Chelsea and Westminster Hospital NHS
NHS Foundation Trust

28 April 2011

Dear Governors,

Council of Governors Meeting
Thursday, 5 May 2011

Please find attached the Agenda and Papers for next week's Council of Governors Meeting.

The items for decision/approval and information which have been 'starred' will not be discussed unless an advance request is made to the Chairman.

The Council of Governors meeting begins at 4pm in the Hospital Boardroom. Refreshments will be available from 3.45pm.

Yours sincerely,

Liz Revell
Interim FT Secretary

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting

Hospital Boardroom
Chair: Prof. Sir Christopher Edwards
Date: 5 May 2011
Time: 4pm

Agenda

		Lead	
1	**GENERAL BUSINESS**		
1.1	Welcome & Apologies	CE	4.00
1.2	Declaration of Interests	CE	
1.3	Minutes of Previous Meeting held on17 February (attached)	CE	
1.4	Matters Arising (attached)	CE	
1.4.1.	IMT Strategy Development (oral)	HL	
1.5	Chairman's Report (oral)	CE	4.15
2	**ITEMS FOR DISCUSSION/DECISION/APPROVAL**		
	STRATEGY		
2.1	The effect of possible withdrawal of paediatric cardiac surgery from the Royal Brompton NHS Foundation Trust. (oral)	CE	4.20
2.2	Our involvement in the Integrated Care Organisation (ICO) (attached)	HL	4.25
	COUNCIL OF GOVERNORS		
2.3	Council of Governors Funding Report * (attached)	LR	
2.4	Report on Senior Nurse/Governor Rounds (attached)	JT	4.40
2.5	Government listening exercise feedback (oral)	ML	4.55
2.6	Governors Questions (attached)	CB	5.10
	QUALITY		
2.7	Quality Sub-Committee report* (draft minutes of 20 April 2011 meeting attached)	CM	5.15
2.8	Quality Account update (oral)	CM	5.15
2.9	Quality Awards (attached)	CM	5.20
2.10	Summary of the Staff Survey (attached)	MG	5.30
	MEMBERSHIP		
2.11	Membership Sub-Committee report* (draft minutes of 7 March 2011 meeting attached)	ML	5.35
2.12	Membership Development Action Plan – Update (attached)	SN	5.35
2.12.1	Council of Governors, Membership Development Action Plan – Review and Planning for 2011/12		
2.13	Membership Report (attached)*	SN	5.45
3	**ITEMS FOR INFORMATION**		
3.1	Finance Report February 2011 – (attached)	LB	
3.2	Performance Report February 2011 – (attached)	AP	
3.3	Open Day 2011 (presentation of flyer)	RMc	
4.	**ANY OTHER BUSINESS**		6.00
5.	**DATE OF NEXT MEETING – 14 JULY 2011**		6.00

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 5 May 2011

AGENDA ITEM NO.	1.3/May/11
PAPER	Draft Minutes of Council of Governors Meeting – 17 February 2011
AUTHOR	Liz Revell, Interim Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper outlines a record of proceedings at the previous meeting.
DECISION/ ACTION	1. To agree the minutes as a correct record. 2. The Chairman to sign the minutes.

Council of Governors Meeting Minutes, 17 February 2010

Prof. Sir Christopher	Edwards	Chairman		CE
Eddie	Adams	Public	Kensington and Chelsea 1	EA
Chris	Birch	Patient		CBir
Nicky	Browne	Appointment	The Royal Marsden NHS Foundation Trust	NB
Cass	Cass-Horne	Patient		CC-H
Anthony	Cadman	Patient		
Alan	Cleary	Patient		AC
Carol	Dale	Staff	Management	CD
Brian	Gazzard	Staff	Medical and Dental	BG
Melvyn	Jeremiah	Public	Westminster 2	JM
Martin	Lewis	Public	Westminster 1	ML
Charlotte	MacKenzie Crooks	Staff	Support, Administrative & Clerical	CMC
Kathryn	Mangold	Staff	Nursing and Midwifery	KM
William	Marrash	Patient		SM
Henry	Morgan	Public	Wandsworth 1	HM
Frances	Taylor	Appointed	Royal Borough of Kensington and Chelsea	FT
Alison	While	Major Education Provider	King's College	AW

IN ATTENDANCE:

Amanda Pritchard	Deputy Chief Executive	AP
Therese Davis	Interim Director of Nursing	TD
Axel Heitmueller	Director of Strategy	AH
Mark Gammage	Director of HR	MG
Matt Akid	Media Director	MA
Catherine Mooney	Director of Governance and Corporate Affairs	CM
Sian Nelson	Membership and Engagement Manager	SN
Liz Revell	Interim FT Secretary	VD

1 GENERAL BUSINESS

1.1 Welcome & Apologies — CE

CE gave a warm welcome to Vida's new-born daughter (as Vida has started her maternity leave) and sent best wishes on behalf of the Council of Governors. CE also gave a warm welcome to new Governors: Anthony Cadman; Melvyn Jeremiah from Westminster 2; Henry Morgan from Wandsworth and William Marrash, Patient. He also welcomed Sir John Baker to the Board of Directors and the representatives from LINk **(**Ms Tera Younger, Ms Patricia Gani and Paula Murphy).

Apologies were received from: Heather Lawrence, Lorraine Bewes, Mike Anderson, Rosie Glazebrook, Catherine Longworth, David Finch, Professor Jenny Higham, Jeremy Loyd, Professor Richard Kitney, Edgar Moyo, Christine Bluest, Charlie Wilson, Susan Maxwell, Jacinto Jesus and Chris Brodie.

AC reported that he had met Walter Bamford the previous week and that he conveyed his good wishes to the Council

1.2 Declaration of Interests — CE

None.

1.3 Minutes of Previous Meeting held on — CE

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

- P5, P2.2: There is an absence of a comma after "the incumbent auditors" which changes the meaning of the sentence.

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

1.4 Matters Arising

2.14.1/Sept10 Signage for Edgar Horne — **CE**

TD said she had walked the corridor to check the signage in response to this and it looked fine.

TD to contact Sandra Smith-Gordon to clarify the particular problem. — **TD**

1.6/Dec/10 Agenda Sub-Committee

CE emphasised the importance of this and asked Governors to let CM know if they wished to be a member of the Agenda Sub-Committee — **CE**

2.5/Dec/10 Community road show — **MAk**

MAk described three possible ways of assessing the success of this initiative. These were: to recruit members (up to 300 new members); the development of videos about services to be a) displayed in GP surgeries for two months from mid-April and their effectiveness evaluated by surveying patients and b) screened on the Trust website and their effectiveness evaluated by monitoring 'hits'

MAk to provide an update at the next meeting. — **MAk**

1.5 Chairman's Report (oral) — CE

CE said there would be a great deal of debate on the consequences of the forthcoming Health Bill. By August 2014 all trusts will be Foundation Trusts and Monitor will be abolished. The economic regulator which will replace Monitor will quadruple in size. There will be additional responsibilities for Council of

Governors as some things done by Monitor will be done by the governors. The Board of Directors will also have more responsibility. It is suggested that 50% of governors will have to agree to any merger or acquisition and any "significant transaction." It will be up to us to define a significant transaction.

A discussion followed on the complexity of the Bill. CE said Trusts will be given no option to opt out of these proposals. AB said that in the USA there are ethical objectives which ensure quality of care can override any financial concerns. CE said that we are held to account for quality of care and finances, but we cannot carry on if we are insolvent. The Strategic Health Authority (SHA) is due to be abolished on 1 April 2012 and an interim arrangement will be in place until all hospitals are required to be Foundation Trusts in 2014. Responsibility will then be devolved to a local level.

WM said that mergers and acquisitions are a fine idea but we need to ensure synergies. CE agreed and also noted that vision and financial risks would need to be taken into account.

Education and Training Bill

CE said this outlined the new structure for education and training. There is a £5b budget with £1b for London, held by the SHA. Health Education England will hold £5b and will commission from provider units. CE said that C&W is leading on Health Innovation Education Clusters (HIECs) which bring together health providers, universities, industry and primary care. This could be the provider units but will need to be legal entities as they will be handling money and be accountable. They would need to be insured as they could be sued. There are many issues and the consultation runs until the end of March. Currently key sources of income for us relates to teaching e.g. Special Increment for Teaching (SIFT) is a sum of money which is given to us to which supports the hospital and allows us time to teach.

Royal Brompton Hospital

There is a great deal of concern surrounding the future of the Royal Brompton Hospital (RBH) following the review of paediatric cardiac surgery which proposes a reduction from 3 to 2 units in London. As a consequence RBH would cease carrying out cardiac surgery and then respiratory work would also cease, thereby losing 20% of their income (as RBH get activity from the whole of the UK). CE noted that only 14% of paediatric cardiac activity comes from London. If the proposal goes ahead RBH, which is a very valuable site, plan to move to Cambridge. This would have major consequences for us.

There was "nothing but praise for RBH". The Council of Governors felt it was important to express their concern and support. Any change at RBH would undermine both C&W and the Royal Marsden Hospital (RMH)**.** RBH share our teaching facilities which are very important to us. RMH will want RBH to stay. C&W, RMH and RBH together have a lot of strengths. The Council of Governors discussed RBH's chances of reversing this proposal and whether there was any possibility of acquisition of RBH by C&W (first proposed three years ago) or the establishment of a Chelsea campus.

It was agreed that CE would write to Robert Finch to express our concern and support. **CE**

Building work at Chelsea & Westminster Hospital

CE noted the changes to the C&W building e.g. the new escalators and the outpatient facility which is excellent.

2 ITEMS FOR DISCUSSION/DECISION/APPROVAL

STRATEGY

2.1 Business planning update AP/AH

CE reminded the governors that they have a key role in business planning. AP introduced the paper. There are three elements: the Corporate Business Plan including our key strategies going forward and key corporate objectives; the financial position and quality objectives.

AP introduced Axel Heitmueller, the Director of Strategy. He said the paper had three main themes. It sets the context, gives updates on the process and outlines the long term strategy challenges. One of the main issues is efficiency savings (£1bn over five years). NWL, together with McKinsey, are developing a plan over 4-5 years. Section 1.1 of the paper lists the areas they are working on and includes more community care and changes to urgent care. Most areas are still under debate. The second area of context is the policy changes and these are outlined in section 1.2 of the paper and includes putting patients first; outcomes rather than targets; commissioning for patients by GPs; and a new role for Monitor. He outlined the main issues relating to quality where governor support would be welcome including the new outpatient area, better signage and continuing to focus on patient experience.

Longer term strategic challenges are: the acquisition of a new hospital (for which Dean Street is a successful model); and private patients.

ML said that we had previously mentioned informally looking at acquiring West Middlesex hospital. AH said that we have to ensure that our core business would be safe, and we would need to work out the details. Due diligence and a thorough assessment are required. CE confirmed that a joint Fulham Road Trust is not on offer but we are working together including back office facilities (e.g. a joint HR Director) as there are important links between the hospitals.

AP said that if we did look at West Middlesex Hospital we would consider a joined-up approach. A thorough assessment is required for both financial and clinical aspects. West Middlesex Hospital has been asked to put forward a prospectus. CE said that we would have to consider whether it is financially worth it. The historical debt would need to be written off and funding for the Private Financial Initiative (PFI) secured. This would be an ideal opportunity to put our “brand” at West Middlesex Hospital as could other Trusts. However, there are potential problems: Imperial College Health Care Trust is not a Foundation Trust and West Middlesex Hospital is difficult to get to. It was suggested that the Moorfields franchise is a good model.

CE said that we need to think “outside the box’ about opportunities to generate income. Education is one of the biggest industries in the UK. Would it be possible to expand the healthcare market in London and Eastern counties?

CE reminded the governors that they were being asked whether the consultation and involvement to date had been appropriate.

The Council of Governors agreed that the consultation and involvement to date regarding business planning had been appropriate and no further work was required prior to the Board agreeing the Trust’s business plan.

GOVERNANCE

2.2 Infection Control – presentation **TD/BA**

Dr Berge Azadian, Director of Infection Prevention and Control gave a presentation. He outlined how we monitor our standards. MRSA is closely monitored and results reported back to the Health Protection Agency. BA demonstrated our incidence compared with other Trusts of both MRSA and *C.Difficile*. For MRSA C&W are in the middle of the league table with UCHL first and Southampton last. He confirmed that there had bee no fatalities this year as a result of MRSA and during the last seven years he was only aware of one death due to MRSA.

WM asked why some hospitals are so high. BA said it was due to infection control practices, patient mix and how the blood is taken. MRSA cases are counted based on blood cultures and some may be due to contaminates in the sample, i.e. some samples may collect contaminates on the skin as the needle is going in. At C&W blood is taken only by direct access without puncturing the skin. The other source is intravenous lines and cases can be reduced by taking care of lines. Last year C&W had the lowest rate of infection in the UK. Every year we have about 400 bacteraemia of which only five are MRSA. In contrast other hospitals may be higher risk for MRSA incidence due to their methods of taking blood by puncturing the skin. Inaccurate statistics do not help.

C.Difficile procedures are similar in that monitoring and reporting are both mandatory. North Middlesex Hospital is high on the list whilst Moorfields has 0% incidence. The incidence of *C.Difficile* is affected by antibiotic use and acid suppressing drugs, both of which allow the toxin to proliferate in the gut.

With respect to hand hygiene wards will be “named and shamed” if their hand hygiene rates are sub-standard.

Patients are to be encouraged to hold healthcare professionals to account for their standards of hygiene. The goal is to reduce infection. BA outlined some initiatives to further reduce infection. These include improve signage for dispensers, and encouraging hand washing. In response to a question from CBi, he said that soap and water is the most effective but not as practical as the gel. We try to use products with emollients to reduce the drying effect of alcoholic gels. ML asked how many staff received the influenza vaccine. BA said the number was 1700 during 2010 which was one of the highest in London.

2.3 Constitution Review – feedback **CM**

CM outlined the main issues that the group considered. In addition, the Constitution was reviewed page by page to identify inconsistencies and areas which required clarification or change. The next stage is to undertake a similar exercise with the Board.

AC asked if it would be possible to have a clean sheet approach and one that used plain English. CM said that in preparation for the meeting the Constitution had been colour coded to highlight areas that are part of the model Constitution from Monitor which cannot be changed. The group had discussed keeping the constitution as brief as possible to allow flexibility. With respect to plain English, she said that the Constitution is a legal document so there may be restrictions on the language used.

2.4 Terms of reference of the Quality Sub-Committee* **CM**

This item was starred and considered approved.

COUNCIL OF GOVERNORS

2.5 Open Day 2011 – update **RMB**

RMB reported on the open day plans. The Council of Governors had agreed to fund it and this was appreciated. RMB emphasised the input and enjoyment of the staff. A Steering Group and an Operational Group have been formed and planning has started. RMB would like volunteers for both groups. The outline programme had been agreed with input from CE and Directors.

The aims of the Open Day are to market the Trust and promote its achievements; to promote health and fitness (healthy living and exercise); to address any areas of concern e.g. the Healthcare Bill and how are we responding; to promote fundraising e.g. for the Sunshine Appeal; and to promote partnership working with LINk. We will also be launching the hospital's involvement in the Olympic Challenge.

CE said that the Open Day is a great success story; it is a fantastic day and a great advertisement for our hospital.

Governors are invited to express interest in joining the Steering Group or Operational Group. **ALL**

2.6 Council of Governors Funding Report **VD**

CBi noted that the Notice Board with photos needs a sign to explain who the governors are.

SN to arrange a sign for the Governors notice Board. **SN**

2.7 Chelsea and Westminster Health Charity (oral) **RH**

CE said that Chris Brodie was the new Chairman of the Charity and was having a very beneficial effect. He was unable to attend the meeting and in his absence Rick Holland presented the Sunshine Appeal. The Charity is hoping to raise £5m for the Children's Unit. This should be achievable given that £800,000 had already been committed including large donations of £1,000 and £5,000. The Charity is considering involving corporate partners and would appreciate potential contacts.

CE said that the key would be building a clear vision as to what funding can achieve (similar to Great Ormond Street Wishing Well Appeal). CE is meeting Chris Brodie to identify key projects. The charity would like doctors to work with them and this is not an approach the charity has taken before. It is important to identify projects that are attractive to donors, and giving them and our patients' stories recognition.

2.8 Focus Group on IT Strategy (oral) **CE**

CE explained that we have a very good software product, LastWord, but that it needs to be replaced and this will be very expensive. RK is chairing a committee looking at this and one area they are considering is a portal approach. AC said that he has met some very competent people at Imperial College and we should consider using them. RK pointed out that he was a Professor at Imperial and this was his area of expertise.

QUALITY

2.9 Quality Sub-Committee report (draft minutes of 28 January 2011 meeting) **CM**

CM highlighted a number of issues. A meeting will be arranged with interested governors and K&C Local Involvement Network (LINk) to discuss medicines related issues. The committee had received an update on progress with the quality objectives. K&C Local Involvement Network (LINk) had attended and explained their role and CM highlighted their importance in providing a statement as part of the Quality Account.

She also noted that the governors had scored the Quality Award nominations and they had been awarded to the McMillan Counselling Service, West London Centre for Sexual Health, and the team who had implemented the verious thromboembolism risk assessment screening and Sarah Hamilton, Liaison Health Visitor. CM said a more detailed paper would be coming to the next meeting.

2.10 Quality Account Update **CM**

CM outlined the progress to date and emphasised the importance of engagement with stakeholders. She also explained the content of Quality Accounts and progress on objectives and indicators.

2.11 Kensington and Chelsea Local Involvement Network (K&C LINk) **TD**

TD introduced three LINk representatives Ms Tera Younger, Ms Patricia Gani and Paula Murphy who gave an overview of the LINk which is an independent, one-stop, local service where members of the public can request information and help on all health care issues. They have a number of work streams including: disability, nutrition (they are part of the Trust Nutrition Group) and older people; cancer screening and care and personal healthcare budgets. Health Advice is complementary and the 750 members of LINk are elected. They have a statutory duty to enter premises and inspect. There is an elected management group and they report to the local Borough.

LINk has agreed a joint working protocol with Chelsea and Westminster. There is a local Healthwatch structure. The policy context is changing due to the Health Bill which will create Healthwatch England under the Care Quality Commission. There are 750 members currently and there are similar arrangements in other Boroughs.

CM suggested that LINks could help the public governors link in with their constitutions. CE said this was a very good point and any patient participation groups were of benefit to governors.

K&C LINk will be reviewing the Red Cross 'Next Steps' Pilot (A&E / MAU Assisted Discharge Scheme – Chelsea & Westminster Hospital).

CE asked how Foundation Trusts could work with the LINk network and encourage patient participation in LINk. TY said that they are keen to explore joint working.

LINk has raised concerns about the future of the EPIC Centre, North Kensington and would be issuing a formal response which they will share.

MEMBERSHIP

2.12 Membership Sub-Committee report **ML**

ML said that the "Meet the Governors" sessions would continue but more governors are required to help. Governor photos are now on the Picture Board and a banner has been ordered. The bus has travelled to Shepherds Bush in order to recruit new members. The LINk has been invited to join our meetings. MA has developed a media training package for governors.

2.13 Membership Development Action Plan – Update **SN**

SN reported that the "Meet a Governor" programme and promotional initiatives such as the governors' picture board had both gone well. However, there are no email addresses given on the notice board to enable members/patients to contact governors direct because so few governors have e mail addresses.

The Mobile Health Clinics have been set up at various sites in our area e.g. Westfield Shopping Centre, Chelsea Football Club and .Shepherds Bush Market to target under-represented community for Hepatitis C. A governor has helped there with membership recruitment. We have applied to be part of Comic Relief at the Royal Albert Hall on 14 March. The Learning Disability Steering Group is now meeting monthly and the first forum us taking place in February. CBi said that the message on the electronic message board was not the one that had been agreed at the last meeting of the sub-committee. SN said that this was because there was a limit on the number of characters that could be used. CBi asked what the limit was, and SN said that she would find out and let him know.

SN to find out the number of characters that can be used on the information board and let CBi know. **SN**

2.14 Membership Report **SN**

SN outlined the report and said we were aiming to at least maintain the numbers. We are looking at putting codes on the application forms so we can identify the most successful sources of recruitment. WM emphasised that it is important to people to sign application forms at the time.

SN noted that under-18s cannot become members. Mr Boland, a member of the public, said that teenagers are not necessarily interested in becoming a member of the Trust. BLOKE (a new charity) attempts to reach men who do not normally want to discuss health issues e.g. prostate cancer.

A governor said that Worlds End Estate would be a good target as it contains different age groups and nationalities CE said that more people in social class D should be encouraged to become members and we should be looking over a much longer baseline on the graph. He also said that community events are important in increasing awareness and texts messages etc are useful communication tools. The mobile clinic is a good source for recruitment as it is linked to something which people get. SN confirmed that we have paid people to help with recruitment.

CB said that the statistics could be presented in a better way e.g. to show comparison with previous figures and CE said that a graph might be helpful.

2.15 Trust Media Policy **MAk**

MAk presented the media policy. He noted that there is a small section giving basic media advice to governors e.g. what a governor should do if contacted by a newspaper. The answer should be "no comment**"**. CB said that he had written a letter to a national paper; the letter had been cleared by the communication team within five minutes.

MAk said another purpose of the report was to explain to governors what the

communications team do and he confirmed that media training is available.

2.16 **Enhancing Engagement of Patient and Public Foundation Trust Governors**; **TD**
TD presented the revised paper. She and MG had reflected on the points raised at the last meeting and had simplified the process.

EC asked why a governor would need to be accompanied by a Senior Nurse. CE said that the problem is CRB checks and governors must be accompanied. Befrienders, similarly, go through a clearance process e.g. criminal references, health checks.

ML thanked EC for bringing this idea to the Council and we have made progress. He said that the proposal means that governors get to see patients and meet senior staff. TD confirmed that rounds are just for wards rather than clinics.

CE concluded that the proposal raises interesting problems. He noted ED comments and concerns but felt that we should try the approaches proposed.
Visits to be arranged **LR/TD**

3 **ITEMS FOR INFORMATION**

3.1 **Finance Report – December 2010** **LB**

This item was taken as read.

3.2 **Performance Report – December 2010** **AP**

This item was taken as read.

3.3 **Website development annual report 2010** **MAk**

This item was taken as read.

3.4 **Website optimisation project update** **MAk**
This item was taken as read.

3.5 **Data Protection** **LB**
This item was taken as read.

4 **ANY OTHER BUSINESS** **CE**
Del Hossain has resigned from the Council of Governors due to ill health
Liz Revell was welcomed as the Interim Foundation Trust Secretary whilst Vida Djelic is on maternity leave.

5 **DATE OF THE NEXT MEETING**

The next meeting of the Council of Governors will be held on Thursday 5 May.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 5 May 2011

AGENDA ITEM NO.	1.4/May/11
PAPER	Matters Arising from the Council of Governors Meeting – 17 February 2011
AUTHOR	Liz Revell, Interim 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, Chelsea & Westminster Hospital
Chair: Prof. Sir Christopher Edwards
Date: 17 February 2011
Time: 16:00 – 18:30

Ref	Description	Lead	Subsequent Actions or Outcomes
1.3/Feb/11	**Minutes of Previous Meeting held on 2 December 2010**		
	LR to amend minutes in line with comments received.	**LR**	Completed
1.4/Feb/11	**Matters Arising**		
	2.14.1/Sept10 Signage for Edgar Horne **TD to contact Sandra Smith-Gordon to clarify the particular problem.**	**TD**	Completed
	2.5/Dec/10 Community road show **MAk to provide an update at the next meeting.**	**MAk**	Completed
1.5/Feb/11	**Chairman's Report (oral)**		
	Royal Brompton Hospital		
	It was agreed that CE would write to Robert Finch to express our concern and support		Completed
2.5/Feb/11	**Open Day 2011 – update**		
	Governors are invited to express interest in joining the Steering Group or Operational Group	**ALL**	Completed

2.6/Feb/11	**Council of Governors Funding Report**		
	SN to arrange a sign for the Governors Notice Board.	**SN**	Completed
2.13/Feb/11	**Membership Development Action Plan – Update**		
	SN to find out the number of characters that can be used on the information board and let CBi know		Completed
2.16/Feb/11	**Enhancing Engagement of Patient and Public Foundation Trust Governors**		
	The Trust Board Secretary to find out what times are available.	**LR**	Completed

Council of Governors Meeting, 5 May 2011

AGENDA ITEM NO.	2.2/May/11
PAPER	Integrated Care Pilot (ICP) NWL
AUTHOR	Dewi Harten, ICP project lead Axel Heitmueller, Director of Strategy
LEAD	Heather Lawrence, CEO
PURPOSE	This paper provides an update on the ICP
LINK TO OBJECTIVES	Improve patient safety and clinical effectiveness Improve the patient experience Ensure financial and environmental sustainability
DECISION/ ACTION	For information

An update of the Integrated Care Pilot

1. This paper provides a high level summary of the Integrated Care Pilot (ICP) for North West London that Chelsea and Westminster will join in early summer.

2. Why do we need an integrated care pilot?

2.1. The NHS is facing unprecedented challenges over the coming years. An ageing population, growing expectations amongst patients, availability of new drugs and technology, and the growth in long-term conditions such as diabetes will increase the costs of the health system significantly. At the same time, the NHS is going through a radical re-organisation as set out in the Health and Social Care Bill with a key aim of improving quality and patient experience as well as reducing costs.

2.2. A fundamental problem of providing more efficient health care provision in this country has been the cultural divide between primary and specialised care. Rather than working together, the current system incentivises division. The ICP therefore aims to achieve more integrated care between primary and acute providers as well as social services reducing the number of emergency admissions and enabling effective working of professionals across provider boundaries. At the moment, existing services struggle to join up effectively which is e.g. a particular problem when it comes to discharge planning for the elderly leading to unnecessary long stays in hospital.

3. How will the ICP work?

3.1. The ICP will focus on two groups of patients: patients with diabetes and frail elderly (patients aged 75 and over). These groups account for 9% of the patient base, but absorb to 28% of the healthcare spend in North West London. Reducing emergency admissions among these groups would therefore contribute disproportionately to cost savings for the NHS as a whole.

3.2. In the proposed model, acute providers, GPs, mental health, community care and social care will form Multi-Disciplinary Groups (MDGs). Each MDG will have a number of GP practices with a total number of around 50,000 patients (depending on how many GPs will sign up to the pilot).

3.3. One of the key tasks for the MDG is to segment their patients into pre-defined groups depending on the required levels of care. Care packages for each group have been developed over the past few months by clinicians in accordance with the e.g. NICE guidelines. Depending on the need, each patient will be assigned a care plan that is based on a care package. These care plans will contain the core activities that clinicians need to perform and will therefore give clarity to all providers involved and to the patient. The pilot is therefore not about providing new forms of treatment or pathways, but about liking up existing services more effectively.

3.4. Most patients will continue to receive the care in their local GP practice with their GP as their primary point of contact. But the most complex patients will be discussed in a MDG case conference. By having a truly interdisciplinary approach to the most complex cases, the ICP aims to prevent emergency admissions and helps to keep the patient at home and independent.

3.5. If the pilot succeeds and emergency admissions fall, savings will be shared among participants to align incentives.

4. Why should we join the ICP?

4.1. Initially the ICP only covered those GPs mainly referring to Imperial and Imperial was the only acute provider in the pilot. However, Chelsea and Westminster has now also been invited as well as our GPs.

4.2. Given the challenges to the health economy outlined above, more and more hospital services will move into the community over time to reduce costs to commissioners. In fact, we already provide a number of services successfully in the community including dermatology and gynaecology. Also, our diabetes team is supporting GPs to see more complex cases in the community working closely with community nurses. While this will over time reduce the number of patients needing specialised services in the hospital e.g. in the Beta Cell, expanding into the community has helped us off-set some of the lost activity.

4.3. There are therefore a number of reasons why we should participate in the pilot.

- First, the ICP provides an opportunity for the Trust to participate in and influence a high profile project in North West London exploring new ways of delivering services in a more joined-up fashion.
- Second, the NHS has provided significant pump-prime funding and will allow participants to share any savings which helps mitigate a reduction in services from reduced emergency admissions.
- Third, being part of the pilot will help us demonstrate to our commissioners our commitment to innovate and be part of the solution rather than the problem.
- Finally, the pilot is a natural extension of our existing community offer for diabetes and allows us to explore potential business opportunities in the community.

5. What are the next steps?

5.1. The first wave of the ICP will launch at May 31st. Although there has not yet been a formal sign-up to the project, it is anticipated that Imperial College Healthcare trust as well as GPs from Westminster, Ealing and North Kensington, and CLCH, Social Care and Mental Health will join in the initial wave.

5.2. For the second wave, it is anticipated that Chelsea and Westminster will join at July 1st, together with GPs from Hammersmith and Fulham, South Kensington and Chelsea. In preparation for us joining, we will be working with our clinicians and GPs on the specifics of the model building on our existing community models.

5.3. The pilot will run for one year and will be evaluated afterwards to see if it has achieved its goals and whether the project should be continued.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 5 May 2011

AGENDA ITEM NO.	2.3/May/11
PAPER	Council of Governors Funding Report
AUTHOR	Liz Revell, Interim FT 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 12 of FY 10/11.
DECISION/ ACTION	Part: A: The Council of Governors is asked to note the report

Council of Governors Funding Report

1.0 Background

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

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

2.0 Update

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

3.0 Funding Overview for 2010/11

Of the £100,500 circa £91,587 was accrued for the activities listed in the table below which were approved by the Council of Governors and this figure was reported at the last meeting. However, unless an order has been placed funds which have not been used cannot be carried over. This affects the allocation for the discharge booklets, which are still in development and the allocation for the communication strategy which was not used. Revised bids will be made to the Council at the next meeting. The full allocation of £2400 was not used for the Quality Awards (£850 used)

4.0 Use of funds FY 10/11

Activity 10/11	Estimate
Trust Open Day 2010	£15,000
Recruitment of new members via Campaign for pre-election	£2,000
Recruitment campaign for the Annual Members' Meeting	£2,000
Directory of Services	£19,817
Discharge Booklet	£8,200
Learning Disability Membership Leaflet	£1,304
Membership recruitment via Mobile Health Clinic	£3, 539
Improvements to the Information Zone	£2,158
Quality Award including the staff survey	£2, 400
Communications campaign to publicise the Trust's 4 priorities for quality improvement	£4,000
Mobile Health Clinic awning	£5,875
Community Roadshow	£17,219
Banner to promote 'Meet a Governor' Sessions	£205
Leaflet stand and letter box	£110
Cotton bags and pens for Open Day 2011	£707
Voucher prize draw	£50
Website optimisation project	£7000
TOTAL:	**£85,645**

The revised total of expenditure for 2010/11 including accruals is £71,975.

5.0 Summary of Requests for funding

There are no requests for funding.

Council of Governors Meeting, 5 May 2011

AGENDA ITEM NO.	2.4/May/11
PAPER	Report on Senior Nurse/Governor Rounds
AUTHORS	Jane Tippett, Acting Assistant Director of Nursing Kathryn Mangold, Clinical Nurse Lead, Gynaecology and Assisted Conception unit (ACU) Jane-Marie Hamil, Clinical Nurse Lead, Intensive Care Unit
LEAD	Therese Davis, Chief Nurse and Director of Patient Flow and Patient Experience
EXECUTIVE SUMMARY	This paper provides feedback from the first two Senior Nurse Governor Rounds undertaken on 16 March 2011 and 19 April 2011. It includes personal accounts from Mr Cass J. Cass-Horne, Ms Susan Maxwell , both Patient Governors, and Mr Melvyn Jeremiah, Public Governor of their visits to three different clinical areas
DECISION / ACTION	For information.

Report on Senior Nurse/Governor Rounds

1.0 Introduction

1.1 This paper describes the first Senior Nurse/Governor rounds undertaken following the Council of Governors meeting in February 2011.

1.2 For the first round on the 16th March 2011, Jane Tippett, Acting Assistant, Director of Nursing agreed to meet with Mr Cass J. Cass-Horne, Patient Governor and facilitate the session.

1.3 For the second round on 19th April 2011 Ms. Susan Maxwell, Patient Governor requested to attend the Trust Infection Control Committee meeting and visit Annie Zunz Ward with Ms. Kathryn Mangold, the Clinical Nurse Lead (CNL) for Gynaecology and the Assisted Conception Unit. Mr Melvyn Jeremiah, Public Governor met with Jane-Marie Hamil, Clinical Nurse Lead for the Intensive Care Unit (ICU).

2.0 Feedback from visit to David Evans Ward

2.1 As Mr. Cass-Horne had been a patient on David Evans Ward he requested to visit the ward on this occasion.

2.2 In the morning Jane visited David Evans ward and spoke to four patients to ascertain their willingness to speak to a Governor and Senior Nurse about their experience as a patient in the Trust. The Nurse in Charge was also informed about the visit.

2.3 On this occasion Jane and Mr Cass-Horne spent approximately 45 minutes talking to a patient about his experience on the ward. The patient had been to the pre-assessment clinic in November 2010. Overall, the patient had a positive experience. Elements of his experience that were positive included:

- All staff had been friendly and polite
- During ward rounds the patient had been asked if he had any questions
- Ward environment and bed area was clean and clutter free
- Electronic patient prescribing was felt to be an excellent facility

2.4 Reflecting on his experience as to what aspects of his care that could have been done differently or improved upon the following points were raised and discussed. *(Text in bold and italics reflects feedback/discussion with Caroline Evans, Ward Sister with Jane Tippett):*

- The patient was admitted the day before his surgery. Whilst the reasons for admitting patients the day before their surgery was discussed the patient suggested having the option of being texted when he needed to be seen on the ward to reduce the time waiting on the ward.
  Patients are usually only required to come in the day before their surgery for specific medical reasons. The texting suggestion was discussed however logistically this can be challenging due to the medical staff coming to the wards to see patients between lists and thus their time between patients can be minimal.

- The patient noted that he had not had his height and weight taken on his admission and was not clear from his admission how much information would be re-checked on

admission or given as 'the same' since the pre-assessment appointment. This included his assessment by the nurses on admission and MRSA swabs. MRSA swabs were taken at pre-assessment but the patient reported he had not had them re-done on this admission. It was explained to the patient that MRSA swabs are not re-done on admission; however staff have a list of all admissions stating their screening status.
Patients do not have their height re-done on admission but should usually have their weight re-assessed. It is usual practice that patients have their assessment of activities of daily living reviewed on admission to check if there have been any changes

- The patient commented how the Sister of the Ward introduced herself to the patients in each bay so that they were clear who was in charge, and also gave the opportunity to raise any concerns or questions. This was felt to be evidence of best practice and should be considered by all wards as a role the Nurse in Charge could undertake at the beginning of the shift.

- Ward orientation was discussed. This has also been highlighted in the National Patient Survey and will also be discussed in PEAT. A simple overview of where the toilets and bathrooms are located along with visiting times; mealtimes and tea/coffee facilities that patients can use themselves. This should include how to work the bed and patient call bell controls.
Caroline stated that they do have guides for patients about ward routines however these do not always get left at the bed side and this can be reviewed.

- On one occasion the patient noted that the toilet was not clean. The patient had not informed a member of staff of this problem at the time. The cleaning schedules were discussed. Jane highlighted that patients are also encouraged to inform staff if they find a toilet or bathroom to be in need of cleaning.

- The patient did not need a call bell whilst in hospital however he did not observe any occasion where a patient called for help and did not receive it in a timely manner. However, the patient highlighted that the bell needed to be in reach.

2.3 The questions on the Patient Experience Tracker (PET) were also discussed and this provided the opportunity to discuss how we ensure patients have a positive experience. In particular the opportunity to ask questions in ward rounds and the Nurse in Charge introducing themselves to all patients at the start of the shift were felt to be practical ways that would improve the patient experience.

2.4. The patient was thanked for his feedback.

3.0 Follow-up

Jane Tippett subsequently fed back to Caroline Evans, Ward Sister and the feedback from the patient was shared with other staff members.

4.0 Feedback from Mr Cass J. Cass-Horne

4.1 We went to the 5th floor to the David Evans ward (A ward where I was also a patient 13 months prior to my visit).

4.2 The Acting Assistant Director of Nursing and myself agreed that from a Confidential point, it would be better to talk to the patient in a separate room (made freely available) instead of talking to the patient at his or her bedside which would not have been private. Other patients would have been able to overhear our conversation, also some of the very ill patients were having their afternoon sleep which we did not we wanted to disturb.

4.3 Jane Tippett identified a patient who was due to be discharged on the day of my visit. The Patient openly discussed his negative and positive views on the care he received. We both asked questions: 1. how he felt (most relevantly) 2. his views on the care received 3 overall patient experience whilst being in Chelsea & Westminster Hospital.
Jane Tippett also showed him a (PET)' Patient Experience Tracker'. Use of the PET also gave the patient the opportunity to give a structured feedback.

4.4 The Patient's feedback was well received by both myself and Jane. I would highly recommend other Patient Governors to take the opportunity to arrange a Ward visit in the near future.

4.5 I would like to thank Ms. Jane Tippett (Acting Assistant Director of Nursing) for taking me to the David Evans Ward and introducing me to a Patient who wanted to speak to a Governor.

4.6 As previously discussed by other Patient Governors, in my opinion as a Patient Governor it would not be a viable option to walk round a ward/bays talking to patients. It is better to have a discussion with Patients in a <u>private</u> environment.

5.0 Feedback from visit by Ms Susan Maxwell to the Infection Control Committee and Annie Zunz Ward

5.1 Ms Maxwell found the Infection Control Committee (ICC) meeting very interesting and observed the senior level of involvement in the work of the ICC. Ms Maxwell particularly found the new Synbiotix system for recording the infection control audits to be excellent. Following the meeting Ms Maxwell was given an overview of the system by Mr. Anthony Pritchard.

5.2 In advance of the visit to Annie Zunz Ward it was suggested and agreed with CNL Mangold that Ms. Maxwell would ask each patient seven specific questions with a final more open question so that the patients could feed back any other concerns or issues related to their stay in the Trust.

5.2.1 *Privacy & Dignity*- both patients were satisfied that their privacy and dignity was maintained at all times and that the bed curtains were always drawn when necessary.

5.2.2 *Communication with medical staff*- they were happy with the doctors' explanation of the procedure that they were going to undergo and that were given ample time to ask questions. One patient particularly praised Mr. Roger Marwood.

5.2.3. Nursing care- very happy with the care and attention they received and felt that they were treated as a person and not just a case.

5.2.4. *Cleanliness of the ward*-one patient said her bay was' beautifully' clean and had chosen to come here because of the reputation for cleanliness. The other patient commented that although the cleaning staff came every day she was concerned that when a patient was discharged that the cleaners did not roll the bed out from the bed space and clean underneath the chair and cabinet, although the nursing staff had washed the bed down and changed the linen. This was fed back to the staff.

5.2.5 *Cleanliness of showers/toilets*- they were both satisfied with this- 'fresh and clean'.

5.2.6. *Quality of the food*- one patient had no complaints about the food but the other patients said the salads did not look crisp.

5.2.7. *Noise at night*- both patients had experienced noise at night when emergency patients were admitted .Neither were aware of the availability of ear plugs and eye masks. Matron Mary Knight addressed this immediately by supplying eye masks for both patients and ordered some more ear plugs for delivery that afternoon. CNL Mangold suggested that the nurse in charge on nights could offer these at the start of the shift and Ms. Maxwell suggested that they could be supplied to all patients on admission.

5.3 Overall impression

Ms Maxwell spoke to Acting Matron Mary Knight, the staff nurses on duty and to Mr. Michael Stafford, the Gynaecology Service Director.

'The atmosphere of the ward is very positive and serene, but it's not often that you get staff openly stating that they love working there and that the whole team is a joy to work with. This has a lot to do with Mary Knight's leadership qualities, since she engenders this sort of loyalty and support'.

6.0 Feedback from visit by Mr Melvyn Jeremiah, Public Governor to the Intensive Care Unit and the Intensive Care Facilities on the Burns Unit

6.1 On Tuesday 19th April I took part in a ward round of the ICU with the Clinical Nurse Lead for the ward, Jane-Marie Hamil. The visit lasted one and a half hours.

6.2 Because of the nature of the ICU it is not practical to talk with patients, who are either under sedation or otherwise incapacitated. The wife of a long-stay ICU patient was there, however, and I took the opportunity of a private conversation with her in an office. The lady was very intelligent and fluent, and the conversation was very helpful to me in gauging the effectiveness of the Unit's approach in dealing with family members and more generally. She was also able to draw interesting comparisons with another major London hospital where her husband had previously been admitted for the removal of a kidney.

6.3 Reflecting the main thrust of the hospital's policies, the Unit is sharply focused on the holistic needs of the individual patient. Members of the family are kept fully involved. The difficulty in gaining direct feedback from the Unit's patients has been given particular attention. A series of focus groups has been established, bringing together patients after discharge to reflect on their experience. This has proved to be a very informative process, and has been recognised by an award at the 2010 Conference of the British Association of Critical Care Nurses; it is also a candidate n the current

Council of Governors Quality Awards exercise. Another interesting innovation is the compiling of patient diaries, to record what happens during a patient's stay in the Unit. These are greatly appreciated by patients, sometimes filling in a gap in their memory of an important phase of their life. They are released to the patient some weeks after discharge.

6.4 Issues raised through the focus groups are noted in the supporting paper for the Quality Awards exercise. I was interested in the comment of one patient that the staff photo board reminded him of a prison camp – I was told that this was an example of confusion which a patient in the Unit sometimes experiences when awakening. I looked at the board in its new site, where it is evident to families more than to patients, and noticed that a number of the photos were old and rather tatty. It would be good to update them with good new ones of the staff concerned.

6.5 The lay-out of the ward is efficient, but it would benefit from the creation of two or three single occupancy rooms. Such capital work is not readily accommodated, but it should be kept on a "wish list" to be tackled when possible.

6.6 The Unit provides critical care to other parts of the hospital, for example there are currently two patients in the nearby Burns Unit which it looks after (apart from dressings). This is a sensitive role, and requires careful and thorough discussion with the "host" ward staff to maximise effectiveness. There is also a critical care outreach team which reviews discharges from ICU and prevents admissions to the unit .However there is a limitation on the service at present it is not available "out of hours". It may be worthwhile to examine over a period how many cases occur where this is a real limitation to the care which the hospital can provide.

7.0 Summary

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

7.2 Feedback from these visits will be led by the Senior Nurses who are responsible for the clinical areas however we anticipate this feedback will be discussed at Divisional meetings and relevant Trust Committees to ensure all staff have an opportunity to share best practice and learn where we can improve care for our patients.

7.3 At future meetings we will report actions and further feedback from these visits to the Council of Governors.

7.4 The next senior Nurse/Governor round is scheduled for 12th May 2011 and details of future dates will be posted on the Trust website.

7.5 Finally we would like to thank all three Governors for their time and valuable feedback to ensure that this joint work has begun so successfully.

Council of Governors Meeting, 5 May 2011

AGENDA ITEM NO.	2.6/May/2011
PAPER	Governors' Questions -- A proposal
AUTHOR	Chris Birch, Governor
LEAD	Professor Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	A proposal to have a regular item on all future agendas of the Council of Governors that would allow governors to question the Chief Executive and the other Executive Directors
DECISION/ ACTION	Governors are asked to comment on the proposal, decide whether or not to accept the principle of the proposal, and decide whether to accept or amend the suggested details.

1. Introduction

This paper proposes an opportunity for governors to pose questions to the Chief Executive and the other Executive Directors.

2. Background

I am not a great fan of Parliamentary Questions, but I do approve the principle of giving ordinary MPs the opportunity to question the Prime Minister and other Ministers. I suggest that it would be useful to give governors a similar opportunity to question the Chief Executive and the other Executive Directors.

3. Questions

An example of the sort of question I would like to ask is: "I have the impression that waiting times for appointments have significantly increased in the past six months. Is this so?"

3.1 Notice

Questions would normally be submitted in writing in advance of meetings of the Council's Agenda Sub-committee so that, if there is a large number of questions, the sub-committee would choose which questions are put on the agenda. The Chairman would have discretion to allow questions on the day. Unless a question is directed at a specific Executive Director, the Chief Executive will decided whether she will answer it herself or ask another Executive Director to do so. Supplementary questions would be allowed.

3.2 Time limit

Governors' questions would usually be limited to a total of 15 minutes, with the Chairman having discretion to extend this time limit if he thought it useful to do so

4. Action

The Council of Governors is asked to discuss and accept the proposal.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors meeting, 5 May 2011

AGENDA ITEM NO.	2.7/May/11
PAPER	Draft minutes of the Council of Governors Quality Sub-Committee, 20 April 2011
AUTHOR	Liz Revell, Interim Foundation Trust Secretary
LEAD	Mike Anderson, Medical Director
EXECUTIVE SUMMARY	This is a draft of proceedings of the meeting held on 20 April 2011
ACTION	The Council of Governors Quality Sub-Committee is asked to approve the minutes as a correct record of proceedings.

Council of Governors Quality Sub-Committee meeting, 20 April 2011

Draft Minutes

Attendees	Carol Dale	CD	Staff Governor – Management
	Melvyn Jeremiah	MJ	Public Governor – Westminster 2
	Susan Maxwell	SM	Patient
	Wendie McWatters	WMW	Patient
	Mike Anderson	MA	Medical Director, Chairman
	Therese Davis	TD	Chief Nurse
	Catherine Mooney	CM	Director of Governance and Corporate Affairs
	Christine Vigars	CV	LINk
	Liz Revell	VD	Interim Foundation Trust Secretary

1	**Welcome and Apologies**	**MA**
	Apologies were received from Martin Lewis, Sandra Smith-Gordon, Sian Nelson and Jane Tippett.	
2	**Minutes of previous meeting 28 January 2011**	**MA**
	The minutes were approved as a true and accurate record of the previous meeting except for a typing error on page 6 (should be two rather than tow) and on 7 (should be neighbough instead of neighborough).	
3	**Matters arising**	**MA**
	Nov 10 Leaving Hospital Booklet WMW suggested that the hospital patient booklet be further reduced in size and asked how much it costs to produce. CM said this funding had been approved two years ago and as the funds had not been used this year, they could not be carried over. A revised bid would be made. It is possible that not enough funding was requested. SM said that one half of it describes entering hospital whilst the other half describes the discharge process and wondered whether there should be two separate documents. Two governors had volunteered to comment on it but feedback had not been received. WMW said that there is a lack of communication on progress and TD suggested that a sub-meeting on the patient booklet be set-up. CM suggested that this is discussed further with the Divisional Director for Operations who manages SB. MA asked if it is a long-term project. There are currently financial challenges so the booklet needs "to add value." MA also asked which parts of the booklet had received positive feedback from patients and which had not. **Action: to discuss setting up a sub group to take discharge book forward**	
	3/Jan/11: **Medicines management issues** A meeting has been agreed.	

	6/Jan/11 Medicines management issues This is covered in the item above.	
	8/Jan/11 Terms of Reference of the Quality Sub-Committee This is on the agenda	
	9/Jan/11 Feedback from governors on patient experience - missing signage SM to provide the name of ward to TD TD said that the issue was that signage had been missing outside Edgar Horne ward. She said a Signage Steering Group had been set up to monitor signage across the Trust. There will be a thorough assessment of future requirements and the redesigning of signage in order to make it more user-friendly. External advisors are to be brought in (including representatives from London 2012 and experts on large shopping centres). The plan is to encourage patients to sit on sub-group (with help from Help the Aged and LINk).	
	9/Jan/11 Feedback from governors on patient experience – Rapid Response Team -TD to find out who they are. TD said that the Rapid Response Team includes occupational therapists in A&E. Its main aim is to prevent admissions to hospital. The Trust was looking at various models to reduce admissions e.g. Post-ambulatory care (PACE) which was being piloted at the Royal Free and Chase Farm hospitals. We will also be looking at the role of the Rapid Response Team e.g. MA said the hours that the RRT operate should shift to suit patient' needs.	
	9/Jan/11: In the context of the building on Fulham Road that had fallen down TD confirmed that the building on Fulham Road that had fallen down during January, causing travel delays for patients, had been resolved	
4	**Feedback on Quality Account**	**CM**
	CM presented the most recent Quality Account with the most up to date information available. Heather Lawrence, Chief Executive, will sign the final version. Feedback from governors is welcomed and helpful.	
	Section 2 reviews the quality priorities for 2011. **Section 2.1** describes how we performed. Any current gaps in the information are highlighted. The issue is what we have achieved with our main priorities and whether we should keep them the same. MA outlined the proposed change to the VTE objective and emphasised the challenge. We are meeting the national requirements with respect to risk assessments as demonstrated in the graph. but we need to ensure that risk assessments are translated into medical practice. Our medical record is more advanced than in most hospitals in that it is electronic so it is easy to make electronic and also if over-ridden electronically it can be flagged. WMW said it was great that we were going for the extra push. CD said that reaching "zero" would be a difficult target and if we did not achieve that at the end of the year would that mean that we have failed? MA emphasised that it was preventable VTE and likened it to MRSA. When we had first tried to reduce MRSA there had been 50 cases per annum whilst currently there are only 6 per annum. TD discussed the importance of patient experience (section 2.2.2). This year the focus will be on three key areas; discharge; care of older patients and communication. The current focus on older people is due to the conclusions of the most recent Ombudsman report. Each Division will have a lead and a	

different campaign theme for different areas. Every two months a Non-Executive Director will chair a patient experience group. It was asked how campaign themes would work.

A strategy for the next two to three years will be developed based on International Best Practice. HL and AH had recently observed patient experience and areas of good practice in the USA during their visit. C&W will have a clear plan for patient experience in order to develop a culture where everyone is treated with respect and dignity. 'Magnet' hospitals in the USA attract patients because their level of care is so good. Barts and London Hospital are currently piloting an approach used by "Heart" Hospitals and C&W will take note of what other London hospitals are doing. The strategy will go to the Board tomorrow. We will do some quick wins e.g. lockers have been introduced in three areas for patients to put their possessions and there is a capital bid in for more. We have done a lot on single sex and in the first month of the requirement to have no single sex accommodation, we have had no breaches. MA noted that the challenges will come in the winter.

SM asked for confirmation that the discharge objectives did not just apply across the elderly and TD confirmed that it will apply to all patients. The Divisions will address the patient groups in their areas where they have the most concerns e.g. HIV patients.

CV said that she was very pleased as both are priorities for the coming year for them. She would be interested in doing follow ups when we are a bit further on. She also noted that LINk dignity champions carry out spot checks. TD said we will be considering follow-up calls to patients after discharge asking them about their welfare and their medication.

WMW reported on two patient stories. A female heart patient had to help other patients on her ward to sort out their medication as they were getting very confused. TD said there are lockable medicines lockers rather than the traditional drug trolleys fir medication and nurses should help patients with their medication. Some patients can self-medicate but only if competent and have agreed.
Action: WMW to let TD know the name of the ward so this can be followed up.

CD said that not many Trusts have used staff feedback in their Quality Accounts but there is a link with staff satisfaction and patient experience. She suggested a campaign theme around the staff experience. TD said she would discuss it with Mark Gammage.
Action: TD to talk to MG about staff experience.

SM said that on Annie Zunz ward the team work as a team, are very caring and, as a result get top marks for the patient experience. WMC said that providing coloured meal trays for older patients is a great idea. The volunteers have a buddy system which is very helpful in supporting the elderly. TD praised the work of the volunteers and said that a paper on this subject will go to the May Board. She noted the work of the Nutrition Steering Group and said that dieticians identify the highest risk patients and dietician support workers regularly check on whether patients are eating and drinking correctly.

Page 15. CM noted that the objectives are not SMART (Specific, Measurable, Achievable, Relevant and Timed) at this stage, but an early focus will be to determine measures.

	CM said we have done very well on emergency surgery and reached a 100% target. It is planned to reduce the time to surgery by 10%. Better information needs to be given to patients re nil by mouth. MA explained some of the concerns e.g. when an operation time is given but then cancelled the patient has to be nil by mouth on two consecutive days. CM said that a baseline has to be established. The aim is to reduce nil by mouth by reducing the number of operations being cancelled. The fourth priority (falls) has been dropped as a priority as it has been achieved but we will continue to focus on this and look at falls rates overall. **Section 3**. It is mandatory for C&W to report on certain areas. CV said it was pretty incomprehensible and needs a lot of work. CM agreed and said that this section is still very draft. Regarding data on valid GP practice code, CM noted that our figures appear low because of confidentiality issues relating to GUM patients. MA said we should make this clear. Regarding local indicators, CM said that catheters days has been taken off. There are some gaps to be filled in re discharge waiting time and this will be completed after the medicines meeting with LINks and the governors. **Section 5** CM noted that staff wellbeing has been incorporated into pledge 3. CV noted that complaints were not specifically mentioned. CM said they have been used to determine our priorities and she would ensure that this is noted in the appropriate sections. CD said the Trust Quality Committee should be noted and this committee. CM agreed and would insert in the relevant section. Governors agreed to read the Quality Account and provide comments.	
5	**Quality Awards**	
	.	
	The governors noted the difficulty in making a decision. TD said she had not scored as she was aware of the detail of some of them. TD explained about number 7 and the sensitivities and why the award might not be appropriate, despite the excellence of the care given and the staff input. CM added the marks and the top submissions were discussed. It was agreed to award the team awards to number 3 John Hunter Clinic and number 6 Staff flu vaccination campaign and the individual one to number 8, the Tissue Viability Nurse. **Action: CM to notify winners and to provide feedback.**	
6	**Committee effectiveness**	
	CM asked the group to review its effectiveness based on the terms of reference. CD said we are improving and WMW said things are being achieved. MJ noted a lead in time for some initiatives. MA suggested that comments could be made in private to CM. CM suggested that 3.3 should be revised and that 3.5, 3.6 and 3.7 are not being achieved. CD asked if this is	

	phrased correctly. TD said it is important to bring some patients' stories. CM felt the terms of reference should be reviewed. WMC discussed governor/patient rounds and said it is important not to overwhelm patients and there should only be one governor and a senior nurse at a time and she had withdrawn from a visit. TD confirmed there should only be one and would discuss this with SN. **TD to clarify with SN the numbers of governors to be involved in patient rounds**. **CM to co-ordinate a review of the terms of reference**	
7	**Governor Feedback**	
	CV reported that there had been many complaints that the hydrotherapy pool has not been in use recently. MA confirmed that it is being refurbished and TD said it would re-open by 23 May. CV discussed communication, particularly in regard to this issue. A message should go out in light of the number of complaints. CM reported on feedback submitted by SSG. A local resident had suggested flagging up certain patients. TD said that systems are in place for certain patients e.g. child protection and MRSA and others are in development e.g. safeguarding adults and learning disability. CM asked how we could respond to this lady's complaint. TD suggested Amanda Pritchard's as she chairs the Dementia Steering Group. SM described her AAU experience. She praised the AAU staff but had had problems with her discharge which had taken place in the early afternoon. However, she had not received her medication until that evening and, has a result, did not arrive home until 9.45pm. This was unsatisfactory. She had been told that there were staff shortages as it was Friday. Her discharge letter had been unhelpful and details were wrong e.g. the wrong doctor. MA said that the details should be corrected on the system. SM said she had not been given an injection but had not been given information or a discharge pamphlet. TD offered to organise a meeting for SM to talk to senior AAU staff but SM said that AAU had not been the problem. CM suggested that this was raised at the medicines management meeting the following week. **Action: MA to correct details on the system and pass the incident to the group reviewing discharge information.**	
8	**Any other business**	
	There was no other business.	
9.	**Date of Next Meeting – 24 June at 3pm.**	

Council of Governors Meeting, 5 May 2011

AGENDA ITEM NO.	2.9/May/11
PAPER	Council of Governors Quality Award
AUTHOR	Cathy Mooney, Director of Governance and Corporate Affairs
LEAD	Cathy Mooney, Director of Governance and Corporate Affairs
EXECUTIVE SUMMARY	This paper highlights the winners of the first Quality Awards. It is an opportunity for the Council of Governors to be aware of and recognise initiatives relating to quality undertaken within the Trust.
DECISION/ ACTION	For information

Council of Governors Quality Award

1. Introduction
This paper contains details of the winners of the first Trust Council of Governors Quality Awards

2. Background
The Quality Awards were set up to recognise achievements by staff in quality – safety, effectiveness and patient experience. The Council of Governors agreed to fund a financial recognition of £100 for an individual and £250 for a team. The award submission is available as appendix 1 and illustrates the questions that were asked and which formed the basis for the scoring. There were nine submissions. The awards were scored by a panel of governors and executive directors.

As part of the awards, a governor and a director visited the winners to learn more about their area and the award was featured in Trust News as well as a local paper. This paper provides an opportunity for the Board to learn more about and recognise some of the work that is undertaken in the Trust in relation to quality.

3. Quality Awards

3.1 Team award - patient experience
Macmillan Centre counselling service (Russ Hargreaves, MacMillan Cancer Information and Support Manager and Catherine Gillespie Cancer Manager and the team of volunteers)
Governor lead: Martin Lewis

3.1.1 Background

There was a clear and growing need for emotional support and bereavement support amongst cancer patients and their carers with no clear existing provision within or outside the Trust. With an increasing number of people surviving cancer, it is essential that we are able to support them to return to a 'normal life'. This is a key focus of the Cancer Reform Strategy that was published in 2007 and is a focus of the work of Macmillan Cancer Support.

The Macmillan Cancer Information and Support Manager underwent a 2 year counselling diploma and developed a robust counselling policy. In addition, the Centre developed a relationship with Kensington and Chelsea Cruse. This partnership resulted in two Cruse Counsellors joining the team here at Chelsea and Westminster. The service is also supported by a team of 10 volunteers who advise patients and their families on information available including financial support. Complementary therapy is also offered to patients, provided by a further team of 10 volunteers and the team have created a pleasant and calm area which is sometimes challenged by the proximity to the discharge lounge.

The Counselling Service has offered over 300 hours of counselling since its inception in 2009. The Cruse partnership has helped 21 bereaved relatives with long-term support. Feedback has included:

- "Immense relief at getting it all out to a trained counsellor";

- "I am not sure how I would have coped without this support and knowledge";

- “I found this a very helpful resource at a time when I needed to move on from all the medical aspects of surgery”;

- “Due to the outstanding skills of my counsellor, his knowledge, his dedication to work and ability to convey and communicate knowledge, I feel I am in a position today to be able to cope well with my future life”.

The service has been awarded a "Quality Environment Mark (QEM)" by the Macmillan Cancer Support organisation and is seen as an exemplar site. The QEM is being introduced to help cancer patients and their carers to identify places where they can receive safe and trustworthy cancer information and support. Chelsea and Westminster is one of very few hospitals to have been given the award.

This helps to demonstrate the value added to patient experience and ensures the Trust is able to demonstrate that it is working to address the needs of those who are surviving cancer and its treatment. The service is being formally evaluated through questionnaires to those completing counselling – the information will be used to inform further service development and improvement.

3.1.2 Key features of the award

- The ‘whole person’ approach
- The work of volunteers being recognised.
- Clinical teams really value being able to refer patients to the centre for emotional and other support.
- This type of service is not usual amongst Trusts, with even renowned cancer centres learning from the achievements at Chelsea and Westminster.

3.2 Team award – patient safety VTE Risk assessment development team (IT:Narinder Liddar, Rob Bint, Joyce Anson, John Littlewood, Christine Smith, David Scale; Data Warehouse: Sharon Thompson ; Information: Jovin Synott, Jason Woodward; EPR Education and Training: David Henry; Clinical: Sheena Patel, Catherine Andrews, Helen Yarranton)
Governor lead: Martin Lewis

3.2.1 Background

Many patients admitted to hospital are at risk of developing deep vein thrombosis (DVT) and pulmonary embolism (PE), collectively known as venous thromboembolism (VTE). Patients at risk of VTE can be identified using a simple risk assessment when they are admitted to hospital and can be offered appropriate prophylaxis to reduce their risk of developing VTE in hospital or when they go home. Preventing VTE avoids patients having months of further medical treatment with anticoagulant therapy and avoids the long term problems that can be associated with VTE. Rarely pulmonary emboli can cause death. Assessing patients for their risk of VTE is also a national priority (one of the two national commissioning for quality and innovation (CQUIN) schemes).

Through a multidisciplinary approach an electronic VTE risk assessment on Lastword was developed based on the Department of Health’s 2nd VTE risk assessment tool. This was launched on the 2nd June 2010. On completion of the risk assessment, a pop-up advice box appears informing the assessor of the outcome of the assessment and gives direction on thromboprophylaxis if appropriate. A help screen was designed to give further guidance on individual risk factors.

The risk assessments for individual patients are recorded and the results can be viewed for different assessments over time. This allows for easy audit. The system has also been developed to allow data to be collected centrally. We provide reports on the percentage of risk assessments completed for patients admitted to hospital by department and feed this back to the departments so that they can monitor their own performance and compare this with other departments.

Further enhancements were subsequently made to improve the electronic risk assessments:

- Making the risk assessment mandatory - to increase the numbers of patients being risk assessed (launched on 1st October 2010)
- Providing a list of patients for whom a risk assessment is still required - so that these patients can be easily identified by ward, speciality or consultant (launched on 1st October 2010)
- Developing a maternity specific VTE risk assessment – at the request of the obstetric department to ensure pregnant woman are assessed appropriately (launched on 10th November 2011)

3.2.2 The process

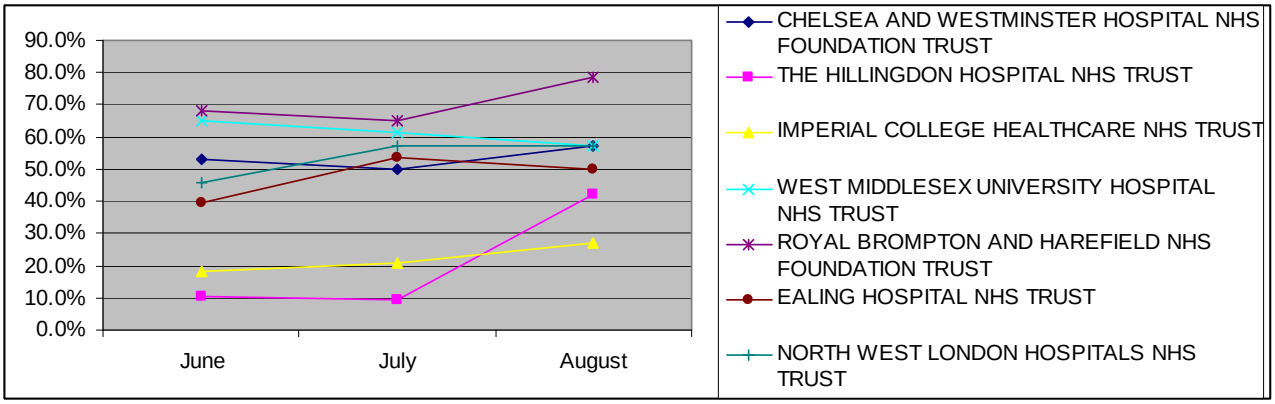
The timescales and key milestones are outlined in appendix 2. This demonstrates the complexity of the work and the need for a team approach. Multidisciplinary meetings involving clinical leaders and the technical team took place to discuss and agree requirements and capabilities of the system. Agreeing priorities and phases for implementation with timelines helped in the successful staged roll out of the quality improvement.

3.2.3 Improvement in patient care

Prior to the introduction of the electronic VTE risk assessment there was no VTE risk assessment tool and audits showed that patients did not have a formal documented risk assessment. Following the launch of the new VTE risk assessment on Lastword, the percentage of patients admitted to hospital between June 2010 and September 2010 ranged between 52% and 62%. The performance in October 2010 showed a dramatic improvement to 89% following the introduction of the mandatory VTE risk assessment.

	June 2010	July 2010	August 2010	September 2010	October
VTE risk assessment completion rates	50%	53%	57%	62%	89%

With this electronic risk assessment tool and the developments instituted, we have achieved excellent results. The comparison with other Trusts in our area for the months of June, July and August 2010 is as follows:



There are very few Hospitals with electronic VTE risk assessments in the country and Chelsea and Westminster Hospital is one of the leaders in this area. Many trusts are at the envy of such a robust system in place.

We are able to reliably and accurately report nationally the percentage of VTE risk assessments completed for all our patients admitted to hospital, where some Trusts are using samples of patients and some are employing extra data collectors.

By investing in and developing this sustainable system with validated reports we are able to continue to monitor performance and provide reports in the future with minimal time input from the information department and without employing extra staff. This work also demonstrates the invaluable input from the IT and information departments in developing an in-house successful electronic risk assessment tool which was implemented in a quick timeframe.

3.2.4 Key features of the award

- Joint working between Trust teams; clinical, information and Information Technology, the Data Warehouse and EPR
- Sustained effort over a period of time to achieve a system which not only supports good clinical practice and patient safety but also has achieved a financial benefit through achievement of the CQUIN target and enables 'seamless' data collection.
- Recognition of how the 'back room' services can support safety initiatives
- The value of our IT system and our teams which have made us exceptional in the country for our ability to easily undertake risk assessments and collect data

3.3 Team award – experience - West London Centre for Sexual Health Team led by Dr. Rachael Jones)
Governor lead: Carol Dale

3.3.1 Background to the service

As highlighted in the recent channel 4 documentary, 'The Hospital', The West London Centre for Sexual Health (WLCSH) delivers a full sexual, reproductive health and HIV service from Charing Cross Hospital (CXH) in the London Borough of Hammersmith and Fulham. The WLCSH is an innovative, award-winning clinic which has led the way in developing community outreach and providing services targeting hard to reach, vulnerable groups from a number of locations in the borough. Prior to Lord Darzi's *Healthcare for London* report we identified the need to strengthen our community provision. Strong partnership working with local organisations including GP practices, polyclinics, Wormwood Scrubs, colleges and charities have facilitated a strong presence within the borough. Novel methods of service delivery e.g. the mobile community clinic have strengthened our ability to target local residents and facilitated the delivery of services to the most inaccessible groups. The WLCSH was the first clinic to provide Saturday opening in an attempt to improve access for service users. Many of the service innovations have been published at national and international conferences and in journals, allowing other service providers to follow our lead.

Originally named the 'Martha and Luke Clinic', sexual health services have been delivered on the CXH site for decades. Over the last three years, the WLCSH has seen a huge expansion in activity-25% increase in GUM and 36% HIV attendances. It appears in the GUMCAD top ten busiest clinic charts each month. As the only fully integrated sexual and reproductive health service capable of delivering level 3 activity

within the Hammersmith and Fulham borough, the clinic remains a well respected and influential service within the local vicinity.

Prevalence in the local borough for HIV and STI diagnoses are well in excess of the England total as indicated in the table below:

Table 1: Rates of selected STI and Acute STI diagnoses per 100 000 population

	Chlamydia (15-24 yoa)	Chlamydia (25+)	Gonorrhea Diagnoses	Syphilis Diagnoses	Genital Warts	Genital Herpes	Acute STIs
H&F	2759	325	95	17	308	131	1864
England	2180	94	28	5	141	49	774

As illustrated above, Hammersmith and Fulham (H&F) has more than twice the rates of acute STI per 100 000 population compared to England in general. Furthermore, the prevalence of diagnosed HIV in H&F is over six times higher than the UK average and has continued to increase in recent years.

Multiple studies have highlighted the association between deprivation and sexual ill health. H&F is a relatively deprived area, the 65th most deprived local authority in England. As the greatest area of deprivation is seen north of the borough, we embedded our services within a polyclinic in White City, hoping to further deliver clinics within the community. Compared to the rest of London, the resident population in H&F is relatively young, comprising a large population of young adults. Almost half (45%) of residents are aged 20-40 years. A relatively high percentage of H&F residents are from non-white groups, the greatest population being black Caribbean (5.2%), followed by black African (5%).

The prevalence of HIV in H&F in 2009 was 8 per 1000 (aged 15-59). The majority of those affected are Men who have Sex with Men, with the greatest prevalence of undiagnosed HIV being found in BME groups.

The WLCSH is well placed to target these high risk groups offering a dedicated clinic for Men who have sex with Men (MSM) (West 6) and multiple community clinics in partnership with allied agencies such as the African Communities Project and Naz Project London, designed to target high risk individuals. In recent years, the rates of late diagnosis of HIV has declined in H&F, this may recognise the efforts of our Outreach clinics within the local community.

Young Persons Services are embedded within the WLCSH. Our Cont@ct2 service sees approximately 15-20 individuals aged 19 and under per day. Working closely with the Teenage Pregnancy Partnership, we deliver Cont@ct2 outreach clinics within the local further education college, Connexions, the Lyric Theatre and the Youth Offender's Service. We hope our work has contributed to the impressive decline in the local teenage pregnancy rate. As we also deliver sexual health education in local schools, we continue to raise our profile.

The H&F sexual health strategy highlighted the need for services to deliver more specialised methods of contraception including long-acting reversible measures. Over the last year, several staff members have trained in these procedures and we are now able to offer level 3 reproductive health services from the WLCSH which

should have a resultant impact on the teenage pregnancy and repeat termination rates in the local borough.

We endeavor to target vulnerable individuals who may find access to sexual health services challenging e.g. those with learning difficulties for whom the Pearl service was designed. Over the next year, we hope to deliver services for women with female genital mutilation, a transgender service and further clinics for Black and Minority Ethnic (BME) populations in whom a high rate of hepatitis B has been detected.

3.3.2 The Quality Award

We have seen a considerable increase in activity within the service over the recent past which reflects, in part, the requests of our service users. A local questionnaire designed to investigate 'What Patients Want' illustrated that our clients wanted Saturday morning services and longer opening hours. With no increment in staffing, we have designed novel ways of working to deliver expanded clinics. Shifts were rearranged to facilitate the opening of more evening, early evening and weekend services. There are no Friday afternoon clinics and staff have the opportunity for a longer weekend.

Monitoring information from the Key Performance Indicators has shown a decrease in did not attend (DNA) rates and a 10% increase in activity. Patient surveys have consistently evaluated the services as excellent and the WLCSH consistently receives positive comment cards through the PALS office.

The lessons learnt from this initiative which may benefit others is that better opening hours, morning (i.e. 8am) evening and weekend service provision benefits patients. The initiative was the result of lengthy staff consultation leading to multiple suggestions as to how the patient experience could be improved and activity increased while tackling the burden of sexual ill health.

3.3.4 Key features of the award

- Direct response to patient feedback
- Improved access to patients within current resources
- Benefits to staff and patients

3.4 Individual award – effectiveness – Sarah Hamilton Liaison Health Visitor Governor lead: Susan Maxwell

3.4.1 Introduction and background

Sarah Hamilton was nominated for an individual award for a wide range of work she was doing but there was also a separate nomination for one specific project.

Sarah came in to a new post with essentially a blank piece of paper to develop the role, and has already made massive strides in the area of safeguarding and infant health. Her contribution to the department has been enormous.

The problem was a lack of health visiting liaison; a lack of focus on child health promotion and accident prevention in the department; no support for the child death process and no paediatric input into the safeguarding training within the adult ED.

3.4.2 Think Family Approach

All professionals have a duty of care to safeguard the welfare of children and practitioners working in the setting of the Adult Emergency Department often see and

treat parents of children. The presentation of those patients may indicate or impact upon the patient's ability to parent their child either in the short or long term. Identification of these cases are made more challenging for several reasons, firstly children are not always present with the parents when they present as patients, secondly patients do not declare at triage that they have been victims of domestic violence, and thirdly mental health issues appear often on a spectrum, and many parents manage their families with good support system. In addition to those challenges the target of a four hour turnaround for patient throughput and the general business of the department are not conducive to encouraging practitioners to step back from the case and reflect upon the presentation, in order to consider other wider factors in relation to the patients presentation.

A smiley face stamp system was introduced for use by triage staff, it is to be applied to certain cases by the triage nurse to highlight to the assessing doctor or nurse the need for them to ask the patient "who else lives with them at home?" and then to "consider does this family need extra support?" The cases that triage staff have been asked to stamp are as follows:

Parents (of children<16yrs) or Pregnant females (>12 weeks):

- Mental Health Issues ,overdose, deliberate self harm
- Substance abuse or alcohol misuse
- Victims of physical, emotional, sexual or domestic assault.
- Frequent concerning presentations in parental behaviour.

Or

16 & 17 year olds:

- Sexual Assault
- Death.
- Repeat concerning presentations.
- Suspicious injuries.

Staff are then asked to think about:

- Why the presentation has occurred?
- Who is with them at home and if they are currently safe?
- What impact will their situation have on them?
- Other support currently available to them?
-

Staff are then to refer to community professionals as suitable, either social services or other community services.

Staff are given a credit card sized information card to keep in their identity badge to remind them of what to refer and how to handle the situation in order to alleviate worry in those situations.

Staff training in relation to child protection is also an essential part of this system working effectively as staff need to be aware of the child and how parental behaviour impacts upon them.

The staff in the Adult Emergency Department have responded well to this innovation and now regularly refer cases to the Paediatric Liaison Health Visitor service so that appropriate support and advice or intervention can be taken to help strengthen families and protect children.

3.4.3 Other areas of work

Sarah works tirelessly in many different areas, over and above her routine daily work. The whole liaison health visitor project success has been down to her strong determination, innovation, commitment and passion. There are so many specific successes to date e.g. improving and tightening the safeguarding system,; developing processes after child deaths; improving our child health promotion and illness information leaflets; improving all of our links with health visiting and social care.

Further, she has had a major success in preparing a Portfolio of Practice and internal Governance for the Paediatric and Adult Emergency Department, and how we interface with other services, for the recent SIT visit. We were given extremely positive Feedback, particularly around her work, but also regarding the Safeguarding Team as a whole.

Sarah describes the role as follows:
The role of the Paediatric Liaison Health Visitor is to support and advise staff in both the Paediatric and Adult Emergency Department in Safeguarding and Supporting families with whom they come into contact. Team work is an essential, my work is dependant on the staff being able to recognise and respond to concerns they may have about children or families that they see, I trust their competence and they trust me to advise appropriately and follow up concerns with services outside of the hospital such as health visitors, school nurses or Children and Families Services as appropriate. Part of my work is being available to staff for them to talk through concerns they may have and to put in place systems that help them to recognise and respond to concerns so that they are empowered to handle them. I also carry a wider public health remit and will see parents in the department and advise regarding breastfeeding and behaviour management.

When I started in post there were structures in place for supporting safeguarding and supporting children in the paediatric emergency department, however these required further development and in the adult emergency department there were no systems established. As all professionals have a duty of care to safeguard the welfare of children a system needed to be developed that was easy to use as practitioners working in the setting of the Adult Emergency Department often see and treat parents of children but also have a wealth of other clinical issues they are responsible for identifying in patients.

Specific areas of her work includes:
- Safeguarding training and communication in the Adult Emergency Department, particularly around domestic violence and mental health issues. This has directly improved the care of some children who would otherwise have been missed.

- She has taken a lead role in the safeguarding arrangements within the Pending UCC – for which Sarah has communicated with the PCT safeguarding Team and our Hospital Team, and Developed the Safeguarding Standards.

- Nursing and Junior Doctor Training regarding Health Visitor Related aspects of care, good practice with regards to early Maternal advice and care, and frequently identifying other Training Needs within the Department.

-Triage note taking and Nursing and Doctor Documentation

-She devised the patient information leaflet which summarises the department for families, to address the sparsity of information for parents when they attend the PED

(Paediatric Emergency Department)

- Other wider issues such as Accident Prevention and our role as a PED

- Coordination of the PED clinical Management forum - since our Doctors have a different Secretarial Body to the Nursing Staff as we fall across 2 directorates.

- Arranged for the department to be represented at the Teddy Bear picnic, as an opportunity for us to improve our profile, and to disperse information about what our role is, among the local community

- She has helped ensure that the staff have been supported throughout the recent turbulent times - she has time for everyone and offers an informal pastoral support

- Supports the Mums who attend the dept with breast feeding issues

- Audits **-** Sarah has completed 3 audits in the past year. All have resulted in recommendations to improve safeguarding Practice and are pending re-audit next year. She has also developed standards and other documents For the UCC.

3.4.4 Lessons learnt

The doctors who nominated Sarah feel that what they have learnt is the benefits of recognising talent and allowing individuals to develop using their own initiative, once the fundamental roles have been met; and allowing staff to think outside the box themselves, and supporting them to go beyond what may have been expected of them.

3.4.5 Key features of the award

- The high regard in which Sarah is held and the work generally that she has undertaken
- The specific project which is simple and unobtrusive but which alerts staff to thinking about areas they may otherwise miss.

Council of Governors Quality Awards

The Quality Awards will be held quarterly to recognise significant improvements in safety, effectiveness or patient experience. Please take a moment to nominate a team or individual who you think have gone out of their way to improve quality in their service—winners will receive £250 (team) and £100 (individual). Click in the grey box under each question and type your response. The deadline for nominations and entries for the inaugural awards is Friday 26 November.

Which individual or team would you like to nominate?

Which aspect(s) of quality does this submission relate to? Tick as many as appropriate.

☐ Safety
☐ Effectiveness
☐ Patient experience

What specific problem, which was affecting patient care, did the project or initiative address?

What actions were taken to tackle the problem?

Continued overleaf…

Please provide evidence showing that this initiative has improved patient care—for example, patient feedback, monitoring information, clinical audit etc.

What lessons have been learnt from this initiative which could be applied elsewhere in the Trust or the NHS?

Please include any other comments or supporting evidence.

Please email your completed form to cathy.mooney@chelwest.nhs.uk

Alternatively, you can print and complete this form by hand—send it by internal post to
Cathy Mooney, Director of Governance & Corporate Affairs, Verney House

The deadline for nominations and entries is Friday 26 November

Appendix 2

VTE assessment project:

July 2009 kick started, when the changes were requested by HY
Oct 2009 – Phase 1 went LIVE
Jun 2010 – Phase 2 went LIVE which was additional changes to Phase 1 and "Mandatory" Field was added
Nov 2010 – Maternity went LIVE

Over a total of 17 months – 7 months was spent on developing/implementing this change.

Below is a table that shows the various stages and phases any LastWord development change requests have to go through irrespective whether they are minor or major changes.

Phase 1		Phase 2		Phase 3	Phase 4 - user acceptance		Phase 5
Stage 1	Stage 2	Stage 3	Stage 4	Stage 5	Stage 6	Stage 7	Stage 8
Functional Specification	Design	Development	Unit Testing	Function Testing	Quality Assurance Testing	Gold Standard Testing	Go Live

Stage 1
Functional Specification is currently done by LastWord engineering team, and we involve the EPR support team as much as possible. This involves taking the requirements and translating them into what areas of LastWord they impact and how it is proposed to incorporate them into the system. It does not detail the code involved but does detail changes to screens, dropdowns and other tailoring elements and any new ones that are required.

Stage 2
Design is done by the engineers. It involves taking the Functional Spec and translating that into the technical changes required to fulfil the functional spec.

Stage 3
Development is done by the engineers. It involves changing the database, if necessary, changing existing code, or adding new code detailed in the functional spec. Includes changing/adding screens, parameters, drop downs as well. It also includes peer review of the code and testing strategy.

Stage 4
Unit testing is done by the engineer who has done the development. It includes testing of all areas changed/added including error handling. If necessary it involves an element of regression testing to ensure that the change has not impacted current functionality.

Stage 5
Function testing is done by Senior Function Tester, it involves testing the change and extensive regression testing to ensure current functionality is not impacted.

Stage 6
QA testing is carried out by the relevant EPR teams together with the users who have requested the change. DataWarehouse team also get involved at this stage to establish the users requirements for reporting.

Stage 7
GS testing is carried out by the relevant EPR team on some occasions users.

Stage 8
Go live testing is done by the relevant EPR team with support from the engineers.

In Summary

Even though we have a Legacy system we have the advantage of in-house developments, which allow us to stay ahead of the game when it comes to system changes required for CQUINS, good practice etc.

For any IT changes success is achieved through collaborative working with clinicians and users and we proactively encourage change and invite users and requestors to meet the teams so that they have a point of contact. Gone are the days when IT developments were done behind closed doors based on bits of paper, e-mails and telephone conversations. We view users as our key customers and the interaction is pivotal when creating system changes which provide the following benefits:

a) Quality of care – as the relevant information is available
b) Patient care – more information available for clinicians to make decisions
c) Cut down on manual processes – stops collection of manual data (as the example about 1 Trust recruiting 6 data collectors for VTE) we have reporting functionality available on line real time within the DataWarehouse.

Council of Governors Meeting, 5 May 2011

AGENDA ITEM NO.	2.10/May/11
PAPER	NHS Staff Survey 2010 - Summary of Results
AUTHOR	Mark Gammage, Director of Human Resources
LEAD	Mark Gammage, Director of Human Resources
PURPOSE	This paper is intended to provide the Board with a summary of the recently published staff survey results.
EXECUTIVE SUMMARY	All NHS organisations are required to conduct an annual staff survey using the same survey questionnaire and choosing from a list of approved providers to administer the questionnaire. The results of the 2010 questionnaire were released in March 2011. Broadly the results of the survey are the same as last year with 31 key areas scoring the same, one area improving and three marginally deteriorating. Compared to the national average 18 key areas are better, eight the same and 12 worse. The Trust's "staff engagement score", which is an amalgam of a number of key areas and includes communication between senior managers and staff and willingness on the part of staff to recommend the trust as a place to work and/ or be treated, was in the top 20% of acute trusts. A further paper will be presented to the April 2011 with more detailed analysis and actions that the Trust is planning to take to address issues of concern.
DECISION/ ACTION	For information.

NHS STAFF SURVEY 2010

CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST

1. Overview

1.1 Research has provided evidence of the link between a satisfied and motivated workforce and good patient care and one way of gaining quantitative and qualitative feedback in a structured way from staff is through the annual staff survey.

1.2 It is a requirement of all NHS organisations to conduct an annual survey and the results of the 2010 survey which took place last autumn were released nationally by the Care Quality Commission (CQC) for publication on the 16th March 2011.

1.3 All NHS organisations use the same staff survey and the majority of organisations, including this Trust, use Capita to collate their reports.

1.4 1,717 staff from Chelsea and Westminster completed the questionnaire with a response rate of 64%, which places the Trust in the top 20% of acute NHS trusts in England in terms of response rates and the second highest rate of acute trusts in London.

1.5 The CQC bases it report on a sample of staff and it is this sample that is used to make national comparisons. Although NHS organisations are only required to survey a sample, we opt each year to survey all our employees and with a response rate of 64% of all staff, we are sure our results are statistically significant and that we have engaged as many staff views as possible.

1.6 The survey report is structured around the four national pledges to staff given in the NHS Constitution and two additional themes around staff satisfaction and equality and diversity. These pledges and themes are reported under 38 key findings (KFs).

2. Results

2.1. Of the 31 existing KFs, the majority (27) stayed broadly the same with 1 area improving since the Trust's 2009 survey and 3 marginally deteriorating. The perception by staff of effective action by the Trust towards bullying and harassment improved and is now better than the national average.

2.2. Of the 7 new KFs, the Trust scored better than average on 1 KF, and worse than average in the other 4 KFs (2 were the same) when compared to other acute trusts.

2.3. When the Trust is compared against the national average, 18 KFs are better, 8 the same and 12 worse than the national average.

2.4. The CQC has calculated a 'Staff Engagement Score' for two years now, which includes communication between senior management and staff, staff's perceived ability to contribute to improvements at work, their willingness to recommend the Trust as a place to work and/ or receive treatment, and the extent to which staff feel motivated and engaged with their work. The Trust's engagement score was of 3.74 (on a 5-point Likert scale) places us in the top 20% of acute trusts in the country for

the second year running. In addition, the Trust along with only one other London acute trust was reported positively in the Evening Standard recently in relation to this score. Comparative analysis is provided in the supplementary papers, with Appendix One providing a comparison with other London acute trusts where we scored well, Appendix Two a similar analysis where we scored poorly and Appendix Three a summary of both good and poor scores. Appendix Four compares our scores year on year and with the national average. Please note that the figures presented in this report ***(Comparative Analysis)*** are **un-weighted**, and, as a consequence there may be some slight differences between these figures and the figures reported in the main trust feedback reports provided by the Care Quality Commission, which are **weighted** according to the occupational group profile of a typical trust.

3. Next Steps

3.1. The Trust is committed to providing an environment which supports staff well being and provides a culture which motivates and values all staff. It will take action to ensure there is a continuous improvement in staff survey results year on year.

3.2. Results are communicated to all staff and managers. The Trust will undertake detailed analysis of this data at organisational, directorate and department level and an action plan will be drawn up which will indicate the key priorities for the Trust as well as more detailed plans for each directorate and department.

3.3. A further, more detailed report will be brought to the April Board of Directors meeting for discussion.

Mark Gammage
Director of Human Resources

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 5 May 2011

AGENDA ITEM NO.	2.11/May/11
PAPER	Draft Minutes of the Council of Governors Membership Sub-Committee meeting held on 7 March 2011
AUTHOR	Liz Revell, Interim FT Secretary
LEAD	Martin Lewis, Chairman
EXECUTIVE SUMMARY	This is a draft of proceedings at the meeting held on 7 March 2011
DECISION/ ACTION	The meeting is asked to note the minutes

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Membership Sub-Committee, 7 March 2011

Draft Minutes

Attendees	Chris Birch	CB	Patient Governor
	Melvyn Jeremiah	MJ	Public Governor – Westminster 2
	Martin Lewis	ML	Chairman Public Governor – Westminster 1
	Susan Maxwell	SM	Patient Governor
	Wendie McWatters	WMW	Patient Governor
	Charlotte Mackenzie Crooks	CMC	Staff Governor
In attendance	Matt Akid	MA	Head of Communications
	Renae McBride	RMB	Communications Manager
	Jane Tippett	JT	Acting Assistant Director of Nursing
	Priti Bhatt	PB	Manager of Diversity and Equality
	Liz Revell	LR	Interim FT Secretary
	Sian Nelson	SN	Membership and Engagement Manager

	Welcome and Apologies	**CB**
	ML informed the sub-committee that Del Hosain had resigned from the sub-committee (due to ill health) and noted his valuable contributions. **LR to draft a thank you letter for ML to sign off.**	**LR**
	ML welcomed Liz Revell as the Interim Foundation Trust Secretary covering for Vida Djelic who is on maternity leave.	
	Apologies were received from Cathy Mooney, Therese Davis and Sam Culhane.	
2.	**Minutes of previous meeting held on 4 February 2011**	**ML**
	Minutes of the previous meeting were accepted as a true and accurate record of the meeting except for the following changes: **P1, Item 1, para 3**: Melvyn Jeremiah corrected a minor typing error. .**P2, Item 3, 5/Nov/10 Membership Development Action Plan**: SN and ML had already signed off the letters of thanks **P3, issue 2, para 2**: CB had received information about the Seasonal Working Conference for Hospital Staff which is to be held on 24 March. He would like to attend this event but not present at it. **P4, Item 5 para 1**: CMC confirmed that there were 150 volunteers in various parts of the Trust: St Stephens, Macmillan, Friends. CB asked how many were members of the Trust. **P5, Item 6 para 6:** RMB confirmed that the Westminster School project to get media coverage in the Evening Standard. **P6, Item 8, para 3:** CB clarified that the current Healthcare legislation is still a Bill and not yet a White Paper P7, Item 8, para 5: RMB said that she had not agreed to send ?	
3.	**Matters Arising**	**ML**
	1/Feb/11: LR to draft thank you letters to CB and SSG for ML to sign off	

4/Feb/11: JT to check with SN if the governors' photos will include their email addresses.
A discussion followed about setting up Chelwest Outlook accounts with remote access for governors, rather than using personal email accounts; Jeremy Thompson had agreed that this would be more professional. CMC suggested using a generic email address whilst WMW thought that "simplicity is best". MJ had had difficulties in opening his email account. Self-help guides are available if needed.
Action: LR to email Governors on this issue after speaking with CM

4/Feb/11/Issue 1: VD to ask SN to download the text suggested by CB
WMW and ML asked if any patient had requested to Meet a Governor. A text message board had been erected at the beginning of February. SN confirmed the agreement from the previous meeting to keep messages on the board short, simple whilst CB asked how many characters were allowed.

4**/Feb/11/Issue 1: Governors to advise SN of their availability**.
SN confirmed to ML that the Meet A Governor sessions are publicised the same day. CB emphasised the importance of giving as much advance notice of Meet a Governor sessions as possible. SM said that the Meet a Governor screen is not working. ML asked if messages can be posted on the big screen which allows easier reading. JT confirmed that whilst new Governors are publicised on the big screen, the others are on the stream.
.
WMW checked the location of the new banner. MA said that monthly engagements are listed on the website and dates of meetings will be publicised in April. RM added that the Trust now publicises dates of meetings via Twitter. CMC said that peoples' attention span is limited.

4/Feb/11/Issue 2: Seasonal Working Conference for Hospital Staff. Governors interested in presenting to contact JT
CB confirmed that he is happy to attend this event but does not want to present.

4/Feb/11/Issue 3: Patient Forums. SN to check the information regarding the Families and Young Children's Forum and get in touch with WMW.
This Patient Forum is currently not active but will resume in the future. WMW will be informed of future dates.

4/Feb/11/Issue 4: Recruitment Campaigns. SN to agree codes for Membership forms before events.
.
5/Feb/11: Report on volunteers work and November 2010 election stats.
LR to provide figures on how many volunteers work

6/Feb/11/para 6: Trust News – Special Members Edition RMB to invite Westminster School to write a story on the project.
The Westminster School Project is work in progress.

7/Feb/11/para 1: Westfield Community Roadshow. **MA to speak with SN and SN to invite Governors.**
An update was to follow later in the meeting.

8/Feb/11: RMB to circulate the funding proposal to the sub-committee before sending to the Council of Governors.
Open day proposal re bags and pens to be included in a funding proposal.
9/Feb/11: Trust Media Policy. MA to raise media training at the Council meeting on

	17 February and arrange training. **Action: LR to send names to MA of Governors interested in media training** **10.1/Feb/11: Website development annual report 2010. MA to add a box for volunteers on the form.**	
	The sub-committee noted that all other actions have been completed.	
4.	**Membership Development Action Plan – Update**	**SN**
	Issue 1. Information Zone: A new plaque and banner is to be added to the board, but kept in the office for use on sessions. Governors can also check dates (e.g. 16th March) on the Trust website. Shadowing of staff has been postponed until June because staff are currently very busy with business planning. JT also said we have supported a new programme of work of engagement. WMW said that healthchecks for new governors are very low key MJ said Governors should be visible near the main reception opposite M-PALS or at the bottom of the escalator, which WMW agreed is the ideal place to engage with any visitors. However, we would not wish to coincide with Meet a Matron on Thursdays or any other cake stalls. CB said he preferred to talk to people at the Information Zone whilst the banner could be placed by the escalators. SM suggested taking people from the table to the Information Zone if confidentiality was required. WMW said that people don't necessarily have time to talk so she takes positive action by talking to people at the coffee shop which made her feel "like I'd achieved something". CB said that Meet a Governor and recruitment are separate things. SM said that many people don't know what Meet a Governor is and that we should communicate we are their voice. MJ agreed that the Information Zone is in the wrong place, but "having paid for it we must work with it". He said that if people really want to Meet a Governor they will find the Information Zone. He thought that more could be done to bring people to it. ML concluded that each Governor should manage Meet a Governor in their own way once the momentum picks up. MA said to see how it develops. Seven Governors have booked 10 Meet a Governor sessions in February and March 2011 **Action: Governors to feed back to C of G meeting and the Trust Board meeting.** **Issue 2. Seasonal Working Conference for Hospital Staff** SN said that WMW, ML, CB (happy to attend but not present) and CMC would attend the Seasonal Working Conference on 24 March. JP said this would be an opportunity for non-staff Governors to describe their work with C&W. SN said that any offer to attend would be very welcome. There would be an unstructured workshop; governors could circulate amongst attendees at coffee and lunchtime. CC said that there are five workshops planned at the moment but governors would not be required to stay all day. **Issue 4. Recruitment Campaigns**: ML and SN had recruited ten new members at Shepherds Bush Market during February (ML was pleased to discover the use of the bus). It was asked whether there are any links between the Young Person's Membership and the Equality Sub-Committee? A discussion followed about LINks. It was asked if the process of joining the Council of Governors could be publicized on the LINks website and via Trust News. SN said that LINks would like us to reciprocate by publicising their work (on e.g. feeding and nutrition) in the Trust News. ML thought it was a good idea and asked for more information about their relationship to the Trust. The Trust already "look after" Westminster LINks but Wandsworth LINk had not wished to follow-up.	

	ML said that it would be helpful if work could be shared by more governors than those who normally attend meetings. Recruitment of more members would help. CB said there had been an item on the Council of Governors agenda re recruitment. SM said that not everyone can regularly attend meetings due to work commitments. ML reminded the Committee that the early days of the Council of Governors had been difficult in terms of numbers and resources: i.e. there had been no website or notice board. **Issue 10. Reaching underrepresented groups in the Membership** There was a discussion about rephrasing the constitution to allow younger people to be recruited. SN discussed the Young Persons Forum and Learning Disability forum in May and said that so far no Governors had signed-up. ML expressed an interest. It was asked if there a space on the form to register interest in becoming a volunteer? SN said that the aim is to work collaboratively with existing resources of black, minority and ethnic groups e.g. Notting Hill Carnival and SM suggested ethnic radio stations. PB confirmed the benefit of links to ethnic festivals/events. The BME forum will be discussed later. WMW asked about the use of the mobile clinic.	
4.	**Council of Governors Membership Sub-Committee. Membership Development Action Plan – Review and Planning for 2011/2012**	**SN**
	The Membership Development Action Sub-Committee was asked to consider the current Action Plan and prioritise actions for 2011/2012. Whilst it remains the main focus it has been streamlined from 9 to 5 points. Key areas for consideration for 2011/2012 are: • Engagement activities within the hospital e.g. Information Zone (Meet a Governor sessions); Governor/Senior Nurse Rounds; shadowing staff. • Mobile Health Clinic – ensuring collaborative work with teams. • Black Minority and Ethnic Groups. • Younger membership (12-16 years) • Geographical areas with low membership. SN said it will require good planning to deliver the key objectives. ML agreed with the stream lining of the plan and MJ said that the four-year framework is a positive step forward. CB would prefer an annual action plan as things can change each year and that the dates before Council of Govs in May are not suitable. PB asked if the Action Plan could contain more information about the equality schemes. SN said that fresh demographic date will be published after the census commencing 27 March. JT is reviewing the plan for 2011/2011 and will come back to May's meeting with specific actions and outcomes. It was asked when the strategy had been developed. The meeting recognised the effort that SN had put into developing the Action Plan. **Action: JT to come to May's Membership Sub-Committee with specific actions and outcomes**.	
5.	**Email to Members - suggestions**	**SN**
	Email to members. Update and more information.	
	An email is to be sent to members in the near future. A discussion arose about the appropriate number of emails to be sent per year so that members "don't feel overwhelmed". MA suggested twice a year: i.e. end April/beg August while SM suggested quarterly. JT was concerned that people would get too many emails. CMC said to ask for submissions and suggestions for dates. SN said that there is space for feedback at the bottom of the email. MA said that the mailing at end of April would also give important information whilst RMB told the meeting about the Twitter profile link for members.	
6.	**Governor Stand at Open Day 2011**	**SN**

	SN led a discussion about recruitment of new members at the Open Day 2011 on 7 May. ML was keen to sign up new members that day. SM suggested a raffle giving M & S vouchers as prizes and also suggested giving away free cotton bags with a message "I am a Member please ask me how to get involved". ML said that bags would be popular but not necessarily reach the right people. CMC suggested that potential members receive a bag containing information after they had signed up. SM said that there are 150 new members. ML thought a small refreshment zone giving free coffees (this would clash with Costa Coffee) sweets and fruit would attract interest and suggested that governors talk to people at the table. Desks would be needed for people to complete the form. There had been problems the previous year with the rota and therefore governors would be paired up and managed during time slots: 11-12; 12-1; 1-2 and 2-3.	
	5.45: LR left the meeting.	
7.	**Westfield Community Roadshow**	**MA**
	A short film "Introduction to C&W Hospital" was shown. From 28 March this will be shown at Westfield Shopping Centre.	
8,	**Any Other Business**	
	Governors discussed the need for a permanent, fixed but reasonably priced table in the Governors/Information Zone instead of sharing a table (which often went missing) with other users e.g. matrons and the Friends of Chelsea & Westminster Hospital. It was suggested that SN put a message on the daily bulletin asking if another department could donate a surplus one to Governors. The table (if nailed to the floor) should be at the back of the Information Zone and point out toward the entrance and NOT sideways pointing inward toward the kiosk. **It was agreed:** (providing the chairs were moveable - since the Governors are of varying heights and some would need more leg room than others).	
13	**Date of next meeting**	
	The next meeting will be held on 16 May 2011 at 4pm	

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting
May 2011

AGENDA ITEM NO.	2.12/May/2011
PAPER	Membership Development Action Plan
AUTHOR	Sian Nelson, Membership and Engagement Manager
LEAD	Sian Nelson, Membership and Engagement Manager
SUMMARY	The Membership Development Action Plan has been updated April 2011 by the Membership and Engagement Manager.
DECISION/ ACTION	The Council of Governors is asked to note the update and agree membership priorities for 2011/12.

Updated February 2011

Chelsea and Westminster Hospital NHS Foundation Trust

MEMBERSHIP DEVELOPMENT ACTION PLAN

2010 – 2011
Updated March 2011

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

ISSUE	OBJECTIVE	ACTION	LEAD	DATE DUE/ COMPLETION STATUS	NOTES
1. Information Zone	To improve communication between Members and Governors and to recruit new members to the	• Develop open, drop in sessions for members and potential members to meet Governors • Develop a roster for Governors to be present in the zone to perform question and answer sessions • Advertise/give notice to patients, public and staff of such events • Erect pictures of Governors in the Information Zone with contact details of each Governor.	CB SN SN/ Norlands	Completed Ongoing Completed	To review notice of sessions to wards and departments Dates confirmed until end of June. Promoting the 'Meet a Governor' session include the • Text message board displays the key dates. • Pop up banner • Internet • Email to members
2. Seasonal Working Conference for Hospital Staff	To create a forum through which Governors can communicate with Members on key issues of patient care.	• Governor presentation at the Seasonal Working Conference • Governor stand at the Seasonal Working Conference • Invite a group of Members to the Seasonal Working Conference through the bi-annual mailings or email.	SN	In progress	A successful day for the Governors at the Spring Seasonal Working Conference 2011. Attended by Martin Lewis, Chris Birch, and Susan Maxwell. Charlotte-Mackenzie-Crooks hosted a workshop for staff attended where the Governors held a discussion with staff regarding the 'role of Governors.
3. Patient Forums	To actively participate in patient forums to receive direct feedback from patients users.	• Governors to participate in chosen patient forum • Governors to feedback important messages to the -appropriate Council of Governors Sub-Committee and action plan as appropriate • Governors to sign to forum to acknowledge participation	SN	In progress	HIV Forum – CB Families and Young Children's forum –WMcW - Awaiting dates for the next meeting Maternity Services Liaison Committee – Christine Blewett and Francis Taylor

ISSUE	OBJECTIVE	ACTION	LEAD	DATE DUE/ COMPLETION STATUS	NOTES
		• Establish relationship with local LINks			Aw Learning Disability Forum – Martin Lewis
4. Recruitment Campaigns	To recruit new members to all constituencies and aim for a representative membership.	• Membership Sub-Committee to review membership bi-monthly and identify opportunities for recruitment and agree a recruitment plan and funding for 2010/11 with the Council of Governors. • The Membership Sub-Committee Action Plan for 2011/12 has been refined and reduced to five key areas to focus on representative membership.	ML	In progress	Membership application forms are coded and identified to special events.
5. Bi-annual membership mailings	To effectively use the bi-annual membership mailings to inform the membership of key issues and explore how the Trust can elicit feedback from members	• Sub-committee to agree the purpose and content of each mail shot • Trust News to be sent to all members bi-annually. The content of the member's Trust News should target patients and the public as well as staff. • Ensure Membership engagement is a priority in membership mailings. Requests to members for their feedback on specific issues or invitations to the Trust should be integrated in each mail shot. • Update members on developments of	SM SN RMcB SN RMcB	In progress Completed In progress	April mailing 2011 completed by Communications department.

ISSUE	OBJECTIVE	ACTION	LEAD	DATE DUE/ COMPLETION STATUS	NOTES
		the hospital and consult with members on key Trust issues for example the hospital extension.			
6. Email communication with Members	Establish an effective use of email communication with Members	• Sub Committee to agree purpose and content of email communication • Update Members email details and encourage use of email in membership literature • Send regular and targeted emails (inc. Trust News link) with Trust updates • Send requests for patient involvement as requested by Trust committees, for example, PEAT, or other patient panels	SN SN	April 2010	Currently there are 3,241 members email- addresses. Email sent to members in March 2011 regarding the launch of Chelsea and Westminster Hospital on Twitter and Chelsea and Westminster Hospital Open Day and dates of 'Meet a Governor' session To confirm frequency of emails to members.
7. Website	To utilise the C&W Hospital website to promote membership involvement and the Council of Governors To ensure Members feel involved in Trust activities.	• Membership Sub-Committee to work with the in house team to refresh web pages, e.g. Clear identification of Governors and the constituencies they represent; Explanation of the role of the Governor; Clear process for contacting Governors • Members feedback box for Governors response	SN	Completed Completed	

ISSUE	OBJECTIVE	ACTION	LEAD	DATE DUE/ COMPLETION STATUS	NOTES
		• On-line Members application form content to reflect the new paper application form • Develop a Members page to provide information regarding Members events and other Trust invites or activities.	SN/GH	Completed Within Foundation Trust Section of the website.	
8. Council of Governor Elections	To ensure members have the information they need to confidently stand for elections	• Agree through the Membership Sub-Committee types of events to support members with the election application process	CB SN	November 2010	
9. Staff Constituency	Encourage staff representatives to agree an annual program of events with staff members including meetings.	• Agree annual program of events e.g. meetings, column in Trust News. .	CD, LB, JJ, BG, SS	Commence April 2010	Carol Dale, Staff Governor for the management constituency has established this approach in her constituency and her method can be applied to the other staff constituencies.
10. Reaching underrepresented groups in the Membership	To improve representation of under-represented groups	• Membership Sub-Committee to review membership bi-monthly and identify underrepresented groups and agree plans for recruitment and engagement in these groups. • Target ethnic minority groups in the community and seek ways of engagement with these groups. • Governors to link with the Mobile	ALL ML SN		Recent health screening and engagement events have taken place in: • Monthly: Shepherds Bush Market, focusing on Black, Minority and Ethnic Groups. • T4 and the Stars event, Earl's Court – health screening for

ISSUE	OBJECTIVE	ACTION	LEAD	DATE DUE/ COMPLETION STATUS	NOTES
		Health Clinic Steering group to reach groups in the local community			the younger age groups • Westfield Shopping Centre – health screening for all, combined with a membership 'road show' where representatives of Chelsea and Westminster Hospital engaged with the shoppers and recruited to membership. • The creation of Chelsea and Westminster Hospital membership DVD, which was showcased at Westfield and will roll out to GP Surgeries in the Borough of Hammersmith and Fulham.
11. Young Persons Membership Group	To create a Young Persons Membership Group to strengthen the membership of young people	• Membership Sub-Committee to agree a proposed 'terms of reference for the group' • Propose the idea of a Young Persons Membership at the next Annual Members Meeting. • Identify a Young Persons 'Champion' to lead the membership group. • Work with the existing children's forums to understand how we can gain insight into the needs of this group, reach this group and offer membership for their benefit	ML SN SM	In progress In progress	Monitor have confirmed we can apply for a change to the constitution To propose as key area for 2011/12 in the Membership Action Plan.

ISSUE	OBJECTIVE	ACTION	LEAD	DATE DUE/ COMPLETION STATUS	NOTES
		• Visit to schools to provide education sessions for young people and link with membership. For example, providing first aid classes or sexual health awareness.			
12. Quality Accounts	To engage members and seek feedback of the Quality Accounts	• Governors to seek the views of members regarding the Trusts Quality Accounts through engagement activities: mail shots, email/website, seasonal working conference and the Governors session in the Information Zone	SN		LINks attend the Quality Sub-Committee.
13. Learning Disability Strategy	To involve members with the implementation of the Learning Disability Strategy	• To create a learning disability patient forum to seek feedback from members with a learning disability with regards to support services, information including leaflets and signage • Share the forum with external agencies (for example, LINks) in the community to gain feedback from the local community of the expectations of the Trust	SN	In progress	LD Steering Group now meeting monthly. Learning Disability Forum was hel in February 2011. However, more work needs to be done to encourage attendees. Joint working protocol with K&C LINks approved at Quality Committee LINks now attend the Quality Sub-Committee.
14. Service Development	To consult members on service development activities	• Consult with members on service development within the Trust, for example the extension and redevelopment of the hospital. Request feedback through mail shots,	SN	In progress	Five Governors have booked numerous 'Meet a Governor' sessions and dates are confirmed until end of June 2011.

ISSUE	OBJECTIVE	ACTION	LEAD	DATE DUE/ COMPLETION STATUS	NOTES
		email/website seasonal working conference and Governors sessions in the Information Zone			To encourage the wider Council of Governors to host a session. Members can request an alternative date if they cannot attend the scheduled dates.

Named Personnel:

TD	Therese Davis	Chief Nurse and Director of Patient Flow and Patient Experience
SN	Sian Nelson	Membership and Engagement Manager/MPALS
LR	Liz Revell	Interim Foundation Trust Secretary
MA	Matthew Akid	Communications Manager
JT	Jane Tippett	Acting Assistant Director of Nursing
CB	Chris Birch	Patient Governor
SM	Susan Maxwell	Patient Governor
ML	Martin Lewis	Public Governor Westminster Area 1 and Chairman of the Membership Sub-Committee
CD	Carol Dale	Staff Governor, Management
RMcB	Renae McBride	Communications Manager

Updated November 2010

WMcW	Wendy McWatters	Patient Governor
MJ	Mervyyn Jermiah	Public Governor Westminster Area 1
CMC	Charlotte Mackenzie-Crooks	Staff Governor, Administration and Clerical

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting
5th May 2011

AGENDA ITEM NO.	2.12.1/May/2011
PAPER	Council of Governors Membership Development Action Plan – Review and Planning for 2011/12
AUTHORS	Sian Nelson, Membership and Engagement Manager
LEAD	Sian Nelson, Membership and Engagement Manager
EXECUTIVE SUMMARY	The Membership Development Action Plan 2010/11 is due for revision and planning for 2011/12. The aim is to focus on priorities for 2011/12 that are clear and feasible.
DECISION / ACTION	This paper outlines key priorities to direct the Membership Development Action Plan 2011/12. The Council of Governors is asked to review and agree the key priorities. Once approved the revised Membership Development Action Plan will be presented at the Council of Governors meeting in July 2011.

Membership Development Action Plan 2011/12

1.0 Introduction

The Membership Development Action Plan 2010/11 was designed to provide a framework for the Membership Sub-Committee to plan membership activities for 2010/11. It is developed in line with the Membership Development and Communication Strategy.

2.0 Background

The Membership Development and Communication Strategy outline how the Trust encourages engagement with its membership. The Membership Development Action Plan 2010/11 has been reviewed at each Membership Sub-Committee since its introduction in 2010 and approved by the main Council of Governors body.

2.1 Some issues within the action plan have required more focus and attention than others, and it is suggested to condense the action plan for 2011/12 so that membership activities are prioritised and more focused for the forthcoming year

3.0 Proposal – Review and plan for 2011/12

3.1 The Membership Development Action Plan has 14 issues. Reducing this to 5 key issues and related objective and action plans will ensure feasibility of membership engagement for 2011/12.

3.2 The Membership Sub-Committee is asked to consider the current Action Plan and prioritise actions for 2011/12. Key areas for consideration for 2011/12 are:

- Engagement activities within the hospital:
  Information Zone – 'Meet a Governor' sessions
  Governor/Senior Nurse Rounds.
  Shadowing staff.

Concentrating on improving membership numbers and engagement with underrepresented groups in the community:

- Black Minority and Ethnic Groups,
- Developing a Younger membership (12-16 years)
- Geographical areas with low membership.
- Ensuring representation from disability groups

3.3 For review and approval from the Council of Governors.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

AGENDA ITEM NO.	2.13/May/2011
PAPER	Membership Report
AUTHOR	Sian Nelson, Membership and Engagement Manager
LEAD	Jane Tippett, Acting Assistant Director of Nursing
EXECUTIVE SUMMARY	This paper reports on the membership numbers for the Trust which currently has a total membership of 14, 501.
DECISION/ ACTION	For review of the Council of Governors

Council of Governors Membership Report

1. Introduction

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

2.0 Background

2.1 Member Constituencies

2.1.1 There are three Member Constituencies, Patient, Public and Staff. Membership for each constituency is illustrated in Table 1. The information in this report was updated 30 March 2011.

30 MARCH 2011	MEMBERS	PERCENTAGE
Staff	3, 173	21%
Patient	5,591	38%
Public	5,737	39%
Total	14,501	100%

Table 1: Membership

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

At the start of April 2010 there was a total of 15, 817 members, since then a total of 2,008 members have joined and a total of 2, 694 members have left or moved constituency and no longer eligible for membership.

2.2 Patient Constituency

2.2.1 There are 5, 591 patient members as at 30th March 2011.
At the start of April 2010, there were 6,010 patient members, since then a total of 396 have joined and 815 members have left or changed constituency.

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

Age (Years)	
0-16	0
17-21	42
22+	3,071
Unknown	2,478

Table 2: Patient membership by age range

2.3 Public Constituency

2.3.1 There are 5,737 public members as at 30th March 2011.
At the start of April 2010 there were 6,131 public members, a total of 257 public members have joined and 651 have left or changed constituency.

2.3.2 Ethnicity in the public constituency demonstrates the highest proportion of membership within the Caucasian category and gender distribution remains

PUBLIC CONSTITUENCY	NUMBER OF MEMBERS	ELIGIBLE POPULATION
Age (years)		
0-16	0	6,154
17-21	41	40,632
22+	4,941	709,475
Unknown	795	
Ethnicity		
White	4,056	581,753
Mixed	237	28,772
Asian	330	48,323
Black	277	67,208
Other	285	29,947
Unknown	552	
***Socio-economic groupings**		
ABC1	4,950	431,344
C2	4	40,531
D	0	63,223
E	766	87,991
Unknown	17	
Gender analysis		
Male	2,257	362,544
Female	3,429	393,249
Unknown	51	

Table 3: Analysis of Public membership

*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).

2.4 Staff Constituency

2.4.1 Staff membership has been updated to include all staff

STAFF CONSTITUENCY	
1 April 2010	3.046
New Members	1,355
Members leaving including (Opt Out)	1,228
January 2011	3,173

Table 4: Staff constituency figures.

3.0 Membership Recruitment and Engagement

3.1.1 Since April 2010 a total of 2,694 members have left membership and 2,008 have joined. A data cleanse is performed twice per year before member mailing which removes those members not at the same address or who have been registered deceased. In addition Capita is notified monthly for requests of members' removal from the database.

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

3.1.3 A Membership Action Plan 2010-11 was approved by the Council of Governors. This provided direction and feasible actions for Governors to increase membership for the 2010-11. The Action Plan 2010-11 emphasised engagement between the Governors and Trust with Members. This has been reviewed bi-monthly at the Membership Sub-Committee meeting.

A proposal for the Membership Action Plan 2011/12 is to be presented at the Council of Governors meeting in May 2011 following approval at the Membership Sub-Committee in March 2011.

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

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

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

3.2 Developing a Representative Membership

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

3.2.2 The Trust has purchased a community mobile health clinic. This was set up with the aim of membership development and engagement in the community. The services from the mobile health clinic aim to target 'hard to reach' groups in the community. Dates are circulated to all Governors to encourage Governor Participation.

3.2.3 The Membership and Engagement Manager 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

The Mobile Health Clinic is visiting Shepherds Bush market area every month and focuses on health screening/outreach work with Black, Minority and Ethnic groups. Membership recruitment is currently being undertaken here.

3.2.4 Membership under-representation continues in the following areas:

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

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

3.2.6 To create equal representation, It is recognised that membership recruitment should focus on increasing its numbers and engagement with Black, Ethnic and Minority groups. The Membership and Engagement Manager is currently developing an action plan with the Equality and Diversity Manager to address this and to ensure the Governor elections in 2012 will be adequately promoted to these groups.

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

4.0 Summary

4.1 Membership engagement has been a priority for 2010-11 and the trust has made significant improvement in providing opportunities for Governors to engage with members.

4.2 Increasing representation in all areas is important, and encouraging growth in hard to reach communities. The Membership Action Plan 2010-11 outlines direction for development.

4.3 The Membership Sub-Committee will seek approval from the Council of Governors in May 2011 to review and agree the key priorities for the Membership Action Plan 2011-12, which will focus on underrepresented groups including Black, Minority and Ethnic groups (BME), developing a younger membership, and representing patients with disability.
The Council of Governors will be asked to review and agree the key priorities. With approval, the revised Membership Development Action Plan will be

presented firstly at the Membership Sub-Committee 16th June 2011 and the final version at the Council of Governors meeting on 14th July 2011.

5.0 Decision/Action Required

5.1 For information and consideration of the Council of Governors.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

CONFIDENTIAL

Council of Governors meeting, 5 May 2011

AGENDA ITEM NO.	3.1/May/2011
PAPER	Finance Report – February 2011
AUTHOR	Mike Fox, Chief Management Accountant
LEAD	Lorraine Bewes, Executive Director of Finance
PURPOSE	To report the Trust financial performance for the eleven-month period ended February 2011.
EXECUTIVE SUMMARY	Year to date the Trust has recorded a net surplus of £12.1m (£1.5m, 14.4% ahead of budget) which includes a £1.0m benefit relating to prior year over-performance meaning the Trust is still ahead of its plan. Clinical Contract Income is continuing to over perform against plan with £4.5m of over-performance year to date due to higher levels of Outpatient, Elective and Non-Elective activity than originally planned. Year to date Pay costs in the Trust are in line with plan when taking account costs relating to Research and recharges to other organisations. Non-Pay costs are £6.0m higher than budget year to date. Provision for Bad Debts is now £4.5m due to increased levels of data challenges by the Trust's commissioners. The remaining £1.5m variance relates to increased costs of Prosthetics (£0.7m) and Pathology tests (£0.4m) as a result of the increased clinical activity undertaken by departments which has generated additional income for the Trust. The Trust has identified 100% of its 2010/11 CIP target of £22.6m and 103% recurrently. The Trust is now focused on the identification and delivery of the CIP target for 2011/12 which is anticipated will be approximately £19.7m. The Trust forecast has improved from last month. The Trust is now forecasting a year end surplus £1.3m higher than plan (£13.7m) with an EBITDA of £30.9m which is in line with plan. The Trust is expecting a rating of **Excellent for the Use of Resources** by the Care Quality Commission.
DECISION/ ACTION	The Board of Governors is asked to note the financial position for the financial year to date ended 28th February 2011 and the updates in this report.

Glossary of Terms

CIP: Cost Improvement Programme

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

Point of Delivery: Type of care, e.g. inpatient, outpatient or daycase.

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

Excess Bed Day Income: Income earned when patients stay in hospital longer than average for a particular procedure.

Elective: Planned Care (non emergency)

Non Elective: Emergency Care, e.g. ITU, Burns.

NICU: Neonatal Intensive Care Unit

SCBU: Special Care Baby Unit

Conversion Rate: The normal % of Outpatient or A&E attendances that become inpatient admissions.

Tariff: Nationally agreed price for a particular procedure.

PASA: NHS Purchasing and Supply Agency

Accrual: Accounting provision for liability where the goods or services have been received but the invoice has not yet been accounted for.

Acuity: Seriousness of a patient's condition

Locum: Temporary doctor covering vacancy or staff absence.

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

BPPC: Better Payment Practice Code

Deferred Income: Income received relating to a future period which is carried forward on the balance sheet.

IM&T: Information Management and Technology

Monitor: Regulatory body for NHS Foundation Trusts.

Council of Governors Meeting, 5 May 2011

AGENDA ITEM NO.	3.2/May/11
PAPER	Performance Report – February 2011
AUTHOR	Sherryn Elsworth, Head of Performance Improvement
LEAD	Amanda Pritchard, Deputy Chief Executive
EXECUTIVE SUMMARY	The purpose of this report is to update the Council of Governors on the Foundation Trust's performance for the period ending 28th February 2011 (the latest period to have been reported to the Foundation Trust Board) and to highlight performance risks going forward. The Trust performed well in the year to date in eight of the nine scored Monitor indicators which could be measured and in twenty four of the twenty five Care Quality Commission indicators which could be measured. Performance relating to a number of indicators cannot yet be measured as these will be assessed via a year end data collection or survey. The Trust is below plan year to date for MRSA, with 6 cases against full year targets of 3 (CQC) and 6 (Monitor). There have been increases in C. Difficile as a result of the introduction of a more sensitive testing regime than that used in the previous financial year. C. Difficile cases are within the 2010/11CQC target of 100 but currently higher than local stretch targets. The Trust is within target for the combined measure of MRSA elective and non-elective screening using the existing Department of Heath measurement methodology but there would be a risk to delivery going forwards if the measurement regime were to change in 2011/12. A series of actions have been agreed with the Divisional Medical Directors and senior nursing team to increase compliance with Infection Control protocols and raise the profile of these targets within the Trust. Going forward, further work is required to ensure compliance with the range of new measures for 2011/12 including new A&E and RTT (Referral to Treatment) targets. In addition, the Trust has declared compliance with single sex accommodation requirements.
DECISION/ ACTION	The Council of Governors is asked to note the report.

PERFORMANCE REPORT FOR THE PERIOD FEBRUARY 2011

1 Introduction

Chelsea & Westminster's performance is monitored by the Care Quality Commission (CQC) who are responsible for assuring the quality of healthcare services in England, Monitor who are responsible for regulating Foundation Trusts and commissioners who contract with Chelsea & Westminster for the provision of a range of services at a defined level of quality. There is significant overlap in the metrics tracked by the CQC, Monitor and health service commissioners but despite this fact Chelsea & Westminster still needs to track around 70 metrics to ensure the Trust is adequately measuring the metrics which are of importance to our key stakeholders. Performance against these metrics is reported monthly to the Foundation Trust Board and summarised via a high level Performance Dashboard, attached at Appendix 1.

The recent announcement of a policy shift away from national targets, and a renewed emphasis on locally defined requirements outlined within service contracts, has led to little real change in performance monitoring requirements for Chelsea & Westminster in 2010/11. It is of note that the Care Quality Commission will no longer be publishing ratings (Chelsea & Westminster was previously rated Excellent for both financial management and the quality of our services) but will instead publish benchmarking data against a range of quality indicators.

The performance metrics measured include access targets such as the proportion of patients treated within 18 weeks of referral, A&E attendees seen within 4 hours of arrival and Cancer referrals seen within two weeks of referral. Quality metrics include emergency readmissions and the provision of discharge summaries. Efficiency metrics include day case rates and the average number of follow up appointments which a patient attends following referral to a hospital consultant.

2 Overall Performance

Chelsea and Westminster performed well year to date, achieving the required level in the majority of the indicators which are monitored by the Care Quality Commission and Monitor, including access targets such as 18 weeks referral to treatment and the A&E 4 hour wait target and reducing last minute operation cancellations.

3 Areas of concern

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

Target	Performance
MRSA	**Year to date 6 cases against full year targets of 3 (CQC), 6 (Monitor), 10 (local stretch target A £100k), 5 (local stretch target B £150k). Divisional Medical Directors are leading initiatives to increase compliance with Infection Control protocols.**
C Difficile	**Year to date 67 cases against part year targets of 91 (CQC), 59 (Stretch target A £100k), 32 (Stretch target B**

	£150k). The target is more challenging as a result of the introduction of a more sensitive test regime than that used in the previous financial year.
Discharge Summaries within 24 hrs	**Year to date 79.94% against a contractual target of 100% Reminders on contractual requirements have been distributed and discussed at divisional boards.**
Patient Experience Tracker Completion	**In month only 44.21% of patients have completed the PET questionnaire against an internal target of 80%. Wards are working to increase uptake to ensure that reported PET results are fully representative of patient experience.**
Outpatient encountering completion and 18 week RTT completion	**Year to date attendance was not recorded for 4.17% of outpatient appointments and 11.22% of outpatient attendances were not flagged with whether the patient had been treated. This hinders the Trust's ability to track referral to treatment times.**
Diagnostic wait < 6 weeks	**Year to date 158 patients have had a wait of greater than six weeks. The majority of the problem is in Endoscopy where a long term solution to capacity issues is being developed. There were no breaches in the month of February.**

4. Other areas of concern going forward

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

Target	Issue
18 weeks / RTT performance	The Trust has met all 18 weeks targets year to date and expects to do so running through to year end.
Cancer performance	Cancer targets have been achieved year to date. Looking forward continued achievement is expected.
Elective MRSA Screening rates	The Trust's overall ratio of elective admissions to MRSA tests is acceptable but detailed analysis shows that some patients are tested more than once and some patients may not be screened at all. The Chief Nurse is leading a project to improve performance in this area.
Emergency MRSA Screening rates	The Trust is not currently screening all emergency admissions; this underperformance is currently being offset by over performance in elective admission screening as performance is measured in aggregate. The Chief Nurse is leading a project to improve performance in this area.
A&E Performance Indicators	The Trust's performance against the 4 hour wait target is above 98% for quarter 4 and remains on track overall, although there have been days where performance has dropped significantly due primarily to exceptionally high numbers of patients or pressure on beds within the hospital.

5. Future Performance Standards & Outcome Measures

Performance standards that apply across the NHS are set out annually in the NHS Operating Framework. There are 21 'headline' measures and 18 'supporting' measures that affect the Trust. Of these, 19 are new measures or are substantial changes to existing measures.

In addition, a range of outcome measures will be included in contracts next year and the North West London Commissioning Partnership has set out 32 'core' measures and 42 'supporting' measures that affect the Trust. Of these, just 23 overlap with the national standards. In total, this means 90 different nationally or locally set standards, before the shadow national outcome measures are included or indeed any of the Trust's own business plan priorities or quality objectives.

However, the indication (formally and informally) is that the real headline areas will be: A&E new standards, Single Sex Accommodation new standards, 18 weeks new median and 95th percentile standards, MRSA and CDiff, Cancer. The most challenging of these will be the new A&E standards and the first priority is to ensure adequate data collection and data quality relating to the new measures. An exercise is currently underway to collect this data. Once this is complete an action plan will be developed with the A&E team to address areas of concern in relation to data and actual performance. Performance against the new 18 week standards is being recorded and meets the required levels.

6. A&E Quality Indicators

There are 5 new core indicators relating to A&E and the Trust is currently able to provide evidence that it is meeting just two of these. The primary issue is data quality and, although there are opportunities to improve this significantly in relation to the indicators, it is unclear whether this will guarantee achievement of the expected level of performance. However it is proving extremely difficult to capture accurate information on one of the indicators and current performance is significantly off track. The new indicators were only published in December and it is anticipated that most Trusts will have data quality / poor performance issues for at least the first quarter of the year.

Indicator	Performance Threshold	Year to Date Performance	Comments	Risk
95th percentile overall time in A&E	<= 4 hours	Overall 3.56	Data quality improvements should ensure compliance	
Unplanned reattendance within 7 days	> 5%	7.3%	Removing planned reattendances should reduce figure to between 4.8 and 6.1%.	
Left without being seen	>5%	3.52%	Significant reduction since the UCC opened	
95th percentile time to initial assessment for patients arriving by ambulance	> 15 minutes	27 mins	Data quality very poor. Will require complete change to data entry process. High risk for April 1st.	
Median waiting time from arrival to initial assessment	> 60 minutes	1.00	Data quality improving. Manual validation may be required.	

7. Action

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

TRUST PERFORMANCE DASHBOARD FEBRUARY 2011

	Indicator Name	Monitored by / Submission to	Trustwide Target / Threshold	Trustwide Performance YTD	Trustwide Performance in Month	Medicine and Surgery YTD	Medicine and Surgery in Month	Women's, Neonatology, Children's and Young people's, HIV, Sexual Health and Dermatology YTD	Women's, Neonatology, Children's and Young people's, HIV, Sexual Health and Dermatology in Month	Clinical support YTD	Clinical Support in Month
Quality	Incidence of Clostridium difficile --Hospital Acquired	Monitor, CQC, Local Stretch	91.67	67	5	52	5	10	0	5	0
	MRSA Bacteraemia --Hospital Acquired	Monitor, CQC, Local Stretch	5.50	6	0	2	0	3	0	1	0
	Meticillin Sensitive Staphylococcus Aureus (MSSA) --Hospital Acquired	Monitor, CQC, Local Stretch	TBC	3	1	2	0	1	1	0	0
	Hand Hygiene Compliance (trajectory)	Quality account	88%	88.65%	90.00%	88.04%	91.00%	86.88%	87.00%	93.02%	96.00%
	Hand Hygiene Completion (trajectory)	Quality account	86%	84.14%	98.25%	84.09%	100.00%	86.15%	96.43%	81.10%	100.00%
	Patient falls resulting in moderate or major harm	Quality account	8.3	10	0	6	0	2	0	2	0
	Never Events	Quality account	0.0	0	0	0	0	0	0	0	0
	Emergency Readmissions within 14 days (COPD, heart failure and diabetes)	Contract	5.2%	3.58%	6.67%	3.58%	6.67%	N/A	N/A	N/A	N/A
	Emergency Readmissions within 28 days (COPD, heart failure and diabetes)	Contract	10.2%	4.90%	8.89%	4.90%	8.89%	N/A	N/A	N/A	N/A
	Elective and Emergency MRSA Screening Ratio (Quarter 4 only)	Monitor, Contract	100.0%	108.77%	112.27%	To be set up for March reporting					
	Mortality (HSMR) (2 months in arrears) (trajectory)	Quality account	85.73	73.78	62.38	66.42	59.76	175.14	80.00	214.29	500.00
	VTE Assessment (YTD measured from Oct in line with CQUIN)	Contract	90%	92.53%	91.15%	91.10%	89.03%	93.17%	92.07%	97.69%	98.61%
	Rapid Access Chest Pain Clinic	CQC, Contract	98.0%	100.00%	100.00%	100.00%	100.00%	N/A	N/A	N/A	N/A
	Quality of Stroke Care	CQC, Contract	80%	94.09%	100.00%	94.09%	100.00%	N/A	N/A	N/A	N/A
	Infant health & Inequalities: % Women known to be smokers	CQC	4.13%	3.92%	2.96%	N/A	N/A	3.92%	2.96%	N/A	N/A
	% Mothers known to initiate breastfeeding	CQC	91.06%	94.09%	92.18%	N/A	N/A	94.09%	92.18%	N/A	N/A
	% Women seen a midwife or obs for assessment by 12+6 (trajectory)	Contract	85%	95.32%	94.88%	N/A	N/A	95.32%	94.88%	N/A	N/A
	Discharge Summaries within 24 hours	Contract	100%	79.94%	81.53%	79.78%	80.84%	81.63%	83.39%	74.92%	78.99%
	Patient Experience Tracker Completion rate	Quality account	80%	49.06%	44.21%	43.58%	35.46%	59.12%	53.90%	43.39%	51.21%
	Patient Experience Tracker overall satisfaction scores	Quality account	90%	90.30%	92.40%	89.90%	90.60%	89.00%	90.70%	95.90%	98.90%
	Complaints and concerns for admissions and appointments	Quality account	196	275	27	127	16	76	8	33	2
	Formal complaints responded in 25 working days	Quality account	90%	83.50%	64.86%	76.76%	52.38%	87.16%	76.92%	96.43%	100.00%
	Best Patient Experience (BPE) - In preparation for PEAT Audit	Quality account	Excellent: Food, environment and P&D - 90%	75.15%	75.71%	74.23%	74.63%	75.55%	74.18%	N/A	N/A
	Breach of Same Sex Accommodation	Contract	0	0	0	0	0	0	0	0	0
Finance	Income variance	Internal	-£ 292,687,351	£ 6,100,187	£ 2,262,180	-£ 165,464	£ 92,866	£ 2,638,540	£ 620,843	£ 898,261	£ 157,086
	Pay variance	Internal	£ 150,622,556	£ 262,329	£ 166,663	£ 36,933	£ 5,235	£ 706,281	-£ 59,012	-£ 927,947	-£ 164,184
	Non Pay variance	Internal	£ 114,700,110	-£ 5,972,774	-£ 2,145,939	£ 122,940	-£ 26,579	-£ 2,010,882	-£ 425,325	-£ 94,242	£ 78,362
	EBITDA	Internal	-£ 27,364,685	£ 389,742	£ 282,904	-£ 5,591	£ 71,522	£ 1,333,939	£ 136,506	-£ 123,928	£ 71,264
	Clinical Activity Value	Contract	£ 242,064,712	£ 3,085,019	£ 443,454	£ 1,535,951	£ 484,660	£ 2,642,082	£ 241,440	£ 656,356	£ 71,886
	Follow Up Value above Plan	Contract	0	£ 3,487	-£ 13,291	£ 483,852	£ 30,379	£ 25,756	£ 2,341	£ -	£ -
	Emergency Activity above Threshold	Contract	£0	£ 78,372	£ 141,934	£ 58,405	£ 82,603	£ 19,967	£ 59,331	£ -	£ -
	Unfunded Consultant to Consultant Referrals	Contract	0	0	0	0	0	0	0	0	0
	Encountering	Contract	100%	96.08%	95.83%	93.82%	91.75%	97.34%	98.06%	98.91%	99.83%
Activity	Regular Day Attender	Contract	6024	6429	646	1655	140	4773	506	1	0
	Same day procedure	Contract	17806	19152	1781	8225	806	6135	535	4792	440
	Elective Against Plan	Contract	6496	6418	493	3960	296	2380	190	78	7
	Non-Elective Against Plan	Contract	34390	35814	3078	15108	1267	20441	1792	264	19
	Outpatient New	Contract	147595	159853	15443	40693	3650	107247	10659	11058	1068
	Outpatient Follow Up	Contract	202429	212546	18246	102661	9169	94858	7491	6526	777
Workforce	Turnover Rate	Internal	14%	16.89%	1.93%	12.78%	0.78%	11.04%	0.46%	6.81%	0.00%
	Vacancy Rate	Internal	10%	13.54%	13.54%	14.50%	14.50%	11.03%	4.97%	5.12%	1.66%
	Sickness Rate	Internal	3.60%	3.38%	3.36%	4.03%	4.11%	2.97%	2.95%	3.38%	4.55%
Efficiency	Elective length of stay	Internal	3.00	3.26	3.94	3.88	5.02	2.31	2.63	6.98	1.39
	Non-Elective length of stay	Internal	3.08	3.12	3.14	4.84	4.89	1.99	2.03	9.42	12.39
	Total Length of Stay	Internal	3.04	3.15	3.27	4.59	4.92	2.03	2.10	8.76	8.73
	New:Follow Up Ratio	Contract	As per contract	1.55	1.49	1.93	1.90	1.11	1.04	N/A	N/A
	Daycase rate	Internal	78%	74.90%	78.32%	67.50%	73.14%	72.05%	73.79%	98.40%	98.43%
	Basket Daycase Rate	Contract	95%	72.82%	78.64%	76.74%	84.52%	67.73%	71.63%	N/A	N/A
	Delayed Transfers of Care	CQC	3.5%	0.66%	0.60%	1.01%	0.94%	0.00%	0.00%	0.00%	0.00%
	Non birth related admissions Ratio	Contract	0.7	0.71	0.79	N/A	N/A	0.71	0.79	N/A	N/A

TRUST PERFORMANCE DASHBOARD FEBRUARY 2011

Access	18 Weeks Data Completeness - Admitted patients -	CQC, Contract	90% - 110%	94.78%	92.86%	102.68%	98.87%	105.18%	101.61%	44.38%	35.21%
	18 Weeks Data Completeness - Non- Admitted patients -	CQC, Contract	90% - 110%	94.11%	100.02%	97.50%	116.43%	96.19%	97.86%	N/A	N/A
	18 weeks Admitted performance	CQC, Contract	90%	95.00%	95.18%	94.03%	93.59%	96.10%	97.67%	92.00%	98.44%
	18 weeks Non-Admitted performance	CQC, Contract	95%	99.18%	98.82%	97.32%	96.00%	99.70%	99.58%	N/A	N/A
	Incomplete Pathway (Source Pathway PTL) - Median Waits	DoH	7.20	N/A	5.93	N/A	6.88	N/A	4.77	N/A	3.54
	Incomplete Pathway (Source Pathway PTL) - 95th Percentile	DoH	36.00	N/A	35.92	N/A	41.04	N/A	21.99	N/A	17.18
	Non Admitted (OP Attendances) Median Waits	DoH	6.60	N/A	0.83	N/A	4.61	N/A	0.68	N/A	0.00
	Non Admitted (OP Attendances) 95th Percentile	DoH	18.30	N/A	10.70	N/A	16.16	N/A	6.56	N/A	0.00
	Admitted (Admissions) -Median Waits	DoH	11.10	N/A	8.11	N/A	8.94	N/A	7.56	N/A	0.00
	Admitted (Admissions) -95th Percentile	DoH	27.70	N/A	17.75	N/A	20.97	N/A	17.57	N/A	0.00
	Percentage of treatment functions achieving the 90% standard for admitted	CQC, Contract	100%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	RTT Outcome Compliance	Internal	100%	91.05%	88.78%	91.34%	88.72%	90.54%	88.87%	N/A	N/A
	CWT: 31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	Monitor, CQC	96%	99.63%	100.00%	99.40%	100.00%	100.00%	100.00%	N/A	N/A
	31-Day Wait For Second Or Subsequent Treatment: Surgery	Monitor, CQC	94%	100.00%	100.00%	100.00%	N/A	100.00%	100.00%	N/A	N/A
	31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug	Monitor, CQC	98%	100.00%	100.00%	100.00%	100.00%	100.00%	N/A	N/A	N/A
	31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments	Monitor, CQC	94%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	CWT: 62-Day (Urgent GP Referral To Treatment) Wait For First Treatment	Monitor, CQC	85%	95.29%	88.89%	91.21%	84.62%	100.00%	100.00%	N/A	N/A
	62-Day Wait For First Treatment From Consultant Screening Service Referral	Monitor, CQC	90%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	62 Consultant upgrade	Monitor, CQC	85%	100.00%	N/A	100.00%	N/A	100.00%	N/A	N/A	N/A
	Cancer urgent referral to first outpatient appointment waiting times: All 2WW	Monitor, CQC	93%	96.26%	98.25%	97.72%	100.00%	95.20%	97.14%	N/A	N/A
	2WW for Symptomatic Breast Patients	Monitor, CQC	93%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Inpatient 26 Weeks	Internal	0.03%	0.016%	0.000%	0.036%	0.000%	0.00%	0.00%	0.00%	0.00%
	Outpatient 13 Weeks	Internal	0.03%	0.02%	0.00%	0.04%	0.00%	0.00%	0.00%	0.00%	0.00%
	Diagnostic <= 6 Weeks	Contract	0	158	0	8	0	4	0	146	0
	GUM Access within 48 hours	CQC	98%	100.00%	100.00%	N/A	N/A	100.00%	100.00%	N/A	N/A
	GP Referrals	Internal	45250	71031	5626	33755	2493	37276	3133	N/A	N/A
	Slot Issues per DBS booking (trajectory)	Contract	4%	13.23%	5.31%	DoH has not published DBS bookings by Specialty since October					
	Cancelled operations by the hospital for non-clinical reasons on the day of or after admission	CQC, Contract	<=0.8%	0.31%	0.42%	0.59%	0.90%	0.10%	0.00%	0.00%	0.00%
	Cancelled operations by the hospital for non-clinical reasons on the day of or after admission, who were not treated within 28 days.	CQC, Contract	<=5%	0.00%	0.00%	0.00%	0.00%	0.00%	N/A	N/A	N/A
	No A&E patient to wait for admission more than 4 hours from decision to admit	Contract	0%	N/A	4.37%	N/A	4.09%	Not applicable			
	A&E 4 median waits	DoH	TBC	N/A	02:06	Not applicable					
	A&E 4 Hour Target	Monitor, CQC, Contract	98%	98.50%	98.42%	98.50%	98.42%	N/A	N/A	N/A	N/A
	A&E Minors 4 Hour Target	Contract	100%	99.47%	98.97%	99.47%	98.97%	N/A	N/A	N/A	N/A
Other	Ethnic Data Quality	CQC	95%	95.28%	94.77%	98.10%	97.05%	92.50%	93.02%	94.49%	92.04%

NB: Where there are multiple targets (e.g. MRSA/C Diff CQC/local stretch) the RAG rating is against the most challenging target