned series of visits to a range of services within the Trust. Mr Morgan met with Mr Mike Maguire, the Clinical Practice Educator within the Emergency Department, who explained the work of the department and provided a tour of the clinical areas.

2.2. Mr Morgan then met with Ms Sally Ann Sharman, who provides a retinal screening service with the outpatient department. Ms Sharman demonstrated a range of investigations and discussed her role within the service. Mr Morgan was impressed with the work of these two services and found the visit to be both informative and instructive.

2.3. On Saturday April 21st, Mr Chris Birch visited Ron Johnson Ward accompanied by Mr Steve Akehurst from the National Aids Trust. They completed a tour of the ward and Day Care facilities, discussing the work of the ward with Staff Nurse Poveda. Mr Birch and Mr Akehurst met a number of patients who discussed their experience of care and treatment within the ward.

3. Future Individual Governor Visits

3.1. Mr Morgan would like to arrange a future visit during May to learn more about the stroke service and services for older people.

3.2. Mr Martin Lewis has planned a visit to the Emergency Department on Friday May 4th.

4. Clinical Rounds

In October 2011, the Senior Nursing and Midwifery Committee initiated clinical half days for the team. During these clinical sessions, designated leads work with Matrons, Ward Sisters, General Managers and other staff to assess the standards of our care and treatment within wards and clinical departments. This is completed through observing the clinical environment and through discussing care and treatment with patients, families and staff. Further details are contained in appendix 1.

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

A number of Governors joined our clinical rounds in February and felt that this process was valuable as it allowed them to consider individual standards in detail, and to understand the

components of these. The summary discussion and sharing of ideas was seen to be valuable in learning from one another.

5. Future Clinical Rounds

A calendar of future dates for rounds, and the associated CQC standards is attached in appendix 2. We would welcome Governors to join the Senior Nursing and Midwifery team on any of these dates. Planning for these is coordinated by the Deputy Chief Nurse.

6. Summary

This report has provided a summary of Governor Rounds and visits conducted during February, March and April 2012 and those that are planned during May. The Details of future Senior Nursing and Midwifery Clinical Rounds have been provided.

Tony Pritchard
Deputy Chief Nurse
April 2012

Appendix 1

CQC Standards

In March 2010, the Care Quality Commission (CQC) published their essential Standard of Quality and Safety. These are the standards we are required to demonstrate as a Trust in order to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These identify a total of 28 outcomes, 16 of which relate to clinical activities.

Assessing our standards

We have translated the CQC standards into a local toolkit which we use to assess standards of care and treatment within our clinical areas. Each standard defines a range of outcomes that we would expect.

Within each standard, the method for assessing this is defined. This includes, for example, documented evidence, interviews with staff and patients, and families.

Assessment and assurance of these standards is coordinated and monitored by the Senior Nursing and Midwifery Advisory Committee.

On each clinical half day, designated leads work with matrons, ward sisters, general managers and other staff to assess defined standards across a range of clinical areas,

Evaluation

Following each clinical half day, leads document the results of assessment and provide any feedback to the relevant leads in clinical areas

The assessment team meet to provide feedback as a group, define any key generic themes and define an action plan for improvement.

Appendix 2

Senior Nursing & Midwifery Clinical Rounds – Assessment of CQC Standards

Feb 1st 12	Feb 15th 12	March 7th 12	March 21st 12	April 4th 12	April 18th 12	May 2nd 12	May 16th 12	June 6th 12
8. Cleanliness and infection control	7.Safeguarding people from abuse 9. Safe and appropriate management of medicines	1. Respecting & involving service users	4. Care & welfare of people who use the service	12, 13 & 14. Workers, Staffing and supporting staff	5. Meeting peoples nutritional needs 6. Co-operation with other providers	2. Consent to care and treatment 21. Maintaining records of peoples care	10. Safety & suitability of premises 11. Safety, availability & suitability of equipment	16. Assessing, monitoring and improving the quality of service provision 17. Complaints
June 20th 12	**July 4th 12**	**July 18th 12**	**August 1st 12**	**August 15th 12**	**September 5th 12**	**September 19th 12**	**October 3rd 12**	**Oct 17th 12**
8. Cleanliness and infection control	7.Safeguarding people from abuse 9. Safe and appropriate management of medicines	1. Respecting & involving service users	4. Care & welfare of people who use the service	12, 13 & 14. Workers, Staffing and supporting staff	5. Meeting peoples nutritional needs 6. Co-operation with other providers	2. Consent to care and treatment 21. Maintaining records of peoples care	10. Safety & suitability of premises 11. Safety, availability & suitability of equipment	16. Assessing, monitoring and improving the quality of service provision 17. Complaints

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 12 July 2012

AGENDA ITEM NO.	2.13/Jul/12
PAPER	Council of Governors Funding Report
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Cathy Mooney, Director of Governance and Corporate Affairs
EXECUTIVE SUMMARY	The report provides an overview of the use of the Council of Governors budget to Month 3 of FY 2012/13. Following feedback from the governors the structure of the report has been revised. A request for funding is enclosed in part A.
DECISION/ ACTION	The Council of Governors is asked to note the report and approve a request for funding.

Council of Governors Funding Report

1.0 Background

A decision was made at the November 2008 Council of Governors meeting that a recurring budget should be available to the Council of Governors to spend at their discretion on relevant projects. This is £80,000 for the financial year 2012/13.

2.0 Update

At the last meeting the Council of Governors agreed to support funding of a letterbox drop and local press advertising for the Open Day May 2012.

3.0 Funding Overview for 2012/13

Of the £80k circa £53k was accrued for the activities listed in the table below which were approved by the Council of Governors. It leaves circa £27k available for the remainder of the 2012/13 FY.

4.0 Use of funds FY 12/13

TABLE 1

Date Presented	Projects	Amount Committed	Decision	Spent to date
June 2010 and recurring	Quality Awards	£2,000	Agreed 2012/13 FY	£1,000
December 2011	Open Day 2012	£15,000	Agreed 2012/13 FY	£8,917.20
December 2011	Engagement Activity - Membership mailing (Jan 2013)	£10,000	Agreed 2012/13 FY	
December 2011	Engagement Activity - 12 Members' News monthly emails (April 2012-March 2013)	£2,520	Agreed 2012/13 FY	£216
December 2011	Engagement Activity - Annual Members' Meeting + 2 associated events (Sept 2012)	£5,000	Agreed 2012/13 FY	
December 2011	Engagement Activity - 5 'Medicine for Members' events	£5,000	Agreed 2012/13 FY	£283
December 2011	Engagement Activity - Christmas event (Dec 2012)	£5,000	Agreed 2012/13 FY	
February 2012	Small Membership branded gifts for the Open Day May and Annual Members' Meeting September 2012	£1,500	Agreed 2012/13 FY	£150.60
February 2012	Members Recruitment Campaign for Open Day May 2012	£2,340	Agreed 2012/13 FY	£1,800
May 2012	Open Day 2012 advertising via letterbox drop and in the local press	£4,793	Agreed 2012/13 FY	£1,711.40
May 2012	Giggle Doctors	£4,600	Declined	-
	TOTAL	**£53,153**		**£14,078.20**

5.0 Use of funds FY 11/12

Date Presented	Projects	Amount Committed	Decision	Spent to date
June 2009	Discharge Booklet	£8,200	Carried forward from 2009/10 FY	No further carry forward
December 2009	Web Optimisation	£7,000	Carried forward from 2009/10 FY	£7,000
September 2010 and recurring	Quality Awards	£2,400	Agreed 2011/12 FY (£400 was for staff survey)	£1,350
December 2010	Trust Open Day 2011	£15,000	Agreed 2011/12 FY	£15,000
December 2010	Recruitment Campaign for Open Day May 2011	£2,000	Agreed 2011/12 FY	£2,000
December 2010	Communications campaign to publicise the Trust's 4 priorities for quality improvement – from 10/11	£4,000	Carried forward from 2010/11FY	No further carry forward
July 2011	Maternity and Children's Services Events	£5,000	Agreed 2011/12 FY	£5,000
July 2011	Members Recruitment Campaign for Annual Members' Meeting	£2,340	Agreed 2011/12 FY	£2,340
July 2011	Improvements to the Information Zone - Supply of one maple face table and two chairs	£580.80	Agreed 2011/12 FY	£580.80
July 2011	Badges for governors	£104.40	Agreed 2011/12 FY	£104.40
December 2011	Engagement activity - 1 extra membership mailing (Jan 2012)	£10,000	Agreed 2011/12 FY	£10,000
December 2011	Engagement activity - 2 monthly emails (Feb & March 2012)	£420	Agreed 2011/12 FY	£385
December 2011	Engagement activity - 1 'Medicine for Members' event (Feb 2012)	£1,000	Agreed 2011/12 FY	£845.20
December 2011	Capita Membership Recruitment (via Mobile Health Clinic)	£3,300	Agreed 2011/12 FY	£900
December 2011	Blog system	£2,520	Agreed 2011/12 FY	£2,160
February 2012	Council of Governors Handbook printing	£144	Agreed 2011/12 FY	£144
February 2012	Equipment required for producing podcasts	£1,200	Agreed 2011/12 FY	£916.79
February 2012	Consultant database	£2,000	Agreed 2011/12 FY	£2,100
	TOTAL	**£67,209.20**		**£50,826.19**

6.0 Progress report re projects for FY 2012/13

6.1 For an update on projects re membership engagement including the Open Day May 2012 approved by the Council of Governors for FY 2012/13 see paper 2.17 and 2.19.

6.2 For an update on projects re the Members Recruitment Campaign for the Open Day May 2012 see paper 2.18 and for Small Membership branded gifts for the Open Day May 2012 see paper 2.19.

6.3 Quality Awards

Four awards were agreed in June 2012, each for a team at £250.

Part A

Membership Recruitment proposal

1.0 Background

The Council of Governors at its meeting on 9 February 2012 agreed to support funding of the annual budget for the main recruitment events in May & September at cost of £2,340.

However, we have identified that the amount agreed is not sufficient.

Cost of May recruitment session was £1,800.

2.0 Funding request

This proposal provides an additional funding request and the Capita costs for additional membership recruitment sessions in September 2012.

An outline of September recruitment sessions linked to the Annual Members Meeting and elections promotion is as follows:

2 x 3 day sessions will be costed at £1,800.

The total cost for the events in May and September will be £3,600. There is an additional funding requirement of £1,300.

3.0 Action

The Council of Governors is asked to approve the request for additional funding of 1,300 for the recruitment sessions in September.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 12 July 2012

AGENDA ITEM NO.	2.14/Jul/12
PAPER	The tenth FTGA National Development Day - 23 May & 27 June 2012 – feedback*
AUTHOR	Susan Maxwell - Patient Governor Alan Cleary – Patient Governor
LEAD	Susan Maxwell, Patient Governor Alan Cleary – Patient Governor
EXECUTIVE SUMMARY	This paper provides feedback from the tenth FTGA National Development Day held on 23 May and 27 June 2012.
DECISION/ ACTION	The Council is asked to note the paper.

JOINT DEVELOPMENT PROGRAMME FOR FOUNDATION TRUST GOVERNORS

Held on 23rd May 2012 at
Hamilton House, Mabledon Place, London, WC1H 9BD

Attending:
Kathryn Mangold (Staff Governor) and Susan Maxwell (Patient Governor)

Unlike other Development programmes, this time the governors were allocated separate tables. It was explained that this was in order to make sure that we met and talked to as many other Trust governors as possible.

The meeting got off to a start with Kim Hutchings, Head of Development and Engagement of the Foundation Trust Network (FTN) welcoming the governors and introducing the speakers for the day.

Policy Update

Part 1:
The first speaker in the morning session was Paul Betts, an Economic Adviser to the FTN. He was an excellent orator and gave an easily understood policy update of the Health and Social Care Act – from the original principles of inception through to the compromise result.

Please see photocopied slides to the ***Policy Update*** (attached).

He concluded his talk by outlining the implications for Foundation Trust Governors, stating that their role would now have more clout. (See last slide of Policy Update attachment, page 10).

Part 2:
He then handed over to Kim Hutchings so that she could outline how the Act might affect the governor role. She talked us all through the required duties of a governor (see first slide on page 12 of Policy Update attachment). She made a point of stating that it would be in the interests of governors to also become involved in their local Healthwatch and Clinical Commissioning groups or forums.

She concluded by saying that each Trust must take steps to ensure that governors are in future equipped with the skills and knowledge they require to undertake their role. To this end the last slide on page 13 of the Policy Update attachment gives details of the new national training programmes for governors.

The question and answer sessions centred mainly on future board meetings being held in public (in those FTs where they are not at present) and on the governor input on the constitution and the subsequent approval of it.

Accountability in Action

In the afternoon we had a choice of workshops. Both Kathryn and I separately attended the *Accountability in Action* talk given by John Coutts, Governance Adviser (FTN).

He outlined that in the new system the governors will have an explicit duty to hold non-executive directors to account. He emphasised that accountability is not a form of appraisal, but rather a means of forming a working relationship whereby the governors have a duty to ask the NEDs to be answerable for the board. For instance, have they 'triangulated' to obtain assurance that any stated data can be trusted? That is, have they nodded through on the board's word, or have they studied and checked them thoroughly to their satisfaction that nothing is amiss? Will they then give us a signed document to that effect? This ensures the governors have asked, and got answers to, matters of accountability, thus (hopefully) eliminating the chance of another "Mid Staffordshire" type of situation arising.

The two slides on page 6 of the accompanying attachment entitled ***Accountability in Action*** outlines what accountability is required by the governors from the NEDs.

The question and answer session was almost entirely taken up with how NEDs are kept at a distance and it was made very clear that it is the role of governors to meet with the NEDs and have a working relationship with them.

Best practice was thought to be a meeting of at least one hour between the governors and the NEDs without the Chairman (since he is a member of the executive board) so that they could chat through the state of play.

Effective Questioning and Challenge

Again, Kathryn and I both chose to attend the same session, again on different tables – this one entitled ***Effective Questioning and Challenge*** which was headed by Sandra Marshall, Networks Manager (FTN).

In the write-up to the session, it explained that in the new system the governors' enhanced role will call for a greater understanding of decisions made by the board of directors and their impact on patients, members and the public as a whole. It states that governors will now be expected to hold NEDs individually and collectively to account for the performance of the board and that it is important that they feel equipped for that. To this end a national training programme for governors will be put in place.

This session, therefore, concentrated on the confidence levels of questioning and challenging. It gave tips on how to think about what you needed to know and how best to prepare to ask without (for instance) waffling or asking in an accusing manner.

It asked us NOT to think in terms of how good (say) 85% was in terms of a national average of 80%, but to ask the pertinent question of why the 15% failure!

As a group exercise we were asked to look at a dashboard for an anonymous Mental Health Trust (enclosed) and to think what questions we should ask about it. (See first slide on page 5 of attachment entitled *Effective Questioning & Challenge – developing the right*

skills to get your views across.

–

All in all it was an extremely interesting and informative day.

Kathryn and I would like to thank the Trust board for the opportunity to attend. As well as the content of the sessions, speaking to other governors is always a good learning experience.

Susan Maxwell
26 May 2012

Governor Development Programme
27 June 2012

West One Portland Place London

Attending: Alan Cleary

A copy of the programme is attached. The Organisers permitted me to attend in the absence of our official delegates. I have been asked and set out below some brief observations on the proceedings.

As on previous occasions I have attended, accommodation and location were adequate. This was essentially a conference of Governors, ie people expecting to become better and more meaningfully informed on NHS issues than the general public. It would have been useful for some limited reading list to have been issued in advance, so as to ensure some common level of shared relevant information beforehand and for speakers to be aware of that. Together Governors contributed something in excess of 200 man hours by their attendance.

Whether resultant benefits will be proportionate to that effort is questionable due to the constant problem of FTGA - speakers being required to cover a range of esoteric subjects and making them more than partly comprehensible to an audience with such wide-ranging backgrounds and abilities. By contrast, in the context of local authorities, speakers at Association of Metropolitan Authority gatherings in the past could properly assume knowledge close to university graduate level of the subject under discussion, whereas those addressing meetings of the Association of District Councils or Parishes had to use material of a more basic kind to avoid losing the attention of most of the audience. If the move to Foundation Trusts proceeds at the pace and scale the government wishes, increased membership of FTGA might encourage a more focused approach in presentations closer to the former local authority associations.

The day was geared throughout to the underlying perspective and implications of the recent legislative changes and commentary. The Health and Social Care Act 2012 contains enough material for three 90 minute lectures in order to attain a reasonable grasp of its legal machinery and a similar number to impart a balanced understanding of its immediate management implications. Due to the breadth of the subject the success of the various speakers today was really limited to assuring delegates that genuine attempts are being made to produce sound working arrangements out of the new complex and controversial framework with FTGA remaining primarily a distributor rather than originator of practical guidance.

Professor Kierean Walshe of Manchester University was quoted. He it was who acted as Mentor to the local government professionals who devised and implemented the highly successful reorganisation of Scottish Health Services some years ago, from which valuable benefits are still being derived today. "At a national level it is difficult to see who, if anyone, will be in charge of the National Health Service. There will be five key national bodies: The Department of Health, The National Institute for Health and Clinical Excellence, The Care Quality Commission, The NHS Commissioning Board and the economic regulator Monitor" To that list must be added now a sixth body - The NHS Board Commissioning Authority. It is intended to be of limited duration though perhaps best qualified of all in terms of its members and Chairman.

PFI was discussed in at some length in the context of the South London news report but without raising the more practical aspects especially the idea of Trusts securing discretionary damages in some cases under The Misrepresentation Act 1967.

There was a consensus among delegates that the sheer complexity of NHS operational systems will continue to inhibit highly talented individuals from outside the health service contributing valuable enhancements from within their own areas of expertise.

For me the valuable experience of the day consisted primarily in listening to accounts from other Governors relating to adverse experiences of patients in their area with which they are familiar. All were problems of care, attention, honesty and common sense - the kind which I had come across many times before professionally. All shared one feature in common. They all had taken far too long to resolve causing anxiety and distress to patients and families - 14 to 18 months as against the system where a Medical Officer of Health was identified as the link joining social and medical services, when 3 to 4 weeks would be a reasonable estimate to achieve the same result. The new legislation is commendable in seeking to establish afresh the link between services albeit in a muddled and roundabout way.

Alan Cleary
27 June 2012

A JOINT DEVELOPMENT PROGRAMME FOR FOUNDATION TRUST GOVERNORS

27th June– Agenda

West One, 9-10 Portland Place, London, W1B 1PR

10.00 – 10.30am	**Arrival and coffee**
10.30 – 10.40am	**Welcome and Introductions** Kim Hutchings, Head of Development and Engagement, FTN
10.40 – 11.25am	**A policy update from the Foundation Trust Network:** **The Health and Social Care Act – what it means for FTs** Paul Betts, Economics Adviser, FTN
11.25 – 12.10pm	**How will the new Act affect the governor role?** **Sharing experience and good practice** Discussion session led by Kim Hutchings, Head of Development and Engagement, FTN
12.10 – 1.10pm	**Lunch**
1.10 – 2.20pm	**Workshop 1** A choice of 3 workshops, please see overleaf for options.
2.20 – 3.30pm	**Workshop 2** A choice of 3 workshops, please see overleaf for options.
3.30pm	**Close**

FTGA and FTN representatives will be contributing to table discussion throughout the event.

The programme is intended to give governors plenty of opportunity to meet other governors and learn how other councils of governors operate. Come along ready to share your ideas and experiences.

Workshops

Session 1 1.10 – 2.20pm	1. Appointing non executive directors (part 1)	2. Accountability in action	3. Understanding finance and business development
Session 2 2.20 – 3.30 pm	Appointing non executive directors (part 2)	4. Effective questioning and challenge	5. Really representing the views of members

1. An introduction to appointing non executive directors (2 hours and 20 minutes)
Sheila Williams, Trainer, FTN

One of the statutory roles of the Council of Governors is to recruit the FT chair and non-executive directors, a process which is undertaken by the Appointments Committee, for who this intensive two hour session is designed. It will include an overview of the recruitment process including key principles of recruitment to public appointments, the role and required skills of non-executive directors, relevant legislation, as well as practical advice on person specifications, short-listing and interviewing
Please note that attendees will need to attend both part one and part two sessions.

2. Accountability in action
John Coutts, Governance Adviser, FTN

In the new system governors will have an explicit duty to hold non-executive directors to account. This session will help governors to understand what holding the board to account means and what they will need to do to fulfil their duty. The session will also address some common misconceptions and provide tips to avoid pitfalls through participation and discussion.

3. Understanding finance and business development in the NHS
Paul Betts, Economics Adviser, and Helen Crump, Commercial and Regulatory Adviser, FT N

In the new system FT governors have been given a greater role in scrutinising the strategic direction of their FT, and in approving decisions around mergers & acquisitions and the amount of private income received. This session aims to support governors in developing their capabilities to understand the financial information that FTs provide to them as well as explaining the wider business environment in which FTs operate. There will be plenty of opportunity for debate and discussion so that governors can learn of good practice from other FTs.

4. Effective questioning and challenge – developing the right skills to get your views across
Sandra Marshall, Networks Manager, FTN

In the new system the governors' enhanced role will call for a greater understanding of decisions made by the board of directors and their impact on patients, members and the public as a whole. Governors will now be expected to hold non-executive directors individually and collectively to account for the performance of the board of directors and it is important that they feel equipped for that. This session will help governors begin to think about how they can be more effective in getting their views heard, and will provide them with the opportunity to both practice their questioning skills and discuss their needs.

5. Really representing the views of members
Dianah Pritchett-Farrell, Chair of the FTGA and Public Governor, Royal Devon and Exeter NHS FT and Carly Wilson, Preparation Programme Manager, FTN

Governors have a duty to represent the views of their members and the public. This workshop will discuss ways of gathering the views of members and how to deal with those views, particularly when they don't feed into the role of the council and must be directed to other trust channels. Governors will have a chance to work through scenarios based on real-life examples of member feedback, using table based discussion. This session will be facilitated by FTGA representatives.

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Policy Update

Paul Betts
Economic Adviser

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Political and Economic Framework

- Coalition government has survived so far but Health Bill has been a key test of coalition
- Economic outlook remains gloomy : implications for promise to protect NHS spend
- NHS Reform: debate was emotionally charged and politically positioned – where next for the "losing" side?
- Not reforming not an option: Rising demand, escalating cost, demography, life style, technology.

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Financial Risk – Funding, Inflation & Demand

- Flat cash... but need to take £20 billion out of the system (Nicholson Challenge)
- In-built inflation
  - Agenda for Change (cost of increments in the pay system)
  - Product and cost inflation
- Many policies are transferring risk onto providers
- At least 4.5% efficiency requirement expected this year
- PFI? (total repayments about £1.5bn a year)
- Impact of local authority cuts

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Financial Risk – Funding of secondary services

- Tariff :
  - Efficiency adjustment -4%, pay and price adjustment +2.2%
  - -1.8 % impact across all providers as starting point for changes to non-tariff prices
- Draconian contract clause penalties
- Marginal rate payments on emergency activity
- Non payment of readmissions
- Mental health and community services hit by local authority/voluntary sector cuts cuts and no tariff
- Has not been a clear national story/ leadership around the need to change the NHS and moving services out of hospitals

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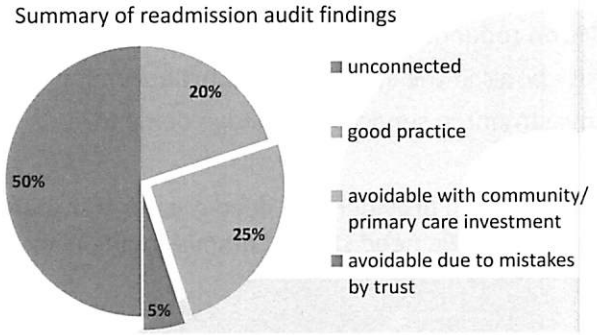
Financial Risk: Re-admissions Policy

- Providers have to pick up the costs of readmissions within 30 days of first discharge and will not be reimbursed for these



- Policy penalises providers around £500m

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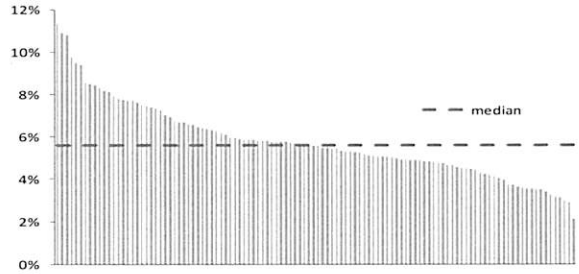
Financial Risk: How Big is the Challenge?

- Our survey said average 5.7% cost improvement programmes



- How can trusts achieve this? Take a hit on profitability?
- Many organisations facing problems that need whole health economy solutions

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Financial Risk: Where Has The Money Gone?

PCTs have on average received budget increases of 2.5% this year

- 1% on redundancies
- Risk pools in the system to support upcoming change?
- Investment in services to manage demand?

Given the risk to providers we need greater transparency to track the spend and we need strong commissioning plans

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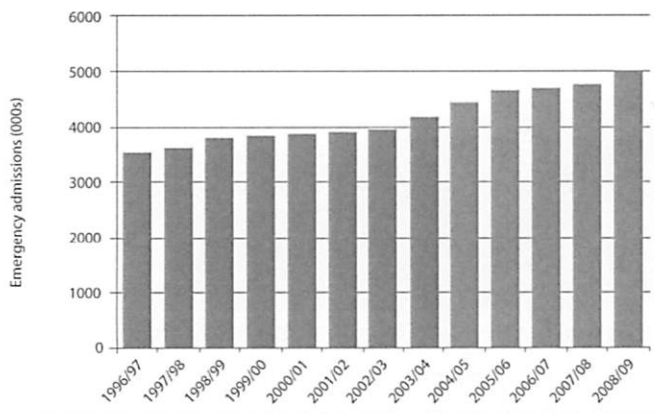
Can The Pattern Of Increased Demand Be Halted?



Emergency admissions increased 11.8% between 2004 -9, with a large increase in short stay admissions.

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Health And Social Care Act

- Significant changes to win political coalition to get bill through
- Have the original principles behind the reform survived?
- Now position as continuation of previous Government's reform agenda?
- Tilts the balance away from independence, pluralism and localism towards more central control

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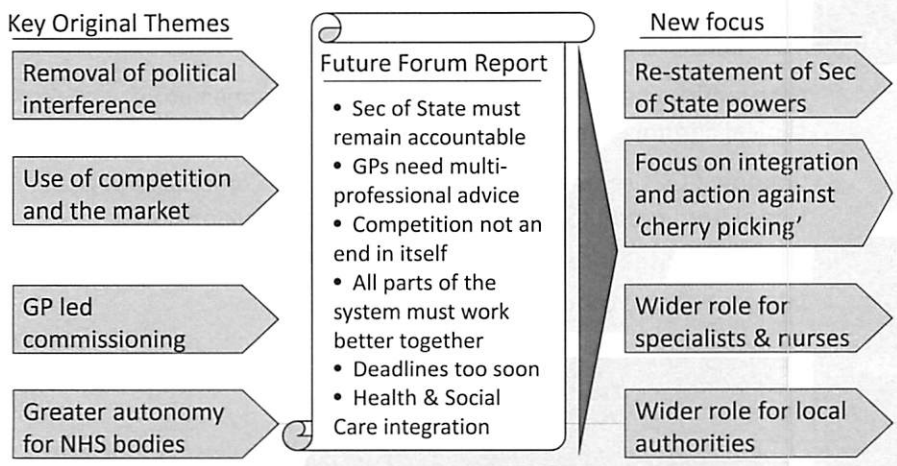
HEALTH AND SOCIAL CARE BILL – POST PAUSE



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SECRETARY OF STATE RETAINS SIGNIFICANT ROLE

- Original intention to remove the day to day running of the NHS from political interference
- Ultimate accountability for securing the provision of services: extensive powers of intervention in the event of significant failure
  - Direct powers over national bodies
  - Veto powers over some reconfiguration
- Retains duty to promote autonomy alongside other 'new duties' of promoting quality improvement and reducing inequalities

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COMMISSIONING – NEW CLINICAL COMMISSIONING GROUPS

- PCTs cease to exist April 2013
- GP practices become members of authorised or shadow clinical commissioning groups (CCGs)
- Shadow CCGs remain under auspices of NHS Commissioning Board until ready to take on their budgetary responsibility
- NCB authorises local Clinical Commissioning Groups
- Involvement of other clinicians, not just GPs

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COMMISSIONING – NEW SYSTEM

- Secretary of State hands 'choice mandate' to National Commissioning Board (NCB) to determine rules of competition
- Any Qualified Provider (AQP) applies to a range of procedures, opening up competition, but only where a national or local tariff in place
- New duties for commissioning groups to promote integrated services for patients
- SHAs remain as four clustered entities
- Clinical senates - proposed in future forum report to achieve greater levels of professional input to CCG authorisation, local service redesign and education & training arrangements ?

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COMMISSIONING AND LOCAL AUTHORITIES

- Directors of public health now part of local authorities
- Greater influence, challenge and referral for local authorities and their Health and Wellbeing Boards but not formal accountability. Could be a key local body?
- Overview and Scrutiny Committees still intact
- New patient representative bodies – HealthWatch.

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PROVIDER REGULATION

- Monitor = Sector regulator but not 'economic' regulator as originally described. Retains economic functions however.
- Prime duty now more clearly to promote patient interest
- Will police behaviour around competition rules
- Independent price setting remains but NCB develop tariffs for integrated pathways
- Responsible for "continuity of services" and license conditions
- CQC retains role as the prime quality regulator

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QUALITY 'REGULATORS'

- Care Quality Commission
  - needs clarity of purpose around inspecting on acceptable quality standards
  - not improvement role
  - thought leadership
  - judges non-compliance against standards
  - proportionate judgement on degree of harm of non-compliance
- Greater use of clinical audits and publication of quality data

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FOUNDATION TRUST MODEL ENDORSED BY REFORMS

- De-authorisation disappears
- FT pipeline deadline of 2014 (the date by which all public providers must be FTs) weakened
  - No lowering of the bar
  - Need business case exemptions
  - Putting off difficult decisions about FTs until after the election in 2015?
- Monitor jurisdiction extended to **all** FTs until 2016

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SOME SIGNIFICANT CHANGES TO FTS HOWEVER

- Board meetings to be held in public
  - Whole Parliament agreement
- More control over training and education?
- Private patient income cap has been eased (49% with restrictions)
- Removal of borrowing restrictions (or will it?)
- Introduction of Provider licenses

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SERVICE RECONFIGURATION

- Policy on integrated services and long term conditions is driving reconfigurations
- Money is driving reconfiguration
- FT pipeline is driving reconfiguration
- 4 tests: *First, there must be clarity about the clinical evidence base underpinning the proposals. Second, they must have the support of the GP commissioners involved. Third, they must genuinely promote choice for their patients. Fourth, the process must have genuinely engaged the public, patients and local authorities*
- Overview and Scrutiny Committees still intact

= Harder to reconfigure services

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IMPLICATIONS FOR FT GOVERNORS

- Approval of changes in the FT constitution
- Powers to call directors to meetings
- New powers around, Private Patient Cap, transactions and M&As
- What role for governors in relation to other bodies?
  - Health and Well Being Boards, CCGs, Overview and Scrutiny, Healthwatch
- Governors not replacing Monitor role
- Need to prepare governors for new role

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CONCLUSIONS

- Very difficult and risky transition period for providers against backdrop of 'Nicholson challenge'
- New system not easy to understand or navigate
- Greater pace needed for reconfiguration and whole health economy solutions
- Increased centralisation through NCB
- All now depends on detail of rules and behaviours of different agencies and inter-action between them
- To stay independent and in control FT Boards will have to be more attuned to signs of distress
- FTs will need to prepare their governors for their greater role

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How the Act might affect my governor role: Sharing ideas

Kim Hutchings

Head of Development and Engagement

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A reminder ...

- Hold the board of directors to account for the performance of the trust via the NEDs
- Represent the interests of members and the public
- Approve entering into any kind of significant transaction
- Approve any application by the trust to enter into a merger, acquisition, separation or dissolution
- Approve any increase of 5% or more in private patient income
- Approve amendments to the constitution
- Require one or more directors to attend a meeting for the purpose of obtaining information about the Trust's or directors' performance
- Receive Board of Directors meeting agendas before and minutes after Board meetings

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Finally...

- The trust must take steps to ensure that governors are equipped with the skills and knowledge they require to undertake their role.

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New national training programme for governors

- Department of Health initiative
- Four distinct packages:
  - General awareness/pre-induction training to help members make an informed decision on applying to become a governor
  - Governor induction to support locally provided training from the host FT
  - Core skills including finance, strategy, quality
  - Specialist skills eg. legal, audit, remuneration responsibilities

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Accountability in action

John Coutts,
Governance Advisor,
FTN

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What we will cover

- Context: the 2012 Act, the board and the council of governors
- What accountability is and is not
- Why accountability is important
- What is involved in a good accountability relationship
- Some tips and some things to avoid
- Conclusions, discussion and questions

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The Health and Social Care Act 2012

- 'The general duty of the board of directors, and of each director individually, is to act with a view to promoting the success of the corporation so as to maximise the benefits for the members of the corporation as a whole and for the public.'
- 'The general duties of the council of governors are:
  - to hold the non-executive directors individually and collectively to account for the performance of the board of directors, and
  - to represent the interests of the members of the corporation as a whole and the interests of the public.'

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Accountability – what it is

- To be accountable is to be liable to explain or justify ones actions and decisions.
- Accountability is the process of explanation and justification.
- So holding to account is the process of requiring explanation and justification, but it is also about testing, forming a judgment and if necessary taking action.
- Accountability implies responsibility – It is reasonable only to hold people to account for those things for which the are responsible.

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Accountability – what it isn't

- It is not synonymous with responsibility
- It does not imply a management relationship
- It is not a 'one off' annual event
- It is not the same as appraisal
- It is not about confrontation, 'putting someone in their place' or 'giving them a hard time'

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Why is accountability important?

We are working through difficult times:

- On-going economic uncertainty
- Fewer resources
- Loss of faith in institutions and businesses
- Reflected by adverse press coverage
- Mid Staffordshire Enquiry

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The case for local accountability

- Boards do not 'own' foundation trusts, they direct them on behalf of the 'owner' – local communities and the general public.
- FTs have disparate groups of stakeholders all of whom should have a voice.
- External regulation tends to be retrospective, encourages compliance rather than high levels of performance and distorts the allocation of resources in a way that might not accord with local priorities.
- Being answerable for what we do promotes self knowledge, being answerable to lay people promotes self awareness.

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Boards can get it wrong

- Overconfidence, complacency and inertia at board level
- Strong membership, but board members not applying their skills and knowledge or being prone to 'group think'
- The right processes in place, but not used effectively
- Management styles not conducive to challenge or scrutiny
- Focus on one performance factor to exclusion of others
- Inadequate information to consider the risks associated with its strategy
- Inadequate controls properly to mitigate risk
- Insufficient discipline in questioning and challenging
- Insufficient attention to cumulative risks

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Accountability implies a relationship

Your accountability relationships will work in two directions:

- You will be given an account, an explanation, of the trust's performance, the reasons for it and what is being done to bring about improvement and you will be able to test that out and form a judgment about the acceptability of past performance and of future plans.
- But you will also need to give account of your collective performance to the membership and be prepared to act on their judgment.

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Exercise: Holding the board of directors to account

- What would the format be? How would you set about the task?
- What behaviours are important and what commitments would you need to make?
- What support and advice would you need?
- What do you need the board to do?
- What information would you need?
- What preparation would you need to make?
- Anything else?

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Accountability and governors

NEDs giving account to you might include:

- How the board manages risk
- How the board gains assurance that the main risks to achieving strategy and performance are controlled.
- Examples of where the board has intervened to deal with issues of performance.
- The reliability of past performance as a predictor of future performance.

- It is the board's job to convince governors.

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Some things you might want to know about

- The overall picture: what has gone well and what has gone badly – and why.
- How NEDs have 'triangulated' to obtain assurance that the figures can be trusted
- If the board is satisfied with performance and if not why not.
- If the chair is satisfied with the level and quality of challenge in the boardroom.
- How governors can assure themselves that they have the full picture

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Making the relationship work

Some suggestions:

- Agree the ground rules
- Stick to them
- Don't try to do the NED's job
- Use your experts.
- Don't be afraid to question
- No subject is off limits

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To conclude..

- Self regulation starts with the board and the buck stops with the board
- Governors are not a substitute for Monitor, but they can help boards to reflect honestly and to understand how well they are doing
- This will always be a work in progress – stick with it

john.coutts@foundationtrustnetwork.org

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Effective Questioning & Challenge – developing the right skills to get your views across

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The Council of Governors:

- Holds board of directors to account (primarily through the NEDs)for the performance of the trust
- Represents the interests of patients, staff, public, service users, carers and other local organisations involved in the running of the foundation trust
- Helps shape the future direction of the organisation

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QUESTIONS

Why do we ask them?

Why don't we ask them?

How do we ask them?

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Some of the reasons why we ask questions:

- To help clarify
- To evaluate what's happening
- To broaden debate
- To cause deeper thought
- To create time and space to stand back
- To create expectation
- To encourage high standards

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Some of the things that stop us:

- Bad experience with asking or answering questions
- Lack of skills in asking or answering questions
  - Lack of experience or opportunities
  - Lack of training
  - Lack of mentoring
- Perceived lack of knowledge
- Corporate cultures and working environments that discourage questions

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Types of questions:

- **Open** – expansive, promote reflection, probing, clarifying, exploratory
- **Closed** – can be used to limit debate and make decisions, to find out specific information, to identify preferences, to bring something to closure and move ahead

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Ways of asking questions:

- **Passive** - when we're not confident in our view
- **Aggressive** – when we feel frustrated or feel it's the only way to make ourselves heard
- **Assertive** – based on need, rationale, logic

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I keep six honest serving men,
They taught me all I knew;
Their names are **What** and **Why** and **When**
And **How** and **Where** and **Who**.

Rudyard Kipling

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Group exercise

As a group, look at the Quality Dashboard and narrative for Q3 (on your tables) and come up with some questions you'd want to ask and how you would ask them. Maybe think about:

- An assumption you want to question
- Something that is not clear
- Something you want to challenge
- Something that is missing that you feel should be there
- Are your questions open or closed?
- Are they assertive, passive, aggressive?
- Will they help you get the answers you need?

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Tips for asking your questions and getting your views across:

- Prepare beforehand
- Keep it succinct
- Listen
- Build on response to the previous question
- Respect others
- Be assertive (not too passive, not aggressive)
- Be constructive and supportive
- Be willing to reflect, develop and learn
- Remember you are part of a team – you are doing it together

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Next Steps:

For you

- Identify one thing that you will now do differently that will help you perform your role as a governor
- Complete our short survey about the session, so that we can evaluate its usefulness

For us

- We will send you a tips sheet and examples of some good questions including those we have come to today
- We will review the feedback you give us and decide whether to include this session (or similar) in future programmes

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"The fool wonders, The wise man asks."

Benjamin Disraeli

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 12 July 2012

AGENDA ITEM NO.	2.15/Jul/12
PAPER	Draft Minutes of the Council of Governors Quality Sub-Committee meeting held on 15 June 2012*
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Mike Anderson, Chairman of the Quality Sub-Committee
EXECUTIVE SUMMARY	Draft minutes are enclosed.
DECISION/ ACTION	To note.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Quality Sub-Committee meeting, 15 June 2012

Draft Minutes

Attendees	Melvyn Jeremiah	MJ	Public Governor – Westminster 2
	Martin Lewis	ML	Public Governor – Westminster 21
	Susan Maxwell	SM	Patient Governor
	Wendie McWatters	WMW	Patient Governor
	Sandra Smith-Gordon	SS-G	Public Governor – Kensington & Chelsea 2
	Maddy Than	MT	Staff Governor – Support, Admin & Clerical
	Cathy Mooney	CM	Director of Governance and Corporate Affairs
	Therese Davis	TD	Chief Nurse
	Tony Pritchard	TP	Deputy Chief Nurse
	Patricia Gani	PG	LINk representative
	Melanie van Limborgh	MvL	Head of Quality and Assurance
	Debbie Basham	DB	PA to Director of Governance and Corporate Affairs

1 Welcome and Apologies **CM**

Apologies were received from Dr Mike Anderson and Vida Djelic.

2 Minutes of previous meeting 27 March 2012 **CM**

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

It was agreed that apologies should be separate from attendees.

It was noted that Mike Delahunty attended.

CM reported that MA asked that the statement 'there is a procedure in place and each appointment cancelled reviewed had to be done by clinicians' is confirmed by MD as he is not aware of this.

P3 4th para sentence to read 'the sub-committee discussed various reasons impacting on the length of hospital stay and noted the importance of a patient being seeing *by a consultant* within 12hrs of being admitted'.

Objective 3 Patient Experience 1st sentence to read 'TD said that this is a key objective which was discussed with the divisions and is directly linked to the *work being done on values across the Trust'.* Last paragraph on this page : ' improve' to be replaced by 'ensure that this is implemented '

Para at the top of the p.4 replace 'kept in' with 'retained'.

Under item 6 Quality Awards delete the last sentence starting 'SM felt that …'

P4, 3rd para to read 'website', not 'web'.

p.4 last para to read ML 'suggested a 'how can we help you banner' at the main entrance door.

P.5 first sentence to clarify that this is referring to the entrance door on the lower ground floor by the welcome screen in the outpatients area.

3 Matters arising **MA**

A 'how can we help you' banner at the main entrance door was discussed.

It was agreed that the principle is that the main reception area should be made more welcoming and its role in helping patients and relatives to be made clearer. The Wayfinding Group to be asked to include this in their work plan. This may or may not result in a banner. **TD to ask Wayfinding Group to include how to make the reception more welcoming in the work plan.** **TD**

Meet a governor banner
TP confirmed that this is now in place; it is put at the front entrance on the day. It is not clear if it is having any effect.

Re classes for patients with osteoporosis
SM reported that the physiotherapy department had advised that the work had temporarily been put on hold due to due to the work that the musculo-skeletal team had been undertaking for the contract. This has now been awarded and work is expected to start in September.

4 Quality Report – next steps **CM**

The Quality Account with photographs was circulated for information. It is proposed that this will be launched at the Annual Members' Meeting (AMM). MA has done a paper for the Board which will subsequently be presented to the Council. He is suggesting the order of the Annual Members day be changed to be business, then question time then presentations and that the presentation is based around some areas in the Quality Account.

CM suggested that this should focus on patient experience and VTE. It was also suggested that the Quality Account could be distributed to members attending the Annual Members' Meeting.

CM also suggested that the same questionnaire with minor amendments that was used prior to the development of the Quality Account was used to measure the impact of the new Quality Account and this could be distributed with the Quality Account at the AMM.
To consider slightly amended questionnaire to measure the impact of the new Quality Account. **MvL**

MvL thanked everyone present for their help which had made the Quality Account much more inclusive – the input was invaluable. The Quality Account is due to go to Heather and the Chairman imminently for final approval.

ML thanked MvL for all the hard work in developing the Quality Account. He suggested that the Quality Account could also be promoted by having copies in outpatients and having a section of it on the wall as an exhibition. It was suggested that Hospital Arts be approached for advice on how to do this.

5 Quality Report commentaries – further action

5.1 Kensington and Chelsea Local Involvement Network (LINK) – draft commentary and responses **CM**

CM thanked LINKs for their very comprehensive review of the draft Quality Account. This paper demonstrated the changes that had been made as a result of their comments and she had extracted some of the areas where they had indicated further discussion would be valuable.

MPALS – regular reports
It was noted that patients may not be very well aware of MPALS or do not know what to do if they have a complaint. TP said that we want to encourage local resolution.

It was agreed that the quarterly report that MPALS do of themes and actions taken and the results of their survey to patients asking for their opinions on MPALS to be presented to the Quality Committee. **TP**

TP outlined the issue of leaflets on the wards which were located in leaflet racks by the entrance and not near patients e.g. on beds. The plan is to produce a laminated document which will give information about ward routines which will be secured to the bedside. This will include what to do if patients have concerns. He also described how 'Hospedia' might be used for information. He noted the feedback from the MPALS team from an Away Day where they described their role as giving information and advice. There was some discussion about what that meant for patients and what MPALS could be called.

Information on information management and availability of patient records for consultants.
CM explained that information on the availability of patient records to consultants was an issue and has been for quite some time. There are numerous examples of problems with unavailability of information. However, the Trust has recently purchased an electronic document management (EDM) solution which was now being implemented. MJ was part of the EDM group.
It was agreed that further information on this would be provided to the Sub-Committee in due course and the focus on this for the benefit of the patients could be included in next years' Quality Report. **VD**

Operationalisation of objectives
The third area raised by LINKs was how the objectives might become part of the operational work. CM described monitoring templates which had been developed to be specific about how each objective in the Quality Account could be measured. Quarterly reports would be provided to the committee.

Older people involvement in patient experience objectives
The LINk had suggested that they could help in getting patients involved in the patient experience objective. Specifically, they had asked how older

people were involved in the priority around older people. TP said that this was a very good question and they had recently recognised that there were no patients involved in the Falls Group. He would ask for volunteers.
TP to invite patient volunteers to join the Falls Group. **TP**

CQUINs(Commissioning for Quality and Innovations)
LINKs asked about CQUINs. CM suggested that the Quality Sub-Committee should be aware of the CQUINs as these will partly reflect the commissioners' priorities. It will also give the group an opportunity to request more information.

Invite Helen Byrne, Interim Head of Performance Improvement to a future meeting to present on the CQUINs. **CM**

5.2 Royal Borough of Kensington and Chelsea's Health, Environmental Health and Adult Social Care Scrutiny Committee commentary **CM**

The key points raised by them included that the Trust had scored poorly for 'waiting in the hospital' in the national outpatient survey.

TD reported on the plans for improving the outpatient and inpatient surveys. The disadvantage of the current survey is that they are run every year and therefore are out of date by the time they are received. We have commissioned the Picker Institute to run smaller surveys on a more regular basis based on key issues for us. These will be run in inpatients and out patients, maternity and paediatrics. There will be approximately 10 questions which will be accessed via Hospedia, the bedside facility and 20 questions through a survey in outpatients. How this may be done in practice and the disadvantages of technology were discussed. It was suggested that volunteers may help patients to complete the survey. It was confirmed that the patient experience trackers were not being used and had been disbanded.

TD noted that the revised Terms of Reference of the Patient and Staff Experience Committee would come to Monday Executives next week and she is going to ask governors to become members.
Circulate the Terms of Reference of the Patient and Staff Experience Committee and invite governors to express interest in joining the committee. **TD**

The Borough response also highlighted that the Chelsea and Westminster Hospital could become more involved in major public health campaigns. It was felt that this could be done via the Health and Wellbeing Boards.
It was agreed that when more information is available on these the Quality Sub-Committee will discuss again and how this might relate to the work of the Trust. **CM**

It was also noted that the Local Overview and Scrutiny Committees would be willing to be invited to future stakeholder events around the Quality Account. The Trust uses this committee as a key stakeholder. The group were asked for their comments on invitations to the Borough.

To discuss the Quality Sub-Committee membership with the Chief Executive. **CM**

The comment about the Trust long term plan was noted but this was felt to be outside the remit of the Quality Account.

5.3 North West London PCTs – draft commentary and responses

It was noted that there was no representative from the PCT Cluster at the Quality Sub-Committee. It was felt that it would be more helpful to discuss responses from them when they are present and this was deferred to the next meeting.

5.4 Council of Governors commentary **CM**

The governors were thanked for their commentary. The main point that they raised was about appraisals. They would like assurance that poor performance is being addressed through appraisals.

CM noted that the progress on the quality objectives would be brought back to the sub-committee every quarter and as this was a quality objective there would be a focus on it. In addition, Carol Dale would be in a position to comment in more detail. **CD to comment in more detail at the next meeting.** **CD**

6 Quality Accounts/Report **CM**

This is attached for information. Thank you to MJ who had identified an important editing error and CM had requested advice from external auditors as to whether the document could be amended.

7.1 Quality Awards - winners **MvL**

MvL announced the four winners and noted the high standards of the applications.

7.2 Quality Awards – process **MvL**

MvL reported that the governors had discussed in some detail whether the award should be two or three times per year and this would be agreed outside of the meeting.

8 Quality Sub-Committee Terms of Reference **CM**

CM introduced the paper and said that the changes were outlined in blue. On reflection she felt that 3.10 should be removed from the Terms of Reference as this was a function of the governors and not the Quality subcommittee. **This was agreed.**

She also noted that the 4.3 should not read that the members of the Trust staff are invited to attend as it implies they are not full members.

MJ highlighted the attendance requirements and queried why they had been added and consequences if they had not been met. CM said that this was added to reflect the standard template for terms of reference for the rest of the Trust. It adds to the validity of the committee. The usual process is if a member does not attend 2/3 of meetings is to call this to their attention and request that their attendance is improved or a deputy is sent or the membership is reviewed.
CM to check if MA will continue to chair while he is Acting Chief Executive. **CM**

MJ felt that it was not appropriate to assign a Chair to a role. CM noted that this was common practice for terms of reference throughout the Trust.

The issue of who should be the chair was discussed and whether it should be a governor. It was noted that this had been previously discussed and it was agreed that it should be the Medical Director for a number of reasons. There were different views amongst the membership as to who the chair should be.

CM said that the comments at the meeting were very important and should be noted. However, she suggested that the sub-committee agreed the current terms of reference with the changes outlined in blue to be carried forward for further 6 months. The two main reasons for a delay for a final approval of terms of reference being the implications of the Health and Social Care Act 2012 which had not yet been discussed and the new Chief Executive both of which could have a significant impact on the Board, the Council and the sub-committees.

CM to follow up non-attendance by PCT. **CM**

This was agreed.

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

SS-G raised a point about ward hostesses not smiling and asked that they be encouraged to smile.

ML reported on his experience in A&E on Saturday night. It was about midnight and there were two receptionists, one was busy and the other did not attempt to acknowledge him or move to seek to help him. Otherwise A&E was 'spot on'. **TD to look at this.** **TD**

ML noted that the main reception looks much better. He reported on the experience of a patient who said that his call bell was taken away. **He will find out on which night and ward it occurred and pass information to TP.** TD noted that one of questions on Hospedia was how quickly call bells are answered. **ML**

MJ reported on a patient with two artificial hips and him trying to get treatment over a year and he had been referred to various specialists within the Trust. He had a calendar of events to be logged as a formal complaint.

He also reported on a member of staff who described difficulties experienced within her section. This is difficult to follow up without names. **TP to feedback the information that is available to the relevant manager.** **TP**

It was agreed where issues were raised previously and follow up was made it should be reported back to the committee. **VD**

The Daily Mail article was discussed. This is a complex complaint. The ward sister has put support mechanisms in place on the ward for staff and used the article to highlight to staff what could happen if patient needs are not being met. The patient has been offered an independent review of her complaint but she is adamant that she wants financial compensation.

A further point was raised in relation to the Daily Mail article was the impression that was given that patients are not getting intravenous painkillers as staff are not qualified to cannulate. It was confirmed that

there is always a member of staff available to cannulate patients although if there is not one on that ward this could lead to delay.

TP reported on a patient who made a complaint a year after her inpatient stay but this was too late as it was outside the time for complaints to be made.

10 Council of Governors funding report **CM**

This was not discussed

11 Any other business

CM said that Medicines and Surgery Division had set up a Transformation Board which included strands of work such as ambulatory care, out of hospital care and discharge. Debbie Richards, Divisional Director of Operations Medicine and Surgery would come to a subsequent meeting to present this and ask for governor volunteers for discharge group in particular. **It was agreed that Debbie Richards would be asked to circulate a paper in advance of the meeting.**

Invite Debbie Richards to attend the next meeting and to circulate a paper prior to the meeting. **CM**

12 Date of next meeting – 21 August 2012

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 12 July 2012

AGENDA ITEM NO.	2.16/Jul/12
PAPER	Draft Minutes of the Council of Governors Membership Sub-Committee meeting held on 1 June 2012*
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Martin Lewis, Chairman
EXECUTIVE SUMMARY	This is a draft of proceedings at the meeting held on 1 June 2012
DECISION/ ACTION	The meeting is asked to agree the minutes as a correct record of proceedings.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Membership Sub-Committee, 1 June 2012
Draft

Attendees	Martin Lewis	ML	Chairman
	Chris Birch	CB	Patient Governor
	Melvyn Jeremiah	MJ	Public Governor, Westminster 2
	Susan Maxwell	SM	Patient Governor
	Maddy Than	MT	Staff Governor – Support, Admin and Clerical
In attendance	Matt Akid	MA	Head of Communications
	Tony Pritchard	TP	Deputy Chief Nurse
	Priti Bhatt	PB	Equality and Diversity Manager
	Christopher Collister	CC	PALS Manager
	Mel Christodoulou	MC	LINk representative
	Vida Djelic	VD	Foundation Trust Secretary

1. Welcome & Apologies **ML**

Apologies were received from Cass J. Cass-Horne, Sam Culhane and Wendie McWatters.

2. Minutes of previous meeting held on 29 March 2012 **ML**

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

- page 4, 3rd para, 5th line should read ‘last year’ not ‘this year’.

3. Matters arising **ML**

The sub-committee noted that some actions were complete and those that have not have been addressed.

4/Mar/12 Membership Engagement and Communication calendar of events
MA said he would ask Capita to add Governors to email distribution list for Members’ News and other electronic membership communications.

7/Mar/12 Open Day – 2012 - update
Referring to Matters Arising SM asked why the bid for 2013 Open Day funding had not been put to the May meeting of the Council of Governors. MA responded that it was his practice to make the bid towards the end of the calendar year preceding the event.

CB said he did not get the April issue of Members’ News. MA responded that he would ensure CB was added to the distribution list for future editions.

12/Mar/12 Any other business

Follow up appointment letters/invitation to join the Trust

TP said they are developing new system re AP unfortunately there has been no progress and it is with IT department.

9/Mar/12 Membership Recruitment Leaflet

MA said that there is a new membership recruitment leaflet. CC said we received one batch which did not have business reply with barcode.

ML commented that there is no need to order many copies of the membership leaflet due to the current Chief Executive leaving at the end of June and having a new Chief Executive from September.

CB reminded the sub-committee that at the last meeting it was promised that a new photograph would be taken for the membership leaflet with governors and staff without wearing name badges.

4. Membership Recruitment, Engagement and Communication Strategy **MA/TP**

MA introduced the revised Recruitment, Engagement and Communication Strategy and said it was based on the last year's strategy with some revisions. The main revisions included:

- Over last 12 months the membership increased by approx 350
- Strategy focuses on recruitment of new members and developing engagement and communication with existing members
- Trust's arrangements regarding the membership are: MA leads on communication and engagement with members and TP leads on recruitment and developing a representative membership working with PB
- The membership totals just under 15,000
- Staff members are opt-out - they are automatically members unless stated otherwise which impacted on the overall membership number.

MT queried if staff members receive membership mailings. MA responded that they do not get the membership mailings because this would not be cost effective. Copies of Trust News, which is the main element of the mailing, are widely available in the hospital.

TP outlined the recruitment part of the Strategy and highlighted the aim to maintain the current membership level and highlighted that the focus is on events at which we can recruit and the role of MPALS service in promoting the membership recruitment. He said we are also exploring other recruitment opportunities, for example via membership representatives and via mobile health bus. We are also looking at GP surgeries.

TP highlighted a very successful membership recruitment which was organised via mobile health bus at which 30 new members from a Somali women's group were recruited in March 2012.

CB commented on the proposed strategy and noted that it previously was called Membership Development and Communications Strategy and that the new title was much better. He also said that this is the shortest strategy out of all previous ones and he liked it. CB made other comments which included:

- The volunteers constituency needs to be added to the other three constituencies in 1.1 Who can be a member?
- at the end of section 1.3 insert that the Council of Governors Membership Sub-Committee oversees the strategy
- add at the end of the first sentence of 2.1 Recruitment of new members 'and developing a representative members'.

CB said that the electronic message board used to say that members who wanted to make an appointment to see a governor should phone the M-PALS office but this had been changed to 'visit the website'. But, when they visit the website, they are told to phone the M-PALS office, and this is silly.

TP will follow up on distributing the prizes and completed membership forms from the Open Day May 2012 so that these go to Capita for entry on the membership database. **TP to follow up.** **TP**

MJ commented on the section 3 re engagement activity compared with other Foundation Trusts. MA responded that it is a broad statement and it says 'was'. MJ suggested to replace 'was' with 'used to be'.

MJ noted that governors had not been previously aware of the plan mentioned in Section 3.2 of the paper as having been approved by the Trust Board. MA responded that the plan was in very broad terms because specifics about the consultation process were not yet available. There had to be a plan of how support was to be given to the hospital during the "Shaping a Healthier Future" consultation, which was to begin on 2 July. MA asked if governors and the LiINk would be interested in attending a meeting, his department was going to set up, once more information was available, probably in late June. Governors said they would like to attend such a meeting. The LINk representative said that LINk would be supportive of the idea but would have to be careful not to appear to support one hospital against others within their area.

ML commented that the Medicine for Members seminars had been well attended. SM suggested that perhaps a seminar topic of 'The Role of the Governors' could be a means of answering an oft-asked question from both patients and staff. ML said that he had earlier suggested to MA that the Medicine for Members seminars might be chaired by a governor. **This was agreed**.

MA said as the previous seminar on Dementia was extremely well attended the plan is to organise another seminar on the same topic in due course.

MJ observed that Section 3.3 of the strategy required the sub-committee to review the "Meet a Governor" sessions. Some Governors felt that this was not a rewarding way of engaging with members. The primary focus is on engagement, though it was occasionally possible to recruit a new member. MJ regarded the sessions as an important way in which Governors could make themselves available to members and non-members alike, and the sub-committee agreed. It was noted that more

Governors need to be involved in the sessions. They should be encouraged to take part if they did not do so already.

VD to get future dates of meet a governor sessions from TP and to encourage the Council of Governors to attend. **VD**

CB noted that in the past it was agreed that the 'meet a governor' sessions would be published on the website and on the digital screen in the Information Zone with a note saying if people are unavailable on the dates proposed they should contact the MPALS Office to arrange suitable date and time. He pointed out that the note appears on the website but not on the digital screen. CC responded that he will update the digital board.

MT provided feedback from meet a governor session with staff members held at Harbour Yard on 13 March. She also did a meet a governor session on 21 March in the Information Zone.

VD to put the Membership Recruitment, Engagement and Communication Strategy on the July Council of Governors agenda. **VD**

5. Membership engagement and communication calendar of events **MA**

MA highlighted the main changes to the calendar and noted that Paul Mason is yet to confirm his attendance for a proposed talk.

MJ queried £10,000 figure for membership mailing and whether this relates to 1 or 2 mailings a year. MA responded that each mailing costs £10,000. He clarified that the January mailing is paid for from the Council of Governors budget but the April and August mailings are paid for from the Foundation Trust budget.

MA said that the Annual Members' Meeting in September including 2 other engagement events for members will be organised and the finances will be covered by the Council of Governors budget.

MA suggested that the whole week around the Annual Members' Meeting is focused on the membership and proposed to hold two more seminars in that week, one on Dementia and one on another topic. CC commented that Capita recruiters can also help as they will be engaged in the recruitment that week. **The sub-committee agreed.**

MA commented that the careers stand at the Open Day – 12 May was very successful. MT added that Libby Wingfield, Volunteer Services and Work Experience Manager and she are working on the Inspire Project which aims to engage and inspire young people from our wide communities to enter into careers in and around medicine and healthcare.

6 Membership recruitment – update **MA**

TP introduced the paper and highlighted the number of those members who joined and left the Trust membership.

TP highlighted that there needs to be a process put in place for Capita updating the staff membership on the membership database.

TP outlined the membership recruitment events scheduled in for 2012.

CC noted that Capita representatives recruited 355 members over 4 days.

MJ queried if TP received any feedback from Capita re unsuccessful recruitment linked to the mobile bus. MA explained that because of its nature of the sexual health clinic those visiting do not feel confident to disclose their personal detail for the recruitment purposes as they may be identified later on. MJ felt that Capita representatives may need to be briefed to explain the nature of the clinic and suggested to display a large banner about the hospital and what governors do and other activities hospital is involved in.

It was agreed that in view of the low success rate of the bus-based recruitment the present series should not be extended.

ML referred to the recruitment stand in the King Street Mall had been a success, and consideration should be given to a similar exercise in the Shepherds Bush shopping mall.

The sub-committee discussed the possibilities of recruiting diverse members. One suggestion was via Community Centres and BME Health Forums.

ML noted that some staff are not aware of the Council of Governors existence and their role. TP proposed that governors could be invited to staff development programmes as a way of promoting their role. TP would invite governors to the band 7 leadership programme which is currently being run.

VD said that there was an action arising following on the last Council of Governors meeting for the Membership Sub-Committee to consider re governors communicating on what Trust is doing for the local community, for patient services and trust membership. The sub-committee confirmed that this will be done via various engagement activities listed in the membership engagement and communication calendar of events 2012.

With regards to Monitor Code requirement ref D.1.5 and D.2.2 the sub-committee confirmed that evidence for these include: consultation on Trust values, the upcoming consultation on shaping a healthier future and Annual Members' Meeting.

MA left.

7 Open Day 2012 – evaluation **MA**

This item was not discussed.

8 Council of Governors Funding Report **VD**

VD outlined the paper and said that there was an error in the total agreed column which should read £53,153.

The sub-committee discussed presentation of the use of funds grid that is produced quarterly for the Council of Governors meetings and considered template produced by MJ. Governors were interested in being updated at each Membership Sub-Committee meeting with how much money they agreed to commit to individual projects and how much money was spent on each project to date. VD said that it might be a good idea to have the same report as for the Council of Governors and the suggestion to have a progress report for each project agreed by the Council was an excellent idea.

The sub-committee resumed the discussion which took place at the previous meeting about budget reporting (29th March Minutes item 7 final sub-paragraph). The format of a summary report table was agreed, with columns for items agreed, amount agreed, and bills paid to date against that amount. The table to be updated and circulated for meetings in the second, third and fourth quarters of the financial year. Circulation should be to the Council of Governors and its two sub-committees as.

It was noted that to complete the picture it would be desirable when agreeing an item of expenditure to set review points for the project to watch its progress. This should be done separately with the unit concerned for taking the matter forward, with reports to be made to the sub-committee agreeing the project.

SM said if there was still money in the pot to give out in funding there was no point in keep hassling people about whether they had started their projects yet until the end of the year, so that we could give out any unused funding, plus any repatriated funding, from February sub-committee onwards (ie: to be agreed at the April Council of Governors, thus still keeping it within the 2012/13 year).

The sub-committee agreed the following items to appear on the under the use of funds 2012/13:

- **Projects agreed**
- **Money agreed**
- **Money spent to date (invoices paid)**

The sub-committee also agreed to have a progress report for each project at the Membership Sub-Committee meetings.

9 Information Zone racks **CB**

CB said that at the Membership Sub-Committee meeting held in November 2011 there was a major discussion relating to the Information Zone and noted that since then considerable progress had been made on six of the seven decisions but it seemed that no progress had been made with regard to the decision on racks for Trust News and leaflets about the hospital. The zone was called the Information Zone, and we should aim to give as much information as possible with leaflets about as many hospital departments as possible in addition to copies of Trust News. TP suggested a carousel, but it was felt that there probably would not be sufficient space for one.

TP to look into this and order suitable size racks. **TP**

10 Members' Forums **ML**

This item was covered earlier in the meeting.

11 Equality Delivery System workshops – feedback **PB**

PB said that this item had been added to the agenda to specifically report on the fact that workshops had been organised to highlight the purpose of the new equality benchmark tool. PB explained that the workshops dates had now passed and suggested that this item gets removed from the agenda. In future PB proposed that she advises VD to add specific equality agenda items that will be of interest to the sub-committee as required.

The Membership Sub-Committee agreed.

12. Any other business

PB said that at one of previous meetings there was a discussion how we recruit and engage with more Black and Minority Ethnic (BME) members of the population. She said she has a link with the BME Health Forum which is a partnership of statutory, voluntary and community organisations committed to reducing health inequalities.

P.1 of the paper circulated outlined the background and p.2 provides different options on how the forum can support the Chelsea and Westminster Hospital in relation to BME.

The sub-committee discussed 7 options and agreed the following:

- Option a) – who we need to agree an advert about us on BME; TP responded it is MA
- Option b) – PB to make further queries as to whose website it refers to
- Option c) – more information; noted the attendance level 15-20 people.

ML queried if governors can come to any of the BME meetings and noted that the next meeting will be held on 13 June. PB responded that they can.

13. Date of next meeting – 26 July 2012

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 12 July 2012

AGENDA ITEM NO.	2.17/Jul/12
PAPER	Membership Engagement and Communication – update*
AUTHOR	Matt Akid, Head of Communications
LEAD	Therese Davis, Chief Nurse and Director of Patient Experience and Flow
EXECUTIVE SUMMARY	Appendix 1 (Membership Engagement and Communications calendar of events 2012 – updated June 2012) is an update on progress in implementing an enhanced programme of membership engagement and communications activity following the approval of funding at the Council of Governors meeting on 1 December 2011.
DECISION/ ACTION	Governors are invited to note this update and to provide their feedback on the proposed activity and future plans.

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

Date/Month	Event/Activity	Existing or new activity?	Lead	Cost/Funding source
January				
w/c Mon 23 Jan	Membership mailing for all public and patient members (including covering letter from Chairman, Trust News and A5 flyers about details of Medicine for Members seminar and Values focus groups in February)	New activity	Communications Manager	£10,000 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
February				
Fri 3 Feb	Members' News Issue 1 (monthly email newsletter for c. 3,200 patient and public members who have provided us with their email addresses)	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
Wed 22 Feb	Medicine for Members 1st event – Bowel Cancer Awareness seminar	New activity	Communications Manager	£1,000 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
Tue 21 Feb Thu 23 Feb Weds 29 Feb	'Who do you think WE are?' Values consultation focus groups for all patient and public members – members also invited to vote online for their top 4 values as part of the consultation exercise	New activity	Communications Dept	Not from Council of Governors budget
March				
Fri 2 Mar	Members' News Issue 2	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
Fri 2-Fri 23 Mar	Star Awards nominations – Patient Choice category	New activity	Communications Dept	Not from Council of Governors budget
April				
Weds 4 Apr	Members' News Issue 3	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011

Date/Month	Event/Activity	Existing or new activity?	Lead	Cost/Funding source
w/c Mon 16 Apr	Membership mailing for all public and patient members (including covering letter from Chairman, Trust News and A5 flyers about future events for members)	Existing activity	Communications Manager	£10,000 (Foundation Trust budget) - funding already budgeted for in Trust budget as part of our membership 'offer' of 2 mailings/year
May				
Tues 1 May	Medicine for Members 2nd event – Dementia seminar	New activity	Communications Dept	£1,000 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
Fri 4 May	'It's who we are' Values implementation focus group	New activity	Learning & Development Manager (Staff Governor Carol Dale)	Not from Council of Governors budget
Fri 4 May	Members' News Issue 4	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
Sat 12 May	Open Day	Existing activity	Communications Manager	£15,000 (Council of Governors) – funding approved at Council of Governors meeting 1 Dec 2011
Sat 12 May	Open Day enhanced publicity and promotion (letterbox drop and local newspaper advertising)	New activity	Communications Manager	£4,793 (Council of Governors) – extra Open Day-related funding approved at Council of Governors meeting 3 May 2012
Tues 1-Fri 18 May	'Show us the way' consultation to help develop the Trust's new wayfinding strategy	New activity	Head of Communications (with wayfinding consultants Applied)	Not from Council of Governors budget

Date/Month	Event/Activity	Existing or new activity?	Lead	Cost/Funding source
June				
Weds 6 Jun	Members' News Issue 5	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
July				
Fri 6 Jul	Members' News Issue 6	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
Dates TBC	*Shaping a healthier future* public consultation by NHS North West London on changes to NHS services runs for 14 weeks from 2 July-14 Oct – Communications & Engagement Plan including the involvement of members and Governors discussed by Trust Board on 28 May and due to be discussed at Council of Governors on 12 July	New activity	Head of Communications with Directors	Not from Council of Governors budget
August				
Fri 3 Aug	Members' News Issue 7	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
w/c Mon 13 or 20 Aug	Membership mailing (including covering letter from Chairman, Trust News, Annual Members' Meeting invitation and A5 flyers about future events for members)	Existing activity	Communications Manager	£10,000 (Foundation Trust budget) - funding already budgeted for in Trust budget as part of our membership 'offer' of 2 mailings/year
September				
Fri 7 Sep	Members' News Issue 8	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011

Date/Month	Event/Activity	Existing or new activity?	Lead	Cost/Funding source
Thu 13 Sep	Annual Members' Meeting + 2 other engagement events for groups of members who do not traditionally attend the Meeting (eg Maternity, Paediatrics, HIV/GUM)	Existing activity	Head of Communications	£5,000 to cover costs of Annual Members' Meeting + 2 other events (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
w/c 10 Sep	Medicine for Members 3rd and 4th seminars – likely to be a repeat of May's successful Dementia seminar which was over-subscribed and A N Other topic (possibly musculoskeletal problems)	New activity	Communications Dept	£2,000 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
October				
Fri 5 Oct	Members' News Issue 9	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
November				
Fri 2 Nov	Members' News Issue 10	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
Date TBC	Medicine for Members 5th event (seminar/talk or behind the scenes tour)	New activity	Communications Dept	£1,000 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
December				
Fri 7 Dec	Members' News Issue 11	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
Date TBC	Christmas event (mini Open Day)	New activity	Communications Dept	£5,000 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011

Other activity not included in calendar

'Meet a Governor' sessions – dates regularly updated at http://www.chelwest.nhs.uk/get-involved/meet-a-governor

Talk by Paul Mason (Economics Editor, BBC *Newsnight* and author of new book 'Why It's Kicking Off Everywhere: The New Global Revolutions') – no date confirmed at present due to diary commitments

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 12 July 2012

AGENDA ITEM NO.	2.18/Jul/12
PAPER	Membership Report*
AUTHOR	Tony Pritchard, Deputy Chief Nurse
LEAD	Therese Davis, Chief Nurse and Director of Patient Experience and Flow
EXECUTIVE SUMMARY	This paper presents an overview of Foundation Trust membership and provides an analysis of trends for the period April and May 2012. Current total public, patient and staff membership is 14,943. During April and May, 203 new members joined, whilst 118 left, providing an overall gain of 85 in membership during the 2 month period.
DECISION/ ACTION	For information.

Membership Report

1.0 Membership size and movements

Table 1 below shows the size and movement of membership for the year 2011-2012, and for April and May of the current year. This shows a total membership of 14,943.

Table 1. Size and movement of membership

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OVERALL MEMBERSHIP OVERVIEW	Last Year 1 Apr 11 – 31 Mar 12	2012/13 year to date 31 May 12
As at start	**14,501**	**14,858**
New Members	1,512	203
Members leaving or changing constituency	1,210	118
TOTAL	**14,803**	**14,943**
PUBLIC MEMBERSHIP OVERVIEW	**Last Year 1 Apr 11 – 31 Mar 12**	**2012/13 year to date 31 May 12**
As at start	**5,737**	**5,942**
New Members	659	46
Members leaving or changing constituency	454	63
TOTAL	**5,942**	**5,925**
PATIENT MEMBERSHIP	**Last Year 1 Apr 11 – 31 Mar 12**	**2012/13 year to date 31 May 12**
As at start	**5,591**	**5,685**
New Members	487	153
Members leaving or changing constituency	393	51
TOTAL	**5,685**	**5,787**
STAFF MEMBERSHIP	**Last Year 1 Apr 11 – 31 Mar 12**	**2012/13 year to date 31 May 12**
As at start	**3,173**	**3,231**
New Members	508	4
Members leaving or changing constituency	450	4
TOTAL	**3,231**	**3,231**

2.0 Membership Joiners and Leavers April - May 2012

2.1 Public Membership

Table 2 below shows public membership joiners and leaves during April and May 2012. There were 46 public who joined and 63 who left membership during this period

Month	April	May	Total
Joiners	10	36	46
Leavers	58	5	63

Table 2. Public Membership joiners and leavers April and May 2012

2.2 Patient Membership

Table 3 below shows patient membership joiners and leavers during April and May 2012. There were 153 new joiners and 51 who left membership during this period.

Month	April	May	Total
Joiners	24	129	153
Leavers	47	4	51

Table 3. Patient membership joiners and leavers April and May 2012

3. Membership Demographics

3.1 Public Membership Ethnicity May 2012

Within the public membership, the highest proportion (70%) is within the white category of ethnicity, whilst the lowest representation remains within the black (6%), Asian (6%) and mixed (4%) ethnic categories. Figure 1 below shows the analysis of public membership by categories of ethnicity.

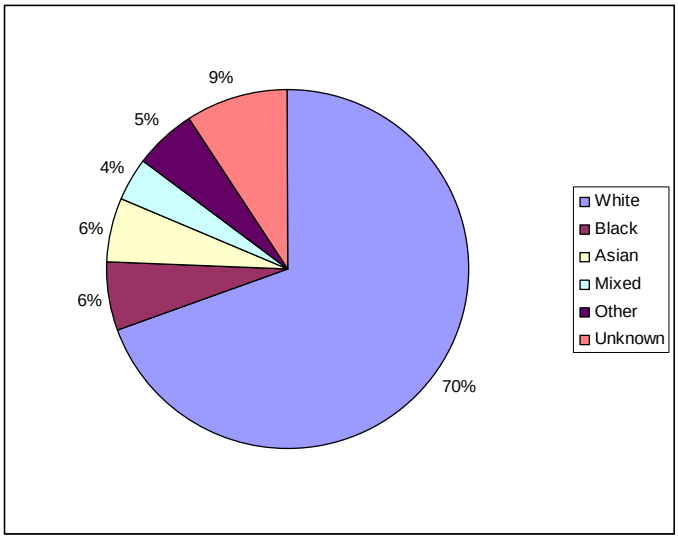
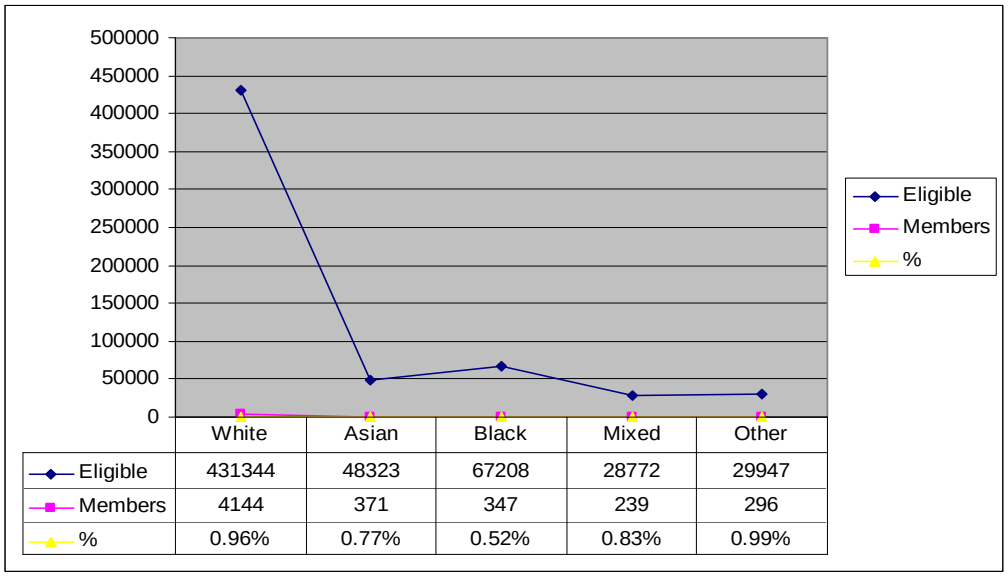


Figure1. Public Membership Ethnicity May 2012

3.2 Public Membership Ethnicity – comparison against local eligible population

Figure 2 shows the public membership comparison against the local eligible population. Representation is also highest in the white population and lowest in the mixed and other categories.



	White	Asian	Black	Mixed	Other
Eligible	431344	48323	67208	28772	29947
Members	4144	371	347	239	296
%	0.96%	0.77%	0.52%	0.83%	0.99%

Figure 2. Public Membership ethnicity comparison against local eligible population

3.3 Public Membership Age

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

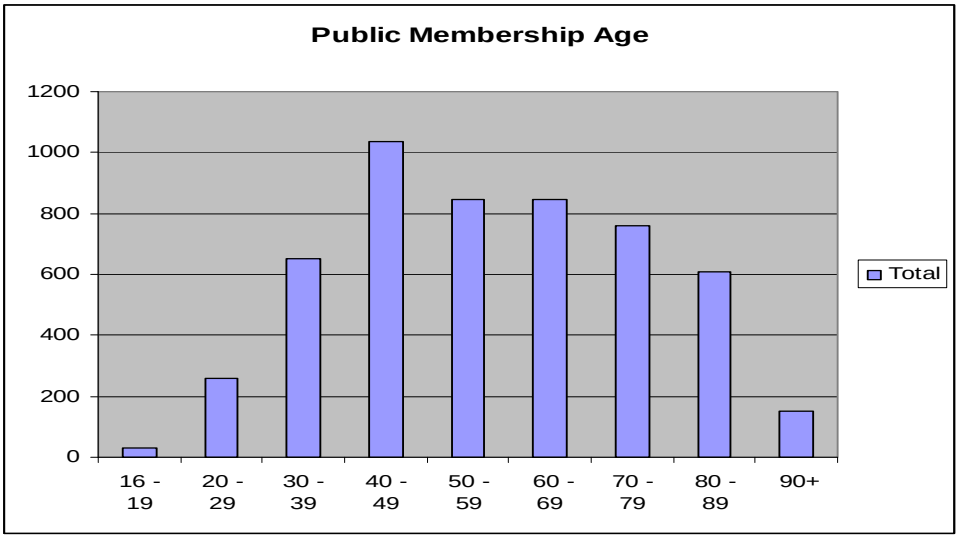
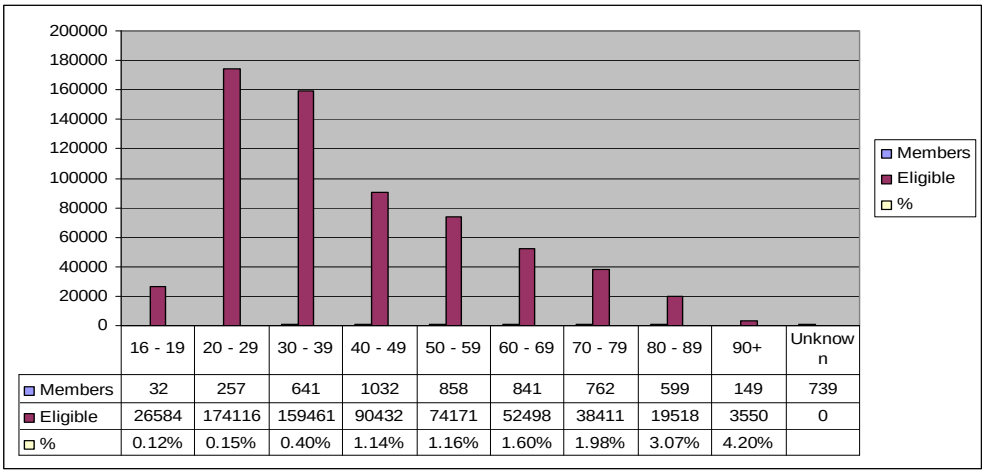


Figure 3. Public Membership Age

3.4 Public Membership Age – Comparison against local eligible population

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

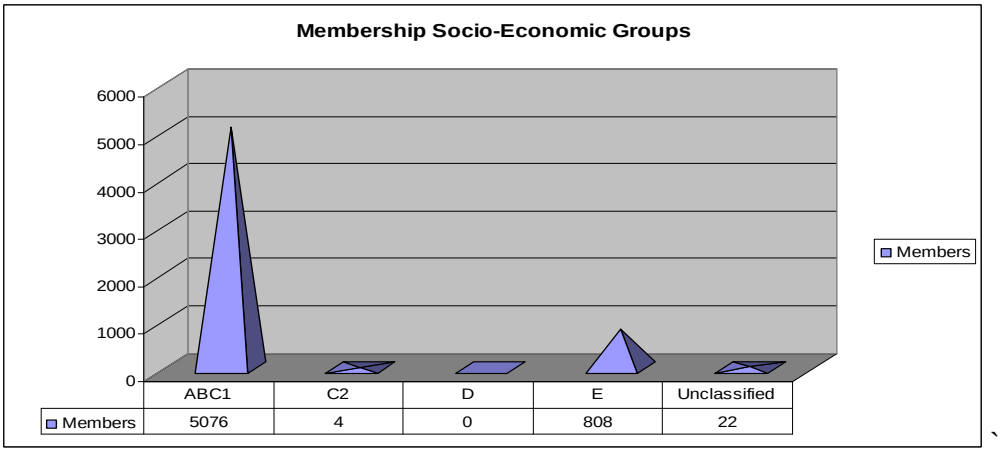


	16 - 19	20 - 29	30 - 39	40 - 49	50 - 59	60 - 69	70 - 79	80 - 89	90+	Unknown
Members	32	257	641	1032	858	841	762	599	149	739
Eligible	26584	174116	159461	90432	74171	52498	38411	19518	3550	0
%	0.12%	0.15%	0.40%	1.14%	1.16%	1.60%	1.98%	3.07%	4.20%	

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

3.5 Public Membership - Socio-economic grouping

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



	ABC1	C2	D	E	Unclassified
Members	5076	4	0	808	22

Figure 5. Public Membership - Socio-Economic Groups*

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

4.0 Membership Recruitment

4.1 At the start of 2012/13 there were 14,858 members. During April and May there was a net gain of 85 new members. Membership at the end of month 2 was 14,943.

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

4.3 The Membership Development Sub-Committee of the Council of Governors develops and reviews the Membership recruitment strategy. Recruitment activity is focused on both maintaining our membership numbers whilst also enabling a diverse and representative membership.

4.4 The community mobile health clinic continues its screening activities and when possible recruiters join the services to recruit new members alongside screening. The services from the mobile health clinic aim to target 'hard to reach' groups in the community.

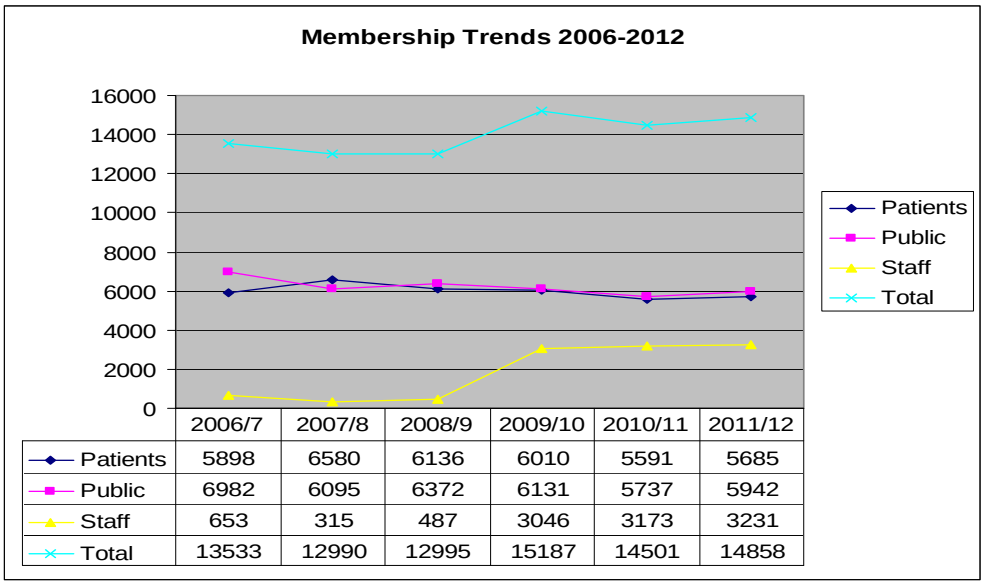
4.5 A Governor now attends the Mobile Health Steering Group. The group plan activities and decide how Governors can link with Trust activities in the community (especially where membership is underrepresented) and decide on appropriate outreach services for these areas.

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

4.7 The Membership – Patient Advice and Liaison Services support membership promotion. Any visitor to the M-PALS office is offered a membership application form when appropriate. The forms are sent with all patient response letters from the M-PALS service and the team will continue to actively promote membership.

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

4.9 Figure 6 shows the trends in Trust membership from 2006-2012.



	2006/7	2007/8	2008/9	2009/10	2010/11	2011/12
Patients	5898	6580	6136	6010	5591	5685
Public	6982	6095	6372	6131	5737	5942
Staff	653	315	487	3046	3173	3231
Total	13533	12990	12995	15187	14501	14858

Figure 6. Membership trends 2006-2012

5.0 Recruitment Campaigns

5.1 In the current year, we have commissioned Capita, our recruitment providers, to run 2 recruitment events in May and September.

5.2 The first event took place within the Trust in May and the objective was to recruit 300 new members whilst also promoting the Trust Open day on Saturday May 12th. A total of 355 members were recruited against a target of 300, though this figure requires final validation.

5.3 Further recruitment events are proposed for September 2012 with the aim of recruiting a further 300 new members whilst also promoting the Governor elections and the Trust Annual General Meeting.

5.4 An initial annual budget of £2,340 was agreed. The cost for each recruitment event will be £3,600 and a request for an additional £1260 of recruitment funding is proposed to support these events

5.5 During the Trust open day on May 12th, a further 64 members were recruited

5.6 We are awaiting developments to the Trust letter distribution system so that initial appointment letters can include a membership application form.

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

6.0 Developing a Representative Membership

6.1 Analysis of the membership database by age, gender and ethnicity ensures we work towards representative memberships within the communities we serve.

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

6.3 In November 2011, the Council of Governors approved a sum of £3,300 to fund additional membership recruitment events. To date, 3 half-day recruitment events have been commissioned through Capita. Two health bus events were attended during November and December 2011, but recruitment numbers were low. On March 28th, Capita attended a Somali Women's group at West London Centre for Sexual Health and 31 new members were recruited.

6.4 These 3 half day events are costed at £300 per session. It is proposed that remaining funding will be used to support additional recruitment events.

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7.0 Summary

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

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

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Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 12 July 2012

AGENDA ITEM NO.	2.18/Jul/12
PAPER	Membership Report*
AUTHOR	Tony Pritchard, Deputy Chief Nurse
LEAD	Therese Davis, Chief Nurse and Director of Patient Experience and Flow
EXECUTIVE SUMMARY	This paper presents an overview of Foundation Trust membership and provides an analysis of trends for the period April and May 2012. Current total public, patient and staff membership is 14,943. During April and May, 203 new members joined, whilst 118 left, providing an overall gain of 85 in membership during the 2 month period.
DECISION/ ACTION	For information.

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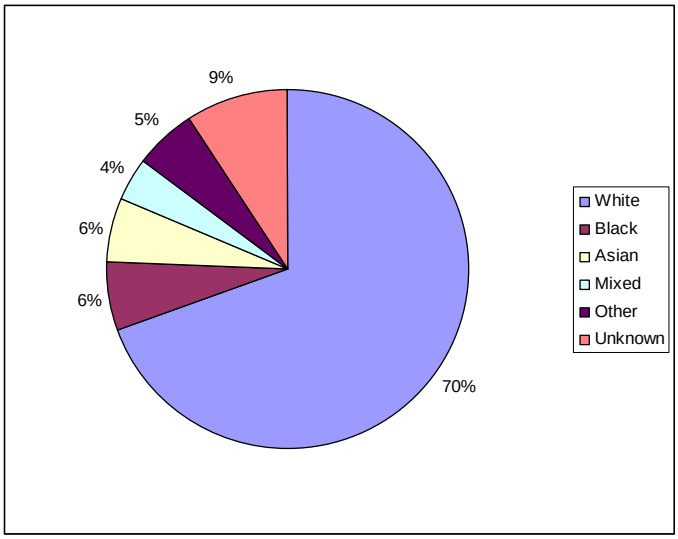

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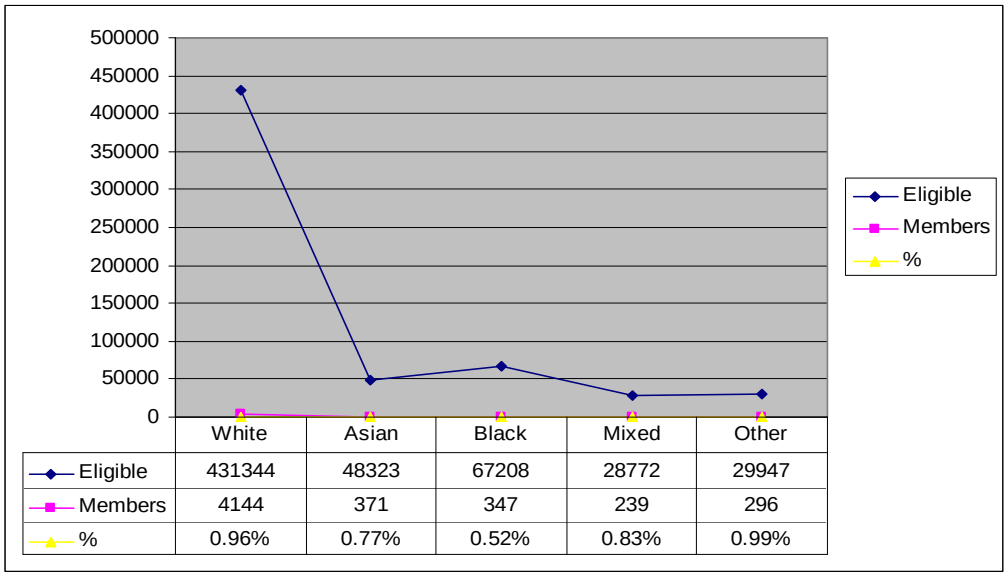

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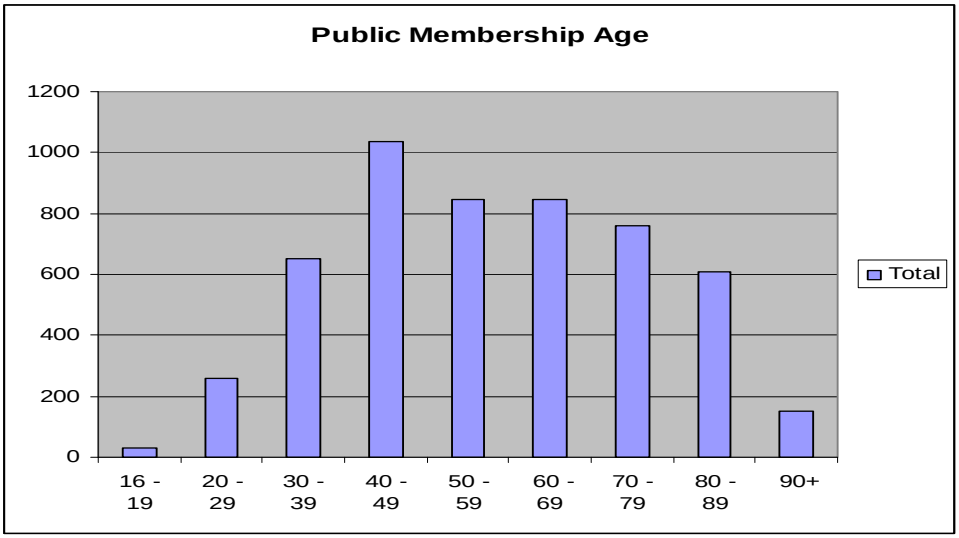

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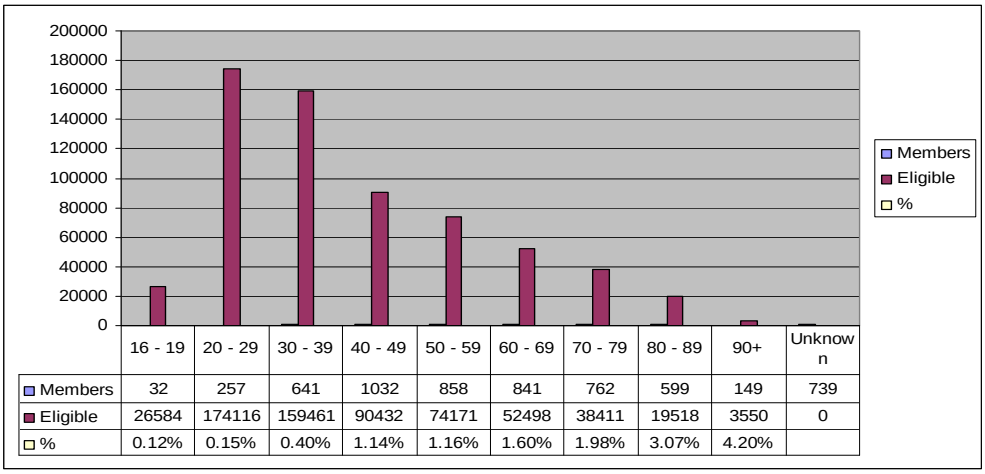

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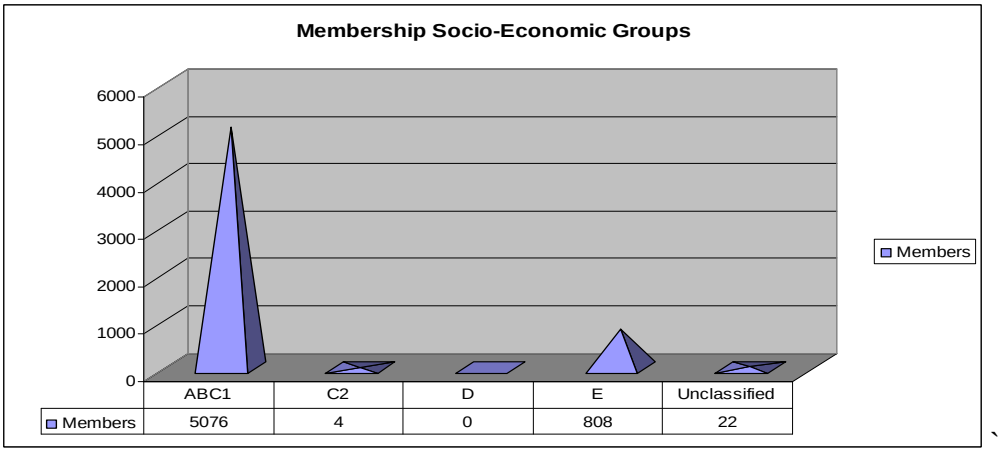

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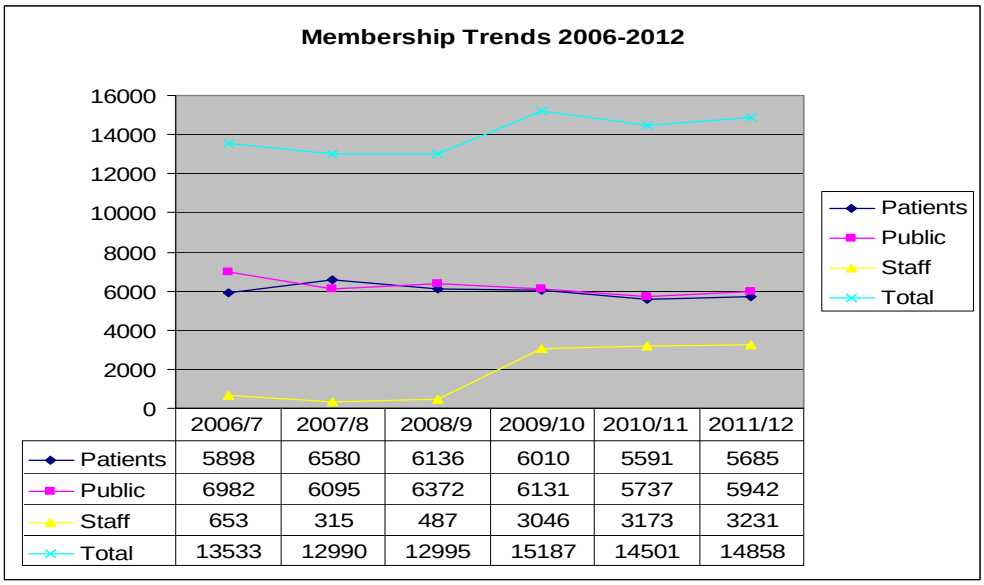

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Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 12 July 2012

AGENDA ITEM NO.	3.1/Jul/12
PAPER	Finance Report - May 2012
AUTHOR	Kelda Alleyne, Finance Change Management Consultant
LEAD	Lorraine Bewes, Director of Finance
EXECUTIVE SUMMARY	The Trust has achieved a surplus of £2.2m in month 2, a favourable variance of £0.175m against plan and an EBITDA of £4.1m, £0.2m above plan. The prior year month 2 comparative is a surplus of £1.1m and EBITDA of £2.8m. The month 2 performance has been driven by strong NHS Clinical over-performance, a prior year benefit and increased work-in-progress for NHS activity offset by marginal costs and high drugs issues associated with the general summer season as well as the Jubilee and Olympic events. Release of provisions of £0.5m for contractual disputes was also a key factor in the positive EBITDA. NHS Clinical income has over-performed by £0.8m in month. The Trust has set a CIP target of £16.2m for 2012/13 and has identified schemes worth £16.1m (99%) with a recurrent value of £16.2m. During month 2 the Trust planned to achieve CIP of £0.3m, to bring the year-to-date achieved to £6.4m. The Trust has agreed the main acute contract value with NHS North West London at a value of £133.7m and the full contract documentation is due to be signed shortly. The London Specialised Commissioning Group contract remains unsigned - there remains a gap of £0.9m relating to the application of CQUIN on ARV drugs. The Trust Finance Director has made a final offer and is awaiting a response from the LSCG. Arbitration papers are being prepared.
DECISION / ACTION	The Council is asked to note the financial position for the month 2 of the FY 2012/13.

Glossary of Terms

AAU: Acute Assessment Unit

BPPC: Better Payment Practice Code

CIP: Cost Improvement Programme

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

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

Monitor: Regulatory body for NHS Foundation Trusts.

PBL: Prudential Borrowing Limit (established by Monitor)

PPI: Private Patients' Income

PDC: Public Dividend Capital

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

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 12 July 2012

AGENDA ITEM NO.	3.2/Jul/12
PAPER	Performance Report – May 2012
AUTHOR	Helen Byrne, Interim Head of Performance Improvement
LEAD	David Radbourne, Interim Chief Operating Officer
EXECUTIVE SUMMARY	Overall, the Trust has performed well in May 2012, achieving the required performance level in all Monitor indicators which could be measured. On 14 June 2012, the Trust signed the Heads of Agreement document with North West London Commissioners to the value of £133,726,910. The Heads of Agreement sets out the productivity and efficiency metrics; the CQUINs agreed; the QIPP (demand management) projects; the transfer of activity associated with specialist commissioning and the Information and Quality Requirements schedules. This sets a challenging performance agenda for 2012/13. In addition to the metrics described in the Board report, there are over 90 KPIs, some of which are new and will be reported to the Board in the coming months, once the underpinning data sources are in place. The Commissioners have indicated that they will deliver demand management schemes (QIPP schemes) which are essentially about referral management and care in settings outside hospital to the tune of over £2m. As stated elsewhere, there are in addition a number of significant challenges to the Trust in 2012/13. Hospital acquired infection, in particular C Diff, will require constant vigilance. As of the end May, there was 3 cases, against the Monitor de minimus of 12 for the entire year. Other patient safety measures including VTE and pressure ulcers will require continued focus and attention. Back up data relating to the performance report can be found in Appendix 1.
DECISION/ ACTION	The Council is asked to note this report.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust
13th June 2012 | www.chelwest.nhs.uk | No: 12 | Hospital Health: Excellent | Month 2

Value of the 2012/13 Metrics

Metrics:	£
1st to follow up ratios	-426,125
PPwT	-300,000
Non GP (C2C) referrals(act)	-482,689
Non GP (Other) referrals(act)	-414,171
Emergency Readmissions	-554,507
Ambulatory care at Op tariff(act)	-79,371
Daycase to Outpatient	-222,499
Reduction in Orthopedics XBDs	-130,540
Total	**-3,609,151**

Metrics Agreed with the Commissioners

This year, the Trust has agreed a number of stretch targets with North West London Commissioning Partnership in the following areas:

1.A reduction in the 1st to follow-up ratio: this metric was introduced in 2011/12 and has been extended this year to move the Trust towards upper quartile or top decile performance when compared with peers. This is particularly challenging in number of specialties including plastic surgery and ophthalmology. The start date for the new metric is 1 July.

2. A 15% reduction in non GP referrals: this metric includes consultant to consultant referrals, other (eg therapists) referrals to Consultants and consultant referrals to other professionals. An audit is to be carried out by end June, led by NWL, which will help to determine the appropriateness of these referrals and will assist the Divisions to identify areas where a reduction is appropriate and aid the development of action plans.

3. An increase in ambulatory care pathways: the Trust has agreed to introduce 11 best practice ambulatory care pathways and 8 other ambulatory care pathways in addition. The intention is to prevent non elective admissions and to treat patients in an ambulatory care setting. These pathways are predominantly in medicine. In introducing the pathways, joint work with primary and community care colleagues will be essential.

4. Reduced excess bed days in orthopaedics: The Trust is considered to have a high excess bed day rate in orthopaedics. On review, this occurs predominantly because patients have a medical condition in addition to the orthopaedic condition. Recording mechanisms will be changed to deliver this metric.

5. A shift of day cases to outpatient procedures: this metric involves a shift of appropriate surgical and gynaecology procedures currently undertaken as day cases, in an outpatient setting.

6. Reduction in emergency readmissions: This metric was introduced in 2011/12 and a programme of work was undertaken to reduce the number of avoidable readmissions. This has continued into 2012/13, and each of the Directorates have refreshed their action plans to further reduce the number of avoidable admissions. A clinical review is to be undertaken by the Commissioners in partnership with the Trust by end September to get an in-depth understanding of readmissions into the Trust.

As set out in the table, each of these metrics have a financial value which has been taken out of the Trust's income.

Clostridium Difficile

At the end May 2012, there has been 3 cases (5 cases as of 18/06/2012) of HAI Clostridium difficile. This is against the Monitor 'de minimus' position of 12 cases in 2012/13. There will need to be a very major focus on control and prevention for the remainder of the year. The actions taken to minimize the exposure to *Clostridium difficile* include:

- Rollout out of the current PPI pathway used in AAU of identifying certain patients who will be suitable for PPI holidays during admission across adult surgery as well as including consideration of this in pre-assessment clinics. The pharmacists are currently working on this and discussing with clinicians. (Expect further information imminently)

- Completion of Root Cause Analysis (RCA) form and feedback to lead nurse, matron, ward manager, consulting team and divisional management of actions identified and improvements in practice required. This will include follow up of actions identified and feedback to all parties involved.

- When a Clostridium difficile toxin positive HAI is identified the infection control team will email the nurse leads, managers and divisional leads. The microbiology team will inform the consulting team.

Never Events. There was a never event in maternity in May: retention of a swab. The patient was seen by an Obstetric Consultant and full apologies were given. Initial review of the incident confirmed failure to follow protocol as the root cause. The swab count was not completed by two staff members

The Never Event assurance document has been revisited since the event with the aim of strengthening controls and reviewing assurances. Recommendations from previous reviews of similar incidents are also being revisited.

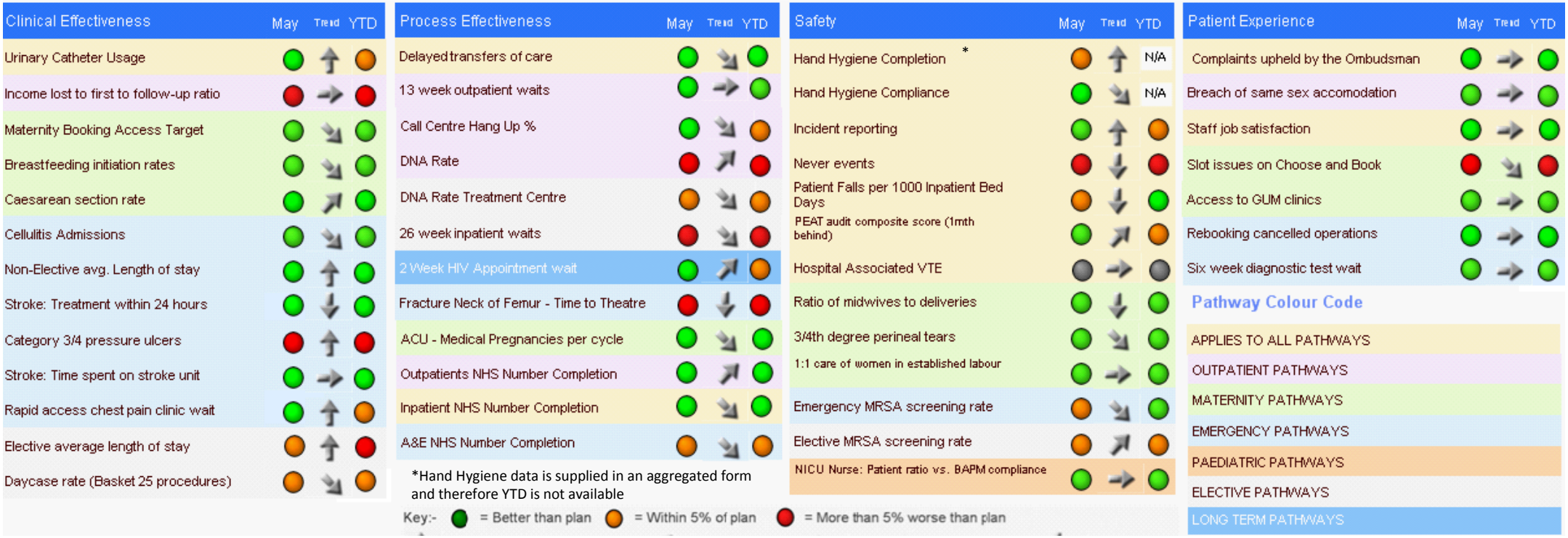
Eradication of never events remains a major priority for the Trust.

Monitor Compliance: 2012/13

NHSQuarter	Target	YTD	May 2012
Clostridium difficile cases	<12	3	2
MRSA objective	<3	0	0
All cancers: 31-day wait from diagnosis to treatment	> 96%	100.0%	100.0%
All cancers: 31-day wait for second or subsequent treatment Surgery	> 94%	100.0%	100.0%
All cancers: 31-day wait for second or subsequent treatment anti cancer drug treatments	> 98%	100.0%	100.0%
All cancers:62-day wait for first treatment from urgent GP referral to treatment	> 85%	90.5%	88.9%
All cancers:62-day wait for first treatment from consultant screening referral	> 90%	100.0%	100.0%
Cancer: Two Week Wait from referral to date first seen comprising all cancers	> 93%	96.9%	97.7%
Referral to treatment waiting times < 18 Weeks - Admitted	> 90%	93.4%	92.7%
Referral to treatment waiting times < 18 Weeks - Non-Admitted	> 95%	99.2%	99.3%
Referral to treatment waiting times < 18 Weeks - Incomplete Pathways	> 92%	92.7%	93.1%
A&E: Total time in A&E < 4hrs	> 98%	98.8%	98.8%
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability		Compliant	Compliant

Quality KPIs

Know your arrows: - The arrows in the dashboard below relate to the month on month variance in Trust performance. An upwards arrow indicates an improved performance across all KPIs. For example DNA rates have increased from 9.91% in Mar to 10.45% in Apr which is a decrease in performance; year to date performance of 10.45% did not meet the target (8.71%).



- **Income lost first follow-ups:** The income lost in relation to the first to follow up metric for May was £ £22,411 mainly in the specialties of Rheumatology, Medical Oncology, and Dermatology. In moving forward the Divisions are tightening their plans to meet this metric for 2012/13, which in most specialties is now at upper quartile or top decile compared to peer organisations.
- **Pressure Ulcers:**There were 2 hospital acquired grade 4 pressure ulcers - both on David Erskine. Root cause analysis documents completed for both. There 2 hospital acquired grade 3 pressure ulcers - ITU and Annie Zunz. Root cause analyses are underway. The pressure ulcer care bundle has been piloted on David Erskine ward and is currently being tested out on Lord Wigram ward. Following feedback from these areas the care bundle will be rolled out Trust wide to all inpatient areas. The multidisciplinary standing panel for review of all grade 4 hospital acquired pressure ulcers will meet for the first time on 4th July and thereafter bi-monthly to agree recommendations and also monitor progress towards their completion. Rapid access chest pain clinic - there were 4 rapid access chest pain breaches in April. This was because clinics were cancelled due to illness and insufficient time remaining in the 14 day pathway to rebook. The booking procedures for these patients will be discussed and reviewed at the next performance meeting with the Central Team to ensure that patients are offered appointments as early as possible and that the importance of this is understood
- **DNA Rate**: There are a number of specialties in which DNA rates are high including pain management, orthodontics and diabetic medicine. The Divisions are undertaking work to reduce DNAs through a variety of initiatives including texting patients and sending reminder letters.
- **26 week waits**: In T&O and craniofacial surgery, there are a number of patients waiting over 26 weeks. This is mainly because of capacity issues in these specialties. Extra lists have been organised in June to reduce the numbers of patients waiting over 18 weeks and therefore the position will improve significantly. The Trust continues to meet the RTT targets for 18 weeks for admitted and non admitted patients.
- **Fracture Neck of Femur:** In May, 1 patient did not make it to theatre in time although medically fit. The issue has been raised with the team to ensure this does not reoccur. Also, in the absence of the clinical nurse specialist, there will be a process to ensure these assessments take place in her absence.
- **Hospital Associated VTE.** The measurement of this indicator requires the number of VTEs to be identified through radiology reports and then each patient record to be checked to see if they were admitted within 3 months of the diagnosis and if so, the VTE risk assessments and the prophylaxis they received is reviewed. This is undertaken by the consultant haematologist only and the ability to undertake this promptly is limited by her time. If there is a possibility that the VTE was preventable the lead clinician is asked to undertake a Root Cause Analysis to confirm whether it was preventable and what measures can be put in place for the future. This adds a further delay.
- **Choose and book slot issues:** There are particular issues in paediatric ophthalmology and paediatric cardiology. The Directorate is setting up new Paed Eyes clinics to deliver extra slots to C&B and in the last few weeks, they have successfully polled slots for the first time in months. With regards to Paediatric Cardiology, partners at RBH have been asked to provide extra clinical time and the Directorate is currently working to match their availability with room availability at the hospital.

Patient Experience (Updated Quarterly)

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

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

Complaints and Concerns for Quarter 4 2011 by Campaign & Division

		Communication								Discharge								Concern Age 75 and Over							
		Type 1				Type 2				Type 1				Type 2				Type 1				Type 2			
Division	**Directorates**	**Q 1**	**Q 2**	**Q 3**	**Q4**	**Q 1**	**Q 2**	**Q 3**	**Q4**	**Q 1**	**Q 2**	**Q 3**	**Q4**	**Q 1**	**Q 2**	**Q 3**	**Q4**	**Q 1**	**Q 2**	**Q 3**	**Q4**	**Q 1**	**Q 2**	**Q 3**	**Q4**
Clinical Support Services		5	0	2	0	0	0	3	2	5	0	0	0	1	1	0	0	1	0	1	1	0	1	0	2
Women, Children, Young People & Neonates, HIV, GUM & Dermatology	HIV GUM Directorate	4	4	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
	Women and Children Directorate	4	4	7	2	6	7	3	6	5	0	0	0	0	0	0	0	1	0	1	0	0	0	0	1
Medicine & Surgery	Medical Directorate	7	4	0	2	5	7	6	7	2	1	2	1	5	5	1	1	3	1	5	8	10	4	7	5
	Surgical Directorate	11	3	9	4	1	4	10	9	11	0	1	1	2	1	1	1	0	14	9	2	0	3	4	3
Central Outpatient Services		0	13	6	5	0	5	10	2	0	0	0	0	0	0	0	0	0	0	4	4	0	2	2	1
Non Clinical Support Services		3	0	1	1	1	0	1	0	0	0	0	0	0	0	0	0	5	0	0	3	0	0	1	0
Totals for Q1, Q2, Q3 and Q4		**34**	**28**	**25**	**15**	**13**	**23**	**34**	**26**	**23**	**1**	**3**	**2**	**8**	**7**	**2**	**2**	**10**	**15**	**21**	**18**	**10**	**10**	**14**	**12**
2011/12 YTD		**102**				**96**				**29**				**19**				**64**				**46**			
2010/11 Total		**177**				**83**				**94**				**14**				**-**				**-**			

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

	Communication	Discharge	Concern Age 75 and Over
Themes	• Next of kin not kept informed regarding future plans • Failure to communicate with family following a fall • Concern withinformation provided re to expect following a procedure. • Patient arrived on time given conflicting advice as to whether operation would go ahead. • Referral to department not received and patients received conflicting information. • Lack of communication between specialities involved in care. • Expressed concern with the care and treatment in fracture clinic, with regard to the late running of clinic and communication with patient • Patients describe leaving numerous messages and no one has called them back	• Concern regarding discharge which relatives felt was inappropriate. Patient re admitted as sustained another fall at home. Thorough assessment of discharge needs was undertaken. Patient had capacity and was aware of risks but wished to go home • Patient discharged from clinic but believes condition not treated	• Lack of information to families regarding the management of care. Difficulties in getting updates and family not informed re changes to care plan • Attitude of staff towards elderly patients requesting help. • Failure to answer call bells refusal to get patient a commode
Actions	• The leaflet for patients having colonoscopy has been amended to provide information on what to expect following a procedure • Pre assessment unit to record notes from their assessments electronically as well as on paper. • All referrals copied to the Medical Admissions staff to ensure they are logged on waiting list. This will ensure there is an accurate record of all patients waiting for the procedure. • The name of the nurse allocated to each clinic [T and O] is now displayed outside each clinic room to ensure that all queries are directed to the appropriate person. • Reception staff are due to take a Customer Service Apprenticeship	• Trust has piloted joint working between hospital and community teams to strengthen discharge planning and to ensure right support is in place following the patients discharge. • Weekly meetings to plan the discharge of those with more complex needs have been introduced. These involve clinical staff, the hospital discharge team and community representatives.	• Taken forward work to ensure that patients with dementia are identified on admission and that a clear plan is in place to enable the communication and coordination of care between different members of the team. • Planning for roll out of care and comfort rounds to 3 further wards

Maternity Real Time Patient Feedback: In Q4 488 patients from 1044 discharges (46.7%) gave us feedback on the following questions. Our local target is to achieve an overall satisfaction score of ≥ 90%

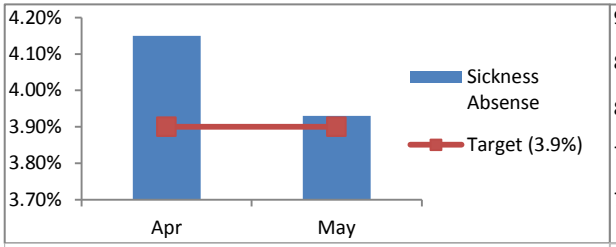
I felt I was not left alone when I didn't want to be, when I was in established labour	96.6%
Overall, how would you rate the care received during your pregnancy?	96.11%

Thinking about the care you have received in hospital after the birth of your baby, have you been treated with kindness and understanding?	93.75%
Do you feel the ward is clean enough?	93.78%

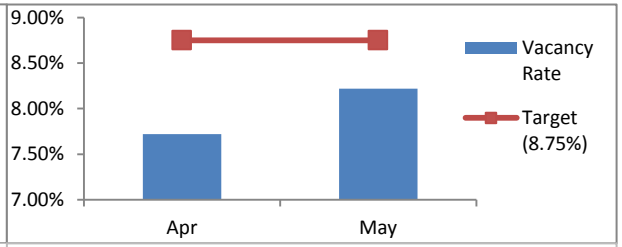
N.B. Due to issues with the patient experience devices it is not possible to report accurately on areas apart from Maternity. All Questions are set nationally and the Trust has scored above 90% on all satisfaction indicators.

	M1 YTD	M2 YTD
EBITDA margin	5.1%	9.7%
EBITDA , % plan achieved	76.3%	96.8%
Net Return after financing	-0.2%	2.9%
I&E surplus margin net of dividend	-1.8%	3.1%
Liquidity days	32.0	35.0
Overall Financial Risk Rating	**3**	**4**

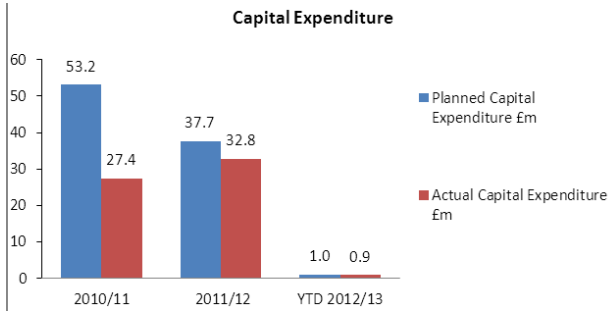
As in previous years, month 1 SLR will not be published. This is to allow sufficient time to assess the movements in EBITDA at service line level between financial years due to (a) new tariff and local prices for 2012-13 (particularly as the contract negotiations for 2012-13 had not been concluded at month 1) and (b) overall decrease in Trust-wide EBITDA from 10% in 2011-12 to 5% at month1. SLR information for 2012-13 will be published from month 2.



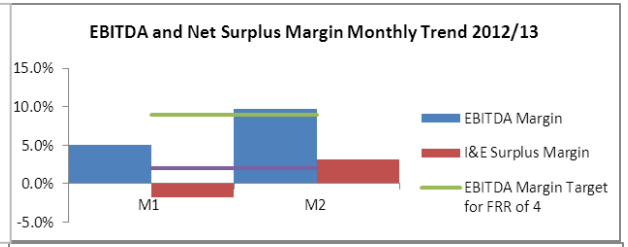
The Trust's sickness absence rate in May was 3.93% which is lower than the previous month (4.15%) but higher than May 2011 (3.69%).All Divisions bar Medicine and Surgery registered an increase on the previous year. This was partly due to improved reporting mechanisms across the Trust which has led to an increase in the number of departments reporting absence. The Trust Senior Operational Group has set up a working group to review Absence management and will introduce recommendations in the new financial Year to improve the management of sickness absence, as part of a QIPP programme to reduce sickness across the Trust.

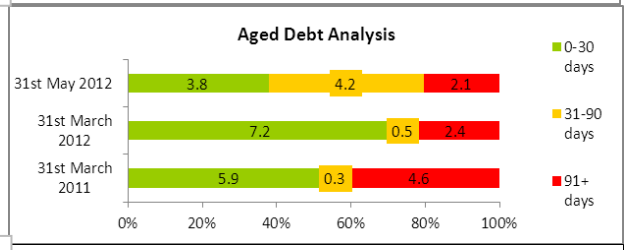


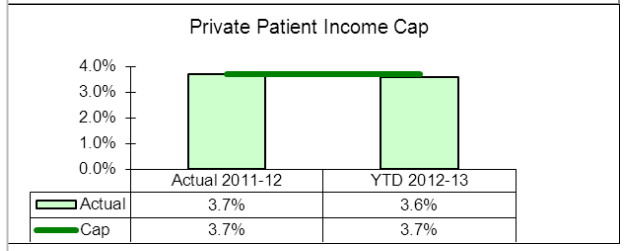
The full Trust vacancy rate for May 2012 was 8.22%, a decrease of 1.70% on the previous year. The increase on the previous month was primarily driven by the addition of new NICU nursing roles which are in the process of being recruited to. The overall reduction on last year is principally due to increased recruitment within the Medicine and Surgery and Women's, Children and Sexual Health Divisions. It is of note that the vacancy rate in Maternity is now nearly 15% lower than in May 2011.



EBITDA margin 9.7% (FRR of 4) and I&E Surplus margin 3.1% (FRR of 5) at M2







Commentary:

1) The Trust has generated private patient income for the two months of the year of £1.8m which equates to 3.6% of total patient related income, i.e. within the PPI cap. The Trust has based its private patient income forward plans on the revision to the cap becoming effective from 1 July 2012, however the commencement order has been revised to take effect at the same time as the change in Monitor's role, which is anticipated to be 1 April 2013. The risk exists that the Trust could breach the cap by year-end and this is being closely monitored.

2) The Financial Risk Rating YTD at M2 is a 4.

3) CIPs: £1m achieved YTD at Month 2 - slippage in delivery of CIP will have to be mitigated in future months either by increased delivery or other underspends.

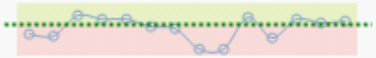
REGULATORY COMPLIANCE & KEY PRIORITIES - May 2012

Key Priorities

	Performance Indicator	Trend	YTD Value	YTD	Forecast
Priorities	VTE Assessment (Target: > 90%)		90.2%		
	OP Letter Turnaround Times (Target: Less than 5 Days)		7.9		
	Discharge Summaries (Target: 100% Complete within 24 Hrs)		91.8%		
	Emergency Re-Admissions following No Elective spell (Target: < 2.8%)		3.2%		
	Emergency Re-Admissions following Elective spell (Target: 0%)		1.3%		
	NCE POD Recommendations (Target: 95% within waiting time)		99.6%		
	Mortality - HSMR (Target: < 87.34)		-		
	LAS Handover - HAS Data Quality (Target > 90%)		89.3%		
	GP Referrals Recieved		Avg: 6,362 Last Month: 5,738		

- OP letter Turnaround Time: The Trust's intention is provide notification of outpatient care electronically to GPs within 5 working days of attendance at clinic . There has been significant improvement year to date with May's performance at 7.07 days. The Divisions have action plans in place to strengthen processes in relation to checking and signing off letters by doctors particularly in relation to cover for periods when a consultant is on leave and for part time consultants who are at the hospital less frequently. There are also changes within secretarial teams to distribute the work across teams other than the traditional approach of a secretary working for the particular doctor.
- In delivering the CQUIN in relation to real-time information to GPs, there is considerable work underway, being led by the IT department to improve the timeliness of discharge summaries to GPs. Further improvements to LastWord, to be delivered in this month, will improve the discharge summary user interface making it easier and quicker for clinicians to complete a summary.
- Readmission rates are being analysed by the Divisions, and at the June meeting, the Divisions provided refreshed action plans to address avoidable readmissions. The readmission rates overall are very low, but concentrated action is required in medicine and surgery to secure improvements.
- Work to reduce unplanned A&E re-attendances continues in parallel with work to reduce readmissions described above. An action plan is in place which includes internal initiatives such as the implementation of an Acute Review Card system in Paediatric A&E and working with external partners to better manage the care of patients who repeatedly attend A&E. In terms of A&E time to treatment there has been a change in recording which indicates a deterioration in performance. Over the next few weeks, this will be closely monitored to ascertain whether there has been a dip.

Monitor Indicators

	Performance Indicator	Trend	YTD Value	YTD	Forecast
Infection Control	MRSA (Less than 2 12/13)		0		
	Clostrium Difficile (Less than 12 12/13)		3		
Accident & Emergency	A&E: Initial Assessment (Target < 15mins)		00:13		
	A&E: Total Time (Less than 4 hours)		03:57		
	A&E: Time to Treatment (Less than 1 hr)		01:02		
	A&E: Left without being seen (Less than 5%)		3.9%		
	A&E: Unplanned Re-Attendances (Less than 5%)		5.75%		
Cancer Services (Quarters)	Cancer: 2-WW Ref to Seen (> 93%)		96.9%		
	Cancer: 62 Day Wait (Consultant Screening) (>90%)		100.0%		
	Cancer: 62 Day Wait (Ref to Treat) (>85%)		94.4%		
	Cancer: Diag to Treat (31 day) (>96%)		99.7%		
	Cancer: Subsequent Surg (31 Day) (>94%)		98.7%		
	Cancer: Subsequent Drugs (31 Day) (>98%)		100.0%		
Access	RTT Admitted (90% < 18 weeks)		93.1%		
	RTT Non Admitted (95% < 18 Weeks)		99.1%		
	RTT Incomplete (92% < 18 Weeks)		92.7%		
	Compliance with requirements regarding access to people with a learning disability (100%)		100%		

Quality Report Actuals **APPENDIX 1**

Clincial Effectiveness	Target	Apr	May	YTD	Trend
% General and acute patients with a urinary catheter	12.5%	17.35%	11.55%	13.89%	33.43%
Income lost due to first to follow-up ratio	£0.0	£22k	£22k	£45k	0.0%
Maternity Access 12 weeks + 6 Days	90.0%	94.0%	93.9%	94.0%	-0.1%
Breastfeeding initiation rates	91.1%	92.7%	92.3%	92.5%	-0.4%
Caesarean section rate	30.0%	31.1%	28.1%	29.6%	-3.0%
Percentage of A& E attendances for cellulitis that end in admission	40.0%	22.4%	19.4%	20.7%	3.0%
Non-Elective average length of stay (Last month target: < 631 long stays)	<631	456	438	894	14.3%
Stroke: % High risk TIA patients assessed and treated within 24 hours	60.0%	80.0%	75.0%	77.8%	-5.00%
Incidence of newly-acquired category 3 and 4 pressure ulcers	6	6	4	10	33.3%
Stroke: Patients who had a stroke who spend at least 90% on a stroke unit	90.0%	100.0%	100.0%	100.0%	0.0%
% Rapid access chest pain clinic patients seen within 2 weeks	98.0%	91.9%	100.0%	96.5%	8.1%
Elective average length of stay (Last month target: < 49 long stays)	<49	45	49	94	19.7%
Daycase rate (Basket 25 procedures YTD Target = 84.1%)	84.1%	80.3%	83.3%	82.0%	3.0%

Process Effectiveness	Target	Apr	May	YTD	Trend
Delayed transfers of care (% Beds effected - snapshot)	3.5%	0.9%	1.0%	1.9%	-0.1%
% Outpatients waiting longer than 13 weeks	0.03%	0.000%	0.000%	0.000%	0.000%
Did Not Attend Rate - Outpatients	< 8.73%	10.42%	10.38%	10.39%	0.04%
Call Centre Hang Up %	9.5%	10.2%	9.3%	9.8%	0.9%
DNA Rate Treatment Centre	3.0%	3.3%	3.3%	3.3%	-0.0%
Inpatients waiting longer than the 26 week standard	0.0%	0.0%	0.0%	0.0%	0
2 week wait for appointments for newly diagnosed HIV	100.0%	96.7%	100.0%	98.0%	3.3%
Fracture Neck of Time to Theatre for Medically Fit Patients	100.0%	70.0%	91.7%	81.8%	21.7%
Outpatients NHS Number Completion	95%	96.0%	96.1%	96.1%	0.1%
Inpatient NHS Number Completion	95%	96.5%	95.8%	96.1%	-0.3%
A&E NHS Number Completion	90%	88.9%	88.7%	88.62%	-0.2%

Safety	Target	Apr	May	YTD	Trend
Hand Hygiene Completion	100%	87.1%	97.3%		10.2%
Hand Hygiene Compliance	90.0%	95.3%	91.3%		-4.0%
Incident reporting rate per 100 discharges	0.8	7.0	8.1	7.6	15.1%
Never everts	0.0	0	1	1	-100.0%
Patient falls resulting in moderate or major harm	2.3	0	0	0	0.0%
PEAT Audit (Composite score 1 month behind)	95.0%	95.0	92.8	28.4	0.0%
Hospital Associated VTE	0.0	0	0	0	0.0%
Ratio of midwives to deliveries	TBC	31.91	33.86	32.88	-16.30%
3/4th degree perineal tears	3.0%	1.7%	3.7%	2.7%	-3.5%
1:1 care of women in established labour	100.0%	100.0%	100.0%	14.3%	0.0%
Emergency MRSA screening rate	95.0%	96.0%	94.4%	95.4%	-1.7%
Elective MRSA screening rate	95.0%	92.9%	93.4%	93.1%	0.5%
NICU Nurse: Patient ratio vs. BAPM compliance	85.0%	97.0%	97.0%	97.0%	0.0%

Patient Experience	Target	Apr	May	YTD	Trend
Complaints upheld by the Ombudsman (1Mth Delay)	0	0	-	0	0
Breach of same sex accomodation	0.0%	0	0	0	0.0%
Staff job satisfaction	60.0%	60.0%	60.0%	60.0%	0.00%
Slot issues on Choose and Book	4.0%	4.1%	4.8%	4.1%	-0.7%
Access to GUM clinics	100.0%	100.0%	100.0%	100.0%	0.0%
Rebooking cancelled operations	0%	0%	0%	0%	0%
Six week diagnostic test wait	0	0	0	0	0
ACU - Medical Pregnancies per cycle - Q3 & Q4	> 30%	30.5%	29.19%	29.19%	-1.31%

Key Commissioner Priorities

Trend - Last 12 Months

MonthYear	Apr 2011	May 2011	Jun 2011	Jul 2011	Aug 2011	Sep 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Apr 2012	May 2012	NHS Year Figures 2011-2012	2012-2013
VTE Assessment	93.0%	92.1%	91.9%	91.9%	94.6%	92.4%	91.3%	91.3%	91.6%	91.9%	90.8%	90.5%	90.7%	0.0%	91.9%	90.2%
OP Letter Turnarounds	-	-	-	9.10	8.40	6.30	6.10	6.93	7.95	6.79	6.80	9.83	8.74	7.07	9.21	8.74
Discharge Summary Completion	71.3%	77.5%	77.5%	79.0%	85.8%	91.6%	91.0%	94.8%	95.1%	95.0%	94.0%	94.5%	93.2%	90.4%	88.0%	91.8%
Emergency Re-admissions Following a Non-elective spell	3.3%	2.7%	2.8%	2.6%	2.8%	2.3%	2.8%	2.7%	2.8%	3.1%	3.0%	2.9%	3.2%	3.2%	2.8%	3.2%
Emergency Re-admissions Following a Elective spell (Target 0)	1.5%	1.2%	1.7%	1.7%	1.5%	1.5%	1.6%	1.4%	1.6%	1.2%	1.4%	1.5%	1.5%	1.2%	1.5%	1.3%
NCE POD Recommendations (One month in arrears)	-	96.6%	98.6%	93.7%	97.0%	94.9%	92.9%	95.5%	92.2%	94.6%	97.1%	97.4%	99.2%	100.0%	95.5%	99.6%
HSMR	66.04	71.43	61.11	71.66	75.60	85.53	81.97	56.48	68.68	76.19	74.25	69.33	-	-	71.50	-
LAS Handover - 90% HAS Data Completeness	66.0%	70.0%	79.0%	81.0%	82.0%	73.0%	72.0%	71.0%	77.0%	76.0%	82.2%	84.8%	90.4%	88.3%	76.2%	89.3%
GP Referrals	5916	7102	7261	6416	5923	6189	6609	6827	5284	6573	6405	6202	5738	6629	76707	12367

Monitor Indicators

NHSQuarter	Target	YTD	May 2012
Clostridium difficile cases	<12	3	2
MRSA objective	<3	0	0
All cancers: 31-day wait from diagnosis to treatment	> 96%	100.0%	100.0%
All cancers: 31-day wait for second or subsequent treatment Surgery	> 94%	100.0%	100.0%
All cancers: 31-day wait for second or subsequent treatment anti cancer drug treatments	> 98%	100.0%	100.0%
All cancers:62-day wait for first treatment from urgent GP referral to treatment	> 85%	90.5%	88.9%
All cancers:62-day wait for first treatment from consultant screening referral	> 90%	100.0%	100.0%
Cancer: Two Week Wait from referral to date first seen comprising all cancers	> 93%	96.9%	97.7%
Referral to treatment waiting times < 18 Weeks - Admitted	> 90%	93.4%	92.7%
Referral to treatment waiting times < 18 Weeks - Non-Admitted	> 95%	99.2%	99.3%
Referral to treatment waiting times < 18 Weeks - Incomplete Pathways	> 92%	92.7%	93.1%
A&E: Total time in A&E < 4hrs	> 98%	98.8%	98.8%
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability		Compliant	Compliant

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 12 July 2012

AGENDA ITEM NO.	3.3 /Jul/12
PAPER	Monitor Code of Governance - compliance
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Cathy Mooney, Director of Governance and Corporate Affairs
EXECUTIVE SUMMARY	This paper briefly outlines the process for declaring compliance with the Monitor Code of Governance.
DECISION/ ACTION	For information.

Monitor Code of Governance - compliance

1.0 Introduction

The Monitor Code of Governance (the 'Code') was first published in September 2006. A revised version was published in April 2010.

2.0 Background

Foundation Trusts are required to report against the Code each year in their Annual Report, on the basis of either compliance with the Code provisions, or, an explanation where they do not.

Each provision of the Code is reviewed early and evidence for compliance assessed noted. This forms the basis of the Board's decision on disclosure in the Annual Report.

The Code contents sections are as follows:

- A Directors
  - A.1 The board of directors
  - A.2 Chairman and chief executive
  - A.3 Balance and independence of the board of directors
- B. Governors
  - B.1 The Council of Governors
- C. Appointment, resignation and terms of office
  - C.1 Appointments to the board of directors
  - C.2 Re-appointment of directors and re-election of governors
  - C.3 Resignation of directors
- D. Information, development and evaluation
  - D.1 Information and professional development
  - D.2 Performance evaluation
- E. Director remuneration
  - E.1 The level and make-up of remuneration
  - E.2 Procedure
- F. Accountability and audit
  - F.1 Financial, quality and operational reporting
  - F.2 Internal control
  - F.3 Audit committee and auditors

The compliance statement, approved by the Board at the March 2012 meeting, reflecting the Trust's declaration as to compliance with the Code is stated in the Annual Report 2011/12.This is as follows:

'For the year ending 31 March 2012 Chelsea and Westminster Hospital NHS Foundation Trust complied with all the provisions of the Code of Governance published by Monitor in March 2010 with the exception of the provision relating to the independent external adviser being a member of the Nominations Committee, which is included in the Trust constitution, and the provision relating to an Executive member of the Board leaving the employment of an NHS Foundation Trust without

the Board first having completed and approved a full risk assessment, which was found to be impracticable in the circumstances.'

A document detailing the evidence to support compliance for each provision of the Code and the action to support full compliance can be obtained from Vida Djelic, FT Secretary on request.

3.0 Decision/Action

For information.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 12 July 2012

AGENDA ITEM NO.	3.4/Jul/12
PAPER	Wayfinding Project Update
AUTHOR	Karen Sorensen, Wayfinding Project Manager
LEAD	Therese Davis, Chief Nurse and Director of Patient Experience and Flow
EXECUTIVE SUMMARY	The Trust Board approved the proposal for the development of a comprehensive wayfinding and signage strategy for Chelsea and Westminster Hospital in December 2011. This paper details the work to date on appointing a specialist wayfinding company, the consultation exercise and the next steps in this project.
DECISION/ ACTION	For information.

1.0 Introduction

1.1 The Trust Board approved the proposal for the development of a comprehensive wayfinding and signage strategy for the Chelsea and Westminster Hospital and its estate in December 2011 and since then, the Wayfinding Strategy Group, chaired by Therese Davis, Chief Nurse and Director of Patient Experience and Flow, has been working on the strategy development. This paper details the work to date on appointing a specialist wayfinding company, the consultation exercise and the next steps for the final strategy.

2.0 Background

2.1 The existing wayfinding signage around the Trust is now significantly out of date and is confusing to visitors to the hospital. There is a pressing need to help today's visitors in navigating around the hospital, as well as a long-term opportunity to enhance wayfinding by building on the successes of the commercial sector, using a combination of new technology, improved branding and more traditional signage. Wayfinding also needs to incorporate the new Netherton Grove Extension as well as identifying off site areas.

2.2 The project began with a deliberate 'step back' to begin with the development of a Wayfinding Strategy for the Chelsea and Westminster, which will encompass a wide range of aspects which influence people's ability to navigate around the sites, including appointment letters, naming and public area design. This will allow a coherent approach to the project which will identify the underlying factors which make navigation difficult, and allow the project to put in place embedded strategies for the future.

3.0 Key Activities to Date

3.1 **Project Structure** – as agreed, an overarching Strategy Group, chaired by Therese Davis, Chief Nurse and Director of Patient Experience and Flow was established to lead the project on behalf of the Board. Membership of this group consists of senior staff from key areas, including a representative of the divisional teams, estates, appointments, patient governors and communications support. The group has met monthly to ensure the project follows the agreed structure and plan.

3.2 **A Wayfinding Operational Group** has been established to agree, support, and deliver the relevant elements of the implementation programme, reporting to the Strategy group. The membership of the operational group consists of representatives of front-line staff, key patient facing teams including MPals, appointments, patient governors and the Trust's diversity lead. The group has met monthly to support the consultation process.

3.3 **Appointment of Specialist Wayfinding Company;** Following a formal tender exercise two strategy companies were shortlisted for final interview and presentations which were held on the 1st March 2012. The Strategy group agreed that Applied Wayfinding Information Design best met the tender criteria and they were appointed to carry out Stage 1 of the Wayfinding consultation (development of the Wayfinding Strategy) on behalf of the Trust.

3.4 **'Show Us The Way' Consultation Programme** – it was agreed with the Trust's communications team that an overall brand for the wayfinding strategy would be helpful in engaging staff, patients and visitors in the exercise. It was important that these groups were engaged to ensure that the final strategy meets the needs of both. The 'Show Us The Way' strapline was agreed for the strategy consultation and communication.

3.5 The first stage of the project was an information gathering exercise to consult staff, patients and visitors on their current experiences. This consisted of:

- A comprehensive audit of the site and the existing wayfinding system
- Observation exercises with patients and staff on site
- A series of focus groups held in May 2012 for staff and governors
- An online survey open to patients, staff and visitors during April and May 2012. A paper version of the survey was also available through MPals
- A 'Show Us The Way' stand at the Trust Open day on 12th May 2012 including a 'wayfinding challenge'

3.6 **Results of the Consultation Exercise** – following the consultation, Applied have analysed all of the data and results collected. There are very clear broad themes emerging across the groups and these are summarised below;

- Human issues - Many patients feel anxious and ask staff for help and it can be time consuming to support this. Staff reported being aware of the frustration patients feel and are willing to help, but sometimes don't have the knowledge to do so. Strategy and signage needs to consider and support a wide range of people, including those who are non English speaking, have disabilities etc.

- Appointment letters – there have been some improvements in appointment letters recently, but significant further improvements would be made by standardising appointment letters across the Trust. Specific comments included the fact that department names used on letters do not always match with signage and that there is no central template for letters. Letters are not standardised and the location detail is often buried in the body of the letter.

- Nomenclature – results showed that there were sometimes multiple names for one location and that staff still used old names for departments. Patients in particular found medical terminology or acronyms confusing and would prefer plain English terminology if possible.

- Circulation – there were a considerable number of comments about lifts and stairs and general circulation, and this is clearly a key target for improvement in the strategy. Waiting times at lifts cause frustration, and this is exacerbated by patients not understanding where the lifts go to, and how they should be used. The issue of the stair closure was raised by some respondents. Specific comments were made about the long route down the corridor to the LG Floor Outpatients department and the need for 'route confirmation'.

- Zoning – there were a range of views on zoning the site, including the use of the lifts and/or colour to aid this. Existing labelling of lifts is not intuitive but people

felt that the lifts banks could be the key to understanding the layout of the hospital. The use of colour was felt to be a good approach, which helps to be able to describe where departments are.

- Signage – current signage is out of date, inconsistent and not correctly placed. There is no policy for replacement signage. Future signage should be managed centrally and kept up to date, must be capable of adapting to changing departments and moves and should be clear and concise. Signage in and around lifts and good directories are very important.

- Technology – the use of appropriate new technologies was supported as long as they are intuitive and user accessible to patients with reduced sight, physical and cognitive capabilities. This should include improved information and maps on the Trust website.

- Communication and Training - Induction does not cover wayfinding and there may be ways in which staff could be supported in helping patients navigate, such as official tours of the hospital and wayfinding training. Simple up to date department lists or maps were essential.

4.0 Next Steps

4.1 **Initial Thoughts on a Strategy** – there are clear themes emerging from the consultation exercise, audits and research, which are being analysed by Applied and the Wayfinding Project Manager to produce some initial proposals for the areas which the strategy should include, and how these might be managed.

4.2 **Stage 2 – Implementation Plan** - during the formal tender process, both shortlisted companies were asked to submit costs for Stage 2 of the project (the further development of the strategy and concept design into detailed specifications and schedules in readiness for the tender) as it was clear during the interview process that a more timely and seamless approach would be achieved if this was considered at an earlier stage. There would be no logical reason or benefit to split the provider of Stages 1 and 2, which would adversely affect continuity and inevitably result in some duplication of effort. Conversely, much is to be gained in time and cost by a seamless transition. It is proposed to discuss this at the next Wayfinding Steering Group meeting with a view to extending Applied's initial contract to cover Stage 2 of the project. In line with the tender process, Applied remain the most cost effective option for both stages.

5.0 Programme Update

5.1 **Stage 1 – Development of Wayfinding Strategy** – this phase commenced in December 2011 and is well underway, with the consultation element complete, as described in 3.4 above. It is planned to complete the draft strategy during July/August and present the final strategy to the Trust Board in September 2012, with details of the implementation plan including proposals for the tender process.

5.2 **Stage 2 – Development of a Detailed Implementation plan** – the agreement to proceed to Stage 2 with Applied allows elements of the implementation and tender process to be worked on alongside the finalisation of the strategy. This will commence in July 2012 and will continue through the summer, with the report to the Board in September 2012.

5.3 **Stage 3 – Implementation of the Strategy** – the tender process for suitable signage and other contractors will be conducted during October 2012, with award of tender in November 2012. Following the tender process, work to clear the site and begin signage roll out is planned to commence in December 2012. Alongside this, the other elements of the strategy, such as work on appointment letters, maps etc will be developed. The signage rollout is scheduled to be complete by April 2013. The implementation programme will be kept under review to ensure that clinical services are not affected, and that budgets can be allocated appropriately.

5.4 **Stage 4 – Evaluation** – once the main elements of the strategy are in place, an evaluation exercise will be undertaken, both with the staff, patients and visitors engaged in the consultation exercise, and the hospital population as a whole, to ensure that objectives have been met and improvements. This is scheduled for May 2013.

5.5 **Ongoing ownership and maintenance of the strategy** – one of the clear messages that is emerging from the consultation is the need to ensure that once the strategy is implemented, the work is maintained on an ongoing basis. This should apply to both public signage and to moves and relocations, new capital schemes etc. Recommendations on how this might be achieved will form part of the strategy recommendations.

6.0 Budget

6.1 The total capital allocation for the Wayfinding Strategy project has been agreed as £1.5m, across three years - £50K 2011-12, £450K 2012-13 and £1m 2013-14. To date, costs have been allocated to the Applied contract (£26k) and the wayfinding project manager (£20k). It is anticipated that the bulk of the budget will be spent as planned in 2012-14, on the implementation programme for the signage, as well as other supporting activities.

7.0 Conclusion

7.1 The Council of Governors is asked to note the report.

Therese Davis
Chief Nurse and Director of Patient Experience and Flow
Karen Sorensen
Wayfinding Project Manager
June 2012

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 12 July 2012

AGENDA ITEM NO.	3.5/Jul/12
PAPER	Director – Governor interaction in NHS Foundation Trust
AUTHOR	Catherine Mooney, Director of Governance and Corporate Affairs
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	A best practice guide for Board of Directors advises FTs on how to develop successful interaction between directors and governors so that governors are able to perform their statutory duties effectively whilst legitimately holding the Board of Directors to account. This is particularly in relation to governors' new powers and duties under the Health and Social Care Act 2012 which is outlined briefly on p.3 – p.5. The attached guidance presents some ideas on how this can be achieved.
DECISION/ ACTION	For information.

PA Consulting Group

Monitor
Independent Regulator of NHS Foundation Trusts

Director-governor interaction in NHS foundation trusts

A best practice guide for boards of directors

Monitor

Independent Regulator
of NHS Foundation Trusts

Monitor is the independent regulator of NHS foundation trusts. It was established in 2004 to authorise and regulate NHS foundation trusts. It is independent of central government and directly accountable to Parliament. There are three main strands to Monitor's work.

1: determining whether NHS trusts are ready to become foundation trusts;

2: ensuring that foundation trusts comply with the conditions they signed up to – that they are well-led and financially robust; and

3: supporting foundation trust development.

Under the Health and Social Care Act (2012), Monitor will become the sector regulator for health care. Monitor's core duty will be to protect and promote patients' interests. It will also have a continuing role in assessing NHS trusts for foundation trust status and for ensuring that foundation trusts are financially viable and well-led, in terms of both quality and finances.

In carrying out its sector regulator role, Monitor will license providers of NHS-funded services in England and exercise functions in three areas:

1: regulating prices;

2: enabling integrated care and preventing anti-competitive behaviour; and

3: supporting service continuity.

More information on Monitor's new functions can be found on its website.

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First published 2012 by Monitor and PA Consulting

Director-governor interaction in NHS foundation trusts: a best practice guide

The role of governors in NHS foundation trusts

Foundation trusts (FTs) are part of the NHS but are independently run and directly accountable to their local communities for the performance and strategic direction of the trust. This is achieved through the trust governance structure, in which a unitary board of directors is scrutinised by, and answers directly to, the governors of the trust.

Governors are the direct representatives of local community interests in FTs. The governing council, or council of governors as it is referred to by the majority of FTs, consists of public governors (and optionally patient, service user and carer governors), who are elected by the public members of the trust (people from the local community who have an interest in the strategic development of the organisation), as well as staff governors and appointed governors. Staff governors represent the interests of the staff members at the FT and appointed governors are representatives of key stakeholders such as commissioners, local councils, universities, local voluntary groups and charities.

The existing statutory duties of FT governors, under the National Health Service Act 2006, are to:

- appoint and, if appropriate, remove the chair and non-executive directors (NEDs);
- decide the remuneration and other allowances of the chair and NEDs;
- approve the appointment of the chief executive officer (CEO);
- appoint and, if appropriate, remove the trust's auditor; and
- receive the annual accounts, auditor report and annual report.

For further details of the existing statutory duties, please see Monitor's publication *Your statutory duties: A reference guide for NHS foundation trust governors.*

The Health and Social Care Act 2012 (the Act) changes some aspects of the role of governors, as listed below. The timing of the introduction of the additional responsibilities will become clear over the coming months. Please watch Monitor's website for further details.

New name

The Act changes the official name of the 'board of governors' to the 'council of governors'.

New general duties

- The Act confirms that the council of governors has a duty to hold the non-executive directors, individually and collectively, to account for the performance of the board of directors.
- It also has the duty to represent the interests of the members of the trust as a whole and the interests of the public.

Additional rights and powers

- The council of governors may require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the trust's performance of its functions or the directors' performance of their duties (and for deciding whether to propose a vote on the trust's or directors' performance).

- ‘Significant transactions’ must be approved by the governors. Approval means that at least half of the governors voting agree with the transaction. The trust may choose to include a description of ‘significant transactions’ in the trust’s constitution.
- The council of governors must approve an application by the trust to enter into a merger, acquisition, separation or dissolution. In this case, approval means at least half of all governors agree with the application.
- Governors must decide whether the trust’s private patient work would significantly interfere with the trust’s principal purpose, i.e. the provision of goods and services for the health service in England or the performance of its other functions.
- The council of governors must approve any proposed increases in private patient income of 5% or more in any financial year. Approval means at least half of the governors voting agree with the increase.
- Amendments to the trust’s constitution must be approved by the council of governors. Approval means at least half of the governors voting agree with the amendments. Amendments will no longer need to be submitted to Monitor for approval.

Additional responsibilities for the trust

- Before each board meeting, the board of directors must send a copy of the agenda to the council of governors.
- After the meeting, the board of directors must send a copy of the minutes to the council of governors.
- The trust must take steps to ensure that governors have the skills and knowledge they require to undertake their role.

Primary Care Trust governor

- There is no longer a requirement for a PCT governor. The trust may, but is not required to, replace the PCT governor with a governor from another commissioning body.

Panel for advising governors

- Monitor has the power to establish a panel of persons to which a governor can refer questions as to whether the trust has failed or is failing to act in accordance with its constitution.
- The council of governors must first approve the referral. Approval means at least half of the governors voting agree with the referral.

Role of members

- The trust must hold annual members’ meetings. At least one of the directors must present the trust’s annual report and accounts to the members at this meeting.
- The trust may combine the annual members’ meeting with the governors’ meeting which is held for the purpose of considering the trust’s annual accounts and reports.
- Where there has been an amendment to the constitution which relates to the powers, duties or roles of the council of governors, at least one governor must attend the next annual members meeting and present the amendment to the members. Members have the right to vote on and veto these types of constitutional amendments.

For more details on any of these points, please refer to the Health and Social Care Act 2012 or to the Trust Secretary.

Further non-statutory duties for governors, as currently specified in Monitor's *Code of Governance* include:

- to act in the best interests of the trust and adhere to its values and code of conduct;
- to hold the board of directors collectively to account for the performance of the trust, including ensuring the board of directors acts so that the trust does not breach the terms of its authorisation; and
- to regularly feed back information about the trust, its vision and its performance to the constituencies and stakeholder organisations that either elected or appointed them.

The *Code of Governance* will be updated in 2013 to reflect relevant changes in the Act, including the duty for governors to hold the board of directors to account via the non-executive directors specifically.

Sometimes the FT's own constitution will also specify additional roles for governors, such as "strategic guardianship".

An essential question for FTs is therefore how to develop successful interaction between directors and governors so that governors are able to perform their statutory duties effectively whilst legitimately holding the board of directors to account. This has been achieved to great effect in some trusts, although the model usually takes time to put into place.

About this guide

Monitor, working in conjunction with PA Consulting, conducted a research project to identify the key factors for establishing strong director-governor interaction within FTs. The findings are encapsulated in this best practice guide, which is aimed at existing FTs and aspirant foundation trusts.

Please note that it is not obligatory to adopt the approaches mentioned in this guide. These are simply ideas of best practice from FTs who are rated by peers and other stakeholder groups as being strong in the area of director-governor interaction.

The research involved interviewing the chair, CEO or senior independent director (SID), trust secretary and lead or other governor at 11 FTs. Areas of best practice were identified and are grouped in this guide for easy reference as follows:

1: building strong relationships;

2: shaping the optimal culture and mind-set;

3: defining processes and structures that work best;

4: supporting the delivery of statutory duties;

5: developing the governors as individuals and as a group;

6: the future role of governors; and

7: key advice to aspirant foundation trusts.

The format of sections 1 to 5 is as follows:

- an introduction to each topic;
- challenges typically faced by FTs in this area;
- 'considerations' to bear in mind when approaching these challenges;
- examples of good practice introduced by experienced FTs to address each challenge; and
- in some cases, 'take cares' to highlight things that FTs and aspirant trusts should take care to avoid.

Section 6 discusses changes to the role of governors following changes in the Act, while section 7 contains advice for aspirant FTs who are setting up new governance arrangements.

Acknowledgements

The following FTs participated in the research that informed this guide. We acknowledge their help and thank each of them for their time and interest in this piece of research.

- Bolton NHS Foundation Trust
- Bradford Teaching Hospitals NHS Foundation Trust
- Chesterfield Royal Hospital NHS Foundation Trust
- Lincolnshire Partnership NHS Foundation Trust
- Oxleas NHS Foundation Trust
- Queen Victoria Hospital NHS Foundation Trust
- The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
- Royal Devon and Exeter NHS Foundation Trust
- Sheffield Teaching Hospitals NHS Foundation Trust
- South Western Ambulance Services NHS Foundation Trust
- Taunton and Somerset NHS Foundation Trust

Contents

1 Building strong relationships

The research findings clearly demonstrate that the governors able to have the greatest impact are those who best understand the organisation they represent and its members. Whilst a structured induction can help to establish a baseline of knowledge, frequent and meaningful interaction with the directors and other key people is critical if governors are to sustain a broad understanding of the issues faced by the trust and how they are being addressed.

Key people with whom the governors should have regular contact are the chair, trust secretary and/or membership manager, senior independent director (SID), executive directors (EDs) and non-executive directors (NEDs) and the FT members whom the governors represent.

1.1 Role clarification

The foundation for effective relationship-building between directors and governors is a clear understanding by both groups of the responsibilities and boundaries of their respective roles.

Integral to this are the statutory duties of each group and a clear view from the trust on how it wishes to engage with governors and support them in carrying out these duties. This view may be developed internally, although some FTs have found it helpful to invest in external support to help define internal roles and processes.

Role clarification is a continuous process that needs to begin at the pre-election stage for each governor seat, be developed during the election and induction processes and be reinforced appropriately thereafter through ongoing training and interaction with the FT and its directors.

Challenges	Considerations	Examples of good practice
Some governors, particularly staff and appointed governors, are unclear about the purpose and extent of their roles. (Staff and appointed governor roles are discussed in greater detail in sections 1.9 and 1.10) Some trusts feel that governors can misinterpret the governor role, perceiving it to be the same as the NED role.	• The roles of the governor, chair, other NEDs and EDs, and the differences between the roles, should be clarified as an essential part of the governor election process, governors' induction and ongoing training. • FTs should also confirm the expected time commitment from governors before they stand for election, so people know what they are signing up for. • Details about the role should be provided to pre-election governor candidates and then reinforced again after appointment as part of the trust induction process, preferably in writing so governors can refer back to it. • Ongoing refresher training for all governors could include	• Pre-election, many trusts clarify the governor role in newsletters, websites and adverts asking for new governor candidates. Some offer 'being a governor' booklets or 'governor surgery' sessions, where prospective governors can talk to directors and existing governors and hear what the role entails. It can be particularly helpful to involve directors in these sessions, as it demonstrates that the governor role is valued by the trust. • Other trusts have specific governor and member websites where the governor role is set out. • After election, many trusts offer one-to-one meetings between the chair and/or trust secretary and each newly appointed governor to confirm the requirements of the role.

Challenges	Considerations	Examples of good practice
	revisiting information about, and clarification of, the different roles.	• Some trusts have job descriptions, a code of conduct or memo of understanding to which governors sign up, indicating that they understand the requirements and boundaries of the role. Some trusts ask third parties to review these documents on a regular basis. • One trust provides governors with a list of 'must-dos' and a separate list of more discretionary areas. • One trust has circulated a 'how we work' paper, setting out committees and processes, which is refined over time.
When a large proportion of governors stand down at the same time, it can be difficult for the council to maintain continuity and understanding of the role.	• The lengths of governor terms of office can be varied so that elections are staggered and new governors appointed at different times.	• Some trusts vary the initial governor terms between one, two and three years.

1.2 Chair – interaction with governors

The role of the chair with the governors is absolutely critical. In trusts where the model works well, the chair typically puts a significant amount of time into developing the relationship with his or her governors and ensuring that the information flow to and from governors is effective. Some chairs say that this area takes as much as 50% of their time in their dual role as chair of the board of directors and chair of the council of governors.

One trust secretary estimated that 60% of the effectiveness of the director-governor relationship is determined by the personality and mind-set of the chair and 40% by the processes which the trust has put in place.

A number of chairs stated that 'openness' and 'transparency' were of the utmost importance when working with the governors.

Challenges	Considerations	Examples of good practice
• Chairs need to engage effectively with the council of governors so that they are comfortable working together and each party can achieve the purposes of their respective roles.	• The chair has the most formal contact with governors and should supplement this with informal contact where possible. • Chairs can foster engagement through an open-door policy, which encourages governors to drop-in/call/email as frequently as they wish if they have issues to raise. • Chairs might also meet governors, or a subset of governors, in scheduled meetings outside of formal governor meetings, to answer questions or confirm decisions taken by the board of directors, especially	• One chair has a 'no-surprises' agreement with the governors, granting them the freedom to call or drop in on the chair and directors at any time on the understanding that they use this time to ask questions and share any concerns in private prior to raising them in a public forum. • Some chairs schedule informal meetings with their lead governor in between formal council meetings. One model is for the chair to meet the lead governor shortly after the formal council meeting to confirm actions from the meeting and clarify how best

Challenges	Considerations	Examples of good practice
	where director meetings have been held in private. • It is important for chairs to show governors that they are respected and that their work is valued.	to complete them. The chair and lead governor then meet again midway between council meetings to update on progress, enabling the chair to intervene and offer support if there are any challenges or blockages and to discuss the agenda for the next meeting. • A number of chairs schedule one-to-one meetings with each new governor to give the new governors the opportunity to clarify their expectations and express their key interests. • The chairs of many trusts convey the message that governors are respected and valued by ensuring that as many directors as possible attend council of governor meetings.

TAKE CARE

- Chairs should avoid creating any kind of "inner sanctum" and should try to involve all governors as much as possible.

1.3 Chief executive officer (CEO) and other executive directors (EDs) – interaction with governors

In high-performing organisations the CEO and EDs take an active involvement in the business of the governors and commit time and effort to developing an effective relationship with them. The EDs are the senior management of the organisation and are responsible for running the trust. Having access to them at appropriate times is therefore necessary to enable governors to ask questions and have influence.

Challenges	Considerations	Examples of good practice
• Some CEOs and EDs find it difficult to develop a meaningful relationship with the governors due to insufficient face-to-face time. • Some CEOs and EDs do not believe themselves to be accountable to the governors, so do not feel they need to interact with them directly.	• Opportunities for contact between the CEO/EDs and governors can take place formally at council of governor meetings and other joint meetings and through more informal methods. • Joint meetings of the board of directors and council of governors are extremely helpful, particularly at trusts where board of director meetings have been held in private. • It is less common for the EDs to attend all council meetings as they are more likely to be involved in the work of specific subcommittees. However, directors and governors have said it is helpful to have the opportunity to invite the EDs to the council as and when their input is required. • Where necessary, the chair should remind the CEO and EDs that the governors have the right to summon them to a meeting, even though the governors are officially tasked with holding the board to account via the non-executive directors.	• In many trusts the CEO attends all council meetings, typically to give a performance report and take part in a Q&A session. • The EDs usually attend some meetings, often to present their particular areas of work. • One trust CEO briefs the council of governors at a bi-monthly, one- to two-hour session and also attends all subgroup and committee meetings as needed. The same CEO attends a bi-monthly walkabout session with a different governor each time, involving visits to wards to further learning. • At the trusts interviewed, formal joint meetings between the council of governors and board of directors were held at least twice yearly and these were often supplemented by frequent informal communication and subcommittee meetings in between.

TAKE CARE

- EDs may not be directly accountable to the council of governors, however, they are accountable to the NEDs who are in turn accountable to the governors. The council must also approve the appointment of the CEO and, under the Act, have the right to summon executive directors to a meeting, so executive directors should also seek to establish and maintain a productive working relationship with governors.

1.4 Non-executive directors (NEDs) including the senior independent director (SID) – interaction with governors

In addition to the role played by the chair, the SID and other NEDs play a key role in interacting with the governors.

NEDs do not undertake executive responsibilities for the FT but sit on the board of directors to bring external expertise that allows them to challenge and scrutinise the decisions of the EDs. The governors' role, as stated in the Act, is specifically to hold the NEDs individually and collectively to account for the performance of the board of directors and to represent the interests of the members of the FT within this.

Generally the SID is appointed by the board of directors in consultation with the council of governors and acts as a point of contact should discussion through the normal channel – i.e. via the chair – prove to be unsuccessful or inappropriate in a particular instance. Should the appointed SID also be unavailable it would be appropriate for governors to discuss the issue with another of the NEDs. As is the case for the chair, a SID who is open and readily accessible to the council of governors is likely to benefit most from the insights that governors can offer.

Challenges	Considerations	Examples of good practice
• Governors have a responsibility to appoint and appraise the NEDs and to determine their remuneration and allowances. The NEDs also have a role to play in supporting the governors should governors feel there are issues that they cannot discuss with the chair. It is therefore in the interests of both groups to maintain regular interaction and keep the other well informed of their intentions and activities. • A frequent complaint by governors is that they don't see enough of the NEDs in action to assess their performance. This is especially the case in trusts where board of director meetings have been held in private and where NEDs do not regularly attend council of governor meetings.	• The participation of NEDs in council of governor meetings, subcommittees and other meetings and events enables the governors to see the NEDs in action.	• In one trust the job description for NEDs includes attendance at all council of governor meetings. In another, it includes attendance at at least two council of governor meetings per annum. • NEDs at another trust attend council of governor meetings on a rotating basis and give a presentation on their respective portfolios of responsibilities so governors understand what they are involved in. Given that NEDs are busy and commit limited days to the work of the trust, this is a practical way for governors to meet all the NEDs over time. • One trust holds quarterly meetings between the governors and NEDs without the EDs being present, so the group can discuss strategic issues. • In many trusts NEDs and governors also work together on governor subcommittees or working groups, which allows governors to become familiar with the NEDs and their work, and also to understand the trust decision making processes. • One trust holds quarterly away days for the board of directors and invites a handful of governors to attend on each occasion. This gives directors a chance to get to

Challenges	Considerations	Examples of good practice
		know a few governors at a time rather than meeting en masse. • The SID is typically involved mainly to chair council meetings if the chair is absent, and to work with the governors when assessing the performance of the chair and setting the chair's remuneration.

TAKE CARE

- Although the board of directors should act as a unitary board, the Act asks governors specifically to hold the NEDs to account for the performance of the trust, so it is critical to ensure sufficient working time between these two groups.

1.5 Trust secretary

The trust secretary is another critical point of contact for governors and it is his or her role to ensure appropriate information flows between directors and governors on a timely basis. The trust secretary, or a member of his/her team, will coordinate the scheduling of council of governor meetings and timely distribution of agendas and minutes. He or she should also be available to provide administrative support to help the governors perform their duties.

Trust secretaries typically commit around 30% of their time to governor-related duties and usually have a significant amount of support from a PA and/or membership manager to assist with this. Trusts and governors alike agree that the trust secretary undertaking his or her role with interest and enthusiasm is integral to the success of the governor role.

Challenges	Considerations	Examples of good practice
• There is a critical role to play in acting as the first point of contact with governors and organising meetings and all communications between directors and governors.	• The trust secretary (or in some cases membership manager) should be the first point of contact for governors. He or she can liaise with directors in order to answer questions from the governors and set up meetings where necessary.	• In some trusts the trust secretary attends governor forums and subgroups in addition to the main council meetings in order to capture potential agenda items for council meetings, take minutes and record action points. • Governors greatly value receiving meeting agendas and minutes on a timely basis. Many trust secretaries aim to ensure meeting minutes are sent out within two weeks of council meetings. • The trust secretary/membership manager should also send out a meeting planner for the year ahead so all know when the various meetings are scheduled.
• FTs need to decide how best to organise governor training and the	• The trust secretary and/or membership manager should create and update an induction pack for new governors, with	• This task is managed by the trust secretary in most trusts, and materials are tailored to the governors' levels of understanding

Challenges	Considerations	Examples of good practice
production of induction and other training materials.	input from the relevant directors.	and time available for the training. • Induction usually includes details about the trust, profiles of the directors, a job description for the governors and information on the meetings and structures in place. It may also include information on the NHS and wider structures.

TAKE CARE

- The trust secretary usually works for the chair, so the chair should recognise the importance of the trust secretary's role with the governors and ensure that he or she has sufficient time or staff resource to devote to this area.

1.6 Governor recruitment – role of directors

It is essential for trusts to continue to generate enthusiasm amongst members for standing in governor elections. Governing councils need to be complete and refreshed with new governors on an ongoing basis to ensure the task of holding the board of directors to account is undertaken with the appropriate level of challenge.

Challenges	Considerations	Examples of good practice
• Previous research has concluded that it may become more difficult over time for trusts to encourage sufficient numbers of people to stand for governor elections, with the numbers of candidates per seat typically falling after authorisation, especially in staff governor constituencies. • The proportion of uncontested elections in FTs overall has also risen considerably since the inception of the FT model in 2004.	• Directors should consider taking an active involvement in the recruitment process. It is important that they at least have oversight of the governor job description and any advertisements so that they, in addition to the governors, are satisfied with what is being asked for. • The involvement of directors in recruitment also helps to demonstrate to potential candidates that directors take the governor role seriously and value its contribution.	• In most trusts the trust secretary initially drafts a governor job description, often working together with the governors. Directors usually give input into this process as well. • During the recruitment process most trusts find it beneficial to hold open sessions where potential candidates can meet the directors and current governors. This indicates the trust's commitment to the governors and gives directors an opportunity to be clear with candidates about what falls within and outside the governor role. • Some trusts also choose to put out adverts identifying any particular skills that are needed, in order to encourage candidates with that skill set to apply.

1.7 Lead governor role and interaction with directors

The lead governor role was originally intended by Monitor only to be a point of contact between Monitor and the trust in exceptional circumstances where Monitor might need to contact the governors directly, or vice versa. This was expected to be in the case of a

potential breach of the Terms of Authorisation, an unresolvable issue with the chair or improper conduct of the trust election process.

Challenges	Considerations	Examples of good practice
• Many FTs have gone on to broaden the lead governor role and to instil this with a range of wider responsibilities. This presents its own set of challenges as the role is not defined other than by individual trusts and confusion can arise. • For information, we therefore detail examples of the lead governor roles which are being carried out, but from Monitor's perspective there is no compulsion for trusts to adopt any of these approaches and Monitor does not endorse any particular model.	• The lead governor is most likely to play a role where the chair cannot be directly involved, such as in the performance appraisal of the chair and setting the chair's remuneration, in which cases the lead governor is most likely to work closely with the deputy chair or SID. • The lead governor often also becomes a communicator between the chair and other directors, and the wider council. For example, the chair often meets the lead governor in separate sessions outside of the main council meetings to discuss issues, training and meeting agendas or to report back decisions from previously private board meetings. • Where trusts choose to expand the role of the lead governor, the council of governors should discuss what they would like the role to include in order to create a definition of the role. The council should be allowed time to draw up this role description and it is important that the chair supports this process but neither the chair nor other directors should become involved in the appointment. The governors alone should vote or otherwise agree on who they wish to become the lead governor.	• The lead governor at one trust gives a presentation at the Annual Members' Meeting and/or Annual General Meeting, oversees the governor training programme, attends governor induction sessions with the chair and attends a private weekly briefing by the chair on key issues for wider dissemination to the other governors. • The lead governor at another trust runs a private session just for governors before the formal council meeting to raise key issues for discussion. • One trust sees the lead governor role as a point of contact between the chair and the governors but also as a pastoral role, particularly for new governors. • One trust regards the role as essential in pulling together the "feeling" of the full council. • Some trusts have chosen not to have one lead governor but rather to have chairs of different working groups, and a lead governor in name only as the point of contact with Monitor.

TAKE CARE

- The board of directors should not be involved in selecting the lead governor. The individual should be chosen by the council of governors, either by consensus or by formal vote.
- The lead governor should not deputise for the deputy chair of the board of directors.

1.8 Patient/carer/service user governors

Specific constituencies for these groups are optional and some trusts have chosen not to have them as they feel the groups are already well represented within public governor constituencies. When considering whether or not to have specific constituencies, it is important that trusts reflect upon the role patient, carer and service user governors could play. The trust should think about whether there are any specific aspects of the work of the council where their experience would be particularly useful and where it would be important to guarantee that a patient, carer or service user governor were in post.

Challenges	Considerations	Examples of good practice
• Patient, carer and service user governors often have very valid points to make and can give great insight into the patient or service user experience at an FT. However in some cases they may have more difficulty interacting with other governors and with directors or may have difficulty attending meetings due to illness	• Establish whether additional training or guidance would be helpful for patient, carer and service user governors. • Are any special arrangements needed, such as transport to council meetings or ways to communicate ideas other than in a public forum? • Consider how best to use their insight and skills; this might include involving them in patient/service user experience or quality working groups. • Public governors in particular often find the insight from patient, carer and service user governors extremely helpful, so chairs should seek to ensure different governors get a chance to speak to each other.	• One trust conducts a skills audit for all governors to identify areas where additional training or support is needed to help them fulfil their roles. • One trust has an 'issues log' in which governors may raise potential issues or ideas. This may be an easier way for patient or service user governors in particular to raise points than in a full meeting of the council of governors. • One chair ensures that service user governors are seated on tables with other public governors, staff governors and directors at council meetings so their views can be included within discussion. • One chair interviewed is firmly of the belief that her service user governors are where the real value of governors lies for her trust.

TAKE CARE

- Be careful to ensure that the views of patient, carer or service user governors are not missed because mechanisms for their effective communication are not in place.

1.9 Staff governors

Often FTs find it difficult to define, and recruit to, the staff governor role. As with all governor roles, no definition of the staff governor role is given in legislation so trusts interpret the role in different ways.

One way to distinguish between staff representatives and staff governors is that governors should be looking at the FT from the staff member perspective and assessing the board of directors' performance accordingly.

It is also worth remembering that public governors often find the views of staff governors extremely helpful in their understanding of how the organisation works.

Challenges	Considerations	Examples of good practice
• Staff governors sometimes find it difficult to understand the purpose of their role. • Staff governors may misunderstand the role and seek to use it as an additional channel for matters which should be reserved for unions and other representative bodies.	• The purpose of the staff governor role is no different to the role of public or appointed governors. It is to hold the board of directors to account for the performance of the trust and to represent the interests of the (staff) members who appointed them and of the public. It is the opportunity for staff to influence the strategic direction of the trust on behalf of these members. • Directors may contribute to the understanding of the staff governor role and arising issues by taking time to meet staff governors separately and away from full council meetings. • As for all governors, induction training should include a clear understanding of what the staff governor role does and doesn't involve. It can be helpful for the chair to take additional time with staff governors to go through any uncertainties around this.	• At one trust, the CEO asked staff side representatives to detail what they wanted the staff governor role to include. Staff governors also speak at road-shows to staff so staff know who they are and what the role involves. • One trust chair describes the staff governor role as giving the 'helicopter view' and 'more strategic role' than staff representatives.
• Staff governors may find it difficult to voice their views freely, fearing their managers may not approve.	• The chair might assist by arranging opportunities for staff governors to give their views in a supportive environment.	• One chair meets staff governors as a group every other month to go through any key issues they would like to raise. She also regards this as a helpful staff 'temperature check'. The chair will then take forward important issues to raise at board meetings. • At one trust, the chair, HR director and trust secretary meet staff governors between full council meetings. The same trust offers one-to-one meetings between

Challenges	Considerations	Examples of good practice
		potential staff governor candidates and the trust secretary to go through the scope of the role. • One trust has a staff governor suggestion scheme, in which staff governors support and put forward any strong ideas from members of staff. • One trust includes a staff governor on all working groups in order to include a staff view on all matters. • Another trust wanted staff governors to give input by way of new ideas, and has found this works best through membership of relevant subcommittees.
• Staff governors may find it difficult to take time away from their day jobs to carry out the responsibilities of the role, especially if they perceive their manager as not being supportive of this.	• The chair might assist by arranging schemes where staff governors are able to take a certain amount of time out from their day jobs without their departments being penalised.	• One trust offers 20 hours per month that can be backfilled for staff governor duties where relevant, although to date no department has taken this up.
• It may prove difficult for trusts to attract sufficient staff governor candidates, especially from junior staff who may perceive that the role is reserved for more senior staff members.	• Directors might assist staff governor recruitment by ensuring that staff elections are well publicised, and that the role of staff governors and their achievements are widely highlighted to staff members, as well as by speaking about the staff governor role so it is seen to be valued.	• One trust has a weekly e-bulletin to staff which includes information about who is standing as a staff governor. This is also communicated via an information area on every payslip. • One trust has a separate web page for staff governors so directors can communicate easily with them and members can see the activities they have been undertaking. • Another trust holds constituency-specific staff governor meetings and their staff governors carry business cards with their role. The chair also conducts exit interviews with all staff governors in order to learn what might be done better for future staff governors.

TAKE CARE

- The staff governor has the same statutory responsibilities as public and appointed governors, but may experience additional challenges in trying to carry out their role. Directors should not dismiss these difficulties and should use their positions to support staff governors so they are able to carry out the role effectively.

1.10 Appointed governors

Like the staff governor role, there is no formal definition of the role of the appointed governor, so it can be difficult for appointed governors to understand. Again, it is imperative for trusts to clarify the role and what is being asked of appointed governors on their appointment.

Challenges	Considerations	Examples of good practice
• Appointed governors frequently do not attend meetings or provide other input. It can be difficult to find individuals who are able and willing to attend and contribute consistently.	• When setting up its initial constitution, the trust should think carefully about the organisations from which it wishes to have appointed governors. • The chair should also make it clear to organisations invited to appoint a governor what the role involves and what will be expected of the appointed individual. • Trusts may consider changing their constitutions if the numbers of appointed governors, or the represented organisations, become inappropriate.	• At one trust the chair writes to organisations with appointed governors asking for an explanation for any non-attendance. • At another, the lead governor is an appointed governor, demonstrating that some are willing to become involved, and indeed might offer more when taking on specific responsibilities such as lead governor or membership of subcommittees.
• It can be difficult to know what level of seniority will work best in the role.	• The chair should ask the organisation to appoint the most appropriate individual for the role, ensuring that the organisation understands what will be involved.	• One trust believes that the value of an appointed governor is someone who does not already have a relationship with the trust, but who can potentially make a difference. The trust believes it is better not to appoint somebody too senior, as they find more senior people may not have the time to give.
• Appointed governors may sometimes experience a conflict of interest between their duties to their primary organisation and duties as an FT governor.	• This is something trusts find difficult to resolve. Appointed governors should be asked to declare an interest in discussing matters such as contracts or significant transactions.	• In some trusts, appointed governors voluntarily leave the meeting if an issue involving a conflict of interest is being discussed.

2 Shaping the optimal culture and mind-set

2.1 Mind-set

Developing the right mind-set within the trust is essential for the governor model to work successfully. This requires planning and the willingness of directors to commit time and effort to training and supporting the governors, and also to demonstrating that they value governors' contribution to the trust. The chair is integral to developing a constructive mind-set, but the whole team of directors impacts on this. Once an effective culture has been established, this is likely to be self-regulating as people buy into the attitude and way of working.

At the core of creating the optimal culture and mind-set is professionalism. Organisations with governors operating effectively repeatedly gave answers exhibiting the professional approach they had taken to recruiting, training and working with their governors. Those interviewed agreed that the time and effort was worthwhile because the resulting returns from the model were so much greater.

Challenges	Considerations	What do other trusts say/do?
• A message that came up repeatedly during the research is that FTs with successful governance arrangements value their governors. The challenge lies in conveying this effectively and avoiding appearing only to pay lip service to the council. There is a danger that governors can otherwise feel they have only a superficial relationship with directors.	• Give governors plenty of time at the beginning of the relationship to get to know directors and each other. Encourage an open culture wherein governors can email, call or meet with the chair to discuss issues. • Involve governors early on in agreeing job specs so all know what they are there to do. • Aim for joint working rather than "discussions". • If something isn't working, ask the governors why and how to improve it.	• "It's not a 'problem' having governors involved." • "We're all in this together." • "We have an integrated but independent approach." • "They are as important as I am." (Chair) • "It's like having a conscience." • "We're all here to learn and to build the place." • "The council of governors can be your best friend or your worst enemy. The board of directors needs to be facilitative and flexible in its approach to the governors." • "Be very clear about roles and responsibilities. Mind-set is part of a broad accountability framework in which all are partners with a role and stake in the organisation." • One trust chair asks governors how they want to "do business" and sets processes in place accordingly.

Challenges	Considerations	What do other trusts say/do?
• It is critical to build trust in directors so governors are confident in them to do their job.	• Consistency and open communication are vital for the development of an effective working relationship. Be transparent with governors and provide information or answers requested on a timely basis. • Directors and governors should not work in a collusive way, but in a way that develops and supports the skills of governors and includes everyone, not just a few governors with certain skills.	• In one trust the chair gives information on arising issues to the governors before his co-directors so governor thoughts can feed into the subsequent board discussion. • One chair shows trust in the governors by providing all information they ask for. Should this trust be breached, he says he may decide to withdraw information, but he reports that "this has never happened so far". • “Always have conversations in the room and not afterwards.”

TAKE CARE

- Trusts must ensure the relationship between directors and governors does not get so "chummy" that the governors are no longer able to hold the board of directors to account effectively.
- It can be tempting for directors to hand-pick a few experienced governors to spend more time with and to offer this group greater responsibility. However, this is divisive and will make other governors feel their voices are not being heard. Trusts should remember that it is the council of governors as a whole which has statutory responsibilities and power, not individuals or subgroups of governors.

2.2 Attendance at council of governor meetings

Attendance by governors at council meetings is essential to ensure that members are being appropriately represented. Where governors are engaged in the process and feel they are making a valuable contribution it is likely that they will want to attend. At the trusts interviewed, typically 70-90% of governors attend all council of governor meetings. However, there are inevitably times when some people do not attend; if this happens repeatedly it may need to be addressed.

Challenges	Considerations	Examples of good practice
• Governors are part-time, unpaid volunteers and will have commitments beyond the FT. Meetings need to be well organised and well run with an open and communicative culture to ensure that governors feel their attendance is worthwhile.	• If governors are repeatedly failing to attend meetings it is important to contact them to find out why. • Schedule meetings as far in advance as possible to encourage good attendance. • When planning meetings, take into account governors' other commitments. For example, it may be necessary to hold evening meetings or to vary the times of meetings so that governors with work or family commitments are not excluded.	• Most trust constitutions set a minimum level of attendance and the chair or trust secretary will call or write to governors whose attendance falls below the minimum. Governors may also be asked to stand down for repeated non-attendance. • Where a governor consistently misses meetings, one trust gives the other governors the chance to vote to decide whether or not to keep the absent governor. • The chair at one trust writes to the absentee stating that if the governor does not contact the chair then he will assume the governor has stepped down. • At another trust, if a governor misses two consecutive meetings he/she must write to the chair and CEO to explain why. • Most trusts schedule meetings a year in advance to ensure governors receive adequate notice and can plan accordingly. • One ambulance trust has decided to rotate the location of their meetings to give governors from all over the region a chance to attend.

TAKE CARE

- Remember that governors may not find it easy to travel and that meeting time should be maximised to make the travel time worthwhile for them.

2.3 Impact of governors

Governors undoubtedly have an impact simply by undertaking their statutory duties, but there is often a desire amongst the council itself and amongst directors to see a tangible benefit from the governors' work. However, many of the perceived benefits that governors bring are relatively intangible, which can make them difficult to measure.

Many trusts report that the governors' greatest impact is the shaping of the trust mind-set towards the needs and experiences of patients or service users and local people, rather than just towards the operating framework. Some trusts say that critical questioning from governors forces good preparation by the executive team, and others have clearly changed some of their approaches to measuring trust performance as a result of governor questioning.

Challenges	Considerations	Examples of good practice
• Having a visible impact can be difficult for governors to achieve without a clear idea of where their efforts should be focused.	• It is important for directors and governors to agree areas of responsibility and be clear about their respective objectives. • A number of trusts say governors have an impact as they "bring the trust and directors down to earth", "make us think" and "act as a voice over the shoulder or additional conscience". It is important that these messages are communicated clearly to the governors, via the chair, to make it clear to them that they are making a difference.	• Some trusts hold informal meetings of the governors in advance of the formal council meetings to allow governors to discuss and interpret information as a group. The chair feels that this results in better discussion in council meetings and allows governors to structure their thoughts and have a greater impact. • At one trust, governors have portfolios of responsibility and work with the director responsible for that area of the trust, e.g. the 'patient experience governor' works and attends meetings with the director of nursing and the 'finance governor' does the same with the director of finance. • At several trusts governors contribute to questions in the patient survey and in one trust the governors conduct the survey themselves, meeting with and interviewing patients before feeding information back to the directors. • One trust has a 'governors issues group' which helps to find out problems of which directors are often unaware. • At another, the governors raised a need for greater marketing and awareness of the trust, and this is now being addressed. • As part of the chair appraisal at one trust, one action point for the chair was to include more agenda items on quality and strategic

Challenges	Considerations	Examples of good practice
		items and this is now being done. • Governors at one trust have been involved in a project to reduce "Did Not Attends", with great success. • At another trust the directors now measure the rates of MMSA as well as C. difficile and MRSA, as governors questioned why they were not already doing so.
• Governors are often thought to have greater impact on quality than on strategy in general.	• Trusts need to find effective ways of incorporating governor and member views into ongoing strategic planning. • Governors may additionally play an increasing role going forwards in helping to promote the trust's services to commissioners and other external stakeholders.	• Most trusts involve governors in strategy and planning days, which may also include members. • In one trust governors were able to lend support to an initiative to rebuild an old surgical unit, which may have helped the case in obtaining funding from the strategic health authority. • In another trust governors are joining patient participation committees on new local clinical commissioning groups, moving towards the idea of a "Senate" of governors of the whole local health economy.

WHAT TRUSTS SAY

- “Now there are three regulators - Monitor, the Care Quality Commission and the governors."
- "The attitude is; “What will the governors think about this?” It pushes items higher up the agenda."
- "Governors keep bringing you back to the patients and the patient experience."
- "The aim is to get directors to the mentality of "I really had to think there" when answering questions from governors."
- "Bringing the trust down to earth - making sure the patients/public are always in the room."
- "Bringing a staff perspective to debates."
- "Helping to choose priorities for quality reports."
- "Governors make us think. Whereas volunteers may come and go, the governors sustain."
- "The governors are a way of testing things out with a trusted dialogue and seeing the reaction."

3 Defining effective processes and structures

The composition of the council of governors is decided locally by the trust whilst ensuring that the balance of staff, public and appointed governors is maintained. Councils are required to complete their statutory duties each year; the way in which they organise themselves to do this is at the discretion of the trusts and councils themselves.

Much like the other elements of the role, a lack of professionalism can lead to an ineffective governing body. It is important that processes and structures are formalised to ensure consistency across the activities in which governors are involved. Robust processes are critical; governors may not be re-elected or may choose not to stand again and staff may move on, so processes are needed to support the governance model through any such changes.

3.1 Council of governor meetings

Council of governor meetings are typically held four times per year, although in some trusts the council meets as often as every six weeks. The attendance of board directors at council meetings varies, although chairs and chief executives almost always attend. Usually trusts also hold joint meetings of the board of directors and council of governors to allow for greater communication and discussion between the two groups.

Challenges	Considerations	Examples of good practice
• It can be difficult to maintain continuity when the council of governors meets only four times per year.	• Meetings in between formal council meetings, such as joint meetings of the board of directors and council of governors and subcommittee meetings, can be helpful in maintaining continuity. In some trusts the governors themselves also set up subgroups and interim meetings for this purpose.	• One trust has a separate governor steering group, to which governors elect eight public governors. This group meets monthly and receives performance reports on finance, quality and manpower from the CEO, which the group then disseminates back to the full council.
• NEDs are often too busy with other trust matters to attend all the council of governor meetings, which may mean governors do not interact very much with the NEDs.	• As well as the attendance of NEDs at council of governors meetings, joint meetings of the directors and governors or other meetings between governors and NEDs can help to build relationships.	• At some trusts NEDs rotate attendance at the council of governors, whilst at others the NEDs' contracts specify a certain number of required attendances. • One trust asks all NEDs and EDs to attend council meetings, which have become "very real meetings with lots of questions".
• Governors may need additional time to meet, with or without the chair being present, as well as formal council meetings with the chair and other directors present.	• Try to ensure that governors are supported in any additional meetings that they choose to hold amongst themselves.	• In many trusts governors hold separate meetings in between or immediately before formal council meetings. The chair may or may not be invited to these sessions, which are often chaired by the lead governor.

Challenges	Considerations	Examples of good practice
		• One trust has a separate “Governors' Forum”, composed of governors only, which meets monthly to discuss agenda items for the full council meetings. The wider council nominates governors to become members of this forum, and membership is rotated annually.
• Meetings are not always held at a convenient time of day for all governors to attend.	• Consider governors’ commitments and be flexible about meeting arrangements in order to enable governors to attend.	• Some trusts vary the times of day at which governor meetings are held, or hold them in the evening to allow as many people to be able to attend as possible. • At one trust council meetings start at 5pm with a briefing from the chair, followed by performance reporting from the CEO. The meeting is followed by supper and small, mixed group discussions.
• Some governors may lack the confidence or knowledge to participate fully in meetings.	• Think about innovative ways to encourage all governors to participate in meetings, for example setting out the room cabaret-style and seating governors at tables with EDs, NEDs and different types of governor, or giving governors voting devices to give their views.	• One trust has moved to a more "workshop" style of council meeting, where governors and directors discuss issues in smaller groups together and report back to the full meeting afterwards. • Different styles can work well. One chair reports in particular how helpful humour is at council meetings and how it is important not to become too formal.
• The size of the council of governors can make it difficult for everyone to raise their views and questions, or sometimes to debate topics effectively and make decisions.	• It is very important to consider the optimum council size carefully when first setting the constitution in place.	• Many trust chairs believe that the most appropriate size of the council might be between 20 and 25 governors. Some trusts are reconsidering the most appropriate size for their councils.
• Some trusts feel that governor meetings are not always productive.	• Trusts might consider having action logs from governor meetings which are revisited at the next meeting to ensure agreed actions have been followed up by all parties. The trust secretary or membership manager typically attends all council meetings to take minutes and capture these action points. • Sometimes a briefer agenda, with a rotating focus on a few key issues can be more productive than trying to cover many topics.	• At one trust, governors have their own business plan and steering group to monitor their own progress. • Another trust uses a "you said, we did" approach in reporting back to the council of governors. • Most trusts have a range of subcommittees or working groups so that business can be split into more manageable areas, to which governors can contribute more specifically.

Challenges	Considerations	Examples of good practice
	• It is important to ensure governors have a general Q&A session so they can ask any questions. Some may have travelled a long way to attend the meeting, so it can be frustrating if there is no time to ask questions.	

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- It is the full council of governors which has statutory duties and power in statute. Take care that the trust does not promote some governors into "more important" roles than others or imply that some people's opinions are less worthwhile.
- It is the chair's responsibility to manage council of governor meetings so that they are productive for all concerned, and to ensure that a few individuals are not allowed to dominate. Change in constitution size should be a last resort only if it is agreed by all that there are too many governors to have effective meetings.

3.2 Joint meetings between directors and governors

Once legislation has been adopted, the Act will require board of director meetings to be held in public. This may help to address the concerns of some governors who felt they had insufficient opportunities to see NEDs in action because board of director meetings were held in private.

Despite this statutory change, joint meetings between directors and governors are expected to continue to be helpful as they are likely to continue to operate differently to main board meetings. Governors are also unlikely to have time to attend director board meetings on a regular basis.

Anticipated challenges	Considerations	Examples of good practice
• Governors may not feel they should participate in public director board meetings and are likely to need separate meetings with NEDs to discuss strategy in particular.	• Try to ensure that governors and NEDs have sufficient time together to discuss strategy, with or without EDs being present.	• Most trusts currently hold joint meetings between the board of directors and council of governors, which may be structured as 'strategy days', 'away days' or 'joint working groups'. These are typically held four or five times per year with attendance by a rotating subset of governors. • Some trusts schedule meetings between governors and NEDs only, to allow these groups an opportunity to get to know each other and discuss the strategic approach. • At one trust governors are buddied up with NEDs so they can get to know them and their work better. • At another trust, NEDs take turns to present their portfolios of work to council meetings so governors have a chance to ask questions on each area.

Anticipated challenges	Considerations	Examples of good practice
• It is unlikely that all governors will have time to attend board of director meetings on a regular basis.	• Some councils might decide to arrange to rotate governors' attendance at board meetings. • Currently most trusts send out a summary of the board's decisions to governors after board meetings, or in some cases the chair meets the lead governor to impart the key decisions and reasons behind these. It is likely that this will continue to be helpful. A summary may be more useful than the full board reports, but it is important to agree the level of detail with the governors.	• At one trust there is currently a non-voting governor representative on the board of directors. The governor is nominated by the full council, with nominations rotated annually, and he/she can observe and speak at meetings, but may not vote. The governor then reports back on the matters discussed to the full council. • At one trust, the three key points to come out of the current Part Two meeting (which is where directors currently meet in private separately to the main open board meeting) are sent out to all governors by email. • The chair of another trust puts together two pages of A4 with the decisions and discussions from the Part Two meeting, but governors may ask for more information if they wish. • Governors at one trust receive the full performance reports coming out of the Part Two meeting.

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- Directors should not identify a subset of governors to brief on decisions from board meetings. Any such group should only be chosen by the governors themselves.
- Any decisions about which governors attend board of director meetings should be taken by councils themselves and not by directors.

3.3 Subgroups

Most trusts have various subgroups or working committees to which different governors belong. These are not set out in legislation but trusts have found it an effective way to break down discussion and tasks into manageable units and to manage communication between the board of directors and the full council of governors. These governor working groups should be distinguished from formal committees of the board of directors, which must include the nominations committee, audit committee and remuneration committee. Governors will sit on the nominations committee when appointing a chair or other NEDs, but otherwise these three committees are committees of directors. Governors may of course be invited to attend in a non-voting capacity.

Challenges	Considerations	Examples of good practice
• The council of governors is likely to be a large body and is not always the most effective forum for debating issues in detail.	• In most trusts, various subcommittees work to support the activities of the board of directors and council of governors. • Subcommittees are most effective when they are sponsored and attended by members of the board of directors to ensure that they carry weight. It can be helpful for NEDs to chair the different subcommittees to increase working time between NEDs and governors. • Governors themselves should decide who attends the different subcommittees. Governors will also often chair and organise these working groups, with the support of the trust secretary. • Governors should not normally be allowed to be members of all subcommittees/working groups. Many trusts restrict membership to a maximum of two per governor. • Many trusts also set up temporary working groups, set up to address specific projects or issues.	• Examples of common subgroups in place include: – nominations committee; – quality and patient experience (often supported by the director of nursing); – planning (often supported by the director of strategy); – audit (often supported by the director of finance); – membership/communication (often supported by the communications team); and – remuneration and recruitment (often supported by the director of HR). • More unusual subgroups include: – scrutiny committee/standards committee; – constitution committee; – social inclusion committee, psychological therapies committee, accessibility and awareness committee (mental health trusts); – quality assurance group; – Care Quality Commission group; – patient and public assurance group; – charitable funds group; – patient involvement committee; and – business management group. • One trust has an additional "issues group" which is chaired by the SID and obtains feedback from 1,000 members on issues within the trust. • All governors at another trust can

Challenges	Considerations	Examples of good practice
		email the chair of the patient experience committee with "nice to know" items, which can be fed back to the board where relevant.
• Deciding which subgroups to have and which governors should attend each subgroup requires consideration.	• Subcommittees and working groups tend to fall into natural groupings based on their objectives: – Groups operating to fulfil the statutory duties of the governors, such as the nominations committee, remuneration committee and audit committee. – Groups focusing directly on developing the membership base and member involvement and engagement levels, such as the membership committee. - Groups operating to improve specific aspects of the trust, such as safety, patient experience, quality and finance committees.	• In many trusts governors give input into decisions about the type of subgroups that are needed, and often run these subgroups themselves with the help of the trust secretary.

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- Involve the governors in deciding which subgroups are most needed.
- Ensure subgroups have a clear reporting structure and that their findings are communicated effectively and can be actioned as appropriate.

3.4 Meeting organisation

Efficient meeting organisation is critical to ensuring that meetings are well attended and productive.

Challenges	Considerations	Examples of good practice
• Good meeting organisation is vital to set the tone for the council and an example of professionalism for governors to follow**.**	• Ensure that agendas, papers and supporting information are circulated in good time in advance of meetings and that trust is shown by sharing relevant information between directors and governors. • Governors should have opportunities to input into the agenda for council meetings. Most trusts also facilitate the chairs of subgroups inputting into agendas. • The papers for meetings should be in an appropriate format for governors to best understand and make the most of the content. • A pre-meeting for governors to discuss and digest content may help to enrich the discussion during the main council meetings. • During the meeting it is essential that notes are taken, actions recorded appropriately and actions are followed up in future meetings.	• At one trust, the chair, CEO, trust secretary, lead governor and a second governor meet to plan the agenda for full council meetings, bringing forward ideas from the wider governing body. • The trust secretary at one trust sends out meeting papers two weeks in advance of every meeting and circulates minutes no later than three days after the meeting. • Another trust uses an issues log to record every action taken as a group and to follow up on any unclosed issues until resolved. This is useful not only to hold people to account but also to provide a track record of the impact that governors are having.

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- Some meeting agendas and minutes are not sent out far enough in advance, especially when sent by post. For governors who have email access, it may be sensible to agree whether to post or email these documents.
- Take time to agree with the governors their preferred format for agendas and minutes in terms of length and style.

4 Supporting the delivery of statutory duties

Governors are responsible for a set of statutory duties which will be expanded by the Health and Social Care Act. It is important for governors to understand their statutory duties in the context within which they are carrying them out – i.e. that governors are there to represent the interests of members and of the public, particularly in relation to the strategic direction of the trust.

Governors should not seek to undertake operational management of their FT; the board of directors is responsible for this. The responsibility of the governors is to hold the board of directors to account, via the non-executive directors, for its performance in managing the trust's operations.

4.1 Annual planning

The board of directors must take account of the views of the governors when devising the annual plan. Governors have a responsibility to represent the interests of members and the public in this process.

Challenges	Considerations	Examples of good practice
• Gathering and articulating the views of governors and members to inform the annual planning process is where the challenge lies.	• Gathering feedback from members should be a continuous process throughout the year. See section 4.7, Communication with members, for more details.	• Most trusts have "strategy days" or "planning days" to discuss the annual plan and gather governor views. These are typically held annually, with a follow-up meeting six months on to assess performance against the plan. • At one trust, the board of directors and council of governors hold focus groups for the members of the trust when preparing the annual plan. Members can vote on proposed initiatives using post-it notes on the walls. • Another trust uses an away day with the board of directors and council of governors to devise the plan in partnership. • At one trust the process involves a consultation with members in August, followed by presentation to governors of the proposed plan in September/October. • At one trust the directors go to members and governors jointly to ask "what does good look like?" and then build the trust strategy accordingly. The trust also holds member days two to three times a year when members are given pretend money to select how they would spend this between different services, e.g. meal services, gown selection.

4.2 Appointment of the chair and NEDs

One of the council of governors' core statutory duties is to appoint the chair and NEDs of the trust. Trusts will have either one or two nominations or appointments committees for this purpose (some may have a separate committee for the appointment of EDs and NEDs respectively), which are chaired by the chair or an independent NED. The nominations committee for NEDs should make recommendations to the council of governors, and should itself consist of a majority of governors.

Challenges	Considerations	Examples of good practice
• Trusts need to establish processes for governors to appoint the chair and NEDs.	• The correct approach is that the chair chairs the appointments committee to appoint NEDs and gives his/her opinion to governors on the committee, who then vote and make recommendations to the full council of governors. • The SID will typically chair the appointments committee to appoint the chair; the process then works in the same way as for the appointment of NEDs. • Governors should be involved in putting together the job descriptions for these roles. It may also be appropriate to undertake a skills audit to see what is most needed on the board. • Governors involved in the appointment process should be provided with training either from within the trust or by a qualified third party. • Independent chairs or NEDs from third party trusts can help organise the process and give an objective opinion during interviews, although they should not be allowed to vote. Governors might also consult other trusts on how their appointment process for the chair and NEDs is undertaken.	• At one trust the council of governors shapes the nominations process, the role and job descriptions. Two governors are then nominated to be involved in the shortlisting and interviewing process and selecting a candidate to be approved by the full council. • A number of trusts use third party recruitment organisations to assist in the process of identifying candidates.

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- The CEO should not be permitted to vote on appointing the chair to whom he or she will be accountable.
- Attracting and securing the right people for these roles can be a lengthy process. Succession planning should be ongoing, with the process for replacing the chair initiated a full year in advance of the required start date.

4.3 Approval of appointment of the CEO

Another core statutory duty for governors is to approve the appointment of the CEO.

Challenges	Considerations	Examples of good practice
• The governors must approve the appointment of the CEO and thus need to be kept informed of, and involved in, the process.	• Governors should self-select a group of governors who will be involved in the process. This group should be given support in assessing candidates and feeding back appropriately.	• At one trust, the nominated governors meet with the candidates and then feed back their thoughts to the chair. The final decision is made by the chair and the governors are asked to endorse this.

4.4 Appointment of the auditor

A further core statutory duty for governors is the appointment of the auditor.

Challenges	Considerations	Examples of good practice
• Finding an auditor is an important role for the governors, but one that they may have little experience of.	• Again, governors should self-select a group of governors who will be involved in the process and this group should be given support in how to assess potential auditors. • This role is more suited to a subcommittee than to the full council.	• At one trust, the director of finance and nominated governors draw up a list of potential auditors and present this to the full governing body for a decision to be made.

4.5 Setting the remuneration of the chair and NEDs

The council of governors is responsible for setting the remuneration of the chair and NEDs. The council should consult external professional advisers to market-test remuneration levels at least once every three years, or when they intend to make a material change to the remuneration.

Challenges	Considerations	Examples of good practice
• Governors may not be aware of current levels of remuneration and may need help and advice in order to remain objective.	• Typically, the chair will lead the process to appraise the NEDs, and the SID or vice chair will lead the process to appraise the chair. Both should ask for feedback from the governors as part of the process. • Governors will often receive help either from the trust's own HR department or from a third party adviser to ensure they are well equipped to set appropriate remuneration levels.	• One trust uses a proforma feedback questionnaire for governors to give feedback on the chair's performance and scores in different areas. The lead governor collates the feedback and sends it to the SID, who then sits down and discusses this with the chair. This performance feedback is then taken into account when setting the remuneration for the chair. • Several trusts use outside recruitment companies to give benchmarks of chair and NED remuneration and take these into account along with performance assessment measures.

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- Governors should remember that the directors running FTs are undertaking roles of significant importance and responsibility. Governors should not expect chairs and NEDs to work for below market rates in return for this.

4.6 Holding the board of directors to account

The Act puts into statute the duty of the governors to hold the NEDs individually and collectively to account for the performance of the trust. Monitor's *Code of Governance* already states the duty for governors to hold the board of directors to account for the performance of the trust, including ensuring that the board of directors acts so that the trust does not breach the terms of its authorisation.

Challenges	Considerations	Examples of good practice
• The term "holding the board of directors to account" is not defined in legislation or by Monitor's *Code of Governance* and can therefore be difficult to interpret. • The strength governors bring is through an objective process of independent challenge. The governors should not be simply "rubber-stamping" decisions made by the board.	• In order to hold the board to account, governors must have appropriate information and an understanding of the decisions being made by the board. They should also have access to the directors to allow for the challenge process on behalf of their members and the local population. In addition, governors need to have a consistent method of feeding back their views and the views of members to directors. • The trust secretary and chair should help governors to understand the decisions of the board and should facilitate time for governors to ask questions of EDs and NEDs. • The annual planning process is a key part of holding the board to account. Governors should receive feedback on whether goals from the prior year were achieved so that they can challenge accordingly. • Monitor's quarterly reports are also indicative to governors of whether the trust is meeting its terms of authorisation. • Q&A sessions at the Annual General Meeting and joint working days of the directors and governors present other opportunities for governors to question directors and give	• One CEO states the following as an appropriate definition: "to represent the local population holding to account the board of directors in decision making for the local population." • At one trust governors use subgroup meetings, attended by relevant directors, to understand and scrutinise the decisions made by the board. They then report back to the main council. • Another trust uses a Q&A session directly following the (public) board meeting for a group of governors to challenge the directors. • One trust has a column for director responses on all governor reports. Directors will also explain if something is not possible and why. • Each governor at another trust has a 'portfolio of responsibility', for which they meet the relevant directors and report back on answers to questions to the whole council. Example portfolios are 'patient experience', 'membership', 'finance' and 'governor development'. • At one trust the representative governor who attends board of director meetings takes questions from the whole council to the board of directors and reports back to the full council.

Challenges	Considerations	Examples of good practice
	input on forward planning. • Governors will also want to see if actions from previous council meetings have been followed up by the board of directors.	
• Directors and governors must balance building a friendly working relationship, but one in which governors are still able to act as the "critical friend" and require answers to questions on director performance.	• Challenge can become quite difficult if a large number of experienced governors leave at the same time. • However, it is also important to refresh the council of governors regularly to ensure the relationship does not lose its questioning nature. For this reason two terms of three years should be the maximum term other than in exceptional circumstances.	• Some trusts vary the initial governor terms between one, two and three years to maintain the council's capacity for critical challenge.

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- Most people want things to go well when working together, so take care that the relationship does not become too 'cosy', with governors not offering appropriate challenge.
- Mental health trusts report that the duty to hold the board of directors to account can be off-putting to many potential service user governors, so trusts need to ensure that service user governors are well supported by other governors or are able to give their thoughts in the way they find least daunting.
- As one CEO states, holding the board of directors to account is "not to develop groupies on behalf of the trust to 'save our hospital' but to provide challenge".

4.7 Communication with members

The Act also puts into statute the duty of governors to represent the interests of members of the trust as a whole and of the public. Monitor's *Code of Governance* already states that governors have a duty to feed back information about the trust to the members who appointed them.

Challenges	Considerations	Examples of good practice
• Engaging all areas of the membership can be difficult, especially as trusts may not have permission to give member contact details to governors.	• Trusts should consider asking members on signing up for permission for the trust or the trust's governors to contact them and asking members for their preferred method and contact details. • Trusts should also consider assisting governors in this area as the FT is likely to have greater resources for	• Most trusts have a membership committee or working group to help organise the approach to member communication. This is typically supported by the trust secretary or membership manager. • Most trusts support governors in the role of communicating with members via some or all of the following: – emails and newsletters sent out by the trust; – member days or evenings such as "medicine for members" events;

Challenges	Considerations	Examples of good practice
	contacting a wide number of people and can help arrange member – governor events.	– annual open days; – member-specific areas of the website; and/or – consultations with members over service areas or other specific topics. • At one trust, the lead governor presents each year at the Annual Members Meeting and describes the activities the governors have undertaken. • One trust is cooperating with neighbouring FTs so members sign up for three trusts at once, although on separate forms. • One trust organises member open evenings once a month providing talks on different medical themes. The meeting location is rotated around the county. The membership committee organises these events, which usually include a talk from a clinician followed by an interactive session. • The same trust has an involvement committee, in which governors write to members on different topics or to ask for help. Members agree for their contact details to be used for this purpose when signing up. • One trust chair believes that it is the responsibility of the trust itself to recruit members and set up an appropriate database with their details so that governors have permission to contact members most easily.

5 Developing as individuals and as a group

5.1 Training

Governors have a number of important duties – both statutory and otherwise. It is important that individual governors, and the group as a whole, are supported with the training and development they need to undertake their duties effectively. Directors will also need to be involved in this. Various organisations are available and able to assist FTs in training their governors and trusts should investigate these options as this may help to ensure consistency in training and reduce the demands on the trust's own resources.

However, FTs should remember that trusts themselves retain overall responsibility in the Act for ensuring their governors are equipped with the skills and knowledge needed to undertake their role.

Challenges	Considerations	Examples of good practice
• Governors come from a wide range of backgrounds and may not be used to formal training and development. As a result it can be difficult to provide appropriate training at the right level for all. However, all governors require induction training on appointment and ongoing training thereafter, particularly in specialist areas.	• It is important to offer governors induction training as soon as possible after election. This is typically within two months of election. • Governors are more likely to take training seriously if directors are involved. • Governor induction materials should contain sufficient detail to cover the key areas and act as a reference, but allow for the fact that governors are a group of part-time volunteers. • Many trusts find governors learn best from working alongside other governors, so buddying systems for new governors can be useful. It may also be helpful to facilitate governors meeting other governors from neighbouring trusts to exchange ideas.	• One trust conducts a training needs analysis and skills audit shortly after each election to establish the areas in which governors need training. • Most trusts involve the chair, CEO, trust secretary and membership manager in governor training. At one trust the chair attends the training events all day unless there is a reason not to be there, and NEDs and EDs attend as needed and as helpful. • One trust uses their HR function to teach the governors how to self-assess their capability and suggest actions for improvement. These forms are then given to the chair and lead governor who work through them together with the HR department to align people's suggestions with possible development opportunities.
• Accessing training opportunities may also be difficult owing to the limited time and resources that governors have available.	• Trusts should consider ways to maximise the use of governors' time.	• At one trust governor training is undertaken one hour before each council meeting to make the best use of governors' time and avoid additional journeys.
• Trusts themselves may also have stretched resources in terms of providing ongoing governor training, especially in specialist areas.	• Outside experts can be used to provide training in specialist areas, such as specialist recruitment companies providing training on appointments. This might be targeted at members of particular working groups or	• Many trusts have a 'governor training' subcommittee so governors can organise elements of their own training. • At one trust executive directors each cover one training session per year on their specialist areas,

Challenges	Considerations	Examples of good practice
	subcommittees. • Where governors attend external training events, it can be helpful to ask them to write a report on this from which other governors can learn.	e.g. finance, remuneration, clinical safety and quality. • In one region, chairs have set up a governor exchange network in which four to five governors from each trust meet each other for training, to exchange information and showcase best practice.
• Many trusts recognise that it can take two years for governors to get up to speed on the issues involved and workings of the trust. A governor may then retire or be up for re-election with no guarantee of being re-elected, which could be regarded as a waste of the trust's resources in training the governor.	• It is important that governors communicate well with the members who elected them to ensure members are aware of their work on behalf of the trust, and to increase chances of re-election where this is sought.	• At several trusts governors have 'portfolios of responsibility' which are reported on in member newsletters, so members can see the work that their governors have been undertaking.

5.2 Governor appraisal

In the governor survey carried out by Monitor in 2010/11, to which 1,671 governors responded, a small number stated that they would like governor appraisal to be conducted at their trust.

Challenges	Considerations	Examples of good practice
• Governors are part-time volunteers, the majority of whom may not welcome appraisal of a role they undertake in a voluntary capacity. • The numbers of candidates per governor seat are typically dropping across the sector.	• All trusts surveyed said they would feel uncomfortable formally appraising governors in their role as volunteers.	• At many trusts, governors self-evaluate the performance of the council as a whole, often using a self-assessment questionnaire put together with the help of the trust secretary. At one trust, this was done using an online evaluation tool, with the results used to guide ongoing training and development. • Other trusts use an external board assessor to assess the board of directors and council of governors as a whole, with a view to clarifying roles and structures, amending processes if needed and guiding training. • At one trust, governors drove a 'what is our role' stocktake, which helped identify the need for further briefing sessions. • Each subcommittee at another trust self-appraises to ensure its processes are optimal. • An annual appraisal of one trust's full council is carried out by a subgroup of governors whose portfolio includes governor effectiveness.

6 The future role of governors

As described in the introductory section of this document, the Health and Social Care Act 2012 gives additional duties and powers to governors. These raise some issues in terms of how FTs and governors will adapt to the enhanced role. Some suggested responses to these issues are given below, focussing in particular on the role that directors can play to assist governors.

6.1 Issues raised

Issues raised	Discussions	Monitor advice
• Many trust boards are concerned that governors may not have the skills or experience to hold the board of directors to account or make decisions on significant transactions. Some also fear that the changes in the Act could result in losing the benefits of member engagement and balance.	• Some trusts suggest a two-tier system of governors, whereby one group of governors with specific skills is responsible for holding the board to account and making decisions on significant transactions, whilst governors with other skills focus on communication with members and work on different subcommittees. However, other trusts are adamantly opposed to such a structure, which they say would be divisive, would undermine collective responsibility and might mean that the voices of patients, carers and service users in particular were lost.	• It is preferable to maintain the cohesiveness of the full council and for governors to continue to nominate their candidates for different subcommittee roles, one of which might include to discuss significant transactions, for example. Different subcommittees might then receive appropriate training and guidance on specific areas as appropriate, such as finance, significant transactions, etc. However, the subcommittees should always report back to the main council for collective decision making.
• There is also concern about governors' own liability and whether they may become 'shadow directors' through making decisions on significant transactions	• Governors should not seek to take on an operational or management role in the trust. They should maintain their role as representatives of the members in ensuring local wishes are fed into decision making on behalf of the trust, and remember that directors are responsible for the day-to-day running of the trust and for recommending the appropriate strategic course of action. Governors should take responsibility for questioning the board of directors on their decisions and endorsing these if satisfied, or continuing to question if they feel due account has not been taken of member views.	• Trusts should agree a process with their governors on how 'holding the non-executive directors to account' will be undertaken and evidenced. • It should be clear from the process and documentation that governors are not making decisions on behalf of the trust, but questioning the NEDs on decisions made and ensuring that the views of members and the public are represented in the decision making process.

Issues raised	Discussions	Monitor advice
• Governors and trusts alike are concerned that governors may need further training to equip them to take on the additional responsibilities in the expanded role.	• It is clearly stated in the Act that it is the responsibility of the trusts themselves to ensure governors are equipped with the skills they need to undertake the role effectively.	• Trusts should make themselves aware of all assistance that can be obtained in this area, including through the planned Department of Health national governor training programme, Foundation Trust Network events, Foundation Trust Governor Association events and any local and regional governor training frameworks already in place. • Trusts should also consider conducting a skills audit or other self-assessment questionnaire so governors can give input into the training they believe they need. • Trusts should then construct a cohesive training programme to address governors' skills requirements, making use of external training opportunities where needed to support the overall training approach.

7 Key advice for aspirant foundation trusts

During the research, trust chairs and CEOs were asked for the key messages they would give to aspirant trusts who are setting up this model anew. The following is a list of their 'top tips'.

1. Constitution

Think carefully about your constitution from the outset. Think about how many governors of each type you really need, and which organisations would be most helpful for appointed governors. Consider staggering governor terms of office to avoid large numbers of experienced governors standing down at the same time.

2. Role clarification

Ensure governors and directors are clear about the boundaries of their respective roles from day one. Reinforce the roles during induction and ongoing training.

3. Mind-set

Involve governors in their roles from the start and ensure they feel valued. Take time for all directors to get to know the governors individually and for governors to get to know each other. Directors' attitudes are paramount and the model works best when all directors are approachable and value the governors' input.

4. Structure and organisation

Think about which meetings and subgroups will be of greatest value. Plan meetings well in advance, giving plenty of notice to everyone. Ensure that agendas and minutes are sent in an appropriate format for governors and on a timely basis. Ensure the communication process between the board of directors and council of governors is clear and effective and that action points are demonstrably followed up.

5. Learning from others

Speak to FTs who have already put the governor model into place and consider a buddying system between new governors and governors of existing FTs.

Further advice

For further advice on the governor role, please visit Monitor's website, where you can access a range of publications including:

- Code of Governance for NHS foundation trusts
- Current practice in NHS foundation trust member recruitment and engagement
- Survey of NHS foundation trust governors 2010/11
- Your statutory duties: a reference guide for NHS foundation trust governors

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