Chelsea and Westminster Hospital NHS
NHS Foundation Trust

12 May 2015

Dear Governors,

Council of Governors Meeting
Thursday, 14 May 2015

Please find enclosed the Agenda and Papers for the Council of Governors Meeting on Thursday 14 May 2015.

The arrangements for the day are as follows:

- 15.00 – 15.40: Council of Governors informal meeting with the Lead Governor over tea/coffee (Gleeson Lecture Theatre, lower ground floor, lift bank C)

- 15.45 – 18.00: Council of Governors General Meeting (Gleeson Lecture Theatre, lower ground floor, lift bank C)

We look forward to seeing you all.

Yours sincerely,

Vida Djelic
Board Governance Manager

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS
14 May 2015, 15.45 – 18.00
Gleeson Lecture Theatre, Chelsea & Westminster Hospital

AGENDA

15.45		Council of Governors Quality Awards presentation	Verbal		Vice Chairman
		GENERAL BUSINESS			
16.00	1.	Welcome to the meeting, Apologies for Absence and Declarations of Interest	Verbal		Vice Chairman
16.05	2.	Minutes of Previous Meeting held on 5 March 2015	Report	For Approval	Vice Chairman
16.10	3.	Matters Arising and Action Log	Report	For Information	Vice Chairman/ Chief Executive Officer
16.15	4.	Chief Executive Officer's Report, *including West Middlesex Acquisition Decision Tree*	Report	For Information	Chief Executive Officer
16.20	5.	Briefing on the on the transaction process	Verbal	For Information	Ernst &Young
16.35	6.	Governors' Questions	Report	For Information	Chief Executive Officer
		STATUTORY/MANDATORY BUSINESS			
16.40	7.	Proposed Post-Acquisition Constitution	Report	For Information	Foundation Trust Secretary
16.50	8.	Council of Governors Sub-Committees proposal	Report	For Approval	Foundation Trust Secretary
17.00	9.	Draft Operational Plan 2015/16 Monitor Submission, *including Long Term Financial Model*	Report	For Information	Chief Executive Officer/Chief Financial Officer
17.10	10.	Draft Quality Accounts	Report	For Information	Medical Director
		TRUST PERFORMANCE			
17.20	11.	Performance and Quality Report	Report	For Information	Chief Operating Officer
		MEMBERSHIP AND ENGAGEMENT			
17.30	12.	Membership Engagement and Communication Calendar of events – update • Open Day 2015 Feedback (Verbal)	Report	For Information	Head of Communications & Marketing

17.40	13.	Council of Governors Funding Report	Report	For Information	Head of Communications & Marketing
		REPORTS FROM GOVERNOR COMMITTEES			
17.45	14.	Quality Sub-Committee Report: 4 March 2015	Report	For Information	Chair of Quality Sub-Committee
17.47	15.	Membership Sub-Committee Report: 3 March 2015	Report	For Information	Chair of Membership Sub-Committee
17.50	16.	Questions from public	Verbal		Vice Chairman
17.55	17.	Any other business			
18.00	18.	Date of next meeting: 28 July 2015			

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 14 May 2015

AGENDA ITEM NO.	2/May/15
REPORT NAME	Draft Minutes of the Council of Governors meeting held on 5 March 2015
AUTHOR	Thomas Lafferty, Foundation Trust Secretary
LEAD	Sir Thomas Hughes-Hallett, Chairman
PURPOSE	To provide a record of any actions and decisions made at the meeting.
SUMMARY OF REPORT	This paper outlines a record of the proceedings of the Council of Governors meeting held on 5 March 2015
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	None.
LINK TO OBJECTIVES	NA
DECISION/ ACTION	For approval.

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Minutes of the Council of Governors
Held at 16.30 on 5 March 2015 in the Boardroom, Chelsea & Westminster Hospital

Present:	Sir Thomas Hughes-Hallett	Trust Chairman	(Chair)
	Walter Bamford	Patient Governor	(WB)
	Chris Birch	Patient Governor	(CB)
	Christine Blewett	Public Governor	(CBL)
	Nicky Browne	Appointed Governor	(NB)
	Dr Anthony Cadman	Patient Governor	(AC)
	Cass J Cass-Horne	Patient Governor	(CCH)
	Tom Church	Patient Governor	(TC)
	Samantha Culhane	Public Governor	(SC)
	Lou De Palo	Staff Governor	(LDP)
	Brian Gazzard	Staff Governor	(BG)
	Angela Henderson	Patient Governor	(AH)
	Jenny Higham	Appointed Governor	(JH)
	Anna Hodson-Pressinger	Patient Governor	(AHP)
	Melvyn Jeremiah	Public Governor	(MJ)
	Martin Lewis	Public Governor	(ML)
	Susan Maxwell	Patient Governor	(SM)
	Philip Owen	Public Governor	(PO)
	Diane Samuels	Staff Governor	(DS)
	Charles Steel	Patient Governor	(CS)
	George Vasilopoulos	Staff Governor	(GV)
	Steve Worrall	Public Governor	(SW)
In Attendance:	Sir John Baker	Non-Executive Director	(JB)
	Jeremy Loyd	Non-Executive Director	(JL)
	Elizabeth McManus	Chief Executive	(EM)
	Lorraine Bewes	Chief Financial Officer	(LB)
	Zoe Penn	Medical Director	(ZP)
	Karl Munslow-Ong	Chief Operating Officer	(KMO)
	Dominic Conlin	Director of Strategy & Integration	(DC)
	Susan Young	Chief People Officer & Director of Corporate Affairs	(SY)
	Vanessa Sloane	Director of Nursing	(VS)
	Rakesh Patel	Director of Finance	(RP)
	Thomas Lafferty	Company Secretary	(TL)
	Layla Hawkins	Head of Marketing & Communications	(LH)
	Vida Djelic	Board Governance Manager	(VD)
Apologies:	Edward Coolen	Public Governor	
	Catherine Faulks	Appointed Governor	
	Kathryn Mangold	Staff Governor	
	Tom Pollak	Public Governor	
	Wendie McWatters	Patient Governor	

1.	**Welcome and Apologies for Absence**	
a.	The Chair welcomed all present to the meeting. He particularly welcomed KMO and TL who were attending their first Council of Governors meeting.	

b.	The apologies for absence received were noted.	
2.	**Declarations of Interest**	
a.	No interests were declared with regard to the matters to be discussed on the Council agenda.	
3.	**Minutes & Actions from Previous Meeting: 4 December 2014**	
a.	The minutes from the previous meeting were agreed as a true and accurate record.	
b.	It was noted that all actions listed within the meeting action log had either been completed or were otherwise covered on the agenda.	
c.	As a matter arising, ML asked whether all new Governors had been afforded a 'Governor buddy'. Whilst this had been arranged in most cases, it was agreed that WB would act as a buddy to CCH.	
4.	**Chairman's Report**	
a.	The Chairman summarised the contents of the report.	
b.	The Chairman additionally raised the issue of the increased legal liabilities of Board Directors under new and future legislation; including criminal liabilities. He advised that he would be liaising with JB and TL with regard to the holistic position and had asked TL to produce a paper to the Board in this regard.	
c.	The Chairman advised that a meeting of Hospital Charity Chairpersons had taken place during the previous week; he noted that this was an important step in ensuring close collaborative working arrangements in future between Hospital charities.	
5.	**Chief Executive's Report**	
a.	In presenting the report, EM noted that, now that KMO was in post, Rob Hodgkiss (RH) would step down from the role of Interim Chief Operating Officer. EM praised the excellent contribution that RH had made to the improved operational performance of the Trust and to the workings of the Executive Team and Board.	
b.	EM noted that the Trust continued its rolling recruitment programme with regard to key clinical and divisional posts. However, staff retention continued to pose a challenge to the Trust; particularly in the context of increasing levels of patient activity. Members of the Council asked what the Trust was doing to prevent good staff from leaving the Trust. EM said that she would check if the Trust was participating in the 'Back to Nursing' initiative but noted that staff shortages in some clinical areas was a national problem.	
c.	EM noted that the 'Freedom to Speak Up' review led by Sir Robert Francis QC had given national attention to the subject of 'whistleblowing procedures within NHS organisations. The Council discussed the extent to which CWFT staff were aware of the Trust's procedures in this respect. EM confirmed that she would be ensuring that the organisation complied with the new standards in relation to whistleblowing and, as part of this, would also seek to increase staff awareness of the issue; encouraging a culture of openness and transparency.	**EM**
	In terms of performance, EM noted that the Trust had improved its Referral to Treatment	

d.	(RTT) operational performance over the last quarter and had maintained a strong level of compliance with regard to the 4-hour ED target. However, the Trust Executive were focusing hard on controlling current levels of expenditure and ensuring that the Trust's revised in-year CIP target would be met. In response to a question from WB, EM confirmed that the Trust was looking at ways to increase its private patient income.	
e.	EM made reference to the Shaping a Healthier Future (SAHF) strategic initiative and noted the work being undertaken to substantially upgrade the CWFT Emergency Department (ED). The current ED was under-sized given the volume of patient activity and EM paid tribute to the staff that continued to provide high quality care, notwithstanding the limitations of the present environment.	
6.	**Acquisition Transaction Prospectus**	
a.	In presenting the report, DC noted that the Transaction Prospectus was derived from the Full Business Case (FBC) relating to the proposed acquisition of West Middlesex University Hospital NHS Trust (WMUH). The document aimed to highlight the key clinical, strategic and financial drivers underpinning the transaction. He noted that the document would be updated as part of an iterative process.	
b.	It was noted that, prior to the meeting, several Governors had welcomed the clarity provided by the document in relation to the transaction; noting that the document was informative and a comprehensive account of the transaction rationale. BG noted that it would now be key to ensure that the document was used to fully engage staff in the transaction process.	
c.	CB asked for clarity on what the 'Transaction Agreement' represented and expressed concern that this was planned to be 'agreed' by the end of April. DC explained that the Transaction Agreement was the formal document which would need to be approved by Monitor in order to enact the transaction but that the April timeline was only in relation to the wording of the Agreement, rather than the sign-off of the document.	
d.	CS asked how the Trust would approach the management of the stated post-acquisition integration risks. EM advised that the Trust was developing a 'Day 1 safe landing plan' to ensure that the fundamental elements which needed to be in place for Day 1 of the enlarged organisation were, in fact, in place. Beyond this, integration would need to take place over several months post-acquisition as it was important that the Trust took the necessary time to embed sound working arrangements. The Chairman noted that, in terms of clinical services, the two Trusts had already started to work collaboratively and that clinical staff across both sites were forming strong bonds.	
e.	The Chairman asked that any further comments on the detail of the Prospectus be sent via e-mail to TL.	**ALL**
7.	**Council of Governors Sub-Committees**	
a.	TL advised that, in the context of the proposed acquisition, the Trust had a duty to ensure that its governance arrangements were fit for purpose and in accordance with legislation/best practice. He noted that SY had taken a proposal to the Board in January 2015 which had been approved which subsequently had increased the number of public Board meetings and refined the Board Committee structure, including the refreshing of the respective Terms of Reference. TL stated that he would now be leading a similar piece of work in relation to the Council of Governors' governance arrangements. Board comments on his proposals were currently being received; however he was hopeful of being in a position of sharing the proposal paper with the Council during the following week.	

8.	**Governors' Questions**	
a.	The Chairman noted that written answers had been provided to the Governors' Questions that had been submitted in advance of the meeting. He asked those who posed the questions to confirm whether they were satisfied with the answers that they had received. Further detail was required on the following questions:	
b.	In relation to question 2, ML asked for assurance that the bullying concerns highlighted by the Trust's CQC Report in relation to NICU were being addressed by the Trust and would not recur. ZP advised that she was working closely with the Department to build constructive relationships and ensure that adequate monitoring was in place through the frequent review of incidents, complaints and other data relating to the area. The Trust would also be asking trainees within the Department to complete questionnaires in order to gauge the culture and working environment of the NICU. The Chairman said that, whilst no guarantees could be offered, the Non-Executive team were pushing the Executive hard to ensure that the concerns raised by the CQC in this regard were being sufficiently addressed.	
c.	In relation to question 3, CB asked for further information with regard to the opening of the Ron Johnson Ward, in particular whether a suitable plaque would be installed. BG noted that, for a variety of reasons, there had been several delays and issues with regard to the official opening of the ward. However, he confirmed that a low key opening ceremony had now taken place and that a suitable plaque was in place. The Chairman noted that the Trust was a world leader in the provision of sexual health care services and asked that ZP work with BG to ensure that the Ward drew the attention that it deserved.	**ZP/BG**
9.	**Business Planning 2015/16**	
a.	EM noted that whilst the Trust was in the process of developing its 2015/16 Operational Plan as part of the annual planning cycle; Monitor had moved the external submission date of the Plan to 7 April 2015, reflecting the national discussions that were currently taking place with regard to the applicable tariff. In response to a question from BG, RP confirmed that the Trust would be looking to negotiate a PBR (Payment By Results) agreement for all services, as opposed to a 'block contract'.	
10.	**Council of Governors' Performance Evaluation**	
a.	In presenting the report, the Chairman noted that the Council was not formally required to complete the specific performance evaluation questionnaire that was reflected within the report. In response to Governor concern expressed with regard to the format of the evaluation, he confirmed that he had asked TL to consider how future performance evaluations could be enhanced and ultimately represent a truer encapsulation of Governor opinion.	**TL**
b	Notwithstanding the concerns expressed, the Chairman advised that the Trust still needed to recognise some of the shortfalls that had been identified as part of the evaluation. He had therefore asked TL to identify the key areas for development and to formulate appropriate remedial actions to address these.	**TL**
11.	**Membership Sub-Committee Meeting: 3 March 2015**	
a.	WB verbally updated the Council on the key areas of discussion held at the meeting. Firstly, the Committee had wholly endorsed the concept of the 'Constituency Meetings' which would commence from March 2015 and provide an opportunity for the Trust and its Governors to engage with the Trust's local constituents. In addition, the Committee had reviewed the Membership Report and discussed preparations with regard to the April Open	

	Day for members and the Star Awards.	
b.	With regard to the Star Awards, it was agreed that DS, MJ, SM, WMW, SC, CCH, ML and PO would contribute to the 'judging panel'.	
c.	CB noted that the Committee meeting had not been quorate. He urged the Trust to consider revising the Terms of Reference for the meeting. TL confirmed that this would be considered as part of his review of the Council of Governors' governance structure.	
12.	**Quality Sub-Committee Meeting: 4 March 2015**	
a.	ZP noted that she had chaired the 4 March meeting. The key issues discussed had been PALS and Complaints issues and the formulation of the 2014/15 Quality Accounts. In relation to the latter, ZP advised that the Committee had chosen the measurement of patient experience via the Friends & Family test as the Governors' selected indicator. This decision was endorsed by the Council.	
b.	The Chairman noted that, in future, all Governor Committees (except where statutorily counter-indicated) would be chaired by a Governor and that all Committee reports to the Council would be accompanied by the physical minutes of the meeting.	
13.	**Membership Report Q3 2014/15 & Membership Engagement**	
a.	The Chairman noted that the Membership Report was a relatively static document that did not need to be reviewed at each Council meeting. He asked TL to consider how the provision of membership information to the Council could be rendered more meaningful.	**TL**
b.	The Communication Calendar of Events was noted and Caroline Pooley (CP), Events Officer, advised as to the arrangement of the first Constituency event which would be held in Chelsea Old Town Hall on 25 March 2015.	
c.	ML asked for further details in terms of what was happening with Medicine for Members.	**LH**
d.	CB congratulated GV on the fresh, new model which had been designed in respect of the forthcoming Members' Open Day. However, he asked that consideration be given to referencing the proposed acquisition of WMUH. Layla Hawkins (LH), Head of Communications, confirmed that a stand would be erected at the Open Day to celebrate the history of the two Hospital sites.	
e.	With regard to the Star Awards, the Council discussed whether a 'celebrity host' was necessary or whether it was, in fact, preferable to ask a distinguished senior clinician to host such an event. The Council agreed that the latter was preferable as it was more in alignment with the Trust's organisational values.	
14.	**Council of Governors' Funding Report**	
a.	The report was received and noted. It was confirmed that the Council would continue to receive such reports as a standing item on future agendas.	
15.	**Trust Performance**	
a.	The Chairman noted that the Council had been provided with a link to access information with regard to Trust performance. He asked that a performance report instead be added to future meetings of the Council.	**KMO**

16.	**Any Other Business**	
a.	The Chairman said that Governors would shortly receive invitations to participate in a series of informal lunches with him and another Non-Executive Director. In addition, a Board/Council Away-Day was being arranged for September 2015. He was hopeful that both events would allow closer interaction and engagement between Non-Executive Directors and Governors. The Council debated whether further opportunities were required for Governors to 'have access' to Non-Executive Directors and it was resolved that MJ and SM would discuss this further outside of the meeting.	**MJ/SM**
b.	AH asked when the video recording of the recent 'Patient Benefits Session' on the WMUH transaction would be made available to the Council. GV confirmed that the recording was currently being edited and would be uploaded to a private site for Governors to access before the end of the week.	**GV**
17.	**Questions from Members of the Public**	
a.	Nil.	
18.	**Date of Next Meeting:** 14 May 2015	

The meeting was closed at 18.15.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 14 May 2015

AGENDA ITEM NO.	3/May/15
REPORT NAME	Matters Arising & Action Log
AUTHOR	Thomas Lafferty, Foundation Trust Secretary
LEAD	Sir Thomas Hughes-Hallett, Chairman
PURPOSE	To provide a record of actions raised and any subsequent outcomes from the March Council of Governors Meeting.
SUMMARY OF REPORT	This paper outlines matters arising from the Council of Governors meeting held on 5 March 2015
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	None.
LINK TO OBJECTIVES	NA
DECISION/ ACTION	To note.

Council of Governors – 5 March 2015

Meeting	Minute Number	Agreed Action	Current Status	Lead
March 2015	5.c	EM to ensure that the organisation complies with the new standards in relation to whistleblowing and, as part of this, would also seek to increase staff awareness of the issue; encouraging a culture of openness and transparency.	Verbal update at meeting.	EM
	6.e	All governors to provide any further comments on the detail of the Prospectus via e-mail to TL.	Complete.	ALL
	8.c	ZP work with BG to ensure that the Ron Johnson Ward drew the attention that it deserved.	Complete.	ZP/BG
	10.a	TL to consider how future performance evaluations could be enhanced and ultimately represent a truer encapsulation of Governor opinion.	This will be incorporate into the 2015/16 Board Development Programme.	TL
	10.b	TL to identify the key areas for development and to formulate appropriate remedial actions to address these.	This will be incorporate into the 2015/16 Board Development Programme.	TL
	13.a	TL to consider how the provision of membership information to the Council could be rendered more meaningful.	This will be considered through the Membership Sub-Committee and also incorporated into the new Membership Strategy which will be duly reviewed and approved by the Sub-Committee.	TL
	13.c	LH to provide further details in terms of what was happening with Medicine for Members.	Medicine for Members is continuing alongside the scheduled Constituency Events. The Events Officer is scheduling all Medicine for Members events for the rest of 2015 and will email the programme to the Council of Governors for review.	LH
	15.a	KMO to add a performance report to future meetings of the Council.	On current agenda and forward plan.	KMO
	16.a	MJ and SM to discuss outside of the meeting whether further opportunities were required for Governors to 'have access' to Non-Executive Directors other than a series of informal lunches with the Chairman and another Non-Executive Director and a Board/Council Away-Day arranged for September 2015.	Complete.	MJ/SM

	16.c	GV to upload the video recording of the recent 'Patient Benefits Session' on the WMUH transaction to a private site.	Complete.	GV

Council of Governors Meeting, 14 May 2015

AGENDA ITEM NO.	4/May/15
REPORT NAME	Chief Executive's Report
AUTHOR	Elizabeth McManus, Chief Executive Officer
LEAD	Elizabeth McManus, Chief Executive Officer
PURPOSE	To provide an update to the Council of Governors on high-level Trust affairs.
SUMMARY OF REPORT	As described within the appended paper.
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	None.
LINK TO OBJECTIVES	NA
DECISION/ ACTION	For information.

Chief Executive's Report

1.0 Staff

1.1 Star Awards

Later tonight, the Star Awards will take place at Chelsea Football Club. The awards recognise the staff that embody our Trust values of Respectful, Kind, Safe and Excellent.

The awards are made possible thanks to the generous support of CW+, who, this year, will also be presenting their own special award. The charity exists to make care better for patients and their families through pioneering research, innovation, art and design.

1.2 Engagement, Culture and Organisational Development

I am delighted to be able to announce that Linda Holland, our new staff engagement, culture and OD lead for the West Middlesex University Hospital NHS Trust (WMUH) acquisition has commenced in post.

Linda will be helping us to develop our organisation through engagement with our staff, both clinical and non-clinical. This will be a key element in the success of our post-acquisition organisation. She will play a leading role in working with staff at all levels of the Trust; stimulating new and better ideas and practices to win the hearts and minds of our people. She will be very involved in the work on the branding for the enlarged Trust, in particular the development of our values and our new "employer brand".

Linda is keen to build on the great work which has already been done in relation to clinical engagement and to spread this across all areas. She will also be supporting Susan Young (Chief People Officer & Director of Corporate Affairs) and I in developing a new leadership programme.

I am sure you will join me in welcoming Linda to the organisation.

2.0 Grip

2.1 Performance: Finance

The Trust achieved a £2.2m surplus at the end of 2014/15, which marked a £4.8m deterioration on the plan set at the commencement of the financial year. As I have previously reported, this was caused primarily by a shortfall in the delivery of the Trust's cost improvement programme and an increased usage of agency staffing, attracting a premium cost.

Going forward, for the first time in the recent history of the Trust, the Trust is planning for a £7.5m deficit in 2015/16 due, in the main, to the application of the new national tariff. It is of note that other teaching specialist Trusts are facing similar pressures and many are also planning for deficit.

The Trust's deteriorating financial position over the last two years has made the financial case for the WMUH acquisition even more compelling. The Trust's revised long-term financial modelling has shown that, assuming a stand-alone position, CWFT would not deliver a surplus over the coming years. In contrast, the model assuming the acquisition of WMUH allows the Trust to achieve a degree of financial sustainability, achieving a c. £2m surplus by the end of 2016/17.

Whilst there are key national drivers which have affected the Trust's financial position in the context of a growing level of uncertainty with regard to the funding of services within the health and social care sector in general, it remains vital that the Trust's senior management team retain an even tighter grip on financial sustainability over the years ahead.

The governors will be aware of previous discussions regarding the Trust's senior management capacity and bandwidth. To this end, I am pleased to report that the Trust has recently made several key appointments to operational and professional management teams, including three new Divisional Nurses as joint appointments with WMUH.

2.2 Performance: Quality & Operational

The Trust achieved the majority of the national key operational performance indicators for Quarter 4 2014/15; exceeding the 4-hour A&E waiting times target and the referral-to-treatment (18 weeks) targets. This is a notable achievement given the operational challenges that other Acute Trusts nationally continue to face; particularly in the context of the demands of winter.

From a clinical perspective, the Trust also continues to excel when compared with its peers across a range of quality indicators: the Trust's mortality indices remain favourable and the Trust's rates of hospital-acquired MRSA and CDiff infection are consistently lower than other Hospital Trusts. The Trust has however been assessed as non-compliant with the national indicator in relation to Learning Disability provision: a plan is in development to address this specific risk.

The governors also remain cognisant of the shortfalls that were identified by the CQC last year following their inspection of the Trust. By the end of this month, the Trust will receive the results of its CQC-Style 'Peer Review', a multi-disciplinary audit commissioned by the Trust with regard to the Trust's current levels of compliance with the national standards. Vanessa Sloane, Director of Nursing, will cover this in more detail later in the meeting agenda.

3.0 Growth

3.1 Quality Strategy

The 13 April Quality Committee meeting reviewed the first draft of the Trust's new Quality Strategy on behalf of the Board.

The Quality Strategy sets out a three-year journey for how we will work to continuously improve the quality of the services provided by CWFT.

In developing the Strategy, account has been taken of the Trust's vision and the recommendations arising from the July 2014 CQC inspection.

The Strategy considers quality on the basis of the four components of Safety, Effectiveness, Experience and Access (recognising that this represents an expanded definition of quality that includes access). For each component, we have set ambitions and supporting priorities, taking into account our current performance.

We will deliver our ambition for quality through tranches of 'special projects' focusing on key priority areas that have been identified through engagement to date with staff and external stakeholders. The initial tranche of projects will focus on Frailty, Admitted Surgical Care, Sepsis and Maternity.

Delivery of the Strategy will be supported by the Trust's two overarching service improvement programmes and enabled through six cross-cutting 'enabler' workstreams. Work across these cross-cutting enablers will be essential for delivering a rigorous and systematic approach to quality, clinically led, with multidisciplinary ownership from doctors, nurses and managers across the Trust.

3.2 Proposed Acquisition of West Middlesex University Hospital NHS Foundation Trust (WMUH)

The Trust continues to make good progress with regard to the transaction pathway relating to the potential acquisition of WMUH.

The Trust submitted its Full Business Case for the acquisition to Monitor last month. Since then, the Trust has

been subjected to Monitor's Transaction Risk Assessment process which involves a relatively intense series of Director interviews and information requests.

The Monitor assessment process will conclude with a 'Board-to-Board' meeting which is currently scheduled to take place on 25 June 2015; this is later than originally anticipated due to the additional time that Monitor require to consider the Trust's re-submitted Long Term Financial Plan (LTFM) which reflects the organisation's up-to-date financial position.

Following the Board-to-Board meeting, Monitor now expects to issue its Transaction Risk Rating on 15 July 2015. Only once this has been received will the Board and the Council of Governors be asked to make their respective formal decisions on the acquisition.

Provided both sets of approvals are given, the Trust will then need to formally submit its application to acquire to Monitor. This will, in turn, trigger a series of regulatory steps external to the Trust, including the sign-off by the Secretary of State as to the dissolution of WMUH and the transfer of all of its assets and liabilities to CWFT. This final 'Gateway 4' process is anticipated to last 2-3 weeks.

As a result, it is now the case that the acquisition of WMUH is forecast to occur as of 1 September 2015. A revised Decision Tree is provided at Appendix 1.

In the meantime, Jacqueline Totterdell, Chief Executive at WMUH, and I continue to engage with staff at both organisations through a series of open sessions.

I will continue to keep governors informed of progress.

Elizabeth McManus
Chief Executive Officer
April 2015

APPENDIX 1

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Acquisition of West Middlesex University Hospital NHS Trust (WMUH) by

Chelsea & Westminster NHS Foundation Trust (CWFT)

NON-EXECUTIVE DIRECTORS' ACTION TREE

Date*	Milestone	Detail / Action Required
28 April 2015	**Acquisition Steering Committee**	Chairman to chair meeting. Chairman to present Tier 1 Board structure for approval. Subject to the approval of the ASC, the specific detail of Executive Director posts should be taken to a meeting of the Nominations & Remuneration Committee. ASC to approve content of Transaction Agreement.
28 – 30 April 2015	**NED Interviews with Monitor**	28 April: Chairman 30 April: Jeremy Jensen, Eliza Hermann, Andrew Jones, Jeremy Loyd, Nilkunj Dodhia
30 April 2015	**Board Meeting**	Chairman to chair meeting. Board to approve content of Transaction Agreement and to receive update on progress of Monitor transaction assessment.
14 May 2015	**Council of Governors Meeting**	Sir John to chair meeting. COG to receive early draft of the proposed post-acquisition Constitution. The Trust to take account of COG comments on the Constitution and produce (and circulate) further iteration. COG to otherwise to receive update on progress of Monitor transaction assessment.
19 May 2015	**Wandsworth Constituency Meeting**	Chairman to Chair event; focusing upon the merits of the WMUH transaction.
20 May 2015	**Clinical Summit: Innovation & Discovery** Holiday Inn, Brentford	Chairman to attend event to show Board support.
26 May 2015	**Board-to-Board: Monitor Rehearsal with EY**	Chairman to Chair process.
26 May 2015	**Board Meeting**	Chairman to chair meeting. Board to approve amended post-acquisition Constitution. Board to otherwise to receive update on progress of Monitor transaction assessment.

Date*	Milestone	Detail / Action Required
27 May 2015	**Acquisition Steering Committee**	Chairman to chair meeting. ASC to receive update on progress of Monitor transaction assessment. ASC to review 'organisational map' including full post-acquisition governance structure.
Late May 2015	**Board-to-Board: Royal Free** *Specific date to be arranged*	Chairman to lead joint session with Royal Free Board (and members of the WMUH Board), gleaning important 'learnt lessons' from acquisition of Barnet & Chase Farm.
Early June 2015	**CEO Appointment**	Chairman to announce appointment of substantive CEO.
Mid June 2015	**Board-to-Board: WMUH & Deloitte** *Specific date to be arranged*	Chairman to introduce items and lead debate which will include a team from Deloitte who will advise Board members from both CWFT and WMUH as to key 'learning points' from previous NHS mergers and acquisitions.
16 June 2015	**Hammersmith & Fulham Constituency Meeting**	Chairman to chair event; focusing upon the merits of the WMUH transaction.
22 June 2015	**Board-to-Board: Monitor Rehearsal with EY**	Chairman to Chair process.
24 June 2015	**Acquisition Steering Committee**	Chairman to chair meeting. ASC to receive preparatory information for the Monitor Board-to-Board and to review, in draft, all Gateway 4 documentation (listed below).
25 June 2015	**Board-to-Board: Monitor**	Format: A short presentation by the CWFT; followed by questions from the Monitor Board on the areas identified as requiring challenge by the risk assessment team's detailed review.
25 June 2015	**Board Meeting**	Chairman to chair. Board to review, in draft, all Gateway 4 documentation (listed below) and to receive update on Monitor transaction assessment.
By 15 July 2015	**Trust Receives Monitor Transaction Risk Rating**	
27 July 2015	**Board Meeting**	Chairman to chair meeting. Board receives Monitor Transaction Risk Rating (expected to include indicative support from Secretary of State). Board to approve Risk Rating position and recommend approval of the acquisition to the Council of Governors. The Board will also receive and be asked to approve: - Independent Accountant Report; - Medical Director's Statement;

Date*	Milestone	Detail / Action Required
		- Board Certification; - Post-Transaction Integration Plan (PTIP).
28 July 2015	**Council of Governors Meeting**	COG to consider the approval of the transaction. Governors must satisfy themselves that the Board of directors has: i) been thorough and comprehensive in reaching its proposal (that is, has undertaken proper due diligence) ii) obtained and considered the interests of trust members and the public as part of the decision-making process.
August 2015	Trust to make application to Monitor to grant the Acquisition.	The application will encompass: i) written acknowledgement from the foundation trust/s of Monitor's risk rating where the transaction was classed as significant; ii) evidence of approval of the transaction by a majority of the governors of the NHS foundation trust(s); iii) a letter of support from the Secretary of State and; iv) the constitution of the acquiring NHS foundation trust following the transaction.
Mid August 2015	Secretary of State approval of Acquisition and Dissolution of WMUH	N/A
1 September 2015	**ACQUISITION COMPLETION DATE**	

***** *All stated dates remain subject to change. When such change occurs, members of the Board of Directors and Council of Governors will be duly notified.*

Council of Governors Meeting, 14 May 2015

AGENDA ITEM NO.	6/May/15
REPORT NAME	Governors' Questions
AUTHOR	Various
LEAD	Elizabeth McManus, Chief Executive Officer
PURPOSE	To note.
SUMMARY OF REPORT	1. The question raised by Martin Lewis: Will PALS now be fully operational to serve our patients? Can we be reassured that this will now happen? Vanessa Sloane, Director of Nursing will provide verbal response at meeting. 2. The question raised by Martin Lewis: Can we please have à comprehensive answer regarding training and ongoing training for receptionist staff? **Response from Karl Munslow-Ong, Chief Operating Officer** The Trust has documentation as evidence to our current training and recruitment standards with regard to our patient facing staff within OPD. We are currently undertaking a process with our staff to ensure staff are both trained and competent in providing a reception function, this is formed in part as 1:1;s, recognition on a monthly basis and patient feedback which is picked up by local managers. In addition to this, part of this process is to understand if staff have a preference as to whether they would prefer a front of house or back of house administrative role to ensure we have the correct staff in the correct areas, where possible. This also fits with the Trusts vision to redesign its administrative processes and will incorporate any additional training required for administrative roles across the organisation. We are also in the process of recruiting reception staff at Band 3 level who have shown a level of competency in their roles who are able to also train and influence

	others i.e. a buddy system. With regard to external training, this was provided by Disney in the early part of last year and I was informed at the time that no more training had been allocated. I am unaware that further training has been identified however this can be explored further if there is a requirement but being mindful that currently we have a significant number of vacancies and are looking to relocate some staff it may be prudent to ensure this piece of work takes place in the first instance.
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	None.
LINK TO OBJECTIVES	NA
DECISION/ ACTION	For information.

Council of Governors Meeting, 14 May 2015

AGENDA ITEM NO.	7/May/15
REPORT NAME	Proposed Post-Acquisition Constitution
AUTHOR	Thomas Lafferty, Foundation Trust Secretary
LEAD	Thomas Lafferty, Foundation Trust Secretary
PURPOSE	To review and, subject to the Council's comments, approve the content of the 'Post-Acquisition Constitution'.
SUMMARY OF REPORT	Assuming that the Chelsea and Westminster Hospital NHS Foundation Trust (CWFT) Board of Directors and Council of Governors approve the proposed acquisition of West Middlesex University Hospital NHS Trust (WMUH), the Trust will be required to submit a legally compliant post-acquisition Constitution as part of its acquisition application to Monitor. The new Constitution will set out the foundation of the enlarged Trust's governance arrangements including, crucially, the future composition, roles and responsibilities of the Board of Directors and Council of Governors. Fundamentally, the wording of the new Constitution must be legally compliant with the requirements of the NHS Act 2006, as amended by the Health & Social Care Act 2012. As part of this, the Trust must ensure that, within its governance arrangements, there is sufficient public representation for its entire, enlarged Public Constituency. Similarly, the Trust should give due consideration to the need to account for key stakeholders/partners within the 'west' constituency areas, in addition to ensuring that WMUH staff have the opportunity to become Trust members and stand as Staff Governors. In addition to reflecting post-acquisition governance arrangements, the requirement to draft a new Constitution for the post-acquisition organisation allows for other enhancements on the pre-existing Constitution to be made; for example: • Inclusion of the Fit & Proper Persons' Test with regard to Board Director & Governor eligibility; • Inclusion of E-Governance as a valid means of Board/Council decision-making; • Inclusion of Standing Orders for both the Board of Directors and Council of Governors; • Inclusion of a process for the election of the Lead Governor;

	• Inclusion of a process for the election of Governor Committee/Working Group members and Chairpersons; • Inclusion of definitions relating to significant transactions. The Council of Governors is asked to consider the draft post-acquisition Constitution and to discuss the significant changes in governance arrangements that it proposes. This paper aims to draw the Council's attention to the most significant changes proposed.
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	None.
LINK TO OBJECTIVES	All
DECISION/ ACTION	For approval.

Post-Acquisition Constitution: Issues for Consideration

1.0 Introduction

1.1 Assuming that the Chelsea and Westminster Hospital NHS Foundation Trust (CWFT) Board of Directors and Council of Governors approve the proposed acquisition of West Middlesex University Hospital NHS Trust (WMUH), the Trust will be required to submit a legally compliant post-acquisition Constitution as part of its acquisition application to Monitor. The new Constitution will set out the foundation of the enlarged Trust's governance arrangements including, crucially, the future composition, roles and responsibilities of the Board of Directors and Council of Governors.

1.2 Fundamentally, the wording of the new Constitution must be legally compliant with the requirements of the NHS Act 2006, as amended by the Health & Social Care Act 2012. As part of this, the Trust must ensure that, within its governance arrangements, there is sufficient public representation for its entire, enlarged Public Constituency which, post-acquisition, will include the London Borough of Hounslow, the London Borough of Richmond upon Thames and the London Borough of Ealing. Similarly, the Trust should give due consideration to the need to account for key stakeholders/partners within the 'west' constituency areas, in addition to ensuring that WMUH staff have the opportunity to become Trust members and stand as Staff Governors.

1.3 In addition to reflecting post-acquisition governance arrangements, the requirement to draft a new Constitution for the post-acquisition organisation allows for other enhancements on the pre-existing Constitution to be made; for example:

- Inclusion of the Fit & Proper Persons' Test with regard to Board Director & Governor eligibility;
- Inclusion of E-Governance as a valid means of Board/Council decision-making;
- Inclusion of Standing Orders for both the Board of Directors and Council of Governors;
- Inclusion of a process for the election of the Lead Governor;
- Inclusion of a process for the election of Governor Committee/Working Group members and Chairpersons;
- Inclusion of definitions relating to significant transactions.

1.4 The Council of Governors is asked to consider the draft post-acquisition Constitution and to discuss the significant changes in governance arrangements that it proposes. This paper aims to draw the Council's attention to the most significant changes proposed.

2.0 Key Changes for Consideration with regard to the Composition of the Council of Governors

2.1 Reformation of the Public Constituencies

2.1.1 Historically, the Trust has chosen to sub-divide its four core Public Constituency areas into two separate electoral area groupings (Area 1 or Area 2), whereby one Public Governor is elected to each electoral area group. Whilst this has allowed for a closer degree of 'proximity' between the elected Public Governors and their particular electorate; this arrangement now needs to be reviewed in view of the fact that the Trust is due to have three additional Public constituency areas post-acquisition: Hounslow, Richmond upon Thames and Ealing[1].

2.1.2 To this end, rather than also sub-divide these three new Constituencies (establishing 14 separate Public Constituency electorates in total); **it is suggested that the current electoral area distinctions are removed and that pre-existing Public Governors become representatives of the entire London Borough.**

[1] In relation to Ealing, this particularly needs to be viewed in the context of the Shaping a Healthier Future (SaHF) proposals which are projected to increase the volume of patients which the enlarged Trust receives from this area.

2.1.3 As above, each of these 'new' Public Constituency areas will require their own Public Governor representatives. Within the first draft of the Constitution, the Trust has sought to ensure that its Governor allocation across the full range of Public Constituency areas is proportionate to patient volume across the catchment area. Within the Trust's Full Business Case (FBC), the following split of total projected income is as follows:

- RBKC: £45.8M = 18%
- Hounslow: £85.3 M = 34%
- H&F: £38.2M = 15%
- Ealing: £8.5M = 3%
- Hillingdon: £1.2M = 0.5%
- Wandsworth: £28.5M = 11%
- Richmond: £26.8M = 11%
- Westminster £17.2M = 7%

2.1.4 In terms of how this relates to Governor numbers per area, there are two guiding principles that must be considered:

a) The need to afford a fair and proportionate degree of representation to each Public Constituency area;

b) The need to ensure that the Council of Governors does not become so large as to render it unwieldy.

2.1.5 On this basis, the following 'thresholds' have been set within the current draft of the Constitution:

3-6%	1 Governor
7-14%	2 Governors
15% +	3 Governors

2.1.6 This generates the following allocation with regard to the Public Constituency areas:

Type of Governor	Number	Elected by
public	3	Royal Borough of Kensington & Chelsea
public	2	City of Westminster
public	3	London Borough of Hammersmith & Fulham
public	2	London Borough of Wandsworth
public	3	London Borough of Hounslow
public	2	London Borough of Richmond upon Thames
public	1	London Borough of Ealing

2.1.7 However, as the Trust currently does not have a valid membership base for Hounslow, Richmond and Ealing, it is not possible to have Public Governors for these areas in place for Day 1 of the post-acquisition organisation. Instead, for a limited-term period, the enlarged Trust will be required to operate without Governor representation for these areas, pending a successful membership recruitment campaign and fresh Governor elections which are expected to have concluded by March 2016.

2.1.8 Furthermore, the Trust recognises the need to ensure a degree of continuity on the Council of Governors immediately post-acquisition to ensure that the substantial expertise and organisational memory of current Council members is not lost. **It is therefore recommended that pre-existing CWFT Governors are permitted to remain in post until 31 March 2015; 'the Initial Stage'.**

2.1.9 Moreover, **as the Trust currently has two Governor positions afforded to each of its pre-existing Public Constituency areas; it is proposed that these Governors continue to remain in post for the duration of their tenure.**

2.2 Reformation of the Patient Constituency

2.2.1 Under the NHS Act 2006 (as amended by the Health & Social Care Act 2012), the Trust has a statutory obligation to ensure that it has members within its Public Constituency and that these members duly elect Public Governor/s to represent their interests on the Trust's Council of Governors.

2.2.2 The Act also permits Trusts, as an option, to establish a Patient Constituency comprised of members who have in the past attended the Trust's hospital/s either as a patient or as a carer. The option of having a Patient Constituency was originally included within the legislation to ensure that patients or carers residing outside of a Trust's core catchment area were not precluded from becoming involved either as a member of Governor of the Trust. This particularly assisted Mental Health Foundation Trusts whose patient base crossed over several local authority boundaries.

2.2.3 However, in recognition of the fact that the Trust frequently provides healthcare services to members of the public who live outside of the Trust's core catchment area (particularly in the context of the Trust's significant specialist services offering) and in respect of the unique perspective on matters that Patient Governors can provide, there remains real value in maintaining a distinct Patient Constituency.

2.2.4 **Notwithstanding this, due to the growth of the Public Constituency areas and the overall need to keep the Council to a manageable size, the draft Constitution assumes that the Patient Governor Constituency reduces from 10 to 6 Governor posts.** This notionally represents three Patient Governor representatives of the clinical services historically provided by CWFT and three Patient Governor representatives of the clinical services historically provided by WMUH[2].

2.2.5 Such changes would necessarily mean that the tenure of all currently elected Patient Governors would terminate at the end of the 'Initial Stage' (31 March 2016) and be replaced, from 1 April 2016 by newly elected Patient Governors.

2.3 Reconfiguration of the Staff Constituency

2.3.1 The current CWFT Constitution currently provides for six Staff Governors in total, with one being elected to represent six sub-classes of staff member. Again, the Trust needs to be conscious of the need to ensure that staff working at WMUH receive an equal degree of representation on the post-acquisition Council of Governors. If the Trust were to keep the existing sub-classes of the Staff Constituency, this would naturally result in six additional Governor posts.

2.3.2 In addition, it is suggested that the existence of six sub-classes of Staff Governors renders the electorate within each class unnecessarily small and narrowly-defined. For these reasons, **it is therefore proposed that the sub-classes of Staff Constituency based upon job type are abolished and replaced with the following:**

[2]Although it should be noted that establishing distinct 'classes' of patient constituency would trigger the following requirement to have a distinct 'Carer' sub-class: "The constitution may divide those who come within (the patient constituency) into three or more descriptions of individuals, one of which must comprise the carers of patients."

Type of Governor	Number	Elected by
staff	3	Chelsea & Westminster Hospital Staff
staff	3	West Middlesex Hospital Staff

2.3.3 Such changes would necessarily mean that the tenure of all currently elected Staff Governors would terminate at the end of the 'Initial Stage' (31 March 2016) and be replaced, from 1 April 2016 by newly elected Staff Governors according to the above allocation.

2.4 Lead Governor to be a Public Governor

2.4.1 As noted above, the attached draft post-acquisition Constitution makes provision for the election of the Lead Governor position. The new process outlined within the draft Constitution explicitly requires that only Publicly-Elected Governors are eligible to stand for election as Lead Governor. This marks a material change from the current arrangements within CWFT where the Lead Governor is a Staff Governor.

2.4.2 This suggested change is prompted by the fact that the Lead Governor plays a prominent role in relation to the appointment and performance evaluation of the Chairman (in particular) and of the other Non-Executive Directors. Given the hierarchical relationship between members of the Board and members of staff, this represents a material conflict of interest. Moreover, an important concept underpinning the Lead Governor position was to establish a key contact with Monitor and other stakeholders which fairly represented the views of local people; rather than the views of staff *per se.* The majority of Foundation Trusts restrict the eligibility for the Lead Governor post to Public Governors.

2.4.3 **It is therefore proposed that the role of Lead Governor is restricted to Publicly-Elected Governors, in accordance with the process set out within the draft Constitution.**

2.5 Reconfiguration of the Appointed Governors

2.5.1 In accordance with the NHS Act 2006, the Trust is required to include within its Council of Governors:

- Appointed Governor/ers to represent Local Authority interests;
- Where a Foundation Trust is affiliated to a University, a Governor to represent that University.

Beyond this, the Trust can choose which 'partnership organisations' it wishes to afford Governor positions to; although overall, appointed Governors must be in the minority on the Council of Governors.

2.5.2 In terms of the draft Constitution, the second of these requirements can be met through maintaining the pre-existing arrangement of a Governor being appointed by Imperial College, University of London.

2.5.3 However, the Local Authority requirement is potentially complex given that the enlarged organisation will have regular engagement with six separate authorities. **In order to afford equal representation to each of the Local Authorities whilst keeping the overall number of appointed Governors to a minimum; it is suggested that the six LAs are represented by two Appointed Governor posts that reflect 'tri-borough' working arrangements.**

2.5.4 The Constitution does not provide for additional Appointed Governor positions beyond what the Trust is legally obliged to provide for. Therefore, the overall breakdown of the proposed Appointed Governors is therefore as follows:

Type of Governor	Number	Elected by
University/medical school	1	Imperial College, University of London
Local authority	1	Shared: Royal Borough of Kensington & Chelsea/ Westminster City Council/ London Borough of Hammersmith & Fulham
Local authority	1	Shared: London Borough of Hounslow/ London Borough of Richmond/ London Borough of Wandsworth

3.0 Recommendation

The Council is asked to consider and, subject to its comments, approve the draft post-acquisition Constitution.

Thomas Lafferty
Company Secretary
May 2015

CONSTITUTION

OF CHELSEA & WESTMINSTER HOSPITAL

NHS FOUNDATION TRUST

Approved by the Board of Directors: *[insert date]*

Approved by the Council of Governors: *[insert date]*

The Trust acquired West Middlesex University Hospital NHS Trust ("**WMUH**") on 1 September 2015 (the "**Acquisition Date**"). This revised constitution takes effect on the Acquisition Date. In the Transitional Period and to reflect the enlarged size of the Trust, the Trust's constituencies shall change on the dates set out in Annex 1 – 4.

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1. Interpretation and definitions

1.1. Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this Constitution shall bear the same meaning as in the 2006 Act.

1.2. Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

1.3. References in this Constitution to legislation include all amendments, replacements, or re-enactments made and references to paragraph numbers are references to paragraphs of this Constitution unless the context provides otherwise.

1.4. Save as otherwise permitted by law and subject to the Constitution, at any Board of Directors meeting, the Chairman's interpretation of this Constitution (on which he should be advised by the Chief Executive or Company Secretary) shall be final.

1.5. In this Constitution, the following defined terms have the following meaning:

the 2006 Act means the National Health Service Act 2006 (as amended, including by the 2012 Act);

the 2012 Act means the Health and Social Care Act 2012;

Accounting Officer is the person who from time to time discharges the functions specified in paragraph 25(5) of schedule 7 to the 2006 Act;

Acquisition Date means the date of the acquisition by the Trust of WMUH, being the date on which Monitor grants the application of the Trust to acquire WMUH pursuant to section 56A of the 2006 Act;

Annual Members' Meeting means the annual meeting of the Trust's Members as defined in paragraph 12.1 of this Constitution;

Audit Committee means the committee established in accordance with paragraph 40 of this Constitution;

Auditor means the auditor of the Trust as defined in paragraph 39 of this Constitution;

Authorisation is the authorisation issued by Monitor under section 35 of the 2006 Act;

Board of Directors means the board of directors of the Trust as constituted in accordance with this Constitution and referred to in paragraph 24 of this Constitution;

Chairman is the non-executive chairman of the Trust appointed by the Council of Governors in accordance with paragraph 27 of this Constitution. The expression "the Chairman" shall be deemed to include the Deputy Chairman or any other Non-Executive Director of the Trust if the Chairman is absent from the meeting or is otherwise unavailable;

Chief Executive means the chief executive and Accounting Officer;

Committee means a committee established by the Board of Directors or the Council of Governors;

Company Secretary means a person appointed to provide advice on corporate governance issues to the Board of Directors, the Council of Governors and the Chairman;

Constitution means this constitution and all annexes to it, established in accordance with schedule 7 of the 2006 Act and as from time to time amended in accordance with paragraph 45 of this Constitution;

Council of Governors means the council of governors as constituted in accordance with this Constitution and referred to in paragraph 13 of this Constitution;

Deputy Chairman means the Non-Executive Director appointed by the Non-Executive Directors to take on the Chairman's duties in accordance with paragraph 28 of this Constitution if the Chairman is absent for any reason;

Director means an Executive Director or Non-Executive Director of the Board of Directors;

Executive Director means a person appointed as an executive director of the Trust under schedule 7 of the 2006 Act and in accordance with paragraph 29 of this Constitution and who is an Officer;

Finance Director means the suitably qualified chief financial Officer of the Trust;

Governor means a person elected or appointed as a member of the Council of Governors in accordance with this Constitution;

Health Service Body means a health service body as defined in section 9(4) of the 2006 Act;

Initial Governors means the Governors of the Trust who hold office immediately prior to the Acquisition Date and who (with the exception of the Public Governors holding office at the end of the Transitional Period) shall cease to hold office at the end of the Transitional Period as set out in Part A of Annex 4;

Lead Governor is the public Governor appointed by the Council of Governors in accordance with the SOs of the Council of Governors (as set out in SO 2.6 Annex 7);

Local Authority means the local authorities listed in Part B of Annex 4;

Member means a person whose name has been entered into the Trust's register of members as a member of the Trust's Public, Patient (for so long as is applicable) or Staff Constituency;

Model Election Rules means those election rules as published by NHS Providers from time to time and set out in Annex 5 of this Constitution;

Monitor is the body corporate known as Monitor, as provided by section 61 of the 2012 Act;

Motion means a formal proposition to be discussed and voted on during the course of a meeting;

Non-Executive Director means a person appointed as a non-executive director of the Trust under schedule 7 of the 2006 Act and in accordance with paragraph 26 of this Constitution and who is not an Officer;

Officer means employee of the Trust or any other person holding a paid appointment or office with the Trust;

Patients' Constituency shall have the meaning given in paragraph 8 of this Constitution;

Public Constituency shall have the meaning given in paragraph 7.2 of this Constitution;

Senior Independent Director means the Non-Executive Director appointed by the Board of Directors in accordance with paragraph 28.2 of this Constitution;

SFIs means standing financial instructions;

SOs/Standing Orders means the standing orders of the Board of Directors and/or the standing orders of the Council of Governors;

Special Members' Meeting shall have the meaning given in paragraph 4.2 of Annex 10 of this Constitution;

Staff Constituency shall have the meaning given in paragraph 9.3 of this Constitution;

Term shall have the meaning given to it in paragraph 15.1 of this Constitution;

Transitional Period means the period from the Acquisition Date until 11.59pm on 31 March 2016;

Trust shall have the meaning given to it in paragraph 2.1 of this Constitution;

Voluntary Organisation means a body, other than a public or local authority, the activities of which are not carried on for profit;

WMUH means West Middlesex University Hospital NHS Trust; and

Working Group means a working group established by the Council of Governors.

2. Name

2.1. The name of the foundation trust is Chelsea & Westminster Hospital NHS Foundation Trust (the "**Trust**").

3. Principal Purpose

3.1. The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

3.2. The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3. The Trust may provide goods and services for any purposes related to:

3.3.1. the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness; and

3.3.2. the promotion and protection of public health.

3.4. The Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

4. Powers

4.1. The powers of the Trust are set out in the 2006 Act. All powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

4.2. Any of these powers may be delegated to a Committee of the Board of Directors or to an Executive Director, provided that where such a Committee includes individuals who are not Directors, the Committee shall have a majority of Directors.

5. Membership and Constituencies

5.1. The Trust shall have Members, each of whom shall be a Member of one of the constituencies in paragraph 5.2.

5.2. The constituencies of the Trust shall be:

5.2.1. the Public Constituencies;

5.2.2. the Staff Constituency; and

5.2.3. the Patients' Constituency.

6. Application for Membership

6.1. Subject to paragraph 10.1 below, an individual who is eligible to become a Member of the Trust may do so on application to the Trust for membership. Where that application has been accepted by the Trust, that individual shall become a Member of the Trust once his name has been entered as such in the Trust's register of Members.

7. Public Constituency

7.1. An individual who lives (during the relevant time periods specified Part 1 and Part 2 of Annex 1) in an area specified in Annex 1 as an area for a Public Constituency may become or continue as a Member of the Trust.

7.2. Those individuals who live (during the relevant time periods specified in Part 1 and Part 2 of Annex 1) in an area specified in Annex 1 as an area for a Public Constituency are referred to collectively as the Public Constituency (the "**Public Constituency**").

7.3. The minimum number of Members in each area for the Public Constituency is specified in Annex 1.

8. Patients' Constituency

8.1. An individual who has, within the period specified in paragraph 8.2 below, attended any of the

Trust's hospitals as either a patient or as the carer of a patient may become or continue as a Member of the Trust.

8.2. The period referred to in paragraph 8.1 above shall be the period of three years immediately preceding the date of an application by the patient or carer to become a Member of the Trust.

8.3. Those individuals who are eligible for membership of the Trust by reason of paragraphs 8.1 and 8.2 are referred to collectively as the Patients' Constituency (the "**Patients' Constituency**").

8.4. An individual providing care in pursuance of a contract (including a contract of employment), or as a volunteer for a Voluntary Organisation, does not come within the category of those who qualify for membership of the Patients' Constituency.

8.5. The minimum number of Members in the Patients' Constituency is specified in paragraph 1 of Annex 3.

9. Staff Constituency

9.1. An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a Member of the Trust provided:

9.1.1. he is employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

9.1.2. he has been continuously employed by the Trust under a contract of employment for at least 12 months.

9.2. Individuals who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, may become or continue as Members of the Staff Constituency provided such individuals have exercised these functions continuously for a period of at least 12 months.

9.3. Those individuals who are eligible for membership of the Trust by reason of paragraphs 9.1 or 9.2 above are referred to collectively as the Staff Constituency (the "**Staff Constituency**").

9.4. The Staff Constituency shall be divided into six descriptions of individuals who are eligible for membership of the Staff Constituency up to and including 31 March 2016; from 1 April 2016, the Staff Constituency shall be divided into two descriptions of individuals who are eligible for membership of the Staff Constituency, and in both cases, each description of individuals is specified within Annex 2 and are referred to as a class within the Staff Constituency. The minimum number of Members in each class of the Staff Constituency is specified in Annex 2

10. Automatic Membership by Default – Staff

10.1. An individual who is:

10.1.1. eligible to become a Member of the Staff Constituency; and

10.1.2. invited by the Trust to become a Member of the Staff Constituency and a Member of the appropriate class within the Staff Constituency,

shall become a Member of the Trust as a Member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made and upon his name being entered in the Trust's register of Members, unless he informs the Trust that he does not wish to do so.

11. Restriction on Membership

11.1. An individual who is a Member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a Member of any other constituency or class.

11.2. An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a Member of any constituency other than the Staff Constituency.

11.3. An individual must be at least 16 years old to become a Member of the Trust.

11.4. Further provisions as to the circumstances in which an individual may not become or continue as a Member of the Trust are set out in paragraph 1 – 3 of Annex 10.

12. Annual Members' Meeting

12.1. The Trust shall hold an annual meeting of its Members (the "**Annual Members' Meeting**"). The Annual Members' Meeting shall be open to the public.

12.2. Further provisions about the Annual Members' Meeting are set out in paragraph 4 of Annex 10 – Further Provisions – Members.

13. Council of Governors – Composition

13.1. The Trust is to have a Council of Governors, which shall comprise both elected and appointed Governors.

13.2. The elected Governors shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of Governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 4.

13.3. During the Transitional Period, the composition of the Council of Governors shall be as specified in Part A of Annex 4 and shall change in accordance with and on the dates set out in Annex 4.

13.4. From 1 April 2016, the composition of the Council of Governors shall be as set out in Part B of Annex 4.

13.5. The Local Authorities shall appoint on a rotational basis one local authority Governor. The Local Authorities shall choose (in accordance with a process agreed by the Local Authorities) which Local Authority shall appoint a local authority Governor for each Term With the length of such term to be agreed between the Trust and the respective Local Authorities.

13.6. If a Local Authority has not been chosen to appoint a local authority Governor on or before the date which is three weeks before the date upon which the Governor's Term is due to commence, the Trust shall determine by lot which Local Authority (if willing to make an appointment) shall appoint a Governor.

14. Council of Governors – election of Governors

14.1. Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules.

14.2. The Model Election Rules, as published and as may be varied from time to time by NHS Providers, form part of this Constitution and are attached at Annex 5.

14.3. A variation of the Model Election Rules by NHS Providers shall not constitute a variation of the terms of this Constitution for the purposes of paragraph 45 of the Constitution. For the avoidance of doubt, the Trust cannot amend the Model Election Rules.

14.4. An election, if contested, shall be by secret ballot.

15. Council of Governors – Tenure

15.1. A Governor (other than Initial Governors affected by the changes brought about by the end of the Transitional Period) may hold office for a period of up to three years. In each case, the period of office shall be known as the **"Term"**.

15.2. The elected Initial Governors (with the exception of the Public Governors holding office at the end of the Transitional Period) may, notwithstanding the terms of their election, only hold office up until 11.59pm on 31 March 2016, on which date they shall cease to hold office.

15.3. The appointed Initial Governors may, notwithstanding the terms of their appointment, only hold office up until 11.59pm on 31 March 2016, on which day they shall cease to hold office. An

appointed Initial Governor shall be eligible for re-appointment as an appointed Governor after the Transitional Period, if that Governor's appointing organisation remains eligible to appoint a Governor following the Transitional Period.

15.4. The returning officer (as referred to in part 3 of Annex 5) will undertake the election of Governors in accordance with the Model Election Rules.

15.5. An elected Governor shall cease to hold office if he ceases to be a Member of the constituency or class by which he was elected.

15.6. An elected or an appointed Governor shall be eligible for re-election or re-appointment as appropriate at the end of his Term and may be re-elected or re-appointed for consecutive Terms provided that a Governor shall not hold office for longer than nine years.

15.7. An appointed Governor shall cease to hold office if the appointing Local Authority or partnership organisation of that Governor withdraws its appointment of him or if any such appointing body ceases to exist and there is no successor in title to its business.

16. Council of Governors – Disqualification and Removal

16.1. A Governor may resign from that office at any time during his Term by giving notice in writing to the Company Secretary or the Chairman, such notice is to specify the date of resignation.

16.2. The following may not become or continue as a member of the Council of Governors:

16.2.1. a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

16.2.2. a person in relation to whom a moratorium period under a debt relief order applies (under part 7A of the Insolvency Act 1986);

16.2.3. a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it; and

16.2.4. a person who within the preceding five years has been convicted in the British Isles of any offence, if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

16.3. Further provisions as to the circumstances in which an individual may not become or continue or be removed as a member of the Council of Governors are set out in paragraph 2 and paragraph 3 of Annex 6.

16.4. Governors must be at least 16 years of age at the date they are nominated for election or appointment.

17. Council of Governors – Duties of Governors

17.1. The general duties of the Council of Governors are:

17.1.1. to hold the Non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors, and

17.1.2. to represent the interests of the Members of the Trust as a whole and the interests of the public.

17.2. The Trust must take steps to secure that the Governors are equipped with the skills and knowledge that they require in their capacity as such.

17.3. Further provision as to the roles and responsibilities of the Council of Governors is set out in paragraph 1 of Annex 6.

18. Council of Governors – Meetings of Governors

18.1. The Chairman of the Trust (i.e. the Chairman of the Board of Directors appointed in accordance with paragraph 27.1 below) or, in his absence, the Deputy Chairman (i.e. the person appointed in accordance with paragraph 28.1 below) (or if such person is not available another Non-Executive Director) shall preside at meetings of the Council of Governors. If the Chairman, the Deputy

Chairman and all Non-Executive Directors are absent, the Lead Governor, if he is present, shall preside. If the Lead Governor is not present, such Governor as the Governors present shall choose shall preside.

18.2. The Council of Governors shall appoint one of the Governors, who is a Member of the Public Constituency, to be the Lead Governor and the Chairman shall liaise with the Lead Governor in relation to the proceedings of the Council of Governors. If the Chairman considers it appropriate (taking into account the matters to be discussed at a meeting of the Council of Governors), the Lead Governor shall preside at such meeting.

18.3. Meetings of the Council of Governors shall be open to members of the public unless the Council of Governors decides otherwise in relation to all or part of the meeting for special reasons of commercial confidentiality or on other proper grounds. The Chairman may exclude any person from a meeting of the Council of Governors if that person is interfering with or preventing the proper conduct of the meeting. The Trust will hold a minimum of four public Council of Governors' meetings each year, as well as at least one joint workshop in private between the Governors and the Board of Directors, such that the total number of meetings will be not less than five per annum.

18.4. The Council of Governors with the approval of the Chairman may appoint Working Groups consisting of its members and other persons including Directors to assist it in carrying out its functions.

18.5. For the purposes of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Trust's or directors' performance), the Council of Governors may require one or more of the Directors to attend a meeting.

19. Council of Governors – Standing Orders

19.1. The SOs for the practice and procedure of the Council of Governors are attached at Annex 7.

20. Council of Governors – Referral to the Panel

20.1. In this paragraph, the panel means a panel of persons appointed by Monitor to which a Governor of a Trust may refer a question as to whether the Trust has failed or is failing:

20.1.1. to act in accordance with its Constitution; or

20.1.2. to act in accordance with provision made by or under chapter 5 of the 2006 Act.

20.2. A Governor may refer a question to the panel only if more than half of the members of the Council of Governors voting approve the referral.

21. Council of Governors – Conflicts of Interest of Governors

21.1. If a Governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the Governor shall disclose that interest to the members of the Council of Governors as soon as he becomes aware of it. The SOs for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a Governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

22. Council of Governors – Travel Expenses

22.1. The Trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the Trust.

23. Council of Governors – Further Provisions

23.1. Further provisions with respect to the Council of Governors are set out in Annex 6.

24. Board of Directors – Composition

24.1. The Trust is to have a Board of Directors, which shall comprise both Executive and Non-Executive Directors.

24.2. The Board of Directors is to comprise:

24.2.1. the Chairman;

24.2.2. at least four other Non-Executive Directors; and

24.2.3. at least four Executive Directors.

such that at any time at least half of the Board of Directors (excluding the Chairman) shall be Non-Executive Directors.

24.3. One of the Executive Directors shall be the Chief Executive.

24.4. The Chief Executive shall be the Accounting Officer.

24.5. One of the Executive Directors shall be the Finance Director.

24.6. One of the Executive Directors is to be a registered medical practitioner (within the meaning of the Medical Act 1983 who holds a licence to practice under that Act) or a registered dentist (within the meaning of the Dentists Act 1984).

24.7. One of the Executive Directors is to be a registered nurse or a registered midwife.

25. Board of Directors – General Duty

25.1. The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the Members of the Trust as a whole and for the public.

26. Board of Directors – Qualification for Appointment as a Non-Executive Director

26.1. A person may be appointed as a Non-Executive Director only if:

26.1.1. he is a Member of the Public or Patient Constituency; or

26.1.2. where any of the Trust's hospitals includes a medical or dental school provided by a university, he exercises functions for the purposes of that university; and

26.1.3. he is not disqualified by virtue of paragraph 30 below.

27. Board of Directors – Appointment and Removal of Chairman and other Non-Executive Directors

27.1. The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chairman of the Trust and the other Non-Executive Directors.

27.2. Appointment of the Chairman or another Non-Executive Director shall require the approval of a majority of the Council of Governors, present at a meeting of the Council of Governors.

27.3. Removal of the Chairman or another Non-Executive Director shall require the approval of three-quarters of the members of the Council of Governors.

28. Board of Directors – Appointment of Deputy Chairman and Senior Independent Director

28.1. The Council of Governors shall appoint one of the Non-Executive Directors as a Deputy Chairman and, if the Chairman is unable to discharge his duties, the Deputy Chairman shall act in his place.

28.2. The Board of Directors shall, following consultation with the Lead Governor, appoint one of the Non-Executive Directors as a Senior Independent Director to act in accordance with Monitor's NHS Foundation Trust Code of Governance (as may be amended and replaced from time to time) and the Trust's SOs.

29. Board of Directors – Appointment and Removal of the Chief Executive and other Executive Directors

29.1. The Chairman and the other Non-Executive Directors shall appoint or remove the Chief Executive.

29.2. The appointment of the Chief Executive shall require the approval of a majority of the Council of

Governors present at a meeting of the Council of Governors.

29.3. A Committee consisting of the Chairman, the Chief Executive and the other Non-Executive Directors shall appoint or remove the other Executive Directors.

30. Board of Directors – Disqualification

30.1. The following may not become or continue as a member of the Board of Directors:

30.1.1. a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

30.1.2. a person in relation to whom a moratorium period under a debt relief order applies (under part 7A of the Insolvency Act 1986);

30.1.3. a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it; and

30.1.4. a person who within the preceding five years has been convicted in the British Isles of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

30.2. Further provisions as to the circumstances in which an individual may not become or continue as a member of the Board of Directors are set out in paragraph 1 Annex 8.

31. Board of Directors – Meetings

31.1. Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons, including without limitation, where business involves information that relates to staff or patients or is commercially sensitive.

31.2. Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors , with suitable redactions as necessary.

32. Board of Directors – Standing Orders

32.1. The SOs for the practice and procedure of the Board of Directors, as may be varied from time to time, are attached at Annex 9.

33. Board of Directors – Conflicts of Interest of Directors

33.1. The duties that a Director of the Trust has by virtue of being a Director include in particular:

33.1.1. a duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

33.1.2. a duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.

33.2. The duty referred to in sub-paragraph 33.1.1 is not infringed if:

33.2.1. the situation cannot reasonably be regarded as likely to give rise to a conflict of interest; or

33.2.2. the matter has been authorised in accordance with the Constitution.

33.3. The duty referred to in sub-paragraph 33.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

33.4. In sub-paragraph 33.1.2, “third party” means a person other than:

33.4.1. the Trust; or

33.4.2. a person acting on its behalf.

33.5. If a Director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to the other Directors.

33.6. If a declaration under this paragraph proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.

33.7. Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

33.8. This paragraph does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question.

33.9. A Director need not declare an interest:

33.9.1. if it cannot reasonably be regarded as likely to give rise to a conflict of interest;

33.9.2. if, or to the extent that, the Directors are already aware of it;

33.9.3. if, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered:

33.9.3.1. by a meeting of the Board of Directors; or

33.9.3.2. by a Committee of the Directors appointed for the purpose under the Constitution.

33.10. A matter shall be authorised for the purposes of paragraph 33.2.2 if:

33.10.1. the Board of Directors by majority, disapplies the provision of the Constitution which would otherwise prevent a Director from being counted as participating in the decision-making process; and/or

33.10.2. the Director's interest cannot reasonably be regarded as likely to give rise to a conflict of interest; and/or

33.10.3. the Director's conflict of interest arises from a permitted cause (as determined by the Board of Directors from time to time).

For the purposes of this paragraph 33.10, a permitted cause may include (without limitation):

33.10.3.1. a guarantee given, or to be given, by or to a Director in respect of an obligation incurred by or on behalf of the Trust or any of its subsidiaries; and/or

33.10.3.2. arrangements pursuant to which benefits are made available to employees and Directors or former employees and Directors of the Trust or any of its subsidiaries which do not provide special benefits for Directors or former Directors.

34. Board of Directors – Remuneration and Terms of Office

34.1. The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chairman and the other Non-Executive Directors. In doing so, the Council of Governors shall be guided by the recommendations of a Committee of Governors known as the Non-Executive Director Nominations and Remuneration Committee.

34.2. The Board of Directors shall establish a Committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other Executive Directors.

35. Registers

35.1. The Trust shall have:

35.1.1. a register of Members showing, in respect of each Member, the constituency to which he belongs and, where there are classes within it, the class to which he belongs;

35.1.2. a register of members of the Council of Governors;

35.1.3. a register of interests of Governors;

35.1.4. a register of Directors; and

35.1.5. a register of interests of the Directors.

36. Removal from the Registers

36.1. The Company Secretary shall remove from the register of Members the name of any Member who ceases to be entitled to be a Member under the provisions of this Constitution.

37. Registers – Inspection and Copies

37.1. The Trust shall make the registers specified in paragraph 35 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

37.2. The Trust shall not make any part of its registers available for inspection by members of the public which shows details of:

37.2.1. any Member of the Patients' Constituency where that Member has not consented to his details being made so available; or

37.2.2. any other Member of the Trust, if he so requests.

37.3. So far as the registers are required to be made available:

37.3.1. they are to be available for inspection free of charge at all reasonable times; and

37.3.2. a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

37.4. If the person requesting a copy or extract is not a Member, the Trust may impose a reasonable charge for doing so.

38. Documents available for Public Inspection

38.1. The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

38.1.1. a copy of the current Constitution;

38.1.2. a copy of the latest annual accounts and of any report of the Auditor on them; and

38.1.3. a copy of the latest annual report.

38.2. The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

38.2.1. a copy of any order made under section 65D (appointment of Trust Special Administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L(Trusts coming out of administration) or 65LA (Trusts to be dissolved) of the 2006 Act;

38.2.2. a copy of any report laid under section 65D (appointment of Trust Special Administrator) of the 2006 Act;

38.2.3. a copy of any information published under section 65D (appointment of Trust Special Administrator) of the 2006 Act;

38.2.4. a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act;

38.2.5. a copy of any statement provided under section 65F(administrator's draft report) of the 2006 Act;

38.2.6. a copy of any notice published under section 65F(administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA(Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD

(Secretary of State's response to re-submitted final report) of the 2006 Act;

38.2.7. a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act;

38.2.8. a copy of any final report published under section 65I (administrator's final report);

38.2.9. a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act; and

38.2.10. a copy of any information published under section 65M (replacement of Trust special administrator) of the 2006 Act.

38.3. Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

38.4. If the person requesting a copy or extract is not a Member of the Trust, the Trust may impose a reasonable charge for doing so.

39. Auditor

39.1. The Trust shall have an Auditor (the "**Auditor**").

39.2. The Council of Governors shall appoint or remove the Auditor at a general meeting of the Council of Governors.

40. Audit Committee

40.1. The Board of Directors shall establish a Committee of Non-Executive Directors as an Audit Committee to perform such monitoring, reviewing and other functions as are appropriate.

41. Annual Accounts

41.1. The Trust must keep proper accounts and proper records in relation to the accounts.

41.2. Monitor may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

41.3. The accounts are to be audited by the Trust's Auditor.

41.4. The Trust shall prepare in respect of each financial year annual accounts in such form as Monitor may with the approval of the Secretary of State direct.

41.5. The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

42. Annual Report, Forward Plans and non-NHS work

42.1. The Trust shall prepare an annual report and send it to Monitor.

42.2. The Trust shall give information as to its forward planning in respect of each financial year to Monitor.

42.3. The document containing the information with respect to forward planning (referred to above) shall be prepared by the Board of Directors.

42.4. In preparing the document, the Board of Directors shall have regard to the views of the Council of Governors.

42.5. Each forward plan must include information about:

42.5.1. the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on; and

42.5.2. the income it expects to receive from doing so.

42.6. Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 42.5.1, the Council of Governors must:

42.6.1. determine whether it is satisfied that the carrying on of the activity will not, to any significant extent, interfere with the fulfilment by the Trust of its principal purpose

or the performance of its other functions; and

42.6.2. notify the Board of Directors of the Trust of its determination.

42.7. If the Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England, it may implement the proposal only if more than half of the members of the Council of Governors of the Trust voting, approve its implementation.

43. Presentation of the Annual Accounts and Reports to the Council of Governors and Members

43.1. The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

43.1.1. the annual accounts;

43.1.2. any report of the Auditor on them; and

43.1.3. the annual report.

43.2. The documents shall also be presented to the Members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

43.3. The Trust may combine a meeting of the Council of Governors convened for the purposes of paragraph 43.1 with the Annual Members' Meeting.

44. Instruments

44.1. The Trust shall have a seal.

44.2. The seal shall not be affixed except under the authority of the Board of Directors.

45. Amendment of the Constitution

45.1. The Trust may make amendments of its Constitution only if:

45.1.1. more than half of the members of the Council of Governors of the Trust voting, approve the amendments; and

45.1.2. more than half of the members of the Board of Directors of the Trust voting approve the amendments.

45.2. Amendments made under paragraph 45.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendments have no effect in so far as the Constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

45.3. Where an amendment is made to the Constitution in relation the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

45.3.1. at least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment; and

45.3.2. the Trust must give the Members an opportunity to vote on whether they approve the amendment.

45.4. If more than half of the Members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

45.5. Amendments by the Trust of its Constitution are to be notified to Monitor. For the avoidance of doubt, Monitor's functions do not include a power or duty to determine whether or not the Constitution, as a result of the amendments, accords with schedule 7 of the 2006 Act.

46. Mergers etc. and Significant Transactions

46.1. The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

46.2. The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust voting, approve entering into the transaction.

46.3. In paragraph 46.2, the following words have the following meanings:

"significant transaction" means a transaction which meets any one of the tests below:

46.3.1. the fixed asset test; or

46.3.2. the turnover test; or

46.3.3. the gross capital test (relating to acquisitions or divestments).

The fixed asset test:

46.3.4. is met if the assets which are the subject of the transaction exceed 25% of the fixed assets of the Trust;

The turnover test:

46.3.5. is met if, following the completion of the relevant transaction, the gross income of the Trust will increase or decrease by more than 25%;

The gross capital test:

46.3.6. is met if the gross capital of the company or business being acquired or divested represents more than 25% of the capital of the Trust following completion (where "gross capital" is the market value of the relevant company or business's shares and debt securities, plus the excess of current liabilities over current assets, and the Trust's capital is determined by reference to its balance sheet); and

46.3.7. for the purposes of calculating the tests in this paragraph 46.3, figures used to classify assets and profits must be the figures shown in the latest published audited consolidated accounts.

A transaction:

46.3.8. includes all agreements (including amendments to agreements) entered into by the Trust;

46.3.9. excludes a transaction in the ordinary course of business (including the renewal, extension or entering into an agreement in respect of healthcare services carried out by the Trust);

46.3.10. excludes any agreement or changes to healthcare services carried out by the Trust following a reconfiguration of services led by the commissioners of such services; and

46.3.11. excludes any grant of public dividend capital or the entering into of a working capital facility or other loan, which does not involve the acquisition or disposal of any fixed asset of the Trust.

47. Procedures and Protocols

47.1. The Council of Governors and Board of Directors will adopt such procedures and protocols as they may deem to be appropriate for the good governance of the Trust from time to time.

48. Indemnity

48.1. Members of the Council of Governors and the Board of Directors and the Secretary who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust.

ANNEX 1
THE PUBLIC CONSTITUENCY

Part 1 – From the Acquisition Date and during the Transitional Period

There shall be four Public Constituencies from the Acquisition Date and during the Transitional Period. Members of the public shall be eligible for membership of the Public Constituencies from the Acquisition Date and during the Transitional Period as shown in the table below:

Name of Public Constituency area	**Minimum number of Members from the Acquisition Date and during the Transitional Period**
Royal Borough of Kensington and Chelsea	500
City of Westminster	500
London Borough of Hammersmith and Fulham	300
London Borough of Wandsworth	300
Total	**1,600**

Part 2 – From 1 April 2016

There shall be seven Public Constituencies from 1 April 2016. Members of the public shall be eligible for membership of the Public Constituencies from 1 April 2016 as shown in the table below:

Name of Public Constituency area	**Minimum number of Members from 1 April 2016**
Royal Borough of Kensington & Chelsea	500
City of Westminster	500
London Borough of Hammersmith & Fulham	300
London Borough of Wandsworth	300
London Borough of Hounslow	300
London Borough of Richmond upon Thames	300
London Borough of Ealing	300
Total	**2,500**

ANNEX 2
THE STAFF CONSTITUENCY

Part 1 **– From the Acquisition Date and during the Transitional Period**

The Staff Constituency is divided into six classes. Staff shall be eligible for membership of a class within the Staff Constituency from the Acquisition Date and during the Transitional Period as shown in the table below:

Staff class	**Minimum number of Members from the Acquisition Date and during the Transitional Period**
Support, Administrative & Clerical Staff	100
Allied Health Professionals, Scientific & Technical Staff	100
Contracted Staff	100
Medical & Dental Staff	100
Nursing & Midwifery Staff	100
Management Staff	100
Total	**600**

Part 2 – From 1 April 2016

There shall be two Staff Constituencies. Staff shall be eligible for membership of the Staff Constituencies from 1 April 2016 as shown in the table below:

Staff class	**Minimum number of Members from 1 April 2016**
Chelsea & Westminster Hospital Staff	1,000
West Middlesex University Hospital Staff	1,000
Total	**2,000**

ANNEX 3
THE PATIENTS' CONSTITUENCY

1. PATIENTS' CONSTITUENCY

Patients shall be eligible for membership of the Patients' Constituency as shown in the table below.

	Minimum number of Members
Patients' Constituency	200
Total	**200**

ANNEX 4
COMPOSITION OF THE COUNCIL OF GOVERNORS

The composition of the Council of Governors set out below ensures that, at all times, the aggregate number of public and patients' constituencies' Governors (together with patient Governors up to the end of the Transitional Period) shall be more than half the total membership of the Council of Governors.

Part A – COMPOSITION OF THE COUNCIL OF GOVERNORS – From the Acquisition Date and during the Transitional Period

Stage 1	**From the Acquisition Date and during the Transitional Period**	
Elected Governors		
Constituency	**Area/Class**	**Number of Governors**
Public Constituencies	Royal Borough of Kensington & Chelsea	2
	City of Westminster	2
	London Borough of Hammersmith & Fulham	2
	London Borough of Wandsworth	2
Patients' Constituency	Patients' Constituency	10
Staff Constituency	Support, Administrative & Clerical Staff	1
	Allied Health Professionals, Scientific & Technical Staff	1
	Contracted Staff	1
	Medical & Dental Staff	1
	Nursing & Midwifery Staff	1
	Management Staff	1
Appointed Governors		
Representative status	**Representative of**	**Number of Governors**
Local authority (required by statute)	Royal Borough of Kensington & Chelsea	1
Local authority (required by statute)	Westminster City Council	1
University/medical school (required by statute)	Imperial College, University of London	1
Partnership/stakeholder organisation	Royal Marsden NHS Foundation Trust	1

Partnership/stakeholder organisation	Royal Brompton & Harefield NHS Foundation Trust	1
Total:		**29**

Part B: COMPOSITION OF THE COUNCIL OF GOVERNORS - from 1 April 2016:

The composition of the Council of Governors set out below ensures that, at all times, the aggregate number of public and patients' constituencies' Governors shall be more than half the total membership of the Council of Governors. The terms of the Governors set out below shall commence on 1 April 2016.

Stage 2	**From 1 April 2016**	
Elected Governors		
Constituency	**Representative of**	**Number of Governors**
Public Constituencies	Royal Borough of Kensington & Chelsea	3
	City of Westminster	2
	London Borough of Hammersmith & Fulham	3
	London Borough of Wandsworth	2
	London Borough of Hounslow	3
	London Borough of Richmond upon Thames	2
	London Borough of Ealing	1
Patients' Constituency	Patients' Constituency	6
Staff Constituency	Chelsea & Westminster Hospital Staff	3
	West Middlesex University Hospital Staff	3
Appointed Governors		
University/medical school (required by statute)	Imperial College, University of London	1
Local Authority (required by statute)	• Royal Borough of Kensington & Chelsea; • Westminster City Council, and • London Borough of Hammersmith & Fulham who shall appoint a Governor on a rotational basis as set out at paragraphs 13.5 to 13.7 of this Constitution.	1

Local Authority (required by statute)	• London Borough of Hounslow; • London Borough of Richmond, and • London Borough of Wandsworth who shall appoint a Governor on a rotational basis as set out at paragraphs 13.5 to 13.7 of this Constitution.	1
Total:		**31**

ANNEX 5
MODEL ELECTION RULES

The Trust is to hold elections in accordance with the single transferable vote version of the Model Election Rules, as set out below.

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2. Timetable
3. Computation of time

PART 3 RETURNING OFFICER

4. Returning officer
5. Staff
6. Expenditure
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10. Candidate's particulars
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13. Signature of candidate
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19. Poll to be taken by ballot
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61. Expenses and payments by candidates
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63. Publicity about election by the corporation
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66. Application to question an election

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67. Secrecy
68. Prohibition of disclosure of vote
69. Disqualification

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PART 1 INTERPRETATION

1. Interpretation

1.1. In these rules, unless the context otherwise requires:

"2006 Act" means the National Health Service Act 2006;

"corporation" means the public benefit corporation subject to this constitution;

"council of governors" means the council of governors of the corporation;

"declaration of identity" has the meaning set out in rule 21.1;

"election" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

"e-voting" means voting using either the internet, telephone or text message;

"e-voting information" has the meaning set out in rule 24.2;

"ID declaration form" has the meaning set out in Rule 21.1;

"internet voting record" has the meaning set out in rule 26.4(d);

"internet voting system" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"lead governor" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code;

"list of eligible voters" means the list referred to in rule 22.1, containing the information in rule 22.2;

"method of polling" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"Monitor" means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

"numerical voting code" has the meaning set out in rule 64.2(b);

"poling website" has the meaning set out in rule 26.1;

"postal voting information" has the meaning set out in rule 24.1;

"telephone short code" means a short telephone number used for the purposes of

submitting a vote by text message;

"telephone voting facility" has the meaning set out in rule 26.2;

"telephone voting record" has the meaning set out in rule 26.5 (d);

"text message voting facility" has the meaning set out in rule 26.3;

"text voting record" has the meaning set out in rule 26.6 (d);

"the telephone voting system" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"the text message voting system" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"voter ID number" means a unique, randomly generated numeric identifier allocated to each voter by the returning officer for the purpose of e-voting;

"voting information" means postal voting information and/or e-voting information.

1.2. Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

2. Timetable

2.1. The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the 40th day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the 28th day before the day of the close of the poll.
Publication of statement of nominated Candidates	Not later than the 27th day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than 25th day before the day of the close of the poll.
Notice of the poll	Not later than the 15th day before the day of the close of the poll.
Close of the poll	By 5pm on the final day of the election.

3. Computation of time

3.1. In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas Day, Good Friday, or a bank holiday; or

(c) a day appointed for public thanksgiving or mourning;

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2. In this rule, "bank holiday" means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

4. Returning Officer

4.1. Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2. Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1. Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1. The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules;

(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1. The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

8. Notice of election

8.1. The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held;
(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency;
(c) the details of any nomination committee that has been established by the corporation;
(d) the address and times at which nomination forms may be obtained;
(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the email address for such return) and the date and time by which they must be received by the returning officer;
(f) the date and time by which any notice of withdrawal must be received by the returning officer;
(g) the contact details of the returning officer;
(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1. Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2. The returning officer:

(a) is to supply any member of the corporation with a nomination form; and
(b) is to prepare a nomination form for signature at the request of any member of the corporation;

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1. The nomination form must state the candidate's:

(a) full name;
(b) contact address in full (which should be a postal address although an email address may also be provided for the purposes of electronic communication);

and

(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1. The nomination form must state:

(a) any financial interest that the candidate has in the corporation; and

(b) whether the candidate is a member of a political party, and if so, which party;

and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1. The nomination form must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1. The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate;

(b) their declaration of interests as required under rule 11, is true and correct; and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2. Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1. Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand;
(b) decides that the nomination form is invalid;
(c) receives satisfactory proof that the candidate has died; or
(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2. The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election;
(b) that the paper does not contain the candidate's particulars, as required by rule 10;
(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11;
(d) that the paper does not include a declaration of eligibility as required by rule 12; or
(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3. The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4. Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5. The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an email address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1. The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2. The statement must show:
(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing; and
(b) the declared interests of each candidate standing;

as given in their nomination form.

15.3. The statement must list the candidates standing for election in alphabetical order by surname.

15.4. The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1. The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2. If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1. A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1. If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2. If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3. If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in

accordance with Part 7 of these rules; and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

PART 5 COUNTING THE VOTES

19. Poll to be taken by ballot

19.1. The votes at the poll must be given by secret ballot.

19.2. The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3. The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4. The corporation may decide that voters within a constituency or class within a constituency for whom an email address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5. Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:
  (i) configured in accordance with these rules; and
  (ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting is to be a method of polling, the telephone voting system to be used for the purpose of the election is:
  (i) configured in accordance with these rules; and
  (ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:
  (i) configured in accordance with these rules; and
  (ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1. The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2. Every ballot paper must specify:

(a) the name of the corporation;

(b) the constituency, or class within a constituency, for which the election is being held;

(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency;

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates;

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available;

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll; and

(g) the contact details of the returning officer.

20.3. Each ballot paper must have a unique identifier.

20.4. Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1. The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) that the voter is the person:

(i) to whom the ballot paper was addressed; and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated;

(b) that he or she has not marked or returned any other voting information in the election; and

(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held;

("**declaration of identity**")

and the corporation shall make such arrangements as it considers appropriate to

facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2. The voter must be required to return his or her declaration of identity with his or her ballot.

21.3. The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1. The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2. The list is to include, for each member:

(a) a postal address; and,

(b) the member's email address, if this has been provided;

to which his or her voting information may, subject to rule 22.3, be sent.

22.3. The corporation may decide that the e-voting information is to be sent only by email to those members in the list of eligible voters for whom an email address is included in that list.

23. Notice of poll

23.1. The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation;

(b) the constituency, or class within a constituency, for which the election is being held;

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency;

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates;

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post;

(f) the methods of polling by which votes may be cast at the election by voters in a

constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3;

(g) the address for return of the ballot papers;

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located;

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located;

(k) the date and time of the close of the poll;

(l) the address and final dates for applications for replacement voting information; and

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1. Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope;

(b) the ID declaration form (if required);

(c) information about each candidate standing for election, pursuant to rule 61 of these rules; and

(d) a covering envelope;

("postal voting information").

24.2. Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by email and/or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required);

(b) the voter's voter ID number;

(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the returning officer thinks appropriate, (d) contact details of the returning officer;

("e-voting information").

24.3. The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or

(b) only be sent e-voting information; or

(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4. If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by email to those members in the list of eligible voters for whom an email address is included in that list, then the returning officer shall only send that information by email.

24.5. The voting information is to be sent to the postal address and/or email address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1. The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2. The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

25.3. There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return to the returning officer:

(a) the completed ID declaration form if required; and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-Voting systems

26.1. If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2. If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as "the telephone voting facility").

26.3. If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as "the text message voting facility").

26.4. The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter his or her voter ID number; and

(ii) where the election is for a public or patient constituency , make a declaration of identity;

in order to be able to cast his or her vote;

(b) specify:

(i) the name of the corporation;

(ii) the constituency, or class within a constituency, for which the election is being held;

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency;

(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates;

(v) instructions on how to vote and how to make a declaration of identity;

(vi) the date and time of the close of the poll; and

(vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote;

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5. The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to:

(i) enter his or her voter ID number in order to be able to cast his or her vote; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation;

(ii) the constituency, or class within a constituency, for which the election

is being held;

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency;

(iv) instructions on how to vote and how to make a declaration of identity;

(v) the date and time of the close of the poll; and

(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote;

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6. The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

(i) provide his or her voter ID number; and

(ii) where the election is for a public or patient constituency , make a declaration of identity;

in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(c) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote;

(d) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(e) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1. An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1. The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2. Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1. If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2. On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3. The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4. After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter; and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it); and

(c) the details of the unique identifier of the replacement ballot paper.

29.5. If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6. On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7. The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8. After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter; and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it); and

(c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1. Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2. The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity;

(b) has no reason to doubt that the voter did not receive the original voting information;

(c) has ensured that no declaration of identity, if required, has been returned.

30.3. After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter;

(b) the details of the unique identifier of the replacement ballot paper, if applicable; and

(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1. If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2. After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter;

(b) the unique identifier of any replacement ballot paper issued under this rule;

(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1. In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1. To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2. When prompted to do so, the voter will need to enter his or her voter ID number.

33.3. If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4. To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5. The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1. To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2. When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3. If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4. When prompted to do so the voter may then cast his or her vote by keying in the

numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5. The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1. To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2. The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3. The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1. Where the returning officer receives:

(a) a covering envelope; or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper;

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2. The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted; or

(b) the unique identifier on a ballot paper.

36.3. The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1. A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2. Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) put the ID declaration form if required in a separate packet; and

(b) put the ballot paper aside for counting after the close of the poll.

37.3. Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper "disqualified";

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper;

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the "list of disqualified documents"); and

(d) place the document or documents in a separate packet.

37.4. An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5. Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6. Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified";

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and

(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)

38.1. Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified";

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper; and

(c) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1. Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2. If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and

(b) mark as "disqualified" all other votes that were cast using the relevant voter ID number.

39.3. Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper "disqualified";

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper;

(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;

(d) place the document or documents in a separate packet; and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4. Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified";

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet; and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1. As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents

inside it;

(b) the ID declaration forms, if required;

(c) the list of spoilt ballot papers and the list of spoilt text message votes;

(d) the list of lost ballot documents;

(e) the list of eligible voters; and

(f) the list of tendered voting information;

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

PART 6 COUNTING THE VOTES

41. Interpretation of Part 6

41.1. In Part 6 of these rules:

"ballot document" means a ballot paper, internet voting record, telephone voting record or text voting record;

"continuing candidate" means any candidate not deemed to be elected, and not excluded;

"count" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates;

"deemed to be elected" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll;

"mark" means a figure, an identifiable written word, or a mark such as "X";

"non-transferable vote" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate;
or
(b) which is excluded by the returning officer under rule 49;

"preference" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference;
(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and
(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on;

"quota" means the number calculated in accordance with rule 46;

"surplus" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus

means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus;

"stage of the count" means:

(a) the determination of the first preference vote of each candidate;

(b) the transfer of a surplus of a candidate deemed to be elected; or

(c) the exclusion of one or more candidates at any given time;

"transferable vote" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate;

"transferred vote" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred; and

"transfer value" means the value of a transferred vote calculated in accordance with rules 47.4 or 47.7.

42. Arrangements for counting of the votes

42.1. The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2. The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:

(i) the use of such software for the purpose of counting votes in the relevant election; and

(ii) a policy governing the use of such software; and

(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1. The returning officer is to:

(a) count and record the number of:

(iii) ballot papers that have been returned; and

(iv) the number of internet voting records, telephone voting records and/or text voting records that have been created; and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2. The returning officer, while counting and recording the number of ballot papers,

internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3. The returning officer is to proceed continuously with counting the votes as far as is practicable.

44. Rejected ballot papers and rejected text voting records

44.1. Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced;

(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate;

(c) on which anything is written or marked by which the voter can be identified except the unique identifier; or

(d) which is unmarked or rejected because of uncertainty;

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

44.2. The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

44.3. Any text voting record:

(a) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate;

(b) on which anything is written or marked by which the voter can be identified except the unique identifier; or

(c) which is unmarked or rejected because of uncertainty;

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

44.4. The returning officer is to endorse the word "rejected" on any text voting record which under this rule is not to be counted.

44.5. The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule 44.1 and

the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule 44.3.

45. First stage

45.1. The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

45.2. The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

45.3. The returning officer is to also ascertain and record the number of valid ballot documents.

46. The quota

46.1. The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

46.2. The result, increased by one, of the division under rule 46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as "the quota").

46.3. At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules 47.1 to 47.3 has been complied with.

47. Transfer of votes

47.1. Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub-parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate; or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

47.2. The returning officer is to count the number of ballot documents in each parcel referred to in rule 47.1.

47.3. The returning officer is, in accordance with this rule and rule 48, to transfer each sub-parcel of ballot documents referred to in rule 47.1 (a) to the candidate for whom

the next available preference is given on those ballot documents.

47.4. The vote on each ballot document transferred under rule 47.3 shall be at a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus; and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

47.5. Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate; or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

47.6. The returning officer is, in accordance with this rule and rule 48, to transfer each sub-parcel of ballot documents referred to in rule 47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

47.7. The vote on each ballot document transferred under rule 47.6 shall be at:

(a) a transfer value calculated as set out in rule 47.4(b); or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred;

whichever is the less.

47.8. Each transfer of a surplus constitutes a stage in the count.

47.9. Subject to rule 47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

47.10. Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote; or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

47.11. This rule does not apply at an election where there is only one vacancy.

48. Supplementary provisions on transfer

48.1. If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) the surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first; and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

48.2. The returning officer shall, on each transfer of transferable ballot documents under rule 47:

(a) record the total value of the votes transferred to each candidate;

(b) add that value to the previous total of votes recorded for each candidate and record the new total;

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes; and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes; with

(ii) the recorded total of valid first preference votes.

48.3. All ballot documents transferred under rule 47 or 49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

48.4. Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule 47 or 49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a

nontransferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

49. Exclusion of candidates

49.1. If:

(a) all transferable ballot documents which under the provisions of rule 47 (including that rule as applied by rule 49.11) and this rule are required to be transferred, have been transferred; and

(b) subject to rule 50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule 49.12 applies, the candidates with the then lowest votes).

49.2. The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule 49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given; and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

49.3. The returning officer shall, in accordance with this rule and rule 48, transfer each sub-parcel of ballot documents referred to in rule 49.2 to the candidate for whom the next available preference is given on those ballot documents.

49.4. The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

49.5. If, subject to rule 50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule 49.1 into sub- parcels according to their transfer value.

49.6. The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

49.7. The vote on each transferable ballot document transferred under rule 49.6 shall be

at the value at which that vote was received by the candidate excluded under rule 49.1.

49.8. Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

49.9. After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule 49.1.

49.10. The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes; or

(ii) the total transfer value of votes transferred to each candidate;

(b) add that total to the previous total of votes recorded for each candidate and record the new total;

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total; and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

49.11. If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules 47.5 to 47.10 and rule 48.

49.12. Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

49.13. If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded; and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

50. Filling of last vacancies

50.1. Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

50.2. Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

50.3. Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

51. Order of election of candidates

51.1. The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule 47.10.

51.2. A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he or she obtained the quota.

51.3. Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

51.4. Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

PART 7 FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

52. Declaration of result for contested elections

52.1. In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected;

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the Trust by section 33(4) of the 2006 Act, to the chair of the NHS trust; or

(ii) in any other case, to the chair of the corporation; and

(c) give public notice of the name of each candidate who he or she has declared elected.

52.2. The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not;

(b) any transfer of votes;

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place;

(d) the order in which the successful candidates were elected; and

(e) the number of rejected ballot papers under each of the headings in rule 44.1;

(f) the number of rejected text voting records under each of the headings in rule 44.3;

available on request.

53. Declaration of result for uncontested elections

53.1. In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected;

(b) give notice of the name of each candidate who he or she has declared elected to the chair of the corporation; and

(c) give public notice of the name of each candidate who he or she has declared elected.

PART 8 DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll

54.1. On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records;

(b) the ballot papers and text voting records endorsed with "rejected in part";

(c) the rejected ballot papers and text voting records; and

(d) the statement of rejected ballot papers and the statement of rejected text voting records;

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2. The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it;

(b) the list of spoilt ballot papers and the list of spoilt text message votes;

(c) the list of lost ballot documents; and

(d) the list of eligible voters;

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3. The returning officer must endorse on each packet a description of:

(a) its contents;

(b) the date of the publication of notice of the election;

(c) the name of the corporation to which the election relates; and

(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1. Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1. Where:

(a) any voting documents are received by the returning officer after the close of the poll; or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent; or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued;

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chair of the corporation.

57. Retention and public inspection of documents

57.1. The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2. With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3. A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1. The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing:

(i) any rejected ballot papers, including ballot papers rejected in part;

(ii) any rejected text voting records, including text voting records rejected in part;

(iii) any disqualified documents, or the list of disqualified documents;

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records; or

(v) the list of eligible voters; or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage;

by any person without the consent of the board of directors of the corporation.

58.2. A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3. The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to -

(a) persons;

(b) time;

(c) place and mode of inspection;

(d) production or opening;

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4. On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent; and

(b) in making the documents available for inspection;

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established:

(i) that his or her vote was given; and

(ii) that Monitor has declared that the vote was invalid.

PART 9 DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

59. Countermand or abandonment of poll on death of candidate

59.1. If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died; and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that:

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted; and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

59.2. The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

60. Election expenses

60.1. Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to Monitor under Part 11 of these rules.

61. Expenses and payments by candidates

61.1. A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses;

(b) travelling expenses, and expenses incurred while living away from home; and

(c) expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1. No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise; or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2. Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1. The corporation may:

(a) compile and distribute such information about the candidates; and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions

as it considers necessary.

63.2. Any information provided by the corporation about the candidates, including

information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair;

(b) equivalent in size and content for all candidates;

(c) compiled and distributed in consultation with all of the candidates standing for election; and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3. Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1. The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2. The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words;

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"); and

(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1. In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2. The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

66. Application to question an election

66.1. An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor.

66.2. An application may only be made once the outcome of the election has been declared by the returning officer.

66.3. An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote; or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4. The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as Monitor may require.

66.5. The application must be presented in writing within 21 days of the declaration of the result of the election.

66.6. If Monitor requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7. Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8. The determination by the person or panel of persons nominated in accordance with rule 66.7 shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9. Monitor may prescribe rules of procedure for the determination of an application including costs.

PART 12 MISCELLANEOUS

67. Secrecy

67.1. The following persons:

(a) the returning officer; and

(b) the returning officer's staff;

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted;

(ii) the unique identifier on any ballot paper;

(iii) the voter ID number allocated to any voter;

(iv) the candidate(s) for whom any member has voted.

67.2. No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3. The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1. No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1. A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation;

(b) an employee of the corporation;

(c) a director of the corporation; or

(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1. If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24; or

(b) the return of the ballot paper;

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

ANNEX 6
ADDITIONAL PROVISIONS - COUNCIL OF GOVERNORS

1. Roles and responsibilities of the Council of Governors

1.1. The roles and responsibilities of the Council of Governors at a general meeting (which may be the Trust's annual general meeting), which are to be carried out in accordance with this Constitution, the Trust's Authorisation and Monitor's Code of Governance, are :

(a) subject to paragraph 27 of this Constitution, to appoint or remove the Chairman and the other Non-Executive Directors;

(b) subject to paragraph 34 of this Constitution, to decide the remuneration and allowances, and other terms and conditions of office, of the Chairman and the other Non-Executive Directors;

(c) to appoint or remove the Auditor;

(d) to consider and be presented with the annual accounts, any report of the Auditor on them and the annual report;

(e) approve (by a majority of the Council of Governors voting in favour) an appointment by the Non-Executive Directors, of the Chief Executive and Accounting Officer; and

(f) to give the views of the Council of Governors to the directors for the purposes of the preparation by the Board of Directors of the forward planning in respect of each financial year (the annual plan to be given to Monitor).

1.2. Paragraph 17 of the constitution sets out provisions as to the duties of the Council of Governors.

2. Disqualification

2.1. The following may not become or continue as a member of the Council of Governors:

(a) a person as referred to in paragraph 16.2 of the constitution;

(b) a director of the Trust or a director of an NHS trust or another foundation trust;

(c) a spouse, partner, parent or child of a member of the Board of Directors of the Trust;

(d) being a Member of the Public Constituency, a person who refuses to sign a declaration in the form specified by the Company Secretary of particulars of their qualification to vote as a Member of the Trust and that they are not prevented from being a member of the Council of Governors;

(e) a vexatious complainant as determined in accordance with the Trust's complaints procedure;

(f) a person who is required to notify the police of his name and address as a result of being convicted or cautioned for relevant sex offences pursuant to the Sexual Offences Act 2003 or other relevant legislation and/or a person who has previously been or is currently subject to a sex offender order and/or required to register under the Sexual Offences Act 2003 or has committed a sexual offence prior to the requirements to register under current legislation coming into force;

(g) a person who has been disqualified from being a member of a relevant authority under the provisions of the Local Government Act 2000;

(h) a person who, on the basis of disclosures obtained through an application to the Disclosure and Barring Service established under section 87 of the Protection of Freedoms Act 2012, (or any other checks required by the Trust from time to time as being consistent with its licence conditions or mandatory or nationally recommended good governance arrangements), they are not considered suitable by the Trust's Director responsible for human resources;

(i) a person who within the preceding two years has been dismissed, otherwise than by reason of redundancy, from any paid employment with the Trust or with a Health Service Body;

(j) a person who within the preceding two years has been subject to a disciplinary sanction within the Trust;

(k) a person whose tenure of office as the Chairman or as a member or director of a Health Service Body has been terminated on the grounds that his appointment is not in the interests of the health service, or for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

(l) a person who has refused without reasonable cause to undertake any training (including any workshop) which the Trust requires all governors to undertake;

(m) a person who has failed to sign and deliver to the Company Secretary a statement in the form required by the Company Secretary confirming acceptance of the code of conduct for the Council of Governors;

(n) a person who has had his name removed or been suspended from any practising or professional list, by a direction under any legislation applicable to the NHS or under any related subordinate legislation or who has otherwise been suspended or disqualified from any healthcare profession, and has not subsequently had his name included in such a list or had his suspension lifted or qualification reinstated (as applicable);

(o) a person who has failed to pay monies properly due to the Trust;

(p) a person who is the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

(q) a person who, following investigations undertaken by the Trust, is determined by the Trust to be an individual who:

(i) is not of good character;

(ii) does not have the necessary qualifications, competence, skills and experience which are necessary in order to undertake their Governor role;

(iii) is unable, by reason of their health, after reasonable adjustments are made, of properly performing the tasks which are intrinsic to the work for which they are employed;

(iv) has been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying out a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity;

(v) any of the grounds of unfitness specified paragraph 16 of this Constitution apply to;

(vi) is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order to like effect made in Scotland or Northern Ireland;

(vii) is included in the children's barred list or the adults' barred list maintained under paragraph 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland; and/or

(viii) is prohibited from holding the relevant office or position, or in the case of an individual carrying on the regulated activity, by or under an enactment.

2.2. In assessing an individual's character for the purposes of paragraph (q)(i) above, the matters considered must include:

(a) whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence; and

(b) whether the person has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals.

2.3. In the event that a Governor no longer meets the requirements set out in this Annex 6, the Trust shall:

(a) take such action as is necessary and proportionate to ensure that the office or position in question is held by an individual who meets such requirements; and

(b) if the individual is a health care professional, social worker or other professional registered with a health care or social care regulator, inform Monitor.

2.4. If a person has been elected or appointed to be a Governor and he becomes disqualified or is removed from office, the Company Secretary shall immediately declare that the person in question is disqualified and notify him in writing to that effect.

2.5. Upon despatch of any such notification, that person's tenure of office shall be terminated and he shall cease to act as a Governor; and the Company Secretary shall inform the Chairman of the actions taken in respect of the person in question and the reasons for such action.

3. Removal

3.1. A Governor may be removed from the Council of Governors by a resolution approved by the majority of the remaining Governors present at the meeting on the grounds that:

(a) he has committed a serious breach of the code of conduct; or

(b) he has acted in a manner detrimental to the interests of the Trust; or

(c) the Council of Governors consider that it is not in the best interest of the Trust for him to continue as a Governor; or

(d) he fails to attend three consecutive formal meetings of the Council of Governors; or

(e) he fails to attend two consecutive workshop meetings of the Council of Governors.

4. Vacancies

4.1. Where a vacancy arises on the Council of Governors for any reason other than expiry of the term of office, the following provisions will apply:

(a) where the vacancy arises amongst the appointed Governors, the Company Secretary shall request that the appointing organisation appoints a replacement to hold office for the remainder of the term of office; and

(b) where the vacancy arises amongst the elected Governors, the Council of Governors may:

(i) call an election within three months to fill the seat for the remainder of that term of office; or

(ii) invite the next highest polling candidate, provided that that candidate received at least 10% of the vote in the last election (such 10% being calculated taking into account first preference votes cast under the transferable vote system set out in Annex 4), and is willing to take office, to fill the vacant seat until the next election, at which time the seat will fall vacant and be subject to election; or

(iii) if the unexpired period of the term of office is less than nine months (or such

other period as the Council of Governors may from time to time determine by majority vote), leave the seat vacant until the next elections are held.

ANNEX 7
STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

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1. INTRODUCTION

Regulatory Framework

1.1. Chelsea & Westminster Hospital NHS Foundation Trust (the "**Trus**t") is a public benefit corporation and is constituted in accordance with the 2006 Act (as amended by the 2012 Act).

1.2. The principal places of business of the Trust are Chelsea & Westminster Hospital within the Royal Borough of Kensington & Chelsea and West Middlesex University Hospital within the London Borough of Hounslow.

1.3. The Trust is governed by the 2006 Act (as amended by the 2012 Act), by its Constitution and by its Foundation Trust Licence granted by Monitor.

2. THE COUNCIL OF GOVERNORS

2.1. **Composition of the Council –** from 1 April 2016, in accordance with Part B of Annex 4 of this Constitution, the composition of the Council of Governors of the Trust shall be:

2.1.1. sixteen public Governors;

2.1.2. six patient Governors

2.1.3. six staff Governors; and

2.1.4. three stakeholder Governors including:

a) two local authority Governors; and

b) one Governor appointed by Imperial College, University of London.

2.2. In accordance with the Constitution, prior to and during the Transitional Period the composition of the Council of Governors shall be as set out at Part A of Annex 4.

2.3. The Chief Executive or any other Director or a representative of the Trust's Auditors or other advisors can attend a meeting of the Council of Governors unless the Council of Governors agrees otherwise.

2.4. **Role of the public Governors** - One of the duties of the public Governors is to facilitate communication between the Board of Directors and the Members of the Trust.

2.5. **Role of the Chairman** - The Chairman is not a member of the Council of Governors. However, he presides at meetings of the Council of Governors and has a casting vote.

2.6. **Role and appointment of the Lead Governor** - For the purpose of facilitating liaison between the Board of Directors and the Council of Governors, the Council of Governors shall appoint one of the public Governors of the Trust to be the Lead Governor in accordance with the following process:

2.6.1. upon the conclusion of the Annual Members Meeting each year, the Chairman shall invite public Governors to put themselves forward for the post of Lead Governor;

2.6.2. if more than one public Governor puts themselves forward for the post of Lead Governor, the Company Secretary will compile a list of Lead Governor candidates and will require the completion of an applicant form from each candidate which will detail the particular candidates suitability for the role;

2.6.3. the completed Lead Governor applicant forms will be distributed to the Council of Governors no less than five working days prior to a decision as to the appointment being made;

2.6.4. the final appointment will require the approval of a majority of Governors present and voting at a Council of Governors meeting or the majority of the full number of Governors if a decision is made to conduct an ‘out of session’ vote via electronic or postal mail.

2.6.5. Appointments will last for a 12 month period. Should a vacancy arise prior to the expiry of the 12 month period or should the postholder be temporarily unable to fulfil their duties for any reason, the Council of Governors shall agree interim arrangements to fill the duties of the post.

2.6.6. The Lead Governor will be eligible for re-election twice after initially being elected but will not be able to serve as Lead Governor beyond a three year period.

3. MEETINGS OF THE COUNCIL OF GOVERNORS

3.1. **Admission to the public** - the meetings of the Council of Governors shall be open to members of the public except for special reasons where the Council of Governors resolves:

3.1.1. that members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the interests of the Trust; and/or

3.1.2. that in the interests of public order, the meeting adjourns for a period to be specified in such resolution to enable the Council of Governors to complete business without the presence of the public.

3.2. Nothing in these SOs shall require the Council of Governors to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than in writing, or to make any oral report of proceedings as they take place without the prior agreement of the Council of Governors.

3.3. **Calling meetings** - ordinary meetings of the Council of Governors shall be held at such times and places as the Council of Governors may determine and there will be no fewer than four meetings per year, as well as at least one joint workshop in private between the Governors and the Board of Directors, such that the total number of meetings will be not less than five per annum.

3.4. Meetings of the Council of Governors may be called by the Company Secretary, or by the Chairman, or by ten Governors who give written notice to the Company Secretary specifying the business to be carried out. The Company Secretary will send (by appropriate means including, without limitation, by email or post, or via the Trust's website) the dates, times and locations of meetings of the Council of Governor meetings to all Governors as soon as possible after receipt of such a request.

3.5. Other, or emergency, meetings of the Council of Governors may be called (by appropriate means including, without limitation, by email or post, or via the Trust's website) in accordance with this Constitution. The Company Secretary shall call a meeting on at least 14 but not more than 28 days' notice to discuss the specified business. If the Company Secretary fails to call such a meeting then the Chairman or ten Governors, whichever is the case, shall call such a meeting. Notice will also be published on the Trust's website and at the main entrances to Chelsea & Westminster Hospital and West Middlesex University Hospital.

3.6. Subject to SO 3.7 below, a lack of service of the notice of the business of the meeting on any Governor shall not affect the validity of a meeting.

3.7. Failure to serve such a notice specifying the business on more than one third of Governors who are elected from the Public Constituency will invalidate the meeting. A notice will be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post or, where the notice is sent by email, at the time at which the email is sent.

3.8. In the case of a meeting being called by ten Governors in default of the Chairman, the notice shall be signed by those members of the Council of Governors and no business shall be transacted at the meeting other than that specified in the notice.

3.9. **Agenda of meetings** - Before each meeting of the Council of Governors, an agenda of the meeting specifying the business proposed to be transacted at it and any supporting papers shall be delivered to each Governor, or sent by post to the usual place of residence of the

Governor, so as to be available to him at least three clear days before the meeting.

3.10. **Setting the agenda** - The Council of Governors may determine that certain matters shall appear on every agenda for a meeting of the Council of Governors and shall be addressed prior to any other business being conducted.

3.11. A Governor desiring a matter to be included on an agenda shall make his request in writing to the Company Secretary at least 15 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 15 days before a meeting may be included on the agenda at the discretion of the Company Secretary.

3.12. **Chairman of the meeting** - At any meeting of the Council of Governors, the Chairman, if present, shall preside. If the Chairman considers it appropriate (taking into account the matters to be discussed at a meeting of the Council of Governors), the Lead Governor shall preside at such meeting. If the Chairman is absent from the meeting, the Deputy Chairman or another Non-Executive Director, if there is one and he is present, shall preside. If the Chairman, the Deputy Chairman and all Non-Executive Directors are absent, the Lead Governor, if he is present, shall preside. If the Lead Governor is not present, such Governor as the Council of Governors present shall choose shall preside.

3.13. **Emergency powers** - The Council of Governors' powers may in emergency be exercised by the Chairman (or in his absence the Deputy Chairman and if the Deputy Chairman is absent, any other Non-Executive Director) together with at least one-third of the Governors elected from the Public Constituency. The exercise of such powers shall be reported to the next formal meeting of the Council of Governors for ratification.

3.14. **Notices of Motion** - A Governor desiring to move or amend a Motion shall send a written notice thereof at least 15 clear days before the meeting to the Company Secretary, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This SO shall not prevent any Motion being moved during the meeting without notice on any business mentioned on the agenda, except that the acceptance of such a Motion for inclusion on the agenda will be at the discretion of the Company Secretary.

3.15. **Withdrawal of Motion or amendments** - A Motion or amendment once moved may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman.

3.16. **Motion to rescind a resolution** - Notice of Motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Governor who gives it and also the signature of four other Governors. When any such Motion has been disposed of by the Council of Governors, it shall not be competent for any Governor to propose a Motion to the same effect within six months; however the Chairman may do so if he considers it appropriate.

3.17. **Motions** - The mover of a Motion shall have a right of reply at the close of any discussion on the Motion or any amendment thereto.

3.18. When a Motion is under discussion or immediately prior to discussion it shall be open to a Governor to move:

3.18.1. an amendment to the Motion;

3.18.2. the adjournment of the discussion or the meeting;

3.18.3. that the meeting proceed to the next business (*);

3.18.4. the appointment of an ad hoc Committee to deal with a specific item of business; or

3.18.5. that the Motion be now put (*);

3.18.6. provided that in the case of sub-paragraphs denoted by (*) above and to ensure objectivity, Motions may only be put by a Governor who has not

previously taken Part in the debate.

3.19. No amendment to the Motion shall be admitted if, in the opinion of the Chairman of the meeting, the amendment negates the substance of the Motion.

3.20. **Chairman's ruling** - Statements of Governors made at meetings of the Council of Governors shall be relevant to the matter under discussion at the material time and the decision of the Chairman of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

3.21. **Voting** – Any vote required by the Council of Governors at a meeting shall be decided by a show of hands. A paper ballot may also be used if a majority of the Governors present so request. Governors may attend Council of Governors meetings by telephone, teleconference, video or computer link and, in which case, shall cast their vote verbally (such verbal vote to be recorded in the minutes).

3.22. Where agreed by the Council of Governors, an absent Governor may vote by proxy.

3.23. **E-Governance -** The Council of Governors may confirm their response to any proposal in writing via e-mail. A response to a proposal sent by email shall be deemed to have been delivered on the date of transmission (if sent before 5pm on a clear day) or by 11am on the next clear day (if sent after 5pm on a clear day). The proposal will pass provided that the majority of Governors approve the proposal. Any decisions so passed via e-governance shall be noted at the next Council of Governors meeting.

3.24. **Written resolutions -** Where the Chairman or a Governor desires that a resolution is passed by the Council of Governors (or any Committee or sub-Committee of the Council of Governors), the Chairman or the Governor (with the consent of the Chairman) may circulate the resolution amongst the Council of Governors (or such members of the relevant Committee or sub-Committee as the case may be) proposing that it is passed as a written resolution. For the resolution to be validly passed, the majority of all the Governors (or such members of the relevant Committee or sub-Committee as the case may be) must sign the resolution. Any written resolution that is so passed shall be noted at the next meeting of the Council of Governors.

3.25. **Minutes -** The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

3.26. No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.27. Minutes shall be circulated in accordance with Governors' wishes.

3.28. **Suspension of SOs -** Except where this would contravene any statutory provision or any direction made by Monitor, any one or more of these SOs may be suspended at any meeting, provided that the majority of the Council of Governors are present and that a majority of those present vote in favour of suspension.

3.29. A decision to suspend these SOs shall be recorded in the minutes of the meeting.

3.30. A separate record of matters discussed during the suspension of the SOs shall be made and shall be available to the Chairman and the Council of Governors.

3.31. No formal business may be transacted while the SOs are suspended.

3.32. The Audit Committee shall review every decision to suspend the SOs.

3.33. **Amendment of SOs**

These SOs shall be amended only if:

3.33.1. a notice of Motion under SO 3.14 has been given;

3.33.2. at least 16 of the Council of Governors are present;

3.33.3. the proposed amendment is made in accordance with paragraph 45 of the Constitution; and

3.33.4. the amendment proposed does not contravene a statutory provision or direction made by Monitor.

3.34. **Record of attendance**

The names of the Chairman and Governors present at the meeting shall be recorded in the minutes. Governors who are unable to attend the Council of Governors meeting should advise the Company Secretary in advance of the meeting so that their apologies may be submitted.

3.35. **Quorum**

No business shall be transacted at a meeting of the Council of Governors unless there are at least 13 Governors present, and of that 13, at least eight must be public Governors. For the avoidance of doubt, the number of public Governors present at a meeting should be in the majority.

3.36. If the Chairman or any Governor has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO 6 or 7) he shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1. Subject to such directions, if any, as may be given by Monitor, the Council of Governors may make arrangements for the exercise, on behalf of the Council of Governors, of any of its functions by a Committee or sub-Committee, appointed by virtue of SOs 5.1 or 5.2 below, subject to such restrictions and conditions as the Council of Governors thinks fit.

4.2. **Overriding SOs -** If for any reason these SOs are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Council of Governors for action or ratification. All Governors have a duty to disclose any non- compliance with these SOs to the Company Secretary as soon as possible.

5. COMMITTEES

5.1. **Appointment of Committees** - Subject to such directions and guidance as may be given by Monitor, the Council of Governors may, and if directed by the Chairman shall, appoint Committees or Working Groups of the Council of Governors, consisting of a majority of Governors.

5.2. These SOs shall, as far as they are applicable and except as set out below, apply with appropriate alteration to meetings of any Committees or Working Groups established by the Council of Governors, in which case the term 'Chairman' is to be read as a reference to the chairman of the Committee as the context permits, and the term 'Governor' is to be read as a reference to a member of the Committee as the context permits.

5.3. Members of Committees and Working Groups of the Council of Governors may participate in meetings of such Committees and Working Groups by telephone, teleconference, video or computer link. In such cases, if any person attends the meeting by telephone, teleconference, video or computer link, then such person shall cast their vote verbally (such verbal vote to be recorded in the minutes). The quorum for a Committee meeting is three Governors.

5.4. Each Committee and Working Group shall have such terms of reference and be subject to such conditions (as to reporting back to the Council of Governors) as the Council of Governors shall decide from time to time and shall be in accordance with any direction or guidance issued by Monitor and any legislation.

5.5. The Council of Governors shall appoint the members of each Committee/Working Group, and the members of each Working Group /Committee shall each appoint a chairman. Such appointments shall be made in accordance with the following processes:

5.5.1. Each Committee or Working Group shall refresh its membership on an annual basis. Appointments to each Committee and Working Group shall take place immediately after the Annual Members Meeting.

5.5.2. The Secretary shall maintain a list of those interested in joining a Committee or Working Group. The Council of Governors shall agree in their absolute discretion the final composition of members on each Committee or Working Group; however each Committee or Working Group must comprise at least three Governors.

5.5.3. Committee or Working Group members shall elect by majority vote a chairman from amongst the Committee/Working Group membership to serve for a term of one year. The election of each Committee/Working Group chairman shall take place immediately after the Annual Members Meeting and following the appointments to the Committees and Working Groups.

5.5.4. A Committee or Working Group chairman may be re-elected after they have served their term of office on two occasions. The maximum amount of time a Governor can chair a Committee or Working Group meeting is three consecutive years.

5.5.5. Each Committee or Working Group must have a minimum of five members. There is no maximum membership, subject to any restrictions imposed by each respective Committee or Working Group's terms of reference, as referred to in SO 5.4 above.

5.6. Where the Trust is required to appoint persons to a Committee or Working Group and/or to undertake statutory functions and where such appointments are to operate independently of the Council of Governors, such appointments shall be made in accordance with any applicable statutory regulations and with any direction or guidance issued by Monitor.

5.7. The Council of Governors shall establish the Non-Executive Director Nominations and Remuneration Committee and such other Committees or Working Groups as required to assist the Council of Governors in discharging its responsibilities.

5.8. Confidentiality - A member of a Committee or Working Group shall not disclose a matter dealt with by, or brought before, the Committee or Working Group without its permission until the Committee or Working Group has reported to the Council of Governors or has otherwise concluded on that matter.

5.9. A Governor or a member of a Committee or Working Group shall not disclose any matter reported to the Council of Governors or otherwise dealt with by the Committee or Working Group, notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors or Committee/Working Group shall resolve that it is confidential.

6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1. **Declaration of interests** - Each Governor shall upon being elected or appointed declare to the Council of Governors via the Company Secretary any pecuniary (which includes monetary), personal or family interests that he has which are relevant to the Trust.

6.2. Interests which should be declared pursuant to SO 6.1 above include:

6.2.1. directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies);

6.2.2. majority or controlling share holdings in organisations, or ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the Trust or the NHS;

6.2.3. a position of authority in a charity or Voluntary Organisation in the field of health and social care;

6.2.4. any connection with a Voluntary Organisation or other organisation that is seeking to contract or has contracted for NHS services or for the provision of the Trust's mandatory or authorised services; and

6.2.5. any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust including but not limited to lenders or banks.

6.3. No Governor shall be treated as having an interest in any contract, proposed contract or other matter by reason only:

6.3.1. of his membership of a company or other body if he has no beneficial interest in any securities of that company or other body; or

6.3.2. of an interest in any company, body or person with which he is connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence him in the consideration or discussion of, or in voting on, any question with respect to that contract, proposed contract or other matter.

6.4. If Governors have any doubt about the relevance of an interest, this should be discussed with the Chairman or the Company Secretary.

6.5. At the time Governors' interests are declared, they should be recorded in the Council of Governor minutes. Any changes in interests should be declared at the next Council of Governors meeting following the change occurring. It is the obligation of the Governor to inform the Company Secretary in writing within seven days of becoming aware of the existence of an interest. The Company Secretary shall amend the Register upon receipt within three working days.

6.6. This SO applies to a Committee or Working Group as it applies to the Council of Governors and applies to a member of any such Committee or Working Group (whether or not he is also a Governor) as it applies to a Governor.

6.7. Directorships of companies reasonably regarded as being likely or possibly seeking to do business with the Trust or the NHS should be published in the Trust's annual report. This information should be kept up to date for inclusion in succeeding annual reports.

6.8. **Register of interests** - The Company Secretary will ensure that a Register of Interests (the "Register") is established to record formal declarations of interests of Governors.

6.9. The details on the Register shall be reviewed every six months.

6.10. The Register will be available to the public and the Chairman will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

6.11. In establishing, maintaining, updating and publicising the Register, the Trust shall comply with all guidance issued from time to time by Monitor.

7. CONFLICT OF INTEREST AND PECUNIARY INTEREST

7.1. **Disclosure of interest** - If a Governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any contract, proposed contract or other matter which is under consideration by the Council of Governors, he shall disclose that interest to the Council of Governors as soon as he becomes aware of it.

7.2. **Conflict of interest** - During the course of a Council of Governors meeting, if a conflict of interest is disclosed, the Governor concerned shall withdraw from the meeting and take no further part in the matter under discussion.

7.3. For the purpose of this SO, the Chairman or Governor shall be treated, subject to SO 7.4 below, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if he, or a nominee of his, is a governor of a company or other body, not being a

public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration.

7.4. The Chairman or a Governor shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

7.4.1. of his membership of a company or other body, if he has no beneficial interest in any securities of that company or other body; or

7.4.2. of an interest in any company, body or person with which he is connected as mentioned in SO 7.3 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence the Governor in the consideration or discussion of, or in voting on, any question with respect to that contract or matter.

7.5. Where the Chairman or Governor:

7.5.1. has an indirect pecuniary interest in a contract, proposed contract, or any other matter by reason only of a beneficial interest in securities of a company or other body; and the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the fewer; and

7.5.2. if the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class;

this SO shall not prohibit him from taking part in the consideration or discussion of the contract or other matter, or from voting on any question with respect to it without prejudice however to his duty to disclose his interest.

7.6. This SO applies to a Committee or Working Group of the Council of Governors as it applies to the Council of Governors and applies to any member of any such Committee or Working Group as it applies to a Governor.

8. STANDARDS OF BUSINESS CONDUCT

8.1. **Policy** - Governors must comply with the Constitution, the NHS Foundation Trust Code of Governance, the requirements of the law and any applicable guidance and directions issued by Monitor.

8.2. **Canvassing of, and recommendations by, Governors in relation to appointments** - Canvassing of Directors or Governors or of any members of any Committee or Working Group of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this SO shall be included in application forms or otherwise brought to the attention of candidates.

8.3. A Governor shall not solicit for any person any appointment under the Trust or recommend any person for such appointment but this SO shall not preclude a Governor from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

8.4. Informal discussions outside appointments panels or Committees, whether solicited or unsolicited, should be declared to the panel or Committee.

8.5. **Relatives of Governors** - Candidates for any staff appointment under the Trust shall when making application disclose in writing whether they are related to any Governor. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

8.6. Every Governor of the Trust shall disclose to the Company Secretary any relationship with a candidate of whose candidature that Governor is aware. It shall be the duty of the Company Secretary to report to the Trust any such disclosure made.

8.7. On election or appointment, Governors should disclose to the Trust whether they are related to any other Governor or Officer. This disclosure will be asked for when Governors sign their declaration of eligibility to vote prior to their first Council of Governors meeting.

8.8. Where the relationship to a Governor is disclosed, the SO headed 'Conflict of interest and pecuniary interest' (SO 7) shall apply.

9. MISCELLANEOUS

9.1. **SOs to be given to Governors** - It is the duty of the Company Secretary to ensure that existing Governors and Officers and all new appointees are notified of and understand their responsibilities within these SOs. Updated copies shall be issued to individuals designated by the Chief Executive. New Governors shall be informed in writing and shall receive copies where appropriate of SOs.

9.2. **Review of SOs** - These SOs shall be reviewed annually by the Council of Governors.

9.3. **Dispute resolution** - Where a dispute arises regarding the interpretation of these SOs and the procedure to be followed at meetings of the Council of Governors, the Trust and the parties to the dispute shall use all reasonable endeavours to resolve the dispute as quickly as possible.

9.4. Where a dispute arises which involves the Chairman, the dispute shall be referred to the Senior Independent Director who will use all reasonable efforts to mediate a settlement to the dispute.

9.5. For the avoidance of doubt, the Company Secretary shall deal with any membership queries and other similar questions in the first place including any voting or legislation issues and shall otherwise follow a process for resolving such matters in accordance with any procedures agreed by the Board of Directors.

ANNEX 8
ADDITIONAL PROVISIONS - BOARD OF DIRECTORS

Disqualification

1. The following may not become or continue as a member of the Board of Directors:

1.1. a member of the Council of Governors;

1.2. a spouse, partner, parent or child of a member of the Board of Directors;

1.3. a member of a local authority's scrutiny committee covering health matters;

1.4. a person who is the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

1.5. a person whose tenure in office as a chairman or as a member or director of a Health Service Body has been terminated on the grounds that their appointment is not in the interests of the health service, non-attendance at meetings, or for non-disclosure of a pecuniary interest;

1.6. a person who within the preceding two years has been dismissed, otherwise than by reasons of redundancy or for reasons of ill health, from any paid employment with a Health Service Body;

1.7. in the case of a Non-Executive Director, a person who has refused without reasonable cause to fulfil any training requirement established by the Board of Directors;

1.8. a person who has refused to sign and deliver to the Company Secretary a statement in the form required by the Board of Directors confirming acceptance of the code of conduct for Directors;

1.9. in the case of a Non-Executive Director, a person who is no longer a member of the Public or Patient Constituency; and

1.10. a person who has had his name removed or been suspended from any practising or professional list, by a direction under any legislation applicable to the NHS or under any related subordinate legislation or who has otherwise been suspended or disqualified from any healthcare profession, and has not subsequently had his name included in such a list or had his suspension lifted or qualification reinstated;

1.11. a person who, following investigations undertaken by the Trust, is determined by the Trust to be an individual who:

1.11.1. is not of good character;

1.11.2. does not have the necessary qualifications, competence, skills and experience which are necessary in order to undertake their Board role;

1.11.3. is unable, by reason of their health, after reasonable adjustments are made, of properly performing the tasks which are intrinsic to the work for which they are employed;

1.11.4. has been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying out a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity;

1.11.5. any of the grounds of unfitness specified paragraph 30 of this Constitution apply to;

1.11.6. is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order to like effect made in Scotland or Northern Ireland;

1.11.7. is included in the children's barred list or the adults' barred list

maintained under paragraph 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland; and/or

1.11.8. is prohibited from holding the relevant office or position, or in the case of an individual carrying on the regulated activity, by or under an enactment.

2. In assessing an individual's character for the purposes of paragraph 1.11.1 above, the matters considered must include:

   2.1. whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence; and

   2.2. whether the person has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals.

3. In the event that a Director no longer meets the requirements set out in this Annex 8, the Trust shall:

   3.1. take such action as is necessary and proportionate to ensure that the office or position in question is held by an individual who meets such requirements; and

   3.2. if the individual is a health care professional, social worker or other professional registered with a health care or social care regulator, inform Monitor.

ANNEX 9
STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

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1. INTRODUCTION

Regulatory Framework

1.1. Chelsea & Westminster Hospital NHS Foundation Trust (the "**Trust**") is a public benefit corporation and is constituted in accordance with the 2006 Act (as amended by the 2012 Act).

9.6. The principal places of business of the Trust are Chelsea & Westminster Hospital within the Royal Borough of Kensington & Chelsea and West Middlesex University Hospital within the London Borough of Hounslow.

1.2. The Trust is governed by the 2006 Act (as amended by the 2012 Act), by its Constitution and by its Foundation Trust Licence granted by Monitor.

2. THE BOARD OF DIRECTORS

2.1. All business shall be conducted in the name of the Trust.

2.2. **Appointment of the Chairman, and Non-Executive Directors** – In accordance with paragraph 27 of the Constitution, the Chairman and the other Non-Executive Directors are appointed and removed by the Council of Governors at a general meeting of the Council of Governors.

2.3. **Appointment of the Chief Executive and the Executive Directors -** The Chief Executive and the other Executive Directors are appointed in accordance with paragraph 29 of the Constitution. The Chairman and Non-Executive Directors appoint or remove the Chief Executive and a Committee consisting of the Chairman, Chief Executive and the Non-Executive Directors appoint or remove the Executive Directors.

2.4. **Terms of office of the Chairman and Directors** - The remuneration and terms of office of the Chairman and Non-Executive Directors shall be decided by the Council of Governors at a general meeting of the Council of Governors in accordance with paragraph 34 of the Constitution.

2.5. The remuneration and terms of office of the Chief Executive and other Executive Directors shall be decided by a Committee of Non-Executive Directors in accordance with paragraph 34 of the Constitution.

2.6. **Appointment of Deputy Chairman** - For the purpose of enabling the proceedings of the Trust to be conducted in the absence of the Chairman, the Non-Executive Directors shall appoint a Non-Executive Director to be Deputy Chairman for such a period, not exceeding the remainder of his term as Non-Executive Director, as they may specify on appointing him.

2.7. Any Non-Executive Director appointed as Deputy Chairman in accordance with SO 2.6 above may at any time resign from the office of Deputy Chairman by giving notice in writing to the Chairman. The other Non-Executive Directors may thereupon appoint another Non-Executive Director as Deputy Chairman in accordance with SO 2.6.

2.8. **Powers of Deputy Chairman** - Subject to SO 2.9 below, where the Chairman of the Trust has died or has ceased to hold office, or where he has been unable to perform his duties as Chairman owing to illness or any other cause, the Deputy Chairman or any other Non-Executive Director shall act as Chairman until a new Chairman is appointed in accordance with the Constitution or the existing Chairman resumes his duties as the case may be; and references to the Chairman in these SOs shall, so long as there is no Chairman able to perform his duties, be taken to include references to the Deputy Chairman.

2.9. Paragraph 18.1 of the Constitution shall apply where the Chairman is unable to perform his duties at a meeting of the Council of Governors.

3. MEETINGS OF THE BOARD OF DIRECTORS

3.1. Nothing in these SOs shall require the Board of Directors to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than in writing, or to make any oral report of proceedings as they take place without the prior agreement of the Board of Directors.

3.2. **Calling meetings** - Ordinary meetings of the Board of Directors shall be held at such times

and places as the Board of Directors may determine and there will be no fewer than six meetings per year.

3.3. Meetings of the Board of Directors may be called by the Company Secretary, or by the Chairman, or by four Directors who give written notice to the Company Secretary specifying the business to be carried out. The Company Secretary shall send (by appropriate means including, without limitation, by email or post, or via the Trust's website) a written notice of the dates, times and locations of meetings of the Board of Directors meetings to all Directors as soon as possible after receipt of such a request. Other, or emergency, meetings of the Board of Directors may be called (by appropriate means including, without limitation, by email or post, or via the Trust's website) in accordance with this Constitution. Subject to SO 3.5 below, the Company Secretary shall call a meeting on at least 14 but not more than 28 days' notice to discuss the specified business. If the Company Secretary fails to call such a meeting then the Chairman or four Directors, whichever is the case, shall call such a meeting.

3.4. In special circumstances, where there is an urgent need to call a meeting, the Company Secretary or Chairman may decide that a meeting shall be called on less than seven days' notice and in such circumstances as much notice as possible shall be given of the meeting to each of the Directors.

3.5. Subject to SO 3.6 below, lack of service of the notice on any Director shall not affect the validity of a meeting.

3.6. Failure to serve such a notice specifying the business on more than two Directors will invalidate the meeting. A notice will be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post or, where the notice is sent by email, at the time at which the email is sent.

3.7. **Agenda of meetings** - Before each meeting of the Board of Directors, an agenda of the meeting specifying the business proposed to be transacted at it and any supporting papers available at that time shall be delivered to each Director, or sent by post to the usual place of residence of each Director, so as to be available to him at least three clear days before the meeting. If it is anticipated that the Directors participating in the meeting will not be in the same place, the agenda should specify how it is proposed that they should communicate with each other during the meeting.

3.8. **Setting the agenda** - The Board of Directors may determine that certain matters shall appear on every agenda for a meeting of the Board of Directors and shall be addressed prior to any other business being conducted.

3.9. A Director desiring a matter to be included on an agenda shall make his request in writing to the Chairman at least 10 clear days before the meeting. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chairman.

3.10. **Participation in meetings** – Directors may participate in meetings by telephone, teleconference, video or computer link and participation in a meeting in this manner shall be deemed to constitute a presence in person at the meeting. In determining whether Directors are participating in a meeting, it is irrelevant where any Director is or how they communicate with each other. If all the Directors are not in the same place, they may decide that the meeting is to be treated as taking place wherever any of them is.

3.11. **Chairman of meeting** - At any meeting of the Board of Directors, the Chairman, if present, shall preside. If the Chairman is absent from the meeting, the Deputy Chairman, if there is one and he is present, shall preside. If the Chairman and Deputy Chairman are absent such Non-Executive Director as the Board of Directors present shall choose shall preside.

3.12. **Notices of Motion** - A Director desiring to move or amend a Motion shall send a written notice thereof at least 10 clear days before the meeting to the Chairman, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This SO shall not prevent any Motion being moved during the meeting, without notice on any business mentioned on the agenda.

3.13. **Withdrawal of Motion or amendments** - A Motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman.

3.14. **Motion to rescind a resolution** - Notice of Motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Director who gives it and also the signature of four other Directors. When any such Motion has been disposed of by the Board of Directors, it shall not be competent for any Director to propose a Motion to the same effect within six months; however the Chairman may do so if he considers it appropriate.

3.15. **Motions** - The mover of a Motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

3.16. When a Motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

3.16.1. an amendment to the Motion;

3.16.2. the adjournment of the discussion or the meeting;

3.16.3. that the meeting proceed to the next business (*);

3.16.4. the appointment of an ad hoc Committee to deal with a specific item of business; or

3.16.5. that the Motion be now put (*),

provided that in the case of the sub-paragraphs denoted by (*) above and to ensure objectivity, Motions may only be put by a Director who has not previously taken part in the debate.

3.17. No amendment to the Motion shall be admitted if, in the opinion of the Chairman of the meeting, the amendment negates the substance of the Motion.

3.18. **Chairman's ruling** - Statements of Directors made at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the Chairman of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

3.19. **Voting** - Questions arising at a meeting of the Board of Directors shall be decided by a majority of votes except that:

3.19.1. in the case of an equality of votes, the Chairman (or in his absence the Deputy Chairman or in the Deputy Chairman's absence a Non-Executive Director who is appointed by the Directors present at the meeting to chair the meeting) shall have a second and casting vote; and

3.19.2. no resolution of the Board of Directors shall be passed if it is unanimously opposed by all of the Executive Directors present or by all of the Non-Executive Directors present.

3.20. All questions put to the vote shall be shall be decided by a show of hands (and if any person is attending by telephone, teleconference, video or computer link such person shall cast their vote verbally (such verbal vote to be recorded in the minutes).

3.21. A paper ballot may also be used if a majority of the Directors present so request, in which case any person attending by telephone, teleconference, video or computer link shall cast their vote verbally (such verbal vote to be recorded in the minutes).

3.22. The Board of Directors may agree that its members can participate in its meetings by telephone, teleconference, video or computer link. Participation in a meeting in this manner shall be deemed to constitute a presence in person at the meeting.

3.23. An Officer who has been appointed formally by the Board of Directors to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An Officer attending the Board of Directors to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

3.24. **E-Governance -** The Board of Directors may confirm their response to any proposal in writing via e-mail. A response to a proposal sent by email shall be deemed to have been delivered on

the date of transmission (if sent before 5pm on a clear day) or by 11am on the next clear day (if sent after 5pm on a clear day). The proposal will pass provided that the majority of the Board of Directors approve the proposal. Any decisions so passed via e-governance shall be noted at the next Board of Directors meeting.

3.25. **Minutes** - The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

3.26. No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.27. Minutes shall be circulated in accordance with Directors' wishes.

3.28. **Written resolutions** - Where the Chairman or a Director desires that a resolution is passed by the Board of Directors, the Chairman or the Director (with the consent of the Chairman) may circulate the resolution amongst the Board of Directors proposing that it is passed as a written resolution. For the resolution to be validly passed, the resolution must be signed by at least six Directors (such Directors to include: (i) either (a) the Chairman or Deputy Chairman and two Non-Executive Directors or (b) three Non-Executive Directors (but only if the Chairman or Deputy Chairman are unavailable for a period of 48 hours from the time at which the resolution is first circulated); and (ii) three Executive Directors (such Executive Directors to include the Chief Executive or Finance Director). Any written resolution that is so passed shall be noted at the next meeting of the Board of Directors.

3.29. **Suspension of SOs** - Except where this would contravene any statutory provision or any direction made by Monitor, any one or more of these SOs may be suspended at any meeting, provided that at least five Directors are present agree to such suspension, including (i) not less than three Executive Directors (one of whom must be either the Chief Executive or the Finance Director) and (ii) two Non-Executive Directors, and that a majority of those present vote in favour of suspension.

3.30. A decision to suspend these SOs shall be recorded in the minutes of the meeting.

3.31. A separate record of matters discussed during the suspension of the SOs shall be made and shall be available to the Chairman and the Directors.

3.32. No formal business may be transacted while the SOs are suspended.

3.33. The Audit Committee shall review every decision to suspend the SOs.

3.34. **Amendment of SOs** - These SOs shall be amended only if:

3.34.1. a notice of Motion under SO 3.12 has been given;

3.34.2. at least six Directors are present, including no less than three Executive Directors (one of whom must be either the Chief Executive or the Finance Director) and three Non-Executive Directors;

3.34.3. the proposed amendment is made in accordance with paragraph 45 of the Constitution; and

3.34.4. the amendment proposed does not contravene a statutory provision or direction made by Monitor.

3.35. **Record of attendance** - The names of the Chairman and Directors present at the meeting shall be recorded in the minutes.

3.36. **Quorum** - No business shall be transacted at a meeting of the Board of Directors unless at least six Directors are present including not less than three Executive Directors (one of whom must be either the Chief Executive or the Finance Director) and not less than three Non-Executive Directors.

3.37. An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

3.38. If the Chairman or another Director has been disqualified from participating in the discussion

on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO 6 or 7) he shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least one Executive Director to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting (for example when the Board of Directors considers the recommendations of the performance and remuneration Committee). In such circumstances, the quorum shall be three Non-Executive Directors (including the Chairman).

3.39. **Overriding SOs** - If for any reason these SOs are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board of Directors for action or ratification. All Directors and staff have a duty to disclose any non- compliance with these SOs to the Company Secretary as soon as possible.

4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1. Subject to SO 2.1 and such directions, if any, as may be given by Monitor, the Board of Directors may make arrangements for the exercise, on behalf of the Board of Directors, of any of its functions by:

4.1.1. a Committee or sub-Committee, appointed by virtue of SOs 5.1 or 5.2 below; or

4.1.2. an Officer,

in each case subject to such restrictions and conditions as the Board of Directors thinks fit.

4.2. **Emergency powers** – Subject to paragraph 4.2 of this Constitution, the powers of the Board of Directors may in emergency be exercised by the Chief Executive (or in his absence the Finance Director) and the Chairman (or in his absence the Deputy Chairman or any other Non-Executive Director). The exercise of such powers by the Chief Executive (or Finance Director) and the Chairman (or Deputy Chairman or any other Non-Executive Director) shall be reported to the next formal meeting of the Board of Directors for ratification.

4.3. **Delegation to Committees** - The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by Committees or sub-Committees which it has formally constituted.

4.4. **Delegation to officers** - Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to an executive Committee or sub-Committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall determine which functions he will perform personally and shall nominate Officers to undertake the remaining functions for which he will still retain accountability to the Board of Directors.

4.5. The Chief Executive shall prepare a scheme of delegation identifying his proposals which shall be considered and approved by the Board of Directors, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the scheme of delegation which shall be considered and approved by the Board of Directors as indicated above.

4.6. Nothing in the scheme of delegation shall impair the discharge of the direct accountability to the Board of Directors of the Finance Director to provide information and advise the Board of Directors in accordance with statute or Monitor's requirements. Outside these regulatory requirements the Finance Director shall be accountable to the Chief Executive for operational matters.

5. COMMITTEES

5.1. **Appointment of Committees** - Subject to such directions and guidance as may be given by Monitor, the Board of Directors may, and if directed by Monitor shall, appoint Committees of the Board of Directors that shall include at least one Director.

5.2. A Committee appointed under SO 5.1 may, subject to SO 5.5 below and such directions as

may be given by Monitor or the Board of Directors, appoint sub-Committees consisting wholly or partly of members of the appointing Committee (whether or not they include Directors) or wholly of persons who are not members of the appointing Committee (whether or not they include Directors).

5.3. These SOs shall, as far as they are applicable, apply with appropriate alteration to meetings of any Committee or sub-Committee established by the Board of Directors, in which case the term 'Chairman' is to be read as a reference to the chairman of the Committee as the context permits, and the term 'Director' is to be read as a reference to a member of the Committee as the context permits.

5.4. Each Committee and sub-Committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors) as the Board of Directors shall decide from time to time and shall be in accordance with any direction or guidance issued by Monitor and any applicable legislation.

5.5. Committees may not delegate their executive powers to a sub-Committee unless expressly authorised by the Board of Directors.

5.6. The Board of Directors shall appoint persons to sit on each of the Committees which it has formally constituted.

5.7. Where the Trust is required to appoint persons to a Committee and/or to undertake statutory functions and where such appointments are to operate independently of the Board of Directors, such appointments shall be made in accordance with any applicable statutory regulations and with any direction or guidance issued by Monitor.

5.8. The Board of Directors shall establish the following Committees (and sub-Committees) of the Trust:

5.8.1. Audit Committee;

5.8.2. Nominations and Remuneration Committee;

5.8.3. Finance and Investment Committee;

5.8.4. People and Organisational Development Committee; and

5.8.5. Quality Committee,

and the Board of Directors shall also establish such other Committees (and sub-Committees) as required to discharge the Board of Director's responsibilities.

5.9. **Confidentiality** - A member of a Committee shall not disclose a matter dealt with by, or brought before, the Committee without its permission until the Committee shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

5.10. A Director or a member of a Committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the Committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or Committee shall resolve that it is confidential.

6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1. **Declaration of interests** - Each Director shall upon being appointed declare to the Board of Directors via the Company Secretary any pecuniary (which includes monetary), personal or family interests that he has which are relevant to the Trust.

6.2. Interests which should be declared pursuant to SO 6.1 above include:

6.2.1. directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies);

6.2.2. majority or controlling share holdings in organisations, or ownership or part-ownership of private companies, businesses or consultancies reasonably regarded as being likely or possibly seeking to do business with the Trust or the NHS;

6.2.3. a position of authority in a charity or Voluntary Organisation in the field of health and

social care;

6.2.4. any connection with a Voluntary Organisation or other organisation that is seeking to contract or has contracted for NHS services or for the provision of the Trust's mandatory or authorised services; and

6.2.5. any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust including but not limited to lenders or banks.

6.3. No Director shall be treated as having an interest in any contract, proposed contract or other matter by reason only:

6.3.1. of his membership of a company or other body if he has no beneficial interest in any securities of that company or other body; or

6.3.2. of an interest in any company, body or person with which he is connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence him in the consideration or discussion of, or in voting on, any question with respect to that contract, proposed contract or other matter.

6.4. If Directors have any doubt about the relevance of an interest, this should be discussed with the Chairman or the Company Secretary.

6.5. At the time Directors' interests are declared, they should be recorded in the Board of Director minutes. Any changes in interests should be declared at the next Board of Directors meeting following the change occurring. It is the obligation of the Director to inform the Company Secretary in writing within seven days of becoming aware of the existence of an interest. The Company Secretary shall amend the Register upon receipt within three working days.

6.6. This SO applies to a Committee or sub-Committee as it applies to the Board of Directors and applies to a member of any such Committee or sub-Committee (whether or not he is also a Director) as it applies to a Director.

6.7. Directorships of companies likely or possibly seeking to do business with the Trust or the NHS should be published in the Trust's annual report. This information should be kept up to date for inclusion in succeeding annual reports.

6.8. **Register of interests** - The Company Secretary will ensure that a Register of interests (the "Register") is established to record formally declarations of interests of Directors. In particular the Register will include details of all directorships and other interests which have been declared by both Executive Directors and Non-Executive Directors.

6.9. The details on the Register shall be reviewed every six months.

6.10. The Register will be available to the public and the Chairman will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

6.11. In establishing, maintaining, updating and publicising the Register, the Trust shall have due regard to all guidance issued from time to time by Monitor.

7. CONFLICT OF INTEREST AND PECUNIARY INTEREST

7.1. **Disclosure of interest** - If a Director has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any contract, proposed contract or other matter which is under consideration by the Board of Directors, he shall disclose that interest to the Board of Directors as soon as he becomes aware of it.

7.2. **Conflict of interest** - During the course of a Board of Directors meeting, if a conflict of interest is disclosed, the Director concerned shall withdraw from the meeting and take no further part in the matter under discussion.

7.3. Any remuneration, compensation or allowances payable to the Chairman or a Director by virtue of the 2006 Act shall not be treated as a pecuniary interest for the purpose of this SO.

7.4. For the purpose of this SO, the Director shall be treated, subject to SO 7.5 below, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if he, or a

nominee of his, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration.

7.5. The Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

7.5.1. of his membership of a company or other body, if he has no beneficial interest in any securities of that company or other body; or

7.5.2. of an interest in any company, body or person with which he is connected as mentioned in SO 7.4 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence the Director in the consideration or discussion of, or in voting on, any question with respect to that contract or matter.

7.6. Where the Director:

7.6.1. has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body; and

7.6.2. the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less; and

7.6.3. if the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class;

this SO shall not prohibit him from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to his duty to disclose his interest.

7.7. This SO applies to a Committee or sub-Committee of the Board of Directors as it applies to the Board of Directors and applies to any member of any such Committee or sub-Committee as it applies to a Director.

8. STANDARDS OF BUSINESS CONDUCT

8.1. All Directors must comply with the Trust's standards of business conduct policy as amended from time to time.

8.2. A Director shall not solicit for any person any appointment under the Trust or recommend any person for such appointment but this SO shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

8.3. Informal discussions outside appointments panels or Committees, whether solicited or unsolicited, should be declared to the panel or Committee.

8.4. **Relatives of Directors** - every Director of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that Director is aware. It shall be the duty of the Chief Executive to report to the Board of Directors any such disclosure made.

8.5. On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Board of Directors whether they are related to any other Director or employee of the Trust.

9. CHARITABLE FUNDS

9.1. Accountability for charitable funds held on trust is to the Charity Commission and to Monitor. Accountability for non-charitable funds held on trust is only to Monitor.

10. TENDERING AND CONTRACT PROCEDURE

10.1. **Duty to comply with SOs** - the procedure for making all contracts by or on behalf of the Trust shall comply with these SOs (except where SO 3.29 (Suspension of SOs) is applied).

10.2. **Contracts** - The Board of Directors may enter into contracts on behalf of the Trust within its statutory powers and shall comply with:

10.2.1. these SOs;

10.2.2. the Trust's SFIs; and

10.2.3. its terms of Authorisation.

10.3. **Personnel and agency or temporary staff contracts** - the Chief Executive shall nominate Officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

10.4. **Contracts involving funds held on trust** - such contracts involving charitable funds shall comply with the requirements of the Charities Act.

11. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

11.1. **Custody of seal** - the common seal of the Trust shall be kept by the Company Secretary in a secure place.

11.2. **Sealing of documents** - where it is necessary that a document shall be sealed, the seal of the Trust shall be affixed in the presence of two Executive Directors or one Executive Director and either the Chairman or Company Secretary, duly authorised by a resolution of the Board of Directors (or of a Committee thereof where the Board of Directors has delegated its powers) and shall be attested by them.

11.3. **Register of sealing** - an entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Board of Directors at least bi-annually. The report shall detail the seal number, the description of the document and date of sealing.

11.4. The seal should be used to execute deeds (e.g. conveyances of land) or where otherwise required by law.

12. SIGNATURE OF DOCUMENTS

12.1. Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, the Finance Director or other Executive Director, unless any enactment otherwise requires or authorises, or the Board of Directors shall have given the necessary authority to some other person for the purpose of such proceedings.

12.2. The Chief Executive, or the Finance Director or other Executive Directors shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board of Directors or any Committee or sub-Committee to which the Board of Directors has delegated appropriate authority.

13. MISCELLANEOUS

13.1. **SOs to be given to Directors and officers** - it is the duty of the Chief Executive, including the Company Secretary of the Trust on the Chief Executive's behalf, to ensure that Directors are notified of and understand their responsibilities within these SOs and the Trust's SFIs. Updated copies shall be issued to the Directors.

13.2. **Review of SOs** - these SOs shall be reviewed annually by the Board of Directors.

13.3. **Dispute resolution** - where a dispute arises out of or in connection with the Constitution, including the interpretation of these SOs and the procedure to be followed at meetings of the Board of Directors, the Trust and the parties to the dispute shall use all reasonable endeavours to resolve the dispute as quickly as possible.

13.4. Where a dispute arises which involves the Chairman, the dispute shall be referred to the Senior Independent Director who will use all reasonable efforts to mediate a settlement to the dispute.

13.5. For the avoidance of doubt, the Company Secretary shall deal with any membership queries and other similar questions in the first place including any voting or legislation issues and shall otherwise follow a process for resolving such matters in accordance with any procedures

agreed by the Board of Directors.

ANNEX 10
FURTHER PROVISIONS – MEMBERS

1 Disqualification from membership

1.1 An individual may not become or continue as a Member of the Trust if:

1.1.1 the individual is under 16 years of age;

1.1.2 the individual has been specifically excluded in writing from any of the Trust's premises or other facilities;

1.1.3 the Board of Directors considers that an individual has or is likely to cause harm or detriment to the Trust and the Board of Directors notifies the individual about his disqualification accordingly.

1.2 Notwithstanding anything contained in this Constitution, no person who ceases to be a Member of the Trust pursuant to paragraph 1.1.2 or 1.1.3 above shall be re-admitted to membership except by a decision of the Board of Directors.

1.3 It is the responsibility of Members to ensure their eligibility and not the Trust, but if the Trust is on notice that a Member may be disqualified from membership, they shall carry out all reasonable enquiries to establish if this is the case.

2 Members - expulsion by the Council of Governors

2.1 A Member may be expelled by a resolution of the Council of Governors.

2.2 A Member may complain to the Company Secretary that another Member has acted in a way detrimental to the interests of the Trust. If a complaint is made, the Council of Governors, or a sub-Committee thereof, may consider the complaint having taken such steps as it considers appropriate to ensure the Member in question has his point of view heard and may either:

2.2.1 dismiss the complaint and take no further action; or

2.2.2 arrange for a resolution to expel the Member complained of to be considered at the next meeting of the Council of Governors, or a sub-Committee thereof.

2.3 If a resolution to expel a Member is to be considered at a meeting of the Council of Governors, or a sub-Committee thereof, details of the complaint must be sent to the Member complained of not less than one calendar month before the meeting with an invitation to answer the complaint and attend the meeting.

2.4 At the meeting of the Council of Governors, or a sub-Committee thereof, the Governors will consider evidence in support of the complaint and such evidence as the Member complained of may wish to place before them. If the Member complained of fails to attend the meeting without due cause, the meeting may proceed in their absence.

2.5 A person expelled from membership will cease to be a Member upon the declaration by the Chairman of the meeting that the resolution to expel them is carried.

2.6 No person who has been expelled from membership is to be re-admitted except by a resolution carried by the votes of the majority of the members of the Council of Governors present at a meeting of the Council of Governors.

3 Termination of membership

3.1 A Member shall cease to be a Member if that Member:

3.1.1 resigns by notice to the membership manager or to the Company Secretary;

3.1.2 ceases to fulfil the requirements of membership as set out in paragraphs 5 to 11 of this Constitution;

3.1.3 dies; or

3.1.4 the Council of Governors, having made reasonable enquiries, determines that the Member no longer wishes to be a Member or he ceases to be eligible as a Member for whatever reason.

4 Members' Meetings

4.1 The Trust shall hold a Members' meeting for all Members (called the "**Annual Members' Meeting**") within six months of the end of each financial year of the Trust.

4.2 Any Members' meeting other than the Annual Members' Meeting shall be called a "**Special Members' Meeting**".

4.3 Both Annual Members' Meetings and any Special Members' Meetings shall be open to all members of the Trust, members of the Council of Governors and members of the Board of Directors, together with representatives of the Trust's Auditors, and to members of the public. The Trust may invite representatives of the media and any experts or advisors whose attendance they consider to be in the best interests of the Trust to attend any such meeting.

4.4 The Board of Directors may convene an Annual Members' Meeting or a Special Members' Meeting when it thinks fit. The Council of Governors may request the Board of Directors to convene a Members' meeting.

4.5 The Board of Directors (or at least one member thereof) shall present to the Members at the Annual Members' Meeting:

4.5.1 the annual accounts;

4.5.2 any report of the Auditor on them;

4.5.3 the annual report;

4.5.4 a report on steps taken to secure that (taken as a whole) the actual membership or the Trust is representative of those eligible for such membership;

4.5.5 the progress of the membership plan; and

4.5.6 the results of any election and appointments to the Council of Governors, and any other reports or documentation it considers necessary or otherwise required by Monitor or the 2006 Act.

4.6 The Trust shall give notice of all Members' meetings:

4.6.1 by notice in writing to all Members;

4.6.2 by notice prominently displayed at the Trust's headquarters and at all of the Trust's hospitals;

4.6.3 by notice on the Trust's website; and

4.6.4 to the Council of Governors, the Board of Directors, and to the Trust's Auditors,

stating whether the meeting is an Annual Members' Meeting or a Special Members' Meeting including the time, date, place of the meeting, and the business to be dealt with at the meeting at least 14 working days before the date of the relevant Members' meeting .

4.7 An accidental omission to give notice of a Members' meeting or to send, supply or make available any document or information relating to the meeting, or the non-receipt of any such notice, document or information by a person entitled to receive any such notice, document or information shall not invalidate the proceedings at that meeting.

4.8 The Chairman, or in his absence, the Deputy Chairman shall preside at all Members' meetings of the Trust.

4.9 The quorum for a Members' meeting shall be four members present and entitled to vote.

4.10 The Chairman may, with the consent of a Members' meeting at which a quorum is present (and shall, if so directed by the meeting), adjourn a Members' meeting from time to time and from place to place or for an indefinite period.

4.11 A resolution put to the vote of a Members' meeting shall be decided on a show of hands.

4.12 No business shall be transacted at an adjourned meeting other than business which might properly have been transacted at the meeting had the adjournment not taken place.

4.13 If the Board of Directors, in its absolute discretion, considers that it is impractical or unreasonable for any reason to hold a Members' meeting at the time, date or place specified in the notice calling that meeting, it may move and/or postpone the general meeting to another time, date and/or place.

4.14 In the case of a Members' meeting adjourned or postponed for 14 days or more, at least seven working days' notice shall be given specifying the time and place of the adjourned Members' meeting and the general nature of the business to be transacted. Otherwise, it shall not be necessary to give any such notice.

4.15 The Board of Directors may make any arrangement and impose any restriction it considers appropriate to ensure the security of a Members' meeting.

4.16 Any approval to speak at a Members' meeting must be given by the Chairman.

4.17 The Board of Directors shall cause minutes to be made and kept, in writing, of all proceedings at Members' meetings.

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6th May 2015

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Dear Sirs

West Middlesex University Hospital NHS Trust ("WMUHT")
Acquisition Application – Statutory Requirements

You have asked Capsticks Solicitors LLP to provide Chelsea and Westminster NHS Foundation Trust (the "**Trust**") with written confirmation that the Trust's proposed constitution, amended on the assumption that the Trust acquires WMUHT, is compliant with the National Health Service Act 2006, (as amended) (the "**Act**") in respect of the mandatory requirements for an NHS foundation trust's draft constitution following such an acquisition.

Having considered the Trust's draft constitution today we confirm that the Trust's amendments to the Model Core Constitution prepared by Monitor (to address the principal points in the Act) are compliant with the Act and have built on the base position established by the Model Core Constitution.

Please do not hesitate to contact us should you have any questions or wish to discuss further.

Yours faithfully

Capsticks Solicitors LLP

Capsticks Solicitors LLP

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 14 May 2015

AGENDA ITEM NO.	8/May/15
REPORT NAME	Council of Governors' Committee Structure
AUTHOR	Thomas Lafferty, Foundation Trust Secretary
LEAD	Thomas Lafferty, Foundation Trust Secretary
PURPOSE	To clarify and enhance the functionality of the Council of Governors' governance structure, paying due regard to statutory requirements and best practice guidance with regard to the roles and responsibilities of the Council of Governors.
SUMMARY OF REPORT	This report follows the work undertaken earlier in the financial year with regard to the enhancement of the arrangements relating to the Board of Directors' Committee structure. It aims to establish a Council of Governors sub-structure that is 'fit for purpose' moving towards the enlargement of the Trust post-acquisition.
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	None.
LINK TO OBJECTIVES	All
DECISION/ ACTION	There are several proposals within this report which the Council of Governors is asked to support. A summary of the proposals for approval are listed at section 2.0.

Council of Governors' Committee Structure

1.0 Introduction

1.1 In accordance with the NHS Act 2006, the principal duties of the Council of Governors of a Foundation Trust (FT) are to:

- Hold the Board of Directors to account, ensuring the Trust conducts itself in a way that is consistent with the needs of the communities it serves, its stated aims, goals and the terms and conditions under which it operates;

- Represent the views of their respective constituency i.e. patients and the local community, staff and stakeholder organisations including CCGs, local authorities.

1.2 The enactment of the Health & Social Care Act 2012 considerably strengthened and enhanced the authority, duties and responsibilities held by the Council of Governors within Foundation Trusts:

- Most crucially, Governors now have a duty to collectively and individually hold Non-Executive Directors (NEDs) to account in addition to their general responsibility to hold the Board to account. There has been considerable debate within the FT community as to how Governors can be afforded the opportunity to effectively discharge this duty;

- Governors must also 'approve significant transactions', including Acquisitions and Mergers. Again, there has over the last 12-18 months within the NHS been discussions held as to what *specifically* the Governors are being asked to 'approve' as part of this duty. Monitor has provided guidance on this point[1].

- There are other new specific powers; such as the ability of the Council of Governors to request that Monitor establish a panel to adjudicate any dispute with regard to compliance with the respective Trust's Constitution and the power to ask that any Board Director attend a meeting for the purposes of answering questions as to the performance of an FT.

1.3 Given these enhanced responsibilities, it is vital that FTs establish governance arrangements in respect of the Council of Governors that are fit for purpose and allow for the satisfactory discharge of these responsibilities. This task is multi-faceted; but there is little doubt that establishing a robust, legally compliant and appropriate Governor meetings structure is a key foundation in achieving this. This paper aims to review the current arrangements and suggests changes to improve the effectiveness of these arrangements.

1.4 In the context of Chelsea & Westminster Hospital NHS Foundation Trust's (CWFT) strategic position, this work is timely as it coincides with the requirement to review the Trust Constitution in light of the proposed acquisition of West Middlesex Hospital NHS Trust (WMUH). Indeed, any changes to the Council of Governors governance arrangements will require embedding within the Constitution applicable to the post-acquisition enlarged organisation.

1.5 However, in recognising the above legislative changes and the Trust's strategic position, it is also important not to lose sight of the clear distinction that should exist between the role of the Governor and the role of the Non-Executive Director:

[1] "Governors are responsible for satisfying themselves that the board of directors has: been thorough and comprehensive in reaching its proposal (that is, has undertaken proper due diligence); and obtained and considered the interests of trust members and the public as part of the decision-making process. Provided appropriate assurance is obtained, governors should not unreasonably withhold their consent for a proposal to go ahead."

Non-Executive Directors
Non-Executive Directors, as Board members, are accountable for the performance of the Trust and are also responsible for the setting of the Trust's strategic direction, working alongside their Executive Director colleagues. Or, as the *Cadbury Report* states; they "should bring an independent judgement to bear on issues of strategy, performance and resources including key appointments and standards of conduct."

In undertaking their duties, there is no legal distinction between Executive and Non-Executive Directors. As a consequence, in the unitary Board structure, Non-Executive Directors have the same legal duties, responsibilities and potential liabilities as their Executive counterparts.

Governors
Governors are not Directors. Governors' have a duty to "hold the non-executive directors, individually and collectively, to account for the performance of the board of directors". However, this does not mean that Governors are legally responsible for decisions taken by the Board of Directors on behalf of the Trust. Responsibility for such decisions remains strictly with the Board.

Aside from the statute-dictated specific Governor 'duties' (appointing the Non-Executive Directors etc.), Governors have an important role in making the Trust publicly accountable for the services it provides. In doing so, they bring valuable perspectives and contributions to its activities.

It is vital that any revised governance arrangements relating to the Council of Governors do not confuse these important distinctions.

2.0 Decision/Action

2.1 The Council of Governors is asked to endorse the following proposals which, thereafter, will be put to the Council of Governors for discussion and agreement. The full detail of such proposals is set out below:

- **Decision 1: The Council is asked to support the establishment of the Council of Governors Nominations & Remuneration Committee.**
- **Decision 2: The Council is asked to support the expansion of the existing Membership Sub-Committee into a Membership Strategy & Engagement Working Group.**
- **Decision 3: The Council is asked to support the principle of Governors' being afforded a Working Group/s to review Trust performance issues in greater detail on a biannual basis and, if approved, to consider the optimal configuration of this, based upon the options suggested above.**
- **Decision 4: The Council is asked to support the establishment of one Board/Governors' Away Day per year.**
- **Decision 5: The Council is asked to support the disbanding of the Agenda Sub-Committee and the establishment of a series of informal monthly 'Core Governors' meetings, hosted by the Chairman.**
- **Decision 6: The Council is asked to consider the suggested Constitutional wording relating to the membership and Chair appointment processes relating to Governor Committees/Working Group.**

3.0 Legislative/Regulatory Compliance re: Governor Committees

3.1 **NED Appointment & Remuneration:** The Council of Governors has a statutory responsibility to appoint and set the remuneration afforded to all NEDs, including the Chairman.

3.1.1 The Monitor Code of Governance confirms that 'the nominations committee/s or committees are responsible for the identification and nomination of executive and non-executive directors." Moreover, that "there may be one or two nominations committees. If there are two committees, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chairperson)."

3.1.2 With regard to setting NED remuneration, the Monitor Code states that "the council of governors should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive."

3.2 **Membership Engagement**: Whilst there are no statutory duties placed upon the Council of Governors with regard to helping to develop the Membership Strategy of an FT, this responsibility is explicitly listed within the Monitor Guide for FT Governors as an 'additional activity' that can utilise the skills and experience of Governors. This also has the potential to provide a clearer connection between the activities of the Council of Governors and the membership base. For this reason, the Monitor Guide for FT Governors suggests the establishment of a Membership Strategy & Engagement Working Group.

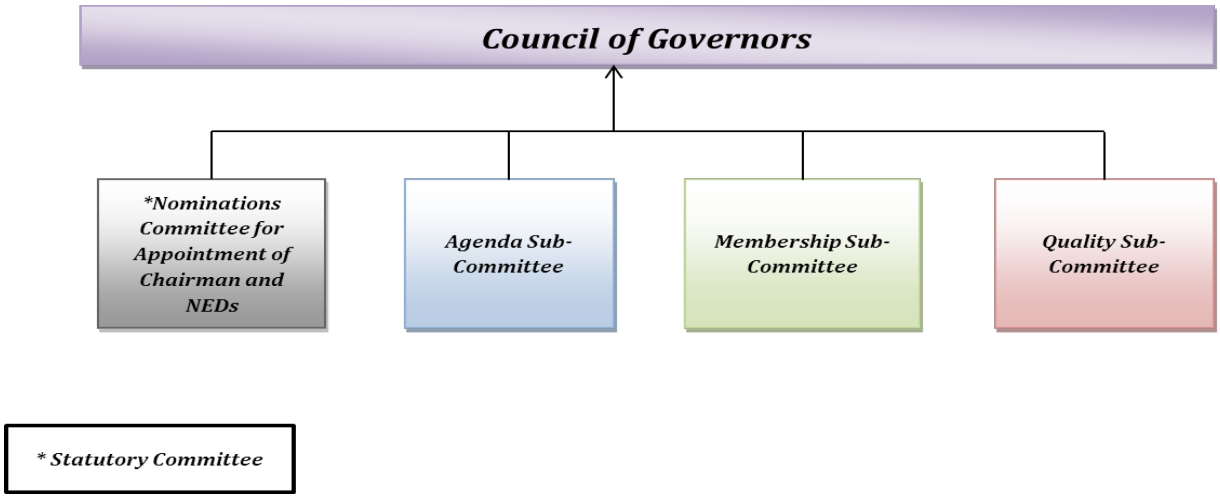
3.3 **Other Options for Governor Committees/Working:** In addition to Membership Strategy & Engagement, the Monitor Guide for FT Governors suggests the following work areas as options for the establishment of Governor Working Groups:

- Clinical quality/patient experience;
- Strategic planning and policy;
- External auditor appointment.

3.4 **Nomenclature:** In accordance with both the Monitor Code of Governance and the Guide for FT Governors, the only recognised formal 'Committee' as it relates to Governors' meetings is the Nominations (and Remuneration) Committee. The Monitor Guide indeed distinguishes between 'Committees' which are formal Committees of the Board and 'Working Groups' which are non-statutory sub-groups of the Council of Governors[2] . It is suggested that the Trust's own arrangements are modified to ensure alignment with this and to ensure that there is 'fair labelling' applied to the roles and responsibilities of the various elements of the Council of Governors sub-structure.

4.0 Current Arrangements & Comments upon the Current Structure

4.1 The current Council of Governors sub-structure is illustrated by the diagram below:



4.2 Through correspondence with members of the Board and representatives of the Council of Governors, the following concerns/views have been identified with regard to the current arrangements[3]:

[2] "Trusts also make use of board committees (*usually comprising directors only*) and working groups, some of which may comprise both governors and directors, as a practical way of dealing with specific issues."
[3] This is not intended to be an exhaustive list and aims to provide key examples of the type of concerns that currently exist.

Current Concerns/Views Re: Council of Governors' Sub-Structure

- That there are presently Governors attending Board Committees as well as a number of other 'Trust meetings'. This is contrary to Monitor guidance on this point (see footnote 2 above), and moreover, it is important that Governors' finite commitment to Trust events is allocated to:

  i) Meetings which support the Governors in the discharge of their duties;
  ii) Meetings where Governor experience and expertise can best be utilised.

  Indeed, the current involvement/membership of Governors on Board Committees/Trust meetings is suggestive of the inadequacy of the Governors own meeting arrangements and access to information.

- That there is currently a Governor Committee specifically charged with the responsibility of setting the agenda for Council of Governors meetings, the 'Agenda Sub-Committee'. This is an unusual arrangement and could be considered to be overly bureaucratic. It is contended that the content of the Council agenda can be agreed through a simpler, streamlined process. A proposal with regard to how future Council of Governors' meeting agendas should be set is detailed at section 6.0, below;

- Meetings arrangements for Governor Committee meetings are haphazard and do not occur in accordance with the agreed Terms of Reference;

- That the remit of the Membership Committee is too narrow and needs to be expanded to encompass public engagement;

- That having a forum within which Governors can obtain a general 'grip' on the general performance of the Trust (through the Quality Committee) is invaluable in allowing the Governors to properly hold the Board to account;

- That the Governors' governance arrangements should make adequate provision for 'strategic thinking' and for Governors to influence the Trust's strategic development;

- That there is no codified process relating to how individual Governors are appointed on to Committees/Working Groups, or how the Chairpersons of such Groups are determined.

5.0 Recommendations regarding Committees

5.1 **Establishing a Council of Governors Nominations & Remuneration Committee:** At the January 2015 Board meeting, the Board of Directors agreed to combine the functions of the Nominations & Remuneration Committees (those charged with recommending the appointment and remuneration of Executive Directors) into a single Committee on the basis that the membership for both Committees is the same and that they often meet at the same time to consider similar business, e.g. salary terms and conditions of a new recruit.

5.1.1 The same rationale can be applied in proposing a separate Council of Governors Nominations & Remuneration Committee responsible for overseeing NED Director appointments and remuneration. Like its Board counterpart, the Committee should also review NED performance and play an active role in the NED appraisal process. The Committee would be ordinarily chaired by the Trust Chairman (or by the Senior Independent Director if the Chairman was the subject of discussion) but with the Committee otherwise comprised of a majority of Governors, in accordance with the Monitor Code. There is clear justification for the separation of the two Nominations & Remuneration Committees:

- It allows for a clear distinction to be made between NED and Governor responsibilities to appoint Executive Directors and NEDs respectively;

- It reduces the potential for a conflict of interest through establishing an entirely different Committee membership;

- It allows the Governors a means by which they can properly be said to be holding NEDs individually and collectively to account.

5.1.2 A draft Terms of Reference for the proposed Council of Governors Nominations & Remuneration Committee can be found at Appendix A.

5.1.3 **The Council is asked to support the establishment of the Council of Governors Nominations & Remuneration Committee.**

5.2 **Confirming the Need for a Membership Strategy & Engagement Working Group:** For the reasons set out at section 3.2 above, the continuation of a Governor Working Group in relation to membership matters is proposed. However, it is suggested that the current Terms of Reference can be strengthened to afford the Group a broader role with regard to public engagement and communication. For example, the establishment of Constituency Meetings (in the context of the WMUH acquisition) marks an important first step towards establishing a better connection between the Council and the local patient population/Trust membership base. The revised Membership Strategy & Engagement Working Group could act as the driver behind such initiatives.

5.2.1 A draft Terms of Reference for the revised Membership Strategy & Engagement Working Group can be found at Appendix B.

5.2.2 **The Council is asked to support the expansion of the existing Membership Sub-Committee into a Membership Strategy & Engagement Working Group.**

5.3 **Confirming the Need for Governors' Working Group/s on Quality & Performance Issues:** In order to hold the Non-Executive Directors and wider Board to account, there is a need for the Council of Governors to understand the current performance of the Trust. In the main, this should be achieved through updates provided to Council of Governors meetings. However, it is recognised that there are limitations to this, given that:

- Council of Governors meetings are held in public which can inhibit free and frank discussion/challenge of performance issues. Private Working Group meetings allow for an elevated level of information disclosure;

- Council of Governors meeting agendas are already congested with statutory business.

5.3.1 Therefore, establishing a separate Governors Working Group (or Groups) on performance matters allows the Governors a far greater opportunity to understand key Trust risks, issues and how such matters are being addressed by the Board. The Governors' pre-existing Quality Committee currently covers matters of patient safety, patient experience and clinical effectiveness; but there is an argument that Governors also require a broader understanding of Trust performance, covering workforce, operational and financial performance issues.

5.3.2 There are two potential options with regard to the establishment of such an arrangement.

- **Option 1:** For the Council to revise and expand the remit of the existing Quality Committee to encompass other areas of Trust performance, thereby establishing a Quality & Performance Working Group;

- **Option 2:** For the Council to establish two separate Performance Working Groups that separate out performance issues. A potential formulation of this would be:

- A Clinical Quality & Patient Experience Working Group (in accordance with Monitor's Guide);
- An Operations, Risk & Resource Working Group (focusing upon operational, financial, workforce and other non-clinical performance matters).

5.3.3 A draft Terms of Reference for a single Quality & Performance Working Group (drafted as Option 1) can be found at Appendix C.

5.3.4 **The Council is asked to support the principle of Governors' being afforded a Working Group/s to review Trust performance issues in greater detail on a biannual basis and, if approved, to consider the optimal configuration of this, based upon the options suggested above.**

5.4 **Why are Other Options in the Monitor Guide Not Being Considered for Working Groups**?

- **Approval of Auditors:** With regard to the option of establishing a specific Working Group to oversee the appointment process relating to the external auditors, this is not recommended on the basis that meeting business would be so infrequent as to render any attempt at developing a meeting 'business cycle' meaningless. The Council could however consider establishing this as a limited term Working Group towards the end of external auditor contract (every three years).

- **Strategic Planning & Policy**: In the context of the WMUH Acquisition, there is a significant degree of strategic discussion and decision-making which, by necessity, will be presented at Council of Governors meetings over the next 6-12 months. Furthermore, there is likely to be specific strategic developments that would benefit from Governor discussion in order to fully utilise the valuable external perspectives and contributions that the Council can offer. Again, it is contended that the Council of Governors' meeting itself will ordinarily represent the most appropriate forum for this.

  However, many Foundation Trusts have also adopted a process whereby once per annum, the opportunity exists for Board members to engage with members of the Council on a more informal footing (through an 'Away Day'), to complement the business conducted at formal Council of Governors meetings and to strengthen the links between Non-Executive Director and Governors, without blurring the boundaries of the respective roles. In the context of CWFT, the purpose of such Away Days could be two-fold:

  i) To allow time for the Board and Council to concurrently receive externally-facilitated educational sessions that, in particular, promote the Trust's commitment to learning, discovery and innovation;

  ii) As above, to allow the Board to present key strategic developments to the Council in greater detail than would be possible at a formal Council meeting.

5.4.1 **The Council is asked to support the establishment of one Board/Governors' Away Day per annum.**

6.0 Agenda Planning

6.1 As noted above, the current arrangement of having an Agenda Sub-Committee is unusual when compared with other FTs nationally. Moreover, it is contended that it is principally the responsibility of the Chairman and Trust Secretary to propose the business to be included at Council meetings based upon statutory requirements and relevant Trust business as part of an annual planning cycle.

6.2 Notwithstanding this, there is value in the Chairman being able to take a select group of Governors through forthcoming proposed agendas to ensure that, aside from the formal business of meetings, specific Governor views/feedback on agenda content are also picked up.

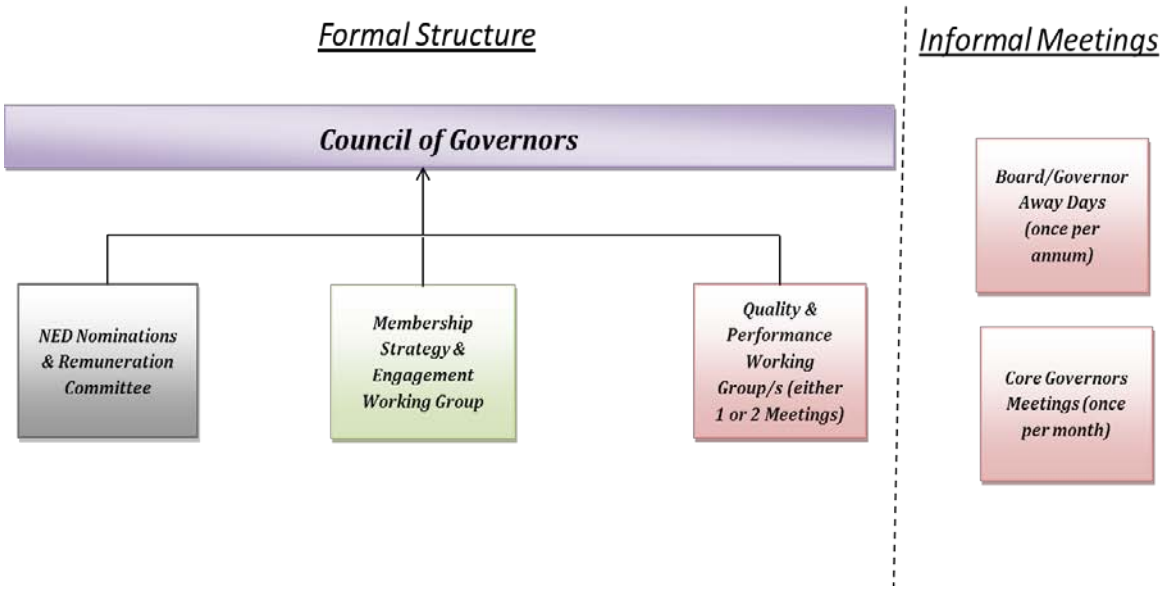
6.3 To this end, it is proposed that a series of monthly informal meetings are established hosted by the Chairman with a Group of 'Core Governors' which will include the Lead Governor. At such meetings, general Governor-relevant matters will be discussed, including the content of future agendas. The Core Governors will be asked to effectively act as a conduit between the Chairman and the wider Council of Governors.

6.4 It is suggested that the 'Core Governors' could comprise the elected Chairs of the Governor Committees, in addition to the Lead Governor.

6.5 **The Council is asked to support the disbanding of the Agenda Sub-Committee and the establishment of a series of informal monthly 'Core Governors' meetings, hosted by the Chairman.**

7.0 Process Relating to Membership of Governor Committees/Working Groups and the Election of Chairpersons

7.1 In accordance with the proposals above, the new Council of Governors sub-structure can be illustrated as follows:



7.2 With the exception of the NED Nominations and Remuneration Committee (which, as per Appendix A will be chaired by the Trust Chairman or Senior Independent Director), it is suggested that each Working Group of the Council of Governors should be chaired by a Governor. Both the Board/Governor Strategy Away Days and the Core Governors meetings would be chaired by the Chairman.

7.3 However, it is important that there is a robust process in place for both the appointment of the Governor Chair and with regard to the general Governor membership of the particular Committee. A suggested draft of these processes can be found at Appendix D. Once approved, the said processes will be embedded within the new Trust Constitution.

7.4 **The Council is asked to consider the suggested Constitutional wording relating to the membership and Chair appointment processes relating to Governor Committees/Working Group (Appendix D).**

8.0 Next Steps

8.1 The Council of Governors is asked to approve the proposals referenced within this paper.

Thomas Lafferty
Foundation Trust Secretary

May 2015

Appendix A: Terms of Reference- NED Appointment & Remuneration Committee
Appendix B: Terms of Reference- Membership Strategy & Engagement Working Group
Appendix C: Terms of Reference- Quality & Performance Working Group (capable of being split)
Appendix D: Draft Constitutional process for the appointment of Governor Working Group members & Chairpersons

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Non-Executive Director (NED) Nominations and Remuneration Committee

Terms of Reference

1. Constitution

The NED Nominations and Remuneration Committee is established as a Committee of the Chelsea & Westminster Hospital NHS Foundation Trust (CWFT) Council of Governors.

The NED Nominations and Remuneration Committee will review these Terms of Reference on an annual basis as part of a self-assessment of its own effectiveness. Any recommended changes brought about as a result of the yearly review, including changes to the Terms of Reference, will require Council of Governors approval.

2. Authority

The NED Nominations and Remuneration Committee is directly accountable to the Council of Governors.

3. Aim

The Committee has the delegated power to act on behalf of the Council of Governors in making recommendations with regard to the appointment and remuneration of Non-Executive Directors, including the Trust Chairman.

Furthermore, the Committee will oversee all aspects of the Non-Executive Director appointment process and the approval of arrangements for the termination of employment and other major contractual terms.

In addition, the Committee has an ongoing duty to review Non-Executive Director performance.

The Committee will operate in accordance with principles outlined in the Monitor Code of Governance.

4. Objectives

The NED Nominations and Remuneration Committee will:

4.1 Non-Executive Director Appointment

- Make recommendations to the Council of Governors on the recruitment, selection and appointment of the Chairman and Non-Executive Directors;
- Review the procedure for the recruitment and selection of the Chairman and Non-Executive Directors;
- Select a shortlist for interview of Chairman and/or Non-Executive Director candidates in accordance with the person specifications from the approved Trust candidate list;

4.2 Performance Appraisal

- Formally review the performance of each Non-Executive Director on an annual basis as part of the Non-Executive Director appraisal process; working with the Senior Independent Director in relation to the appraisal of the Chairman and the Chairman in relation to the appraisal of all other Non-Executive Directors;
- Assist in the designing of performance assessments for use in the Council of Governors' appraisal of the Board collectively and of Non-Executive Directors individually.

4.3 Remuneration

- Keep under review the fee scales for the Chairman and Non-Executive Directors, having due regard to market conditions, other FT Trust scales and national benchmarking information;

- To review Non-Executive Director allowances such as travel and mileage: telephone calls: printing and stationery and any other elated allowances for the Chairman and Non-Executive Directors;

- Make recommendations to the Council of Governors on the fees and allowances for the Chairman and Non-Executive Directors.

4.4 Succession Planning

- Evaluate, at least annually, the balance of skills, knowledge and experience on the board of directors and, in the light of this evaluation, prepare a description of the role and capabilities required for appointment of future Non-Executive Directors, including the chairperson.

- Regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Board and make recommendations to the Board as appropriate.

5. Method of working

The NED Nomination and Remuneration Committee will have a standard agenda. At every meeting, the following item headings will be on the agenda:

Standard Items
1. Apologies for absence
2. Declarations of Interest
3. Minutes of the previous meeting
4. Business to be transacted by the Committee (which is likely to comprise multiple agenda items)
5. Any Other Business
6. Date of next meeting

All Minutes of the NED Nominations and Remuneration Committee will be presented in a standard format. All meetings will receive an action log (detailing progress against actions agreed at the previous meeting) for the purposes of review and follow-up.

6. Membership

The membership of the NED Nominations and Remuneration Committee comprises five publicly/patient elected Governors and the Trust Chairman.

The Trust Chairman will ordinarily Chair the Committee. Where the Committee's business includes discussion with regard to the Chairman role, the Senior Independent Director will Chair the meeting.

The Committee may choose to invite other members of staff to act as advisors to the Committee (e.g. Chief Executive, Chief People Officer & Director of Corporate Affairs), where appropriate.

The Trust Secretary will ordinarily attend meetings of the Committee in order to take minutes, unless this is considered inappropriate given the nature of discussions.

7. Quorum

The quorum will be three publicly elected Governors and the Trust Chairman or Senior Independent Director.

8. Frequency of Meetings

The NED Nominations and Remuneration Committee will meet at least on a biannual basis, with further meetings being arranged where necessary to undertake specific items of business relating to the Committee's duties.

Members are expected to attend a minimum of 75% of Committee meetings throughout the year.

9. Secretariat

Minutes and agenda to be circulated by the Trust Secretary.

10. Reporting lines

All recommendations made by the Committee will be presented to the Council of Governors for approval.

11. Openness

The agenda, papers and minutes of the NED Nominations and Remuneration Committee are considered to be confidential.

Reviewed by:
Date:
Approved by:
Date:
Review date:

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Membership Strategy & Engagement Working Group

Terms of Reference

1. Constitution

The Membership Strategy & Engagement Working Group is established as a Working Group of the Chelsea & Westminster Hospital NHS Foundation Trust (CWFT) Council of Governors.

The Membership Strategy & Engagement Working Group will review these Terms of Reference on an annual basis as part of a self-assessment of its own effectiveness. Any recommended changes brought about as a result of the yearly review, including changes to the Terms of Reference, will require Council of Governors approval.

2. Authority

The Membership Strategy & Engagement Working Group is directly accountable to the Council of Governors.

3. Aim

The Membership Strategy & Engagement Working Group will act on behalf of the Council of Governors in leading the development and implementation of the Trust's Membership Strategy and with regard to the facilitation of communication and engagement with the Trust's membership base and, more broadly, the Trust's local patient population.

4. Objectives

The Membership Strategy & Engagement Working Group will:

- Make recommendations to the Council of Governors on the maintenance and expansion of the FT membership base within the Trust's identified constituencies representing the public;
- Make proposals and subsequently implement plans to 'make membership meaningful';
- Keep under review the demographical proportions of the membership base with a view to achieving a membership that is representative of the local patient population;
- Oversee the production of membership materials (such as the Members' Newsletter, the Trust website and within the Information Zone) and to engage members in the work of the Trust;
- Oversee the expenditure relating to the Council of Governors budget in the implementation and development of the Trust's Membership Strategy and public engagement initiatives;
- Lead the design of the content to be covered at local constituency meetings and co-ordinate the implementation of these meetings, ensuring sufficient and appropriate Governor attendance;
- To oversee and generate new plans for Trust engagement with local communities outside of the Trust's current membership base.

5. Method of working

The Membership Strategy & Engagement Working Group will have a standard agenda. At every meeting, the following item headings will be on the agenda:

Standard Items
1. Apologies for absence
2. Declarations of Interest
3. Minutes of the previous meeting
4. Business to be transacted by the Committee (which is likely to comprise multiple agenda items)
5. Any Other Business
6. Date of next meeting

All Minutes of the Membership Strategy & Engagement Working Group will be presented in an agreed standard format. All meetings will receive an action log (detailing progress against actions agreed at the previous meeting) for the purposes of review and follow-up.

6. Membership

The membership of the Membership Strategy & Engagement Working Group comprises five Governors and the Head of Communications and/or the Trust Secretary (or suitable representatives).

A Governor will be appointed to chair the Working Group.

The Working Group may choose to invite other members of staff to act as advisors to the Working Group.

7. Quorum

The quorum will be four Governors and the Head of Communications and/or the Trust Secretary

8. Frequency of Meetings

The Membership Strategy & Engagement Working Group will meet on a quarterly basis.

Members are expected to attend a minimum of 75% of Committee meetings throughout the year.

9. Secretariat

Minutes and agenda to be circulated by the Trust Secretary.

10. Reporting lines

All recommendations made by the Membership Strategy & Engagement Working Group will be presented to the Council of Governors for approval.

11. Openness

The minutes of the Membership Strategy & Engagement Working Group will be reviewed at public Council of Governors meetings.

Reviewed by:
Date:
Approved by:
Date:
Review date:

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Quality & Performance Working Group

Terms of Reference

1. Constitution

The Quality & Performance Working Group is established as a Working Group of the Chelsea & Westminster Hospital NHS Foundation Trust (CWFT) Council of Governors.

The Quality & Performance Working Group will review these Terms of Reference on an annual basis as part of a self-assessment of its own effectiveness. Any recommended changes brought about as a result of the yearly review, including changes to the Terms of Reference, will require Council of Governors approval.

2. Authority

The Quality & Performance Working Group is directly accountable to the Council of Governors.

3. Aim

The Quality & Performance Working Group will act on behalf of the Council of Governors in seeking to understand (and subsequently scrutinise/hold Board Directors to account in relation to) key Trust performance risks, issues and how such matters are being addressed by the Board.

The Quality & Performance Working Group will review quality performance (patient safety, patient experience and clinical effectiveness) but also broader performance matters, encompassing workforce, operational and financial performance issues.

4. Objectives

The Quality & Performance Working Group will:

- Gain an understanding of the key performance issues and risks facing the Trust and attempt to assist the Board in identifying priorities for performance improvement in line with national and local initiatives;

- Contribute to the structure and content of key performance documentation (e.g. Quality Accounts, Quality & Performance Dashboard) including developing agreed metrics, ensuring that such documentation is clearly presented and can be understood by all stakeholders;

- Where appropriate, challenge Trust performance and any proposals with regard to performance enhancement. Moreover, to consider collaboratively how such issues might best be addressed/approached, drawing on the Governor membership's skills and experiences.

5. Method of working

The Quality & Performance Working Group will have a standard agenda. At every meeting, the following item headings will be on the agenda:

<u>Standard Items</u>
1. Apologies for absence
2. Declarations of Interest
3. Minutes of the previous meeting
4. Business to be transacted by the Committee (which is likely to comprise multiple agenda items)
5. Any Other Business

6. Date of next meeting

All Minutes of the Quality & Performance Working Group will be presented in a standard format. All meetings will receive an action log (detailing progress against actions agreed at the previous meeting) for the purposes of review and follow-up.

6. Membership

The membership of the Quality & Performance Working Group comprises five Governors, the Medical Director, Chief Nurse, Chief Financial Officer, Chief People Officer & Director of Corporate Affairs and the Chief Operating Officer (or suitable representatives).

A Governor will be appointed to chair the Working Group.

The Working Group may choose to invite other members of staff to act as advisors to the Working Group.

The Trust Secretary (or a suitable representative) will ordinarily attend meetings of the Working Group in order to take minutes.

7. Quorum

The quorum will be three Governors and one Executive Director (or suitable representative).

8. Frequency of Meetings

The Quality & Performance Working Group will meet on a biannual basis.

Members are expected to attend a minimum of 75% of Committee meetings throughout the year.

9. Secretariat

Minutes and agenda to be circulated by the Trust Secretary.

10. Reporting lines

All recommendations made by the Committee will be presented to the Council of Governors for approval.

11. Openness

The minutes of the Quality & Performance Working Group will be reviewed at public Council of Governors meetings.

Reviewed by:
Date:
Approved by:
Date:
Review date:

Appendix D

Draft Constitutional process for the appointment of Governor Working Group members & Chairpersons:
Suggested Wording

1 Procedure for standing as a Committee member

On an annual basis, the membership of each Committee/Working Group of the Council of Governors will be refreshed. This will be achieved through a 'call for members' which should take place after the Annual Members Meeting and be co-ordinated by the Secretary.

The number of available Governor positions in respect of each Committee/Working Group will be set out within the respective Terms of Reference document. The Terms of Reference may also specify the class of Governor/s eligible for appointment on to a particular Committee/Working Group.

The Secretary will maintain a list of the Governors interested in joining a Committee.

Where the number of interested Governors exceeds the number of available Governor positions on the particular Committee/Working Group, the Council of Governors will be asked to elect members through a voting process which will be co-ordinated by the Secretary.

Governor membership of Council of Governors' Committees/Working Groups will last for a period of one year; although this may be extended for a further year on two occasions. Therefore, the maximum amount of time a Governor can be included within the membership of a Committee/Working Group is three consecutive years.

2 Procedure for electing a Working Group Chair

The Non-Executive Director Nominations and Remunerations Committee will be chaired by the Trust Chairman.

Council of Governors' Working Group members will elect a Governor Chair from amongst the Working Group membership to serve for a period of one year. The election of each Working Group Chair should take place after the Annual Members Meeting.

The Working Group Chairman may seek re-election after they have served their term of office on two occasions. Therefore, the maximum amount of time a Governor can chair a Working Group meeting is three consecutive years.

Council of Governors Meeting, 14 May 2015

AGENDA ITEM NO.	9/May/15
REPORT NAME	2015/16 Monitor Operational and Financial Plan (including refreshed 5 year Long Term Financial Model (LTFM))
AUTHOR	Lorraine Bewes, Chief Financial Officer
LEAD	Lorraine Bewes, Chief Financial Officer
PURPOSE	To report the final operational and financial plan for 2015/16 and update on the 5 year LTFM
SUMMARY OF REPORT	This paper is in two parts: **Part 1** reports on the final 2015/16 operational and financial plan approved at the April Trust Board for submission to Monitor on 14th May. The 2015/16 financial plan shows a £7.5m deficit and a continuity of service risk rating (COSRR) of 2. This reflects a deterioration of c£10m against the LTFM produced for the Transaction Outline Business Case. The deterioration is driven partly by the impact of the 15/16 tariff which has driven deficits in most specialist trusts but also non-delivery of its planned cost improvement programme in 2014/15. The operational plan to be submitted to Monitor sets out the Trust's strategy and operational plan including a commitment to refreshing its 2014 to 2019 strategy for a combined organisation during 2015/16 following the acquisition of WMUH. The Trust has declared a risk of meeting two targets and indicators from Monitor's Risk Assessment Framework for the Clostridium Difficile target and compliance with requirements regarding access to healthcare for people with learning difficulties. **Part 2** reports on the refreshed 5 year LTFM which was updated in the light of the revised 2015/16 plan. The paper highlights the deterioration in the Chelsea and Westminster standalone position. A comparison between the standalone and the combined organisation LTFM now shows a marked difference between the standalone and combined organisation LTFM, with the combined organisation showing more opportunity for efficiency and margin improvement.

	The combined organisation achieves a financially sustainable surplus by the end of the transaction period though liquidity is tight in the first 2 years, driving a COSR 2 in these years. The CFO has commissioned an independent liquidity review and will discuss options for improving liquidity and COSR with Monitor and external stakeholders as part of the transaction agreement. Options include taking out a fully committed working capital facility, debt restructure, reprofiling of transaction funding package.
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	None.
LINK TO OBJECTIVES	Ensure Financial and Environmental Sustainability Deliver 'Fit for the Future' programme
DECISION/ ACTION	The Council of Governors is asked to: - Note the final 2015/16 operational and financial plan which will be submitted to Monitor on 14th May 2015 - Note the refreshed 5 year long term financial model submitted to Monitor for the transaction review on 31st March.

2015/16 Financial and Operational Plan

1. Introduction

This report provides the Council of Governors with the final operational and financial plan for 2015/16.

2. Background

For 2015/16, Monitor requires all Trusts to produce a detailed one year plan. A draft operational and financial plan was submitted in line with requirements on 7th April, with the final plan to be submitted on 14th May.

The financial and operational plan outlined in this paper has been developed as part of the Trust business planning round for 2015/16.

3. Operational plan

The 2015/16 operational plan is attached in appendix 1. In line with Monitor guidance, the operational plan highlights the strategic context and our progress against our strategy alongside our plan for short term resilience, including our financial plan for 2015/16.

Key areas for the Council of Governors to note from the operational plan are:

- Monitor has specifically asked that the Board recommit to its current strategy (assuming no significant changes), refresh its strategy (where the strategy is broadly correct but the external environment has changed) or recreate its strategy (where the Trust does not have a strategy to meet its goals), as appropriate, within the Trust's operational plan. In section four of the operational plan, we set out that the Board commits to refreshing its 2014 to 2019 strategy for a combined organisation during 2015/16 following the acquisition of WMUH.

- Section 8.4 of the operational plan sets out our explanation for the risk of meeting two targets and indicators from Monitor's Risk Assessment Framework which we have declared in our financial plan return to Monitor. These are the Clostridium Difficile target and compliance with requirements regarding access to healthcare for people with learning difficulties.

4. Financial plan

The Trust is planning a net deficit of £7.5m and an EBITDA of £17.7m (4.7%) in 2015/16, from total income of £380.1m and a COSR rating of 2.

The table below shows the key elements of the financial plan.

	2014/15 Outturn	2015/16 Plan
	£m	£m
Operating Revenue	369.2	380.0
Employee Expenses	-188.6	-195.1
Other Operating Expenses	-152.1	-167.2
Non-Operating Income	0.1	0.1
Non-Operating Expenses	-26.4	-25.3
Surplus/(Deficit)	**2.2**	**-7.5**
Net Surplus %	0.6%	-2.0%
Total Operating Revenue for EBITDA	369.2	380.0

Total Operating Expenses for EBITDA	-340.7	-362.3
EBITDA	28.5	17.7
EBITDA Margin %	**7.7%**	**4.7%**
Period-end cash	11.5	6.5
CIP	12.7	10.0
Liquidity Ratio Rating	4	3
Capital Servicing Capacity Rating	2	1
Continuity of Service Risk Rating	**3**	**2**

Financial plan return

The Board has reviewed and has delegated approval to the Chief Financial Officer to approve, on its behalf, submission of the 2015/16 financial plan return to Monitor. This return primarily sets out the detailed financial plan for 2015/16. Key areas noted by the Board from this return were:

- **Self-certification:** The Board was asked to declare that, on the basis of the plans set out in the return, the Trust will be financially, operationally and clinically sustainable according to current regulatory standards in one, three and five years' time. The Board has confirmed this will be through an acquisition of WMUH and is therefore dependent on Monitor awarding a positive risk rating on the transaction.
- **Declaration of risks against healthcare targets and indicators:** The Board was asked to declare risks against healthcare targets and indicators. The Trust has declared a risk of meeting two targets and indicators from Monitor's Risk Assessment Framework. These are the Clostridium Difficile target and compliance with requirements regarding access to healthcare for people with learning difficulties.
- **Membership:** The membership size and movements, along with an analysis of its make-up
- **Elections:** Governor elections held between 1 April 2014 and 31 March 2015

5. Summary

The final 2015/16 operational and financial plan has been approved by the Trust Board and is due to be submitted to Monitor on 14th May 2015.

The financial plan shows a £7.5m deficit and a continuity of service risk rating (COSRR) of 2.

The operational plan to be submitted to Monitor sets out the Trust's strategy and operational plan including a commitment to refreshing its 2014 to 2019 strategy for a combined organisation during 2015/16 following the acquisition of WMUH.

The Trust has declared a risk of meeting two targets and indicators from Monitor's Risk Assessment Framework for the Clostridium Difficile target and compliance with requirements regarding access to healthcare for people with learning difficulties.

APPENDIX 1
Chelsea and Westminster Hospital NHS Foundation Trust
2015/16 Operational Plan

A. STRATEGIC CONTEXT AND PROGRESS AGAINST DELIVERY OF THE STRATEGY

1. Overarching strategy

Chelsea and Westminster Hospital NHS Foundation Trust's (CWFT's) overarching strategy is founded upon two principle strands – acquisition of West Middlesex University Hospital NHS Trust (WMUH) and designation of CWFT as a major hospital under Shaping a Healthier Future (SAHF) leading to an expected increase in activity from 2017/18. We are committed to the vision set out in the NHS Five Year Forward View and are already taking forward initiatives in line with this vision.

1.1 Acquisition of West Middlesex University Hospital NHS Trust

CWFT's board believes there is a clear case for the acquisition of WMUH which will drive a number of benefits for patients, commissioners and the trust. In particular, it:

- Provides greater assurance to the financial and clinical sustainability of both trusts
- Supports continued access to care locally
- Provides a better patient experience through new models of care and shared best practice that will reduce variations in care
- Supports development of a provider landscape in North West London that provides competition and choice for patients and providers of sufficient scale and resilience to meet the challenges of the NHS Five Year Forward View
- Enables technological advancement through development of a new EPR system which will generate efficiencies trust-wide

The Board formally approved the acquisition full business case (FBC) on 26 February 2015, with Monitor's review of this starting in March 2015. The FBC also sets out four key areas of service development made possible through the acquisition: cardiology; ophthalmology; orthopaedics and bariatric services. Clinical engagement plans and events across both trusts are underway and we continue to develop integration and mobilisation plans, including (but not limited to) those for leadership, governance, clinical services, corporate functions, IM&T integration, workforce, and communications and engagement. These are overseen by an Integration Programme Director who started in March 2015.

The trust aims to secure a COSRR of '3' for the combined organisation by the end of 2018/19. We have commissioned Deloitte to carry out a more in-depth review of WMUH financial position and have developed a financial integration plan for the organisation post-acquisition to grip financial performance from day one.

1.2 Shaping a Healthier Future

Shaping a Healthier Future (SAHF) is a clinically-led programme by the eight Clinical Commissioning Groups (CCGs) in North West (NW) London to deliver significant improvements in clinical, productivity and financial outcomes across the local health economy. The programme's implementation business case (ImBC) was submitted to NHE England and NTDA for comment in March 2015.

During 2015/16, CWFT expects to finalise our OBC and develop our FBC in line with the programme's timetable (once confirmed). We will continue to work commissioners and other providers in NW London (NWL), including WMUH, to consider potential alternative provider responses to accommodate activity changes should PDC funding for the capital programme not be received in full.

2. Clinical, quality and financial strategy

2.1 Clinical services strategy

CWFT treats more than 360,000 patients a year and employs over 3,000 staff. Our clinical services strategy, developed during 2014/15, was influenced by the wider clinician base through two clinical summits held during 2014/15 and we have shared it widely with commissioners, Governors and CWFT's charity.

It is designed to give the best possible patient experience and outcomes through: local acute services (for example, 24/7 adult and paediatric A&E services with co–located urgent care centres (UCCs), a full maternity service (including high risk maternity services), and community-based clinics such as our musculoskeletal and direct access sexual health services); specialised services (for example, HIV and neonatal intensive care); innovation and research; and education and training. To deliver against this strategy, our priorities are:

- Providing integrated urgent and emergency care to reduce demand for non-elective admissions and reduce length of stay
- Improving efficiency of planned care, in particular theatre productivity, outpatients utilisation and day-case rates
- Providing support for ageing well and those with multiple co-morbidities or chronic conditions
- Delivering specialised women's, children's & HIV services across all of NWL
- Multi-professional training for all staff, making this part of our unique selling point
- Translational and health services research
- A focused portfolio of private patient services

We will endeavour to provide all these with excellence in patient experience at the core of what we do. Our clinical strategy is supported by our quality strategy which sets out four components of quality that we are continually aiming to improve: safety; effectiveness; experience of care and access to care. During 2015/16 we plan to develop our clinical strategy through a service line review, starting with an initial ten prioritised services and leading to a proposed approach and action plan for each major service line (developed in the context of both the WMUH acquisition and SAHF, and in the context of developing a coherent and sustainable portfolio of services).

2.2 CQC action plan

In July 2014 the CQC carried out an inspection of CWFT. Whilst this found that we provide good and outstanding care in many areas, their overall rating for the trust was 'needs improvement'. In order to proactively address areas where action is required, speciality specific action plans were developed, with our Quality Committee responsible for monitoring progress and seeking assurance from divisional representatives that actions are being implemented and completed. The majority of actions were completed by March 2015 and programmes are in place to support longer term developments such as the reconfiguration of the emergency department (ED) and IT integration. We have also worked closely with WMUH as it has recently gone through its first CQC inspection, which rated the trust as 'requires improvement', to support us to address actions as a joint organisation following the acquisition.

2.3 Financial position and cost improvement programmes (CIPs)

CWFT achieved a surplus of £2.4m in 2014/15 and an EBITDA of £28.7m (7.7%), leading to a COSRR of 3. This comprises a capital service metric of 2 and a liquidity metric of 4, and compares to an annual plan of £7.1m (a £4.7m adverse variance). The under-performance relates primarily to the under achievement of CIPs, partly offset by over-performance on NHS clinical income and underspends on non-pay. The Trust has delivered £12.4m of CIP schemes against a plan of £24.9m. The capital expenditure in 2014/15 was £15.2m.

In recognition of the need to review and strengthen our CIP processes, focussing on recurrent, cash releasing savings, we brought in Kingsgate to support us to develop a two year savings plan. This sets out a target to deliver savings of £10m in 2015/16 and £11.6m in 2016/17, phased where appropriate to allow for set up of the programmes, leading to the more ambitious target for 2016/17. Following Board approval of the principles of the programme and the 2015/16 savings plan in January 2015, the trust has put in place detailed implementation plans, based on agreed productivity targets (set out in more detail in section 11). Our forecast 2015/16 deficit of £7.5m incorporates this CIP saving. To support delivery of our CIP, we are strengthening our governance and accountability arrangements over financial performance. Furthermore, we have negotiated a payment by result contract with commissioners for 2015/16, with risk share in agreed specialties, to mitigate against the risk of non-payment of activity delivered under a block contract.

3. Enablers

3.1 Estates strategy

Our estates strategy aligns to both the SAHF programme and the acquisition of WMUH. We have commissioned Hunters, an architectural and building consultancy, to support us in developing an estates plan across both the CWFT and WMUH sites. This is due to report in summer 2015 and will enable activity changes under SAHF, alongside service developments and estates rationalisation through the acquisition.

3.2 Workforce

Our 'people strategy' is a core component of our drive to ensure the right people with the right skills, competencies, values and behaviours are working within the right culture and structure. It has six core elements: inspirational leadership and talent; workforce strategy and planning; HR and learning processes; skills and capability; performance, reward and recognition; and culture, values and engagement.

Our staff turnover rose steadily in 2014 which has led to significant work to improve vacancy and retention rates, particularly in nursing. A large cohort of newly qualified nurses was recruited in the autumn of 2014 and recruitment and retention plans were discussed at Board in January 2015. We will continue with targeted recruitment and retention programmes through 2015/16 to reduce vacancy and turnover rates. Other key projects that will impact our workforce include the expansion of the ED, clinical pathway admin redesign, the reduction of junior doctor training posts (which requires us to look at new ways of working) and the move towards seven day services. CIPs will also include a review of consultant job plans and a significant reduction in the use of temporary staffing.

The proposed acquisition of WMUH also presents a major workforce challenge for 2015/16. We are developing a single integrated people strategy for the combined organisation, reflecting the best of both organisations and ensuring 'safe landing' on 'day one' of the new organisation when WMUH staff will TUPE across. We will continue to focus on talent management, leadership, and succession planning in order to realise the new organisation's vision and achieve its strategic objectives.

3.3 Information management technology strategy

Our information management technology (IMT) strategy is aligned to the acquisition of WMUH. The founding principal is the application of our current IMT strategy to integrate WMUH technology, plus the procurement and implementation of a new EPR solution across both sites. The key steps are:

- Step 1: Pre-day one activities and transition to IT Shared services ('Sphere') at WMUH during year one – provides core infrastructure and support for all non-clinical systems
- Step 2: IMT rationalisation – integration of core elements, including a single data warehouse and organisational reporting, pre-day one, during year one and ongoing
- Step 3: Clinical functionality enhancement – identification and deployment of clinical systems across both trusts prior to the implementation and go-live of the new EPR

- Step 4: Adoption of a full EPR - full scale EPR implementation from year one to year three

A 'Design Authority' to support the EPR and transformation programmes of work will be set up prior to the acquisition, ensuring that these are clinically led and provide the forums for coherent and timely decision making to enable successful delivery of our strategy.

4. Refresh of strategy

Given the current position, CWFT's Board commits to refreshing its 2014 to 2019 strategy for a combined organisation during 2015/16 following the acquisition of WMUH.

B. PLAN FOR SHORT TERM RESILIENCE

5. Safe landing and integration with WMUH

A detailed mobilisation and integration plan has been developed by workstream leads, supported by the acquisition PMO. It includes an overall integration timeline and the project management structure for the integration alongside detailed integration plans for clinical services, corporate and back-office functions. The plan, which applies best practice and learning from previous acquisitions and mergers, is structured around CWFT's existing three divisions, with clinical and managerial resource to support site leadership and ensure local responsiveness

The objectives of the mobilisation and integration plan are covered in 3 phases:

- **Pre-integration and first 100 days:** Safe and effective organisation established aka "safe landing"
- **Years one to three:** service standardisation programme, cultural/organisational fit and drive for early delivery of a range of programmes to deliver quality, productivity and financial benefits
- **Year three onwards:** Introducing and leveraging strategic enablers to transform services and deliver long term clinical and financial sustainability

The critical path to deliver has been agreed with key stakeholders and the PMO. Over the course of 2015/16, the PMO will continue to work closely with the Project Board and workstreams to monitor progress and ensure delivery, supported by regular 'dashboard' reports. An independent accountant will provide the Board with assurance over the integration plan prior to acquisition. Following acquisition, the Integration Programme Director will continue to provide this assurance to the Board.

6. Developments under Shaping a Healthier Future programme

During 2015/16 our key SAHF related priority is the expansion of our ED. Phase one of the ED redevelopment (primarily an expansion of 'majors' from 11 to 21 trollies and an expansion of emergency observation trollies from five to eight trollies) is due to go live from July 2015. Phase 2 (the resuscitation area) is due to go live from October 2015, with the full ED going live from June 2016, doubling our current ED capacity. Recruitment to new posts to cover the expanded ED footprint is underway. We will continue to monitor any increases in activity related to an expanded ED and the upcoming activity changes related to SAHF to ensure that key areas likely to be affected, such as diagnostics (and radiology in particular) and emergency surgery remain appropriately resourced to continue to provide a timely service.

We will also potentially see the closure of Ealing Hospital's maternity unit during the first half of 2015/16. Whilst it is not anticipated that CWFT will see a significant increase in deliveries from the Ealing catchment area, the boundary changes agreed with Imperial College Healthcare NHS Trust (ICHT) means we will see an increase of about 350 deliveries per year, largely from the Hammersmith & Chiswick areas. The maternity unit will be able to absorb the additional demand, having built additional capacity last year in the form of the midwifery led birthing unit. Through recruitment to core roles, the trust expects to improve our midwifery to birth ratio from 1:32 to 1:30, and to improve consultant hours from the present 110 hours coverage to 115 hours coverage following transition.

7. Developments in line with the Five Year Forward View

We are actively pursuing opportunities to develop our out of hospital services in line with the vision set out in the five year forward view.

8. Quality

8.1 CQC action plan

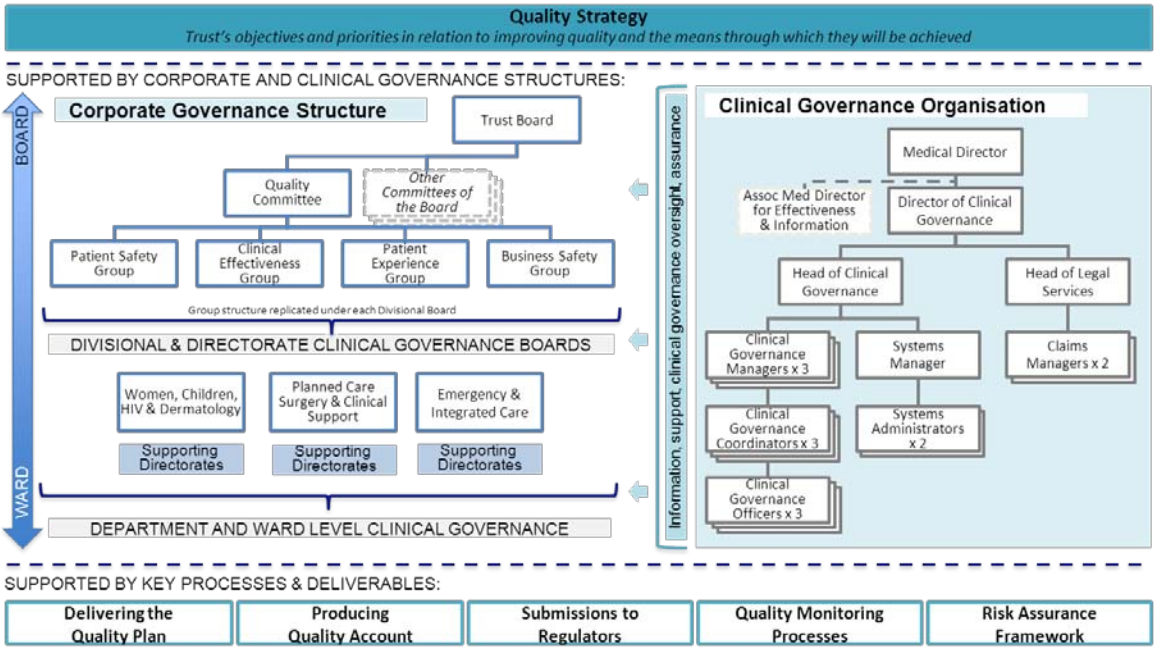
CWFT is currently undergoing a quality 'peer review', replicating the full CQC inspection, to provide assurance over our current compliance with the whole CQC inspection regime. This is being carried out by staff from a range of London trusts including The Royal Marsden NHS Foundation Trust, The Hillingdon Hospitals NHS Foundation Trust and WMUH. A second peer review is planned for October 2015 which we expect to cover both CWFT and WMUH sites. These provide an ongoing learning and assurance approach over quality and the second review provides the first opportunity to gain assurance over progress from WMUH CQC action plan.

Given the majority of actions from our CQC action plan have now been addressed, our focus is to embed the changes made and address any additional areas of improvement identified through peer reviews to enable continuous improvement. Key areas of improvement and focus for 2015/16 are:

- Strengthening visibility of our leadership teams through continuing our 'back to floor Fridays' for lead nurses, matrons and the Chief Nurse Cabinet, alongside a weekly walk-around by each member of the Executive with feedback taken to and actioned by Corporate Directors.
- Embedding our new quality governance structure, set out in section 8.2, which was put in place following a review of our quality governance structures.
- Embedding Datix, our recently introduced web based incident reporting system, a project led by a dedicated project manager to enable us to more easily identify and disseminate learning from incidents and to provide feedback to those reporting the incidents.
- Ongoing improvements to ensure patients with mental health needs are cared for in the most appropriate setting in a timely manner, through continuing work with our mental health partner provider CNWL.
- Embedding enhanced nursing structures, including a third registered nurse at night in adult areas with more than 18 beds (introduced following a review of our staffing model over the last six months) and investment in children's nursing staff to align to Royal College of Nursing Standards, both from 1 April 2015.
- Ensuring access to LastWord (our electronic patient record system) for all agency staff, with passwords accessible in assigned wards.
- Continue to provide our recently introduced seven day end of life cover.
- Work towards putting in place the gold standard framework for end of life care as led by Professor Keri Thomas.

8.2 Quality governance

Our updated quality governance structure better enables us to maintain and continually improve quality across the trust from 'Board to ward':



It is ultimately led by the Quality Committee, which reports into the Board and is chaired by one of our NEDs with the Medical Director as Executive lead. Divisional Medical Directors chair the Divisional Clinical Governance Boards. It is supported by the clinical governance team, led by the Director of Clinical Governance. Together, this framework monitors quality performance and risk, including complaints and investigations, as well as being responsible for overseeing delivery against our four special quality projects.

8.3 Special quality projects for 2015 to 2018

We have identified four special projects as areas of focus for the medium term to support the delivery of particular objectives and priorities underpinning the quality strategy.

1. Frailty

Identifying and providing the right care for patients suffering from frailty has been shown to improve patient outcomes and experience and reduce length of stay in hospital. This project will implement the adoption of an intervention 'bundle' across the trust focused on areas where we know care can be improved for frail and elderly patients:

- Earlier and more effective discharge
- Improving nutritional care and reducing healthcare acquired complications
- Prevention of healthcare acquired pneumonia (HAP)
- Improving identification and care for those with delirium.

Our initial focus for 2015/16 is consistent reduction in prevalence of stage 3 and stage 4 pressure ulcers.

2. Planned care / admitted surgical care

Planned care offers a significant opportunity to improve quality of care through consistent adoption of evidence-based best practice. We have made significant progress in improving care but there is still more that we can do to address areas such as ensuring our never events are zero, reducing incidence of surgical site infection and reducing unplanned ITU admissions. This project comprises a series of intervention 'bundles' to help more reliably deliver the best possible care for patients undergoing particular treatments with inherent risks, including:

- Full compliance with the WHO Surgical Checklist
- Pre / peri / post-operative bundles to address surgical site infections
- Enhanced recovery programmes that improve patient outcomes and experience and reduce length of stay
- Medication Safety (especially analgesia, antibiotic and thromboprophylaxis)

- Interventions to prevent ventilator-associated pneumonia (VAP).

Our initial focus for 2015/16 is full compliance with WHO surgical checklist, as measured through clinical audit.

3. Sepsis

Sepsis is a significant driver of mortality and morbidity and it has been shown that early intervention and effective care will improve patient and clinical outcomes and reduce the chances of death. We have an agreed pathway (care bundle) for patients with sepsis and the ED is taking part in a national research project on the treatment of sepsis. This project will build on existing work, targeting a reduction in ITU admissions, reduction in length of stay and reduction in the rate of severe infections. It will implement a process to rapidly identify potentially unwell and/or septic patients and institute prompt treatment, in order to reduce mortality and morbidity.

Our initial focus for 2015/16 is consistent improvement in prompt identification of deteriorating patient measured through clinical audit.

4. Maternity

The Maternity Department at CWFT delivered 6,000 babies in 2014. Of those structurally normal babies at term, approximately 3% were admitted unexpectedly to the neonatal unit (5% nationally). This is one of the top 3 incidents reported within the department and although most babies are discharged home with an anticipated normal outcome, the period of separation creates anxiety for parents and involves additional bed days for the mother. For the small minority that have permanent brain injuries the impact for those families is immeasurable, and the financial costs of litigation are significant. This project seeks to:

- Improve identification of at risk babies in the antenatal period
- Ensure safe intrapartum care
- Improve postnatal care of vulnerable babies

Our initial focus for 2015/16 is a reduction in avoidable term baby stillbirths.

8.4 Declaration of risks against healthcare targets and indicators

We have declared risks against delivery of two healthcare targets and indicators in our 2015/16 return:

- **Meeting the C.Diff objective:** In 2014/15 we had 8 cases of C.Diff. Therefore, the reduction of the threshold from 8 cases to 7 cases for 2015/16 does represent a risk to the trust.
- **Compliance with requirements regarding access to healthcare for people with a learning disability:** The Trust is not currently fully compliant with all six indicators, but working to achieve compliance in 2015/16, in line with the Trusts CQC action plan. The Trust expects to be compliant by Q4 2015/16.

9. Contracting round

CWFT's clinical income is forecast at £314m (83%) of the total income of £380.1m for 2015/16. In common with other London acute and specialised providers, NHS England represents approximately one third of the clinical contract income (£117.8m) and the rest of the clinical income base is very diverse. This dilution is mitigated by the existence of collaborative commissioning arrangements in health (North West London £113m, South West London £35.4m) and for 2015/16 in Local Authorities for GUM (£23m). These collaborative commissioning arrangements have the impact of concentrating the contracting debate into four major contracts, leaving a residual £25m of other smaller collaborative contracts and non-contractual income.

9.1 Demand and capacity analysis

The key principles adopted in the contracting round have been to establish the recurring contract baseline position moving forward from 2014/15 as a starting point and then to identify pressures and issues for 2015/16. Our demand and capacity analysis formed a main part of identifying pressures. CWFT regained overall compliance on RTT in December 2014 but we are not yet compliant by specialty. As part of action planning, the

elective Intensive Support Team (IST) came in to undertake a stocktake with us on our future demand and capacity resilience. The work was based on the methodologies employed by the IST who look at capacity needed to clear referrals as they come in 65% of the time. They undertook two exercises with divisions: 1) review of backlog compared to backlog consistent with RTT delivery and 2) review of weekly referrals compared to weekly capacity.

The exercise was completed in December 2014 and when extrapolated appeared to imply that a significant amount of activity and capacity (£10m) was need to secure our future positions. This was initially introduced as a place marker into the contracting round. During the business planning round, divisions worked with the specialties to interpret the exercise and this led to the development of business cases for extra capacity in key specialties: trauma and orthopaedics; plastics; orthodontics; ophthalmology; and non-obstetric ultrasound. NWL commissioners have reflected additional activity in their latest contract position.

9.2 Recurrent 2014/15 forecast outturn

The recurrent forecast outturn is agreed with commissioners and is based on the first six months' activity and income extrapolated for year end and adjusted for factors such as seasonality, non-recurrent items and other changes agreed with Divisions. In order to arrive at a recurrent (underlying) deficit, a number of adjustments were made to the 2014/15 outturn. The impact of these adjustments is to move from a £2.4m surplus to a £4m recurrent deficit, which forms the starting point for the 2015/16 financial plan.

9.3 Demographic Growth

Demographic growth in the plan is based on NWL assessment of population growth and the same methodology has been applied to other commissioners. The total value is £2.4m, of which £1m is assumed to be delivered through productivity improvements as a CIP scheme (i.e. no additional expenditure).

9.4 Winter resilience funding

For 2015/16, the planning guidance has outlined changes to winter resilience funding, which is now included in CCG baselines as recurrent funding. Commissioners have established a local bidding process for this and agreed that it is reasonable to plan on the same quantum as in 2014/15.

9.5 Tariff Deflator and CQUIN

As a result of its decision not to opt in the recent tariff choice exercise, CWFT is now planning and contracting on the basis of the Default Tariff Rollover (DTR) which means that the Trust has planned for no tariff deflator, but loss of £5.5m CQUIN income instead (though we are continuing voluntarily to focus on some of the major strategic deliverables for 2015/16 – IT enablers, 7 day working and transformational change).

9.6 Service Developments and Private Patient Income growth

Service developments included in the financial plan make a contribution, meet our financial investment criteria and are aligned to our objectives. Divisions proposed service development business cases for review and approval by the Director of Finance, Medical Director and Chief Operating Officer. In total the gross income is £4.1m, with a contribution of £0.9m. The service developments include business cases to reduce and maintain the waiting list to a sustainable level in a number of key specialties. Private patient income growth of £3m has been included in the plan, generating a £0.8m contribution, as well as £1.4m full year effect of plans already started in 2014/15.

9.7 Pay award

The national pay award has now been agreed and the plan includes cost pressures for a 1% increase for all Agenda for Change staff band 8a and below and all medical staff and the increase of 0.3% on employers' pension contributions. No impact of incremental drift has been assumed, following full assessment in 2014/15 which identified no net impact, due to high turnover rates at the Trust.

9.8 Non-pay inflation

For clinical supplies, 0.7% inflation has been assumed as per historic inflation and for non-clinical non-pay, the plan assumes inflation based on specific cost inflation for utilities, rates and contracts, plus CNST cost pressure.

9.9 CQC Action Plan and other cost pressures

The plan includes £1.5m of investment associated with implementing the CQC with increased costs incurred from April 2015. There are a number of other unrelated cost pressures (£6.6m), which have been put forward by Divisions and agreed by the Director of Finance and Medical Director as part of the business planning process.

10. Cost improvement programmes (CIPs)

The £10m 2015/16 CIP approved by Board breaks down into 12 workstreams, as follows:

CIP workstream	Target cost saving (£000)
	2015/16
A. Improving clinical services	
1. Outpatient productivity and utilisation	1,000
2. Beds (length of stay, day cases, outpatient procedures)	250
3. Theatre productivity and utilisation	600
B. Improving diagnostic and treatment support	
4. Diagnostic services	50
5. Clinical administration	350
C. Managing the business	
6. Premium cost working	
VAT saving	500
Agency	320
7. Management structure	100
8. Corporate and back office services	
Corporate and back office services	300
PA review	64
9. Estates and facilities management	1,000
10. Procurement	1,500
11. Pharmacy-led savings	
Outpatients pharmacy outsourcing	3,480
Other	130
12. Directorate (local) savings	200
D. Full year effect of 2014/15 savings	200
Total	**10,044**

We have strengthened our governance over CIPs for 2015/16. The CEO remains ultimately accountable for delivery. PIDs for each workstream have been developed and signed off by the Executive Sponsor, as senior responsible officer (SRO), and workstream lead in March 2015. Each PID has also been through a QIA by a panel

chaired by the Director of Nursing and checked against a Gateway process to confirm that they are ready for implementation.

We have appointed a Transition Advisor (TA), reporting directly to the CEO, to ensure delivery of the programme. The TA will hold SROs, workstream project managers and budget holders to account for delivering their workstream. The TA and SROs will ultimately report to the monthly Finance and Investment Committee (FIC) on progress to deliver savings. The TA will also hold fortnightly accountability reviews with SROs and workstream leads, as well monthly divisional finance meetings with budget holders along with finance directors.

11. Productivity plans

Our productivity targets align to our CIP workstreams. Our ultimate aim is to move to best practice standards, but we recognise that it will take time to develop and embed systems and processes to enable this (which is reflected in the size and phasing of the 2015/16 CIP saving).

12. Core CWFT service developments in 2015/16

12.1Growth of HIV/GUM

CWFT's sexual health service is the largest in the United Kingdom with over 170,000 attendances across three sites in London for 2014/15, a 34% growth on prior year. While the Local Authority commissioning arrangements have led to a challenging financial arrangement, the service continues to innovate to drive down costs and benefits from economies of scale associated with this size of service. Both the Sexual Health and HIV service will grow from the 1st April when CWFT takes over running HIV services and works in partnership to deliver GUM services in Hertfordshire. Following the acquisition of WMUH, the cohort of around 8,500 patients will make ours comfortably the largest HIV service in Northern Europe and will mean that we are caring for around 1 in 10 of the patients living with HIV in the UK.

The service aims to continue to grow using the significant innovations created including the 'Express model' for Sexual Health testing.

12.2Private patients

CWFT has approximately 1% market share of London's c£1.4bn private healthcare market. This is an opportunity for us as we are perfectly placed geographically and demographically to increase our share of the market. We have an opportunity to develop this further through the acquisition of WMUH as there is currently no provision on that site for patients wanting to access private patient services.

12.3Joint venture with Royal Brompton & Harefield NHS Foundation Trust

The proposed joint venture for Children's Services with the Royal Brompton and Harefield NHS Foundation Trust (RBH) would generate advantages for both trusts including improved quality of care, better patient experience and creating momentum to widen the collaboration to encompass other clinical services. In quarter three of 2014/15 the Boards of both trusts endorsed the vision of the proposed collaboration and to move forwards to the creation of a full business case (FBC) whilst at the same time progressing a joint programme of work which will bring the collaboration to fruition. We have put a number of clinically-led working groups in place to progress this work in 2015/16, with the collaboration broadly focussed on:

- Closer working to increase the acuity of patients that we can look after in our high dependency unit (HDU)
- Creating a rotation programme for the training and development of nurses and therapists between trusts
- Increasing the management of paediatric and neonatal patients with cardiac pathology at this site

Both trusts will also work together to prepare an FBC for a collaboration for five to ten years, shaped by the delivery of the initial projects.

13. Service developments arising from proposed integration with West Middlesex University Hospital NHS Trust:

- Elective Orthopaedic Centre
- Bariatric Services
- Cardiology
- Ophthalmology

14. Operational risks

14.1 Management structure

CWFT's Board is relatively new and is in the process of embedding itself. There have been several new Executive and Non-Executive appointments in 2014/15, including the new permanent COO who has been in post since March 2015. A process for the appointment of a permanent CEO started in March 2015. We are in the process of reviewing our Governance Framework around the Board, including the Committee structure and risk arrangements which we will adopt in advance of the acquisition of WMUH, and we have scheduled Board development work following the acquisition.

We have also identified management bandwidth and skills gaps lower down the organisation. We have plans in place to replace two of our three DDOs, one of whom is taking on a six month secondment to COO of WMUH from early in 2015/16. We are also recruiting to our PMO to support delivery of key programmes, including CIP.

14.2 Recruitment of neonatal nurses

In the context of a national shortage of neonatal nurses, the expected closure of maternity services at Ealing Hospital in June 2015 under SAHF and the acquisition of WMUH (which is initially expecting an additional 600 births each year from the SAHF changes), we continue to focus efforts on the recruitment of neonatal nurses. Alongside our rolling recruitment programme, we have put in place an overseas recruitment plan to be rolled out early in 2015/16.

In response to the CQC action plan, we have also put in place an externally facilitated team building work programme within NICU. During 2015/16 the unit will undergo a complete redevelopment.

14.3 Delivering the RTT national standard

Delivering the 18 week RTT target, whilst avoiding the development of a waiting list backlog, remains a key operational risk for the trust. In 2013/14, we developed a substantial backlog due to prioritising attaining the RTT targets. Consequently, throughout 2014/15 until the end of Q3, the Trust has missed these targets whilst trying to reduce its patient backlog to sustainable levels.

Daily operational meetings put in place from summer 2014 to ensure focus on meeting the targets whilst avoiding an increase in backlog numbers and will continue through 2015/16. We have also commissioned Deloitte to provide an independent assurance review of our 18 week systems and processes and have a five week data validation exercise supported by the NHS National Data Team. Longer term, as part of our wider IT strategy, we will be rolling out a new PAS system to greatly improve the efficiency of current IT systems.

14.4 Operational capacity

The Chelsea and Westminster Hospital bed base and operational capacity is limited, particularly with regard to HDU post-operative recovery capacity, which can lead to cancelations of elective procedures and regularly 'outlies' medical patients within beds allocated to other specialties. This creates a risk to the Trust's operational resilience to address serious events such as an infection control outbreak or major incident.

We currently manage this risk through daily, cross-division monitoring of bed capacity which, when needed, generate mitigation plans to address any bed shortages. We will continue to develop alternative pathways of care, in particular our ambulatory care pathways, and work with external partners to facilitate patient discharge to relieve pressure on beds.

14.5Staff retention

The Trust currently has a high turnover rate (17.4% across all staff groups), particularly for health care assistants (30%) and band 5 nurses (23%), which contributes to our reliance on premium rate agency staff. During 2014/15 we put in place a number of initiatives to address this, including:

- People Strategy developed, which introduced new recognition and incentive schemes and initiatives (for example, a project targeting HCAs).
- Each Division established a recruitment and retention plan
- Monthly 'deep dive' assessments of divisional recruitment and retention, setting out plans to address problem areas
- The Nursing Workforce Group, which reports to the People Committee, to drive recruitment and retention plans
- 'Higher than normal' volume of recruitment introduced to mitigate against higher than normal turnover rate

We will continue to focus on these and related initiatives in 2015/16, including more frequent recruitment drives planned for HCAs and nurses and considering establishing 'rotational posts' to address individual's developmental needs (building on opportunities created through the acquisition of WMUH where appropriate). We bid for PMO money to fund a nurse to specifically focus attention on recruitment and retention activity including overseas recruitment (particularly in specialist areas) and development of an internal transfer programme. Furthermore, in response to feedback from our teams, we increased our bank rates from 1 April 2015 to build our staff bank and reduce our reliance on agency.

14.6Strengthening our systems around the National Early Warning Score

The Trust uses the National Early Warning Score (NEWS) to highlight patients who are physically deteriorating against a number of clinical indicators. Through our previous incident investigations, we believe there is a need to improve internal processes and staff awareness of this to ensure potential patient deterioration is identified on a timely basis.

During 2015/16 we will carry out a rolling audit of trust-wide compliance with NEWS, overseen by the Safety and Effectiveness Group, to identify areas for improvement. As part of our wider IT strategy, we intend to rollout a trust-wide IT system longer term to automate the NEWS process reducing the potential for human error.

14.7Communications

The trust has a range of strategic priorities, requiring a need for extensive communication, engagement and marking support. To support our relatively small communications team we have already brought in an events officer on secondment to coordinate our flagship events, alongside backfill support for our Head of Communications to enable their focus on integration communications. We will bring in additional backfill support if needed in the short term and consider the 'right-sizing' of the communications team as part of our review across both sites following the acquisition.

PART 2

Overview

1. The purpose of this paper is to provide an overview of updates to the LTFM supporting the transaction IBP for the acquisition of the West Middlesex University Hospital (WMUH) by Chelsea and Westminster Hospital NHS Foundation Trust (CWFT).

2. It compares the version of the model from January 2015 (which was based on a month 4 forecast outturn) to the most recent version which is based upon data from month 11 (February).

3. These updates have been made ahead of the final sign off of the business case and assessment by Monitor so decision makers have access to the most up to date information available to the Trust.

4. Some key points to note are:

    - There is now a far more marked difference in forecast performance between CWFT as a standalone organisation and the combined Trust.
    - The forecast performance of the combined organisation in the early years post transaction is weaker than the previous LTFM because of the deteriorated position of the two standalone organisations.
    - Income for the combined organisation is higher overall (but with a lower margin) with a large proportion of this increase due to higher activity levels in 2014/15 than anticipated at month 4.

Changes to the CW standalone LTFM

5. Key changes:

    - Outturn for 14/15 and plan for 15/16 reflected (deterioration of £10m).
    - CIP delivery reduced to match actual plans in place for 15/16 and 16/17.

Changes to the WM standalone LTFM (risk adjusted)

6. Overall, over the transaction period the performance of WMUH is in line with the adjusted LTFM previously presented, but with slightly weaker performance in early years and slightly stronger performance in later years.

Changes to the Combined Trust LTFM (base case)

7. Key changes:

    - Flow-through of changes to the two standalone models.
    - Enhanced corporate synergies (upper quartile performance for back office).
    - Enhanced clinical synergies from 16/17
    - Re-phasing of transaction funding to account for July transaction date (rather than April). Will need further update for 1st September transaction date.

8. The overall impact is that performance is weaker in early years, with a reduced COSR score (to a 2) in years 2 and 3. However by year 5 the surplus is higher than previously forecast, with liquidity lower but capital servicing capacity higher.

9. There is a significant difference in forecast performance between the CWFT standalone and the combined organisation, with the latter now showing significantly stronger performance due to the acquisition synergies.

10. The new LTFM will require an improvement in liquidity in the early years post transaction. A 3rd party liquidity review is underway looking at a range of options including a fully committed working capital facility, debt restructure, re-profiling of transaction funding.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 14 May 2015

AGENDA ITEM NO.	10/May/15
REPORT NAME	Draft Quality Accounts 2014/15
AUTHOR	Various
LEAD	Zoe Penn, Medical Director
PURPOSE	The Quality Account forms part of the overall Annual Report, and is a record of achievement for last year and to set our aspirations for next year. Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders.
SUMMARY OF REPORT	Draft Quality Accounts 2014/15 enclosed. Please note some content is draft pending final updates taking place 14 to 16 May. Where this is the case we have indicated with appropriate highlighting. An update will be provided on progress of closing off these outstanding items at the meeting.
KEY RISKS ASSOCIATED	None
FINANCIAL IMPLICATIONS	None
QUALITY IMPLICATIONS	None
EQUALITY & DIVERSITY IMPLICATIONS	NA
LINK TO OBJECTIVES	All
DECISION/ ACTION	For discussion

Chelsea and Westminster Hospital NHS Foundation Trust

Quality Account

Draft

2014 /15

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Drafting Note [to be removed from final version of the Quality Account]

- Areas were content is subject to further update are indicated with yellow highlighting.

Foreword by the Medical Director and Director of Quality

At Chelsea and Westminster Hospital NHS Foundation Trust, Quality is at the heart of our Vision, which is to, ***'deliver the best possible experience and outcomes for our patients'***.

In achieving this vision, we are guided by our values, which are to provide **safe**, **kind**, **respectful** and **excellent** care.

Our Quality Account for 2014/15 reports on our progress during the last year and our key priorities for the year ahead. The report will focus on three domains:

- **Safety of Care** – for us this means eradicating harm and ensuring that care delivered is as safe as possible, regardless of when or where patients seek our services
- **Effectiveness of Care** – for us this means ensuring that we deliver the best clinical outcomes possible for our patients, deploying evidence-based care processes and procedures consistently throughout the organisation
- **Experience of Care** – for us this means ensuring that we treat all our patients, their families and carers with kindness and respect in all their interactions with us, all of the time.

We are relentless in our focus on quality and we set ourselves demanding plans and targets to achieve this. This process has gained further momentum through the actions we have taken to address the recommendations made to us by the Care Quality Commission following their inspection of our services in July 2014.

Delivery of our Quality Account priorities for 2014/15 aligns with the ambitions set out in our Quality Strategy. This is enabled by the development and training of our staff; the pursuit of systematic and rigorous processes and systems; and the development of applied research and innovation; all of which will support the delivery of excellent experience and quality outcomes for our patients.

We look forward to working with you now and in the future.

Zoe Penn
Medical Director and Director of Quality

About this report

1.1. What is a Quality Account?

This document, our Quality Account, provides Chelsea and Westminster Hospital NHS Foundation Trust with an opportunity to highlight how we measure and take forward quality for our patients and our stakeholders. This provides us with a yearly process to review and make sure that our services are the best they can be.

It is also a national statutory duty for all providers of NHS services in England to produce an annual report to the public about the quality of services they deliver.

Quality Accounts aim to increase public accountability and drive quality improvement within NHS organisations. They do this by asking organisations to review their performance over the previous year, identify areas for improvement and publish that information along with a commitment to you about how those improvements will be made and monitored over the next year. In the report 'year' refers to the period April 2014 to March 2015 (2014/15).

Quality is often considered under the heading of 3 domains,

- Patient safety
- Clinical effectiveness (how successful is the care provided)
- Patient experience (how patients experience the care they receive)

The way we monitor and drive improvement across all of these domains will be described in the document.

Most of the information provided in this Quality Account is mandatory and reflects the obligations required of us by the Department of Health (DH) and our regulator, Monitor. Some content has been added as it is important to the Trust and our stakeholders. Our stakeholders include patients, parents and carers, Foundation Trust governors, staff, commissioners and regulators.

1.2. Scope and structure of the Quality Account

This report summarises how well Chelsea and Westminster Hospital NHS Foundation Trust did against the quality priorities and goals we set ourselves for 2014/15. It also sets out those we have agreed for 2015/16, and how we intend to achieve them.

In developing this report we have sought engagement and input from a number of key stakeholder groups including our Governors, our local Clinical Commissioning Groups (CCGs), and through the document review stage with local Healthwatch Groups and Overview and Scrutiny Committees.

A separate booklet in an easy to read form will be provided for the Annual Members Meeting. This will be called the 'Annual Review' and will combine the Quality Account and the Annual Report.

This report is divided into three parts:

Part 1: Statement on quality from the Chief Executive
This is a statement summarising the Trust's view of the quality of the health services that we have provided or sub-contracted during 2014/15.

Part 2: Priorities for improvement and statements of assurance for the Board

- 2.1 Sets out the quality priorities for improvement for 2014/15 and explains how we decided on them, how we intend to meet them and how we will track our progress. The section then reviews progress made since publication of the 2013/14 quality report including performance against the priorities selected that year
- 2.2 Statements of Assurance from the board
- 2.3 Shows how the Trust is performing/reporting against a core set of indicators

Part 3: Other Information

Overview of the quality of care of the trust based on performance against indicators selected by the board in consultation with stakeholders

Annex 1: Statements from the Clinical Commissioning Group, Healthwatch, and the Overview and Scrutiny Committee

Annex 2: Statements of directors' responsibilities for the quality report

If you, or someone you know need help understanding this report or you would like a printed copy or would like the information in another format such as large print, easy read, audio or Braille, or in another language, please contact the Director of Nursing and Quality Team by calling 020 3315 6599 or by emailing quality@chelwest.nhs.uk.

1.3. About the Trust

The Trust is a modern, purpose-built hospital with more than 3,000 staff. It has three clinical divisions which are outlined in more detail in Annex 7.

Chelsea and Westminster Hospital NHS Foundation Trust provide general and specialist services for half a million people living in the four local boroughs of Kensington and Chelsea, Westminster, Hammersmith and Fulham and Wandsworth. The Trust also provides specialist tertiary services to patients from a wider area in a range of specialties. These include bariatric surgery, burns, HIV, paediatrics, neonatal care, orthopaedics—foot and ankle and sports injuries (e.g. knee conditions including multi-ligament instability) and plastics—craniofacial surgery, complex wrist and hands.

Most services are provided on the Chelsea and Westminster Hospital site, but the Trust also runs a highly successful network of community HIV and sexual health centres, dermatology clinics, community musculoskeletal therapy and community maternity services across our four local boroughs. Additionally, we provide women's reproductive health (gynaecology) services in Richmond and Twickenham.

The hospital has the busiest and most extensive HIV and sexual health service in Europe based in three different centres across the capital.

Chelsea Children's Hospital, (opened in Spring 2014 by Their Royal Highnesses The Prince of Wales and The Duchess of Cornwall), is a key part of the Trust. We are one of London's largest providers of children's services, catering for more than 75,000 children a year as inpatients, outpatients and as day cases. Chelsea Children's Hospital is home to the UK's only 'da Vinci' robot dedicated to the surgical care of babies and children. Our Neonatal Intensive Care Unit provides the most specialised level of medical and surgical neonatal care in the UK. We have a dedicated children's A&E department and a High Dependency Unit. Pregnant women at high risk of complications are cared for in the Trust's Maternity Unit. For those at low risk the Midwife Led Birthing Unit helps mothers give birth in a less 'medicalised' setting whilst knowing that, should complications arise, specialist obstetrics and neonatal services are close at hand. This investment offers more choice to women with a full range of options for their birth plan – from homebirth all the way through to a consultant led delivery.

The Trust is one of two centres providing weight loss surgery services for London and the South East. It is also the Regional Burns Centre in London for adults and children and London's only dedicated burns service for children that require care in a high dependency setting. A separate unit for children was newly commissioned in January 2013 which has greatly enhanced our children's burns care.

Table 1 Key data for our Trust for 2014-15 with comparative data from 2013-14

Data Item (note not all mutually exclusive)	2014-15	2013-14
Accident and Emergency attendances	116,200	112,500
NHS babies delivered	5,300	5,000
Private patient babies delivered	840	800
Trust total Number of babies delivered	6,140	5,800
Inpatient admissions (Elective and Emergency)	76,080	76,000
…of which day cases	37,400	34,000
Outpatient activity (including physiotherapy)[1]	648,400	590,000
Radiology Direct Access from a General Practitioner referral	35,200	33,000
Radiology Examinations as a result of an outpatient attendance	44,300	44,000
Attendances at our HIV/Sexual Health Services	232,000	180,000
Culminating in services to approximately	**724,500 patients**	**667,000 patients**

[1] Our outpatient activity by CCG are split 24.0% NHS West London CCG; 17.7% NHS Hammersmith and Fulham CCG, 14.0% NHS Wandsworth CCG, 10.6% NHS Central London CCG and 33.8% other CCGs

1.4. 2014 Inspection by the Care Quality Commission

Historically, CWFT has been viewed as being in the top tier for quality. In July 2014 the Care Quality Commission (CQC) carried out an inspection of the Trust. Whilst the CQC found that the Trust provides good and outstanding care in many areas, their overall rating for the Trust was 'needs improvement'.

In order to proactively address areas where action is required, specialty-specific action plans were developed, with the Trust's Quality Committee responsible for monitoring progress and seeking assurance from divisional representatives that actions are being implemented and completed. All feasible actions were completed by the end of March 2015, with appropriate actions and programmes in place to address the actions requiring longer term development (such as the reconfiguration of the Trust's Emergency Department).

Whilst not part of the mandated content of the Quality Account, we believe it essential that we provide a high level account of the steps being taken by the Trust to address the findings of the CQC. This is summarised at the start of Section 3.2.4.

Part 1: Statement on quality from the Chief Executive

I am pleased to present our Quality Account for 2014/15.

Patient experience and patient care are at the very heart of what we do. How patients feel looked after whilst in hospital is how I, as Chief Executive, judge whether we've delivered the right standards of care and experience. This also gives us independent feedback on our services that is vital when we assess whether we have succeeded for our patients, and this has never been so important when we consider the new regime of inspection undertaken by the Care Quality Commission (CQC) from 2014/15.

Our Quality Account provides a snapshot view of the improvements we have made to patient care and experience, as well as what we need to do better in the future. We always want to improve care for every patient where possible and this report details what we will be focussing on in 2015/16 to continue to improve standards and outcomes for the populations we serve.

The report is prepared in line with the requirements set out in the Quality Account legislation (part of the Health Act 2009) and Monitor's annual reporting guidance. It is reviewed by key external stakeholders who hold us to account on what we said we'd do and what we've actually done for the benefit of patients.

This year saw an inspection of our Trust by the CQC in July 2014, reporting in October 2014. Whilst the CQC found that the Trust provides good and outstanding care in many areas, their overall rating for the Trust was 'needs improvement'. We have worked consistently to address the actions and embed the broader learnings raised by the CQC Report.

We recognise it is critical that we maintain a relentless focus on quality as we pursue our growth agenda which over the next year includes the planned acquisition of West Middlesex University Hospital NHS Trust; our engagement in the Shaping a Healthier Future programme for reconfiguring hospital-based and out of hospital care; and the development of integrated care and community-based 'accountable care' models across our health system.

We have developed a Quality Strategy to set out our ambitions for improving the quality of our services over the next three years. This reflects our learnings from the CQC Report, plus our ongoing commitment to quality through delivering the best possible outcomes and experience for our patients. This Quality Account provides a more detailed insight into the objectives and priorities that underpin the first year of the Quality Strategy.

It is important, from the onset of this report, to note that there are a number of inherent limitations in the preparation of Quality Accounts which may impact the reliability or accuracy of the data reported. These include:

- Data is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in internal audits programme of work each year
- Data is collected by a large number of teams across the trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflects clinical judgement about individual cases, where another clinician might have reasonably have classified a case differently.
- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.
- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data.

The Trust and its Board and executive team have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported, but recognises

that it is nonetheless subject to the inherent limitations noted above. Following these steps, to my knowledge, the information in the document is accurate (with the exception of the matters identified in respect of the 18 week referral to treatment incomplete pathway indicator as described in Section 3.1).

I would like to take this opportunity to thank the 3,000 people that make Chelsea and Westminster Hospital what it is today, who have all worked so hard to deliver the best care they possibly can for their patients. I am proud of what they have achieved. There will always be more to do and I sense a great commitment in our team to developing excellent care and experience that is in line with our values.

I hope that you enjoy reading the progress we have made against our priorities and what we plan to focus on next year to provide you, your families and friends with a health service you can all be proud of.

The information presented in the Quality Account is accurate and true to the best of my knowledge.

Elizabeth McManus
Chief Executive

Part 2: Priorities for improvement and statements of assurance from the Board

2.1. Priorities for improvement

2.1.1 Our priorities for 2015-16

Our priorities for 2015/16 have been identified though engagement across a number of areas:

- Engagement and feedback from our Council of Governors' Quality Sub Committee that includes external stakeholders (for example commissioners and Healthwatch)
- Engagement and feedback from our Board's Quality Committee
- The development of the Quality Strategy and Plan for 2015 to 2018.

In addition to the above we are engaging with our local CCGs, Healthwatch groups and local Overview and Scrutiny Committees as part of the process for reviewing and refining this document.

Priority 1: Reduction of acquired Pressure Ulcers both in Hospital and the Community
Objective: to see a reduction in hospital acquired pressure ulcers.

Priority 2: Embedding of the WHO surgical checklist
Objective: to fully embed use of the WHO checklist across the organisation, reflecting feedback from the CQC's review of the services we provide and building on existing progress

Priority 3: Early Identification of the Deteriorating Patient
Objective: to rapidly identify potentially unwell and/or septic patients and institute prompt treatment, in order to reduce mortality and morbidity.

Priority 4: To Reduce Avoidable Admissions of Term Babies to the Neonatal Intensive Care Unit (NICU)
Objective: to deliver a 20% reduction in the number of term babies admitted unexpectedly to the neonatal unit

Priority 5: Friends and Family Test – inpatient responses
Objective: use FFT as a key measure for our continued ambition to provide excellent experience of care in everything we do. This measure was chosen by our Governors.

The following section sets out the context, our plan, and our approach to measurement and tracking for each priority.

Priority 1: Reduction of acquired Pressure Ulcers both in Hospital and the Community

What is the context?

Pressure Ulcers were subject to a national CQUIN during 2014/15 and will not be in 2015/16. Safety Thermometer data collection will continue to be a national requirement and this requires us to conduct a monthly point prevalence audit of a range of 'harms' including pressure ulcers. The safety thermometer measures all pressure ulcers regardless of whether these were acquired in the community or hospital setting.

Last year we set challenging targets in order to see a reduction in the incidence of hospital acquired pressure ulceration. Despite new documentation and evidence of good practice in some areas to support the management of patients, the Trust has seen a rise in reported pressure ulcers. This in part could be due to increased reporting and or inaccurate reporting of incidence i.e. wounds that are not pressure ulcers being reported as such. There is also a greater recognition of pressure ulceration.

What is our plan for 2015/16?

The area where we can make the most significant impact is the incidence of **hospital acquired pressure ulcers**.

- Safety thermometer data collection will continue and the pressure ulcer data will be considered by the Preventing Harm Group (PHG)
- We will embed the approach of carrying out Comfort Rounds
- Root Cause Analysis (RCA) will continue for all grade 3, 4 and unstageable pressure ulcers
- Where a pressure ulcer is identified as avoidable lessons learnt will be cascaded across the whole organisation and targeted support from the tissue viability nurse will be offered to the clinical area where this occurred
- Lessons learnt and common themes from RCA will be cascaded through a new information sharing bulletin
- There will be a focus on grade 2 pressure ulcers as this is where we have the highest incidence
- We will explore what benchmarking information is available above and beyond that of safety thermometer
- Consideration will be given to an external review if our benchmarking information identifies us as an 'outlier' in terms of the incidence of hospital acquired pressure ulcers
- A review of training provision related to pressure ulcer prevention and pressure ulcer management will be undertaken to ensure that this is targeted appropriately
- We will participate in the North West London Pressure Ulcer Network to develop effective protocols, learning and education.

How will we track and report progress?

The PHG will provide oversight of performance in achieving this priority, including:

- Receiving monthly headlines in terms of the numbers and grades of hospital acquired pressure ulcers
- Receiving a 'deep dive' pressure ulcer report every 3 months
- The deep dive report will assist the PHG in terms of agreeing priorities for action and targeting effort where it is most needed.

Priority 2: Embedding of the WHO surgical checklist

What is the context?

In June 2008, the World Health Organisation (WHO) launched a second Global Patient Safety Challenge, 'Safe Surgery Saves Lives', to reduce the number of surgical deaths across the world. The WHO Surgical Safety Checklist is part of this initiative and is a tool to strengthen the commitment of clinical staff to address safety issues within the surgical setting. This includes improving anaesthetic safety practices, ensuring correct site surgery, avoiding surgical site infections and improving communication within the team. The checklist has been mandated across the NHS since February 2010.

Over the past two years, the Trust has been undertaking further work to ensure that the WHO Surgical Safety Checklist is embedded consistently and reliably across the organisation. The Trust has taken a prioritised approach, focusing initially on the theatre stage of surgery ('sign in' and 'time out' parts of the checklist).

The Trust uses the WHO checklist as a learning document – in particular to draw lessons in relation to serious untoward incidents (throat packs and tourniquets being recent examples).

Why focus on this priority during 2015/16?

The July 2014 CQC inspection highlighted that the hospital's surgical safety checklist (based on the WHO checklist), which should be used at all stages of the surgical pathway, was not fully completed in three of five cases reviewed.

In response the Trust has committed to ensure that the surgical safety checklist is followed consistently at each stage of the surgical pathway.

The areas found through audit that need to be improved are the team brief (the meeting of the whole theatre team to discuss the patients on the scheduled operation list – to inform staff of equipment needed and any potential problems).

What is our plan for 2015/16?

The approach to rolling out the checklist consists of implementation, audit (at an individual consultant level of detail), and review to refine the process and ensure compliance. All audits are reviewed at the Theatre Improvement Management Board (TIMB) and appropriate actions taken.

Specific actions taken as part of the CQC action plan have included:

- Undertaking monthly audits of specific specialities.
- Reviewing the use of a training video to outline best practice.

To help support and enable the rollout of the Surgical Safety Checklist the Trust is working with the Imperial College Simulation Centre to roll out a simulation package for theatre staff focusing on communication skills and leadership in the theatre environment. This approach is being piloted during Q1 2015/16 and will be rolled out over the year

How will we track and report progress?

Progress against this priority will be measured through audit with frequent dissemination of results to all staff. Regular reports will be provided to the TIMB and through the Planned Care Improvement Programme.

Priority 3: Sepsis – Early identification of the deteriorating patient

(Electronic National Early Warning Score (NEWS), Maternity Early Warning Score (MEWS) & Paediatric Early Warning Score (PEWS))

What is the context?

Sepsis is a significant driver of mortality and morbidity and it has been shown that early intervention and effective care will improve patient and clinical outcomes and reduce the chances of death. The Trust has an agreed pathway (care bundle) for patients with sepsis and the Emergency Department is taking part in a national research project on the treatment of sepsis. This priority will build on existing work, targeting a reduction in ITU admission, reduction in length of stay and reduction in infection rates.

The treatment of Sepsis across the Trust will be enhanced by utilising an electronic NEWS scoring and escalation system with prompts to identify potentially unwell and/or septic patients. It will enable the use of prompts and algorithms to initiate investigation and treatment according to a recognised sepsis algorithm (such as Sepsis 6). All stages in identification and treatment will be subject to audit of process – and patient impact will be recorded routinely in terms of deaths from sepsis, admissions to ITU with sepsis, and length of stay in hospital.

What is our plan for 2015/16?

This priority will be implemented across the organisation over 2015/16 through a number of overlapping phases.

- Phase 1 will consist of roll out of Electronic National Early Warning Score (ThinkVitals) to the hospital
- Phase 2 will focus on early Identification, investigation and treatment algorithm for Sepsis:
  - Mapping of diagnosis and treatment algorithm
  - Identification and training of Nurses to implement treatment and investigation
  - Identification of additional investigations into algorithm
  - Link to antibiotic guidelines
  - Computer generated appropriate antibiotic and dosage
  - Planning prompt completion of cannulation and blood cultures across the 24-hour period
  - Planning of who is to give first dose of antibiotics.
- Phases 3 and 4 will consist of production of Obstetric and Paediatric versions of ThinkVitals respectively
- Phase 5 will focus on increasing the scope of individuals to include performing the sepsis bundle whilst Phase 6 will consist of introduction of the AKI Bundle.

How will we track and report progress?

The following actions will be tracked and reported regularly through the Sepsis Project Steering Group:

- Establishing the baseline coding for sepsis on admission or during inpatient stay. The data will include the average Length of stay for these patients and numbers admitted to intensive care or who have died with this diagnosis.
- Establishing from a literature review or international comparison the potential size of the improvements to be made by our intervention to set a challenging target and trajectory.
- Planning for a reduction in deaths from sepsis, admissions to ITU with sepsis and length of stay in hospital
- Reviewing and developing a dashboard of ongoing process and outcome data.

Priority 4: Reducing avoidable admissions of term babies to the Neonatal Intensive Care Unit (NICU)

What is the context?

The Maternity Department at Chelsea and Westminster Hospital delivered 6,140 babies during 2014-15. Of those babies which were structurally normal at term, approximately 3% (around 180) were admitted unexpectedly to the neonatal unit. The national rate of admission is quoted as 5% (NHS England) This is one of the top 3 incidents reported within the department and although most babies are discharged home with an anticipated normal outcome, the period of separation creates anxiety for parents and involves additional bed days for the mother. For the small minority that have permanent brain injuries the impact for those families is immeasurable and the ongoing costs of care are significant.

Unexpected admissions to the neonatal unit are all reviewed using a root cause analysis approach by the Risk and Governance Midwife. Any admissions where care or service delivery issues are identified are escalated according to the Trust serious incident policy and investigated accordingly. Every 6 months all cases are reviewed as a group to identify any common themes and learning shared with staff. In the most recent audit of 88 cases, 6 were investigated via the serious incident process. Of the total number it was noted that 51% were admitted from the postnatal ward and 58% were hypothermic on admission. The main admission diagnoses were presumed sepsis and respiratory compromise. The length of stay ranged from 1-15 days.

What is our plan for 2015/16?

Our ambition is to achieve a 20% reduction in unexpected term admissions to NICU. To achieve this we will focus on the following objectives:

- **Improve identification of at-risk babies in the antenatal period**. Identify at risk babies i.e. those who are growth restricted prior to the onset of labour who will have limited reserve for the additional stress of labour
- **Ensure safe intrapartum care**. Review practice and target teaching and education regarding labour management and interpretation of the fetal heart rate in labour (both intermittent auscultation and CTG interpretation)
- **Improve postnatal care of vulnerable babies**. Review practice on the postnatal ward in caring for babies that are vulnerable to hypoglycaemia and hypothermia. To ensure babies receive IV antibiotics within the recommended timescale.

The outline approach for the project is as follows:

- **Quarter 1** – Increasing the information from existing audits and gathering evidence about current systems in place to support staff and women
- **Quarters 2 and 3** – Anticipated that the review and audit results will have clarified metrics that can be used in the following quarters. Rollout of GROW software to improve antenatal detection of growth restriction. New fetal heart rate monitoring teaching sessions will be implemented and an assessment tool will be introduced for key staff. Results of the postnatal audit will have identified areas for change that will be implemented within these quarters.
- **Quarter 4** – Re-audit will be undertaken on key areas: postnatal admissions, compliance with new CTG classification and monitoring tool, identification of growth restricted babies.

How will we track and report progress?

A quarterly report of progress towards completion of the action plans will be presented for review at the Maternity Services Meeting for progress.

We will also be contributing appropriate cases to the national review of babies born with brain injury to the Each Baby Counts database. This is a national project launched by the Royal College of Obstetricians to reduce the incidence of stillbirth, early neonatal death and brain injuries by 50% by 2020.

Priority 5: Friends and Family Test – inpatient responses

What is the context?

As part of the Trust Values, the Trust is committed to ensuring that all patients and their families receive consistent first class care and treatment in a timely manner and in a supportive environment. As part of ensuring and monitoring this commitment, the Trust has been engaging with the Friends and Family Test (FFT) during the financial year 2014/15. This is one important mechanism of measuring what we are doing and how our responses to patient and family feedback can ensure best care. The Trust Governors have chosen to focus on FFT as a priority measure of quality during 2015/16.

Patients who have been cared for in the Trust are asked to evaluate their care and treatment after they have been discharged from hospital. This is done in one of three ways; by responding to a text, completing a hard copy of the survey on discharge and some are contacted by an agency to rate the care they received. The feedback is shared with the Divisional teams and the clinical areas implement actions to ensure good practice and address any shortfalls.

The response rate to the FFT during the year (2014/15) has been variable across the Divisions, and months ranging from 15% to 40%. The FFT report shows that some clinical areas continue to have a very low response rate. The percentage of people who would recommend the Trust ranges from 85% (Inpatients) to 94% (Day Cases). However, the percentage of people who would not recommend the Trust ranges from 8% (Inpatients) to 3% (Maternity), this scoring sets the Trust in the lower quartile of London Hospitals.

What is our plan for 2015/16?

The Trust recognises:

- The need to consistently improve our response rate to FFT across all the Divisions and clinical areas
- That there should be a variety of mechanisms for patients and families to respond to the survey
- The need to target clinical areas where there is a particularly low response rate
- That the number of people who would recommend the Trust needs to be improved and some clinical areas have been highlighted of concern
- That there is a need to raise the importance of FFT and to ensure that positive and negative feedback is acted on and remedial actions taken to address FFT feedback
- That some of the poorer qualitative results reflect the themes coming from complaints, i.e. poor communication, lack of or conflicting information and staff attitude/behaviour

During 2015/16 we will work to ensure that at least 95% of respondents will recommend the Trust. We will undertake the following actions, overseen by a re-established Patient Experience Committee:

- Focus on improving communication, accurate patient-centred information and staff attitudes and behaviours
- Improve our response rate to FFT consistently across all the Divisions and clinical areas
- Provide FFT training sessions for staff
- Support clinical areas where there is a particularly low response rate

- Ensure FFT results are sent to each Division to disseminate to all staff and to recognise achievements and shortfalls
- Ensure that positive and negative feedback is acted on and remedial actions taken to address FFT feedback
- Support clinical areas that have been highlighted by FFT as an area of concern
- Triangulate findings from complaints, PALS and FFT to identify trends, monitor and improve the patient experience.

How we will track and report progress?

These metrics will be reviewed each quarter though the Divisional structure and reported to the Chief Nurse Cabinet, the Patient Experience Group and the Executive Board.

2.1.2 Progress made since the 2013/14 Quality Account

As part of the 2013/14 Quality Account the Trust identified 4 quality priorities to focus on during 2014/15. This section is a summary of what we said we would do and the progress we have made against each priority.

Priority 1: Patient Safety: To have no hospital associated preventable venous thromboembolism (VTE)

VTE is an umbrella term for potentially serious blood clots called deep vein thrombosis (DVT) and pulmonary embolism (PE). A DVT usually develops in the leg or pelvis. Sometimes part of the blood clot breaks off and ends up in the lung (PE) where it can block the blood supply. This can be fatal.

The risk of developing VTE is increased after surgery and/or periods of immobility, and in certain situations such as pregnancy or advanced cancer. Around half of all cases arise in patients who have recently been in hospital. Around one third of patients will develop VTE despite the best care but in the remaining two-thirds of patients a VTE can be avoided with preventive treatment.

What we said we would do in 2014/15 and what we actually did

Our goal is to have no hospital associated preventable VTEs by ensuring VTE risk assessments are completed, preventive treatment is prescribed, patients are educated and nurses and doctors are trained in VTE prevention.

We have continued to undertake a thorough review (root cause analysis) of cases where patients with a potentially preventable VTE associated with a hospital admission, defined as during or within 90 days of admission, did not receive appropriate preventive treatment.

What we said we would do	**What we did**
We set ourselves a target of 25% fewer hospital associated VTEs than in the previous year — i.e. to have no more than 7 potentially preventable hospital associated VTEs	From April 2014 to March 2015, we have identified 7 potentially preventable hospital associated VTEs. We continue to focus on addressing the contributory factors e.g. management of patients in lower limb immobilisation, updating patient agreement to investigation or treatment consent form to include VTE risks, education on accurate completion of VTE risk assessments to identify those patients at risk of VTE requiring preventative medication if not contraindicated, weekly and monthly monitoring of VTE risk assessment completion rates and ensuring patients receive VTE information.

VTE risk assessments

All adult patients should have a VTE risk assessment completed on hospital admission to identify any risk factors that may be present.

What we said we would do	**What we did**
	This target has been achieved with weekly and monthly monitoring of completed VTE

Continue to ensure that we meet our target of 95% adult patients admitted with completed VTE risk assessments.	risk assessments, with feedback to departments.

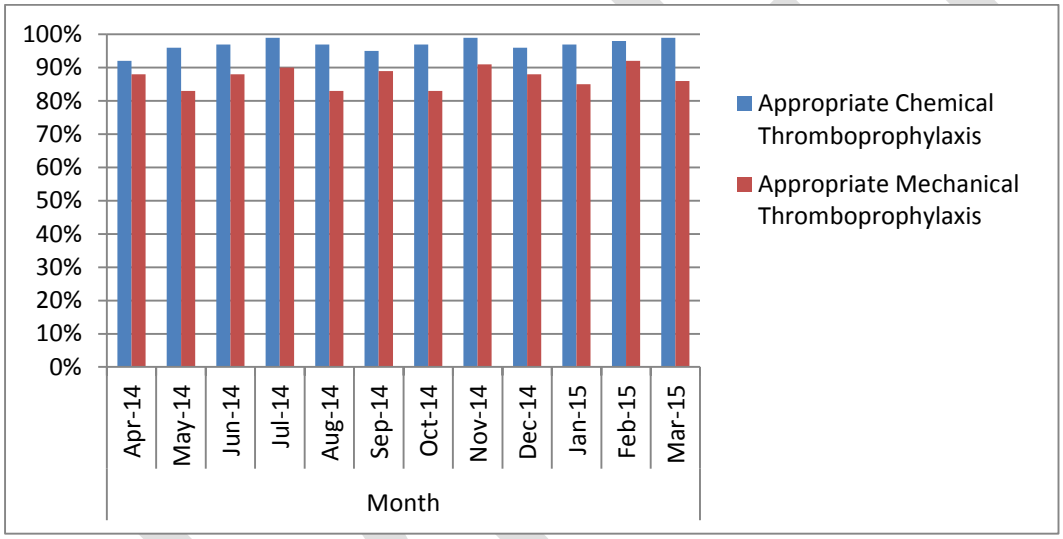
Preventive treatment

Adult patients at risk of VTE should receive appropriate preventive medication and the use of compression stockings, if indicated and no contraindications present, to help prevent blood clots developing during hospital admission.

What we said we would do	What we did
We set a target of 90% of adult patients to receive appropriate medication and compression stockings.	During 2014/15, we performed monthly audits and on average 97% of adult patients received appropriate preventive medication, and approximately 87% of adult patients received compression stockings.

Our monthly delivery against this measure is illustrated in below.

Figure 1 Monthly audit on VTE prevention (medication and compression stockings)



Patient information

What we said we would do	What we did
We recognised the importance of providing patients with information about the risks of VTE, its signs and symptoms, and when to seek urgent medical attention.	VTE patient information leaflets are available and visible on all adult wards, assessed by monthly audits. The patient information leaflet *'Are you at risk of blood clots?'* is offered to all patients admitted to the hospital, all pregnant women and all patients attending A&E who require a lower leg plaster cast. VTE patient information has been included on the admission and discharge checklist, and in admission packs to ensure patients receive written information.

VTE training

What we said we would do	What we did
We said we would monitor completion rates and uptake of our online VTE training module on VTE prevention and treatment for all doctors with a target of 75% over 2 years. The aim is to ensure all frontline staff are aware of the preventive treatments we use in this hospital and standardise training.	From April 2014 to March 2015, 20% of new doctors have completed the online VTE training module. 79% of Foundation Year 1 and 2 doctors have completed the online VTE training module. As this has not met the quality initiative we set ourselves, a plan of action is in place to highlight training uptake at a divisional level, and significantly improve the percentage uptake of new doctor's training around VTE in the coming year Mandatory training reports are circulated monthly highlighting staff performance and for managers to follow up on incomplete training.

VTE ward rounds

What we said we would do	What we did
We said we would roll out VTE ward rounds to medical and surgical wards, following the successful implementation on maternity wards, to assess VTE risk assessment completion and check patients are offered appropriate preventative treatment to help reduce their risk of developing blood clots.	We have performed regular VTE ward rounds on medical, surgical and maternity wards with education to ward staff and dissemination of findings and improvements to departments e.g. awareness on anti-embolism stockings, ensuring prescribed medication doses are given, documentation of management plans. The ward rounds have improved VTE prevention measures and increased VTE awareness with feedback to staff at ward level for medical, surgical and maternity inpatients ensuring optimum delivery of care and better outcomes e.g. no missed doses of thromboprophylaxis, patients at risk of VTE prescribed appropriate medication, appropriate use of anti-embolism stockings; thus delivering benefit to inpatients and staff.

Priority 2 for 2014-15: Patient Experience – Continue to focus on communication, discharge, and delivering safe and compassionate care to all our patients

What we said we would do in 2014/15 and what we actually did

Communication

What we said we would do	**What we did**
Introduce the Great Expectations project, a coaching programme to stimulate debate and challenge poor attitude. The project aims to give managers the tools and skills to deal with difficult situations within their teams effectively.	We teamed up with The Royal Central School of Speech and Drama who co-designed and delivered the innovative and interactive training to over 150 members of staff in the organisation.
Continue to run Schwartz rounds in the Trust	In total, 678 people attended the first 11 rounds. The rounds aim to support staff in the more emotional aspects of their roles. The table below shows the feedback from these Schwartz Rounds.

Table 2 Feedback from Schwartz rounds

94% agreed that the case was relevant to their daily clinical work
82% gained knowledge that will help them care for patients
88% felt that the round will help them work with colleagues
95% found the overview and presentation helpful
95% found the open discussion helpful
96% gained an insight into how others think/feel in caring for patients
75% of attendees rated the round either 'exceptional' or 'excellent' and 21% rated it 'good'

Discharge Projects

What we said we would do	**What we did**
Review and evaluate the discharge support tools we have implemented and develop training programmes for staff to support this.	The Nurse Delegated Discharge (NDD) project has been rolled out on David Evans Ward for elective surgical patients. Our experience here has meant that the model has moved towards an opt-out rather than opt-in model. The effect of this is being monitored by the ward staff for its efficacy and improved patient experience. The paperwork for patients on medical wards has been adapted and is being rolled out on a trial basis on Edgar Horne Ward during the Spring of 2015.

It is planned to continuing rolling out NDD across the Trust in both medical and surgical areas where appropriate, learning lessons and assessing additional efficiencies and improved

patient experience as we go. The next area of focus is likely to be the Supported Discharge Suite (SDS) which is our Intermediate Care Ward.

Listening and Learning

What we said we would do	**What we did**
Strengthen the ways we listened to feedback from our Friends and Family Test (FFT) results.	The Nurse Delegated Discharge (NDD) project has been rolled out on David Evans Ward for elective surgical patients. Our experience here has meant that the model has moved towards an opt-out rather than opt-in model. The effect of this is being monitored by the ward staff for its efficacy and improved patient experience. The paperwork for patients on medical wards has been adapted and is being rolled out on a trial basis on Edgar Horne Ward during the Spring of 2015. Our overarching FFT results are reported on the performance dashboard to the Board, whilst at a divisional level, sisters and ward managers are responsible for reviewing the results within their areas and developing action plans from the feedback. We are currently undertaking some training to help our staff develop their knowledge and act on our patients' feedback.

Our analysis so far has shown high rates of satisfaction from the feedback we have received and next year we will be working with our FFT provider on finding new ways to encourage more patients to take an active part in this feedback.

The next roll out of the FFT is to our paediatric wards from April 2015 and this will mean that all our inpatient areas will be providing useful feedback on their experience whilst in our care.

Table 3 Friends and Family Test Results for Quarter 2 2014/15

Area	Response Rate	Recommended	Non Recommended
A+E	22%	263	16
Day Case	16%	344	14
Inpatients	30%	332	26
Out Patients	18%	2445	121
Maternity	20%	75	4

Priority 3 for 2014-15: Patient Experience (Staff Engagement) – To be in the top 20% of acute Trusts nationally for staff engagement and staff appraisals

We work against each of the seven staff pledges in the NHS Constitution to create and maintain a highly skilled and motivated workforce capable of improving the patient experience. Our progress against each pledge is set out in further detail in Section 3.2.4 of this report.

What we said we would do in 2014/15 and what we actually did

Staff engagement and appraisals

What we said we would do	What we did
Be in the top 20% of acute Trusts nationally for staff engagement and staff appraisals as measured by the NHS staff survey	The results of the National Staff Survey 2014 show that Chelsea and Westminster remains in the top 20 per cent of acute trusts in the country as an organisation that staff would recommend as a place to work or to receive treatment. Staff ability to contribute towards improvements at work ranked above average compared with other acute trusts. Also scoring well in the survey was staff felt they were able to make valuable contributions to improve the work within their team and have frequent opportunities to show initiatives in their current role. NHS Staff Survey results also show that we are in the top 20% of acute Trusts for the quality of our staff appraisals (with 44% of staff reporting having a well-structured appraisal). However, it is unlikely that we will achieve our target of 85% of staff having had an appraisal in the last 12 months and we will be working hard over the next year to improve on this. See Section 3.2.4 for further details.

Friends and Family Test for staff

What we said we would do	What we did
Ensure our agreed trust values inform everything that we do and include the staff FFT test to help measure this	The National FFT for staff was launched in April 2014 and had a response rate of 20% (466 of 2,300 staff surveyed) in Quarter 1. Results showed 91% of staff were likely to recommend the trust as a place to receive care or treatment, and 75% would recommend this as a place to work. For Quarter 2 a total of 245 paper based surveys were distributed to a specific staff group - Support Workers/ HCA's. 42 staff responded to the survey and it was positive to note that from the responses received 76% were likely or extremely likely to recommend the trust as a place to receive care or treatment and would also recommend the trust as a place to work.

Priority 4 for 2014-15: Clinical effectiveness - To improve choice and quality in End of Life Care

What we said we would do in 2014/15 and what we actually did

A key priority for 2014-15 was to work together to implement the Trust End of Life Care Strategy. The 'End of Life Care Committee' was very pro-active in guiding, directing and monitoring progress during the year, with strong engagement from across the Trust and community services, including adult, paediatric, midwifery, clinical and non-clinical staff.

Following a successful funding bid to Macmillan and the Trust to increase the specialist palliative care nursing, the team are delivering a seven day face to face specialist palliative nursing care service. The service has been warmly received by patients, families and staff.

We have also responded to the Care Quality Commission (CQC) report on our end of life care by building on good practice and addressing limitations. Our progress against key components of this priority are set out below.

Coordinate my care (CMC)

What we said we would do	**What we did**
Roll out offering the use of CMC database to help ensure patient's preferences and choices are shared by people and services involved in the patient's care, including the hospital, the GP, community nursing and care teams enabling patient's choices to be managed and delivered.	Staff worked together and increased the number of patients identified as moving towards the end of life in order to plan care and to enable patients to die in their preferred place of care. This was supported by offering more patients and families the opportunity to have their wishes recorded on the CMC database, thereby ensuring their choices were met by the hospital, the GP and community services.

Personalised Care

What we said we would do	**What we did**
Ensure that all people approaching end of life are sensitively offered the opportunity to talk about an advance care plan. Continue to support and address the needs of the family including partners, parents, children, friends and informal carers. Ensure staff will work together in a timely manner to identify when a patient may be moving towards the end of life in order to plan care and to enable them to die in their preferred place of care.	Staff were supported to sensitively offer patients and families the opportunity to talk about their needs and wishes. Staff continued to support and address the needs of the family including partners, parents, children, friends and informal carers. Personalised care during the last days of life was based on the patient and families', physical, social, emotional, spiritual & religious wishes and needs, overseen by their medical consultant and ward manager.

Working with Partners

What we said we would do	**What we did**
Continue to enhance care, working with statutory, voluntary, community and charitable partners, to ensure that each	We continued to work collaboratively with statutory, voluntary, community and charitable (including Macmillan Charity, Trinity Hospice) partners.

patient and their family receive co-ordinated seamless care.	

Education, research and innovation

What we said we would do	What we did
Deliver an educational programme to ensure support, education and training is provided to all clinical and non-clinical staff to support them in delivering high quality end of life care	We have delivered educational and training programmes for staff including; 'I can make a difference' - three rotational programmes for health care assistants and junior nurses, end of life care training for senior members of staff, CMC training for teams, end of life care training is now part of all non-medical staff induction programmes, medical staff are supported in end of life care needs and priorities. A training needs analysis in end of life care was undertaken and the findings are being used to develop a training programme for staff.
Work creatively with our patients/families and partner organisations to deliver excellent care and participate in practice based projects and research in order to improve end of life care.	We have engaged in a CLAHRC (Collaboration for Leadership in Applied Health Research and Care) fellowship research programme, aimed at improving leadership of care at the end of life. Alex Mancini and the Neonatal Intensive Care Unit (NICU) published guidance to support staff caring for very young babies with life limiting conditions who require palliative or end of life care. The guidance now forms part of national guidance for all NICUs on the appropriate care to be provided to babies and families receiving end of life care.

Monitoring our progress

What we said we would do	What we did
Monitor ourselves through audit and benchmarking against quality agreed standards, this will also include learning from listening to bereaved relatives, and a regular review of good practice and complaints.	We were able to learn through meeting bereaved relatives, having bereaved families on our end of life care committee and regular reviews of good practice and complaints.

2.2. Statements of assurance from the Board

During 2014/15 the Chelsea and Westminster Hospital NHS FT provided and or sub-contracted 87 relevant health services. The Chelsea and Westminster Hospital NHS FT has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2014/15 represents 100% of the total income generated from the provision of relevant health services by the Chelsea and Westminster hospital NHS FT for 2014/15.

2.2.1. Participation in clinical audits

Clinical audits collect information on the treatment patients receive and its consequences in important areas of medicine. Participation in them enables healthcare professionals to evaluate their clinical practice against national standards and guidelines, so that they can continuously improve the quality of treatment and care they provide.

National confidential enquiries perform a similar role, but additionally include critical assessment by senior doctors of what actually happened to patients, with a view to driving up standards and enhancing patient safety.

During 2014/15, 46 national clinical audits and 6 national confidential enquiries covered relevant health services that the Trust provides.

During that period Chelsea and Westminster Healthcare NHS Foundation Trust participated in 91% of the national clinical audits and 100% national confidential enquiries which it was eligible to participate in.

The tables below responds to the following assurance statements from the guidance:

- The national clinical audits and national confidential enquiries that Chelsea and Westminster Hospital NHS FT **was eligible to participate** in during 2014/15
- The national clinical audits and national confidential enquiries that Chelsea and Westminster Hospital NHS FT **participated in** during 2014/15
- The national clinical audits and national confidential enquires that Chelsea and Westminster Hospital NHS FT **participated in, and for which data collection was completed during 2014/15, with the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.**

Table 4 National clinical audits for inclusion in the Quality Account 2014/15 – including those in which the Trust was not eligible to participate due to the Trust not providing those services or procedures

Subject	Participated	Cases Indicated or Required	Cases Submitted	% Cases Submitted	Comment
ACUTE CARE					
Case Mix Programme/Intensive Care National Audit & Research Centre	No	N/A	N/A	N/A	Application to participate in this audit from April 2015 submitted
National emergency laparotomy audit (NELA)	Yes	51	51	100%	All eligible cases submitted
National Joint Registry (NJR)	Yes	412	412	100%	All eligible cases submitted
Cardiac Arrest (National Cardiac Arrest Audit)	Yes	44	44	100%	All eligible cases submitted

Subject	Participated	Cases Indicated or Required	Cases Submitted	% Cases Submitted	Comment
Severe Trauma (Trauma Audit & Research Network, TARN)	Yes	72	27	36%	
Adult Community Acquired Pneumonia	Yes	30	TBC	TBC	Trust is participating. Data to be submitted by 31/5/15
Non-Invasive Ventilation	N/A	N/A	N/A	N/A	Audit not taking place in 2015.
Pleural Procedures	Yes	Min 8	31	100%	All eligible cases submitted.
BLOOD					
National Comparative Audit of Blood Transfusion programme	Yes	3	3	100%	20 October 2014: Two part audit: Part 1 closed on 31 January 2015, part 2 closed on 31 March 2014.
2015 Audit of Patient Blood Management in Scheduled Surgery	Yes	N/A	N/A	N/A	Data collection commences 1st April 2015
2015 Audit of the use of blood in Lower GI bleeding	Yes	N/A	N/A	N/A	
2016 Audit of the use of blood in Haematology (submitted for all)	Yes	N/A	N/A	N/A	Data collection starting date in January 2016
CANCER[6]					
Lung Cancer Audit	Yes	*80	72	97.2 %	
Bowel Cancer (National Bowel Cancer Audit Programme)	Yes	*82	82	100%	
Head & Neck Cancer (DAHNO)	N/A	N/A	N/A	N/A	Not eligible – the trust do not treat cancer of the head & neck
Oesophago-Gastric Cancer (National O-G Cancer Audit)	Yes	<50	28	100%	
National Prostate Cancer Audit	Yes	36	36	100%	All eligible cases submitted.
HEART					
Acute Myocardial Infarction & other acute coronary syndrome (MINAP)	Yes	53	53	100%	All eligible cases submitted.
Cardiac Arrhythmia (Cardiac Rhythm Management Audit)	Yes	46	33	72%	
Heart Failure Audit	Yes	94	24	26%	
Coronary Angioplasty (NICOR Adult Cardiac Interventions Audit)	N/A	N/A	N/A	N/A	Not eligible
Adult cardiac surgery audit	N/A	N/A	N/A	N/A	Not eligible
National Vascular Registry	N/A	N/A	N/A	N/A	Not eligible
Pulmonary Hypertension	N/A	N/A	N/A	N/A	Not eligible
Congenital Heart Disease (Paediatric Cardiac Surgery)	N/A	N/A	N/A	N/A	Not eligible
LONG TERM CONDITIONS					
Diabetes (National Adult Diabetes Audit)	No	N/A	N/A	N/A	Participation requires compatible database/ IT for submission[7]
Paediatric Diabetes (Royal College Paediatrics and Child Health)	Yes	N/A	N/A	N/A	Data submission commences 01 April 2015
Inflammatory bowel disease (IBD) – Biological Therapy audit	Yes	36	36	100%	All eligible cases
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Yes	25	23	92%	
Renal Replacement Therapy (Renal Registry)	N/A	N/A	N/A	N/A	Not eligible
Rheumatoid & early inflammatory arthritis	Yes	All eligible	8	100%	Data collection commenced 01 Feb'14 and closes early '17. Next data submission 30.04.2015
Chronic Kidney disease in Primary Care	N/A	N/A	N/A	N/A	Not eligible

[6] (HES data do not provide a gold standard for comparison but can give an indication on major discrepancies between patients submitted and patients documented to be receiving care in HES)

[7] The decision to move to a new Diabetes database is complex due to the need to maintain links with the community system. Participation in 15/16 is a divisional priority

Subject	Participated	Cases Indicated or Required	Cases Submitted	% Cases Submitted	Comment
National Audit of Dementia	N/A	N/A	N/A	N/A	Data collections for all hospitals will take place from April 2016
MENTAL HEALTH					
Mental Health (Care in Emergency Departments) (CEM)	Yes	29	29	100%	
Suicide & homicide in mental health (NCISH)	N/A	N/A	N/A	N/A	Not eligible
Prescribing Observatory for Mental Health	N/A	N/A	N/A	N/A	Not eligible
OLDER PEOPLE					
Falls and Fragility Fractures Audit rogramme (FFFAP): National Hip Fracture Database	Yes	160	160	100%	Continuous data collection however audit requires hospitals to submit min. 100 cases per year
Sentinel Stroke (SSNAP)	Yes	188	188	100%	All eligible cases
Sentinel Stoke (SSNAP) – Organisational Audit	Yes	N/A	N/A	N/A	N/A – organisational audit (questionnaire – non clinical)
Older People (Care in Emergency Departments) (CEM)	Yes	73	73	100%	All eligible cases submitted
OTHER					
Elective Surgery- Hernia (National PROMs Programme)	Yes	126	43	34%	Using validated data only from April – Sep 14 as advised by PROMS
Elective Surgery: Hip Replacement (National PROMs Programme)	Yes	83	33	40%	
Elective Surgery: Knee Replacement (National PROMs Programme)	Yes	77	27	35%	
Elective Surgery: Varicose Veins (National PROMs Programme)	Yes	64	32	50%	
National Audit of Intermediate Care	Yes	N/A	N/A	N/A	Data entry commences 04 May'15
Adherence to British Society for Clinical Neurophysiology (BSCN) & Association of Neurophysiological Scientists (ANS) Standards for Ulnar Neuropathy at Elbow (UNE) testing	TBC	TBC	TBD	TBC	An individual workstream report was published 19 December '14. Status/details of audit to be confirmed.
WOMEN'S & CHILDREN's HEALTH					
Epilepsy 12 audit (Childhood Epilepsy)	Yes	17	17	N/A*	*Data submitted up to the 18th March 2014 – Data collection closes on the 12th May 2014
Maternal, Newborn & Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	41	41	100%	All eligible cases submitted
Neonatal Intensive & Special Care Audit (NNAP)	Yes	All eligible	TBC	100%	
Paediatric intensive care (PICANet)	N/A	N/A	N/A	N/A	Not eligible
Fitting Child (care in emergency departments)	Yes	50	50	100%	All eligible cases submitted

Table 5 National confidential enquiries for inclusion in the Quality Account 2014/15

Subject	Participated	Cases Indicated or Required	Cases Submitted	% Cases Submitted	Comment
Child Health Review UK – Confidential Enquiry	Yes	N/A	N/A	N/A	Participation dependent on occurrence of relevant episodes. Consultants contacted directly to report relevant occurrences. No input required from Trust
Tracheostomy related complications Insertion	Yes	4	3	75%	
Tracheostomy related complications Critical Care	Yes	4	4	100%	
Tracheostomy related complications Ward Care	Yes	4	4	100%	
Lower limb amputations	Yes	N/A	N/A	N/A	No eligible cases identified

Subject	Participated	Cases Indicated or Required	Cases Submitted	% Cases Submitted	Comment
Gastrointestinal haemorrhage	Yes	5	1	20%	Eligible cases to be identified by NCEPOD
Sepsis	Yes	5	4	80%	This study is still open and figures have not yet been finalised.

National Clinical Audits and Confidential Enquiries – Published reports

The reports of 13 national clinical audits were published in 2014/15. The reports of **9** clinical audits were reviewed by the Chelsea and Westminster Hospital NHS FT and Chelsea and Westminster Hospital NHS FT intends to take the following actions to improve the quality of health care provided (as detailed below).

Clinical teams are routinely required to routinely review the results and recommendations from National Clinical Audits using a standardised 'gap analysis/action plan' tool, which is a document designed to enable leads to identify gaps in service and to assess compliance levels and risks associated with non-compliance.

Whilst 15 audits have been published in 2014/15 (set out in the table below), 9 gap analysis documents have been completed. The remaining 6 were published toward the end of the year, are being considered by specialty multidisciplinary teams, and are scheduled for reporting back to the Trust Executive Safety and Effectiveness Group in line with the publication date of the relevant clinical audit report.

Table 6 National Clinical Audits and Confidential Enquiries – Published reports

Audit Title	Dept Leading Review	Actions Agreed
National Prostate Cancer Audit	Urology Department	• The lead Urology consultant reviewed the results from this audit. The trust was found to be compliant in 4 out of 5 areas. It was identified that complete and accurate data is submitted to the NPCA (National Prostate Cancer Audit) for every patient with newly diagnosed prostate cancer through an MDT (Multidisciplinary Team) Proforma, whilst a separate database is in place for patients to facilitate future audits. • Multoparametrix MRI is also routinely used prior to biopsy to reduce unnecessary initial biopsies resulting in improved treatment decision making for patients with potential curable disease. There is support in place by personal support services ranging from the MacMillan Centre, dedicated erectile dysfunction service, continence MDT, psychosexual service, oncology specific counselling ensuring patients are provided the best available care. Two clinical nurse specialists have also been trained to allow patients to have access to specialists with a background in urology.
Aneurysmal Subarachnoid Haemorrhage	Emergency Department	• The Emergency Department reviewed Aneurysmal Subarachnoid Haemorrhage and identified good areas of practice whereby pathways were in place for referrals to the neurosurgical registrar on call at Charing Cross Hospital. A thorough induction programme is also in place for new doctors, whereby handbooks are received outlining the management on SAH, with emphasis on red flags, referral pathways and the need for senior review of all patients presenting with acute onset headaches. The drug Nimodipine is regularly stocked within the Emergency Department in accordance with the National Clinical Guideline for Stroke; and policies are in place establishing pathways to ensure organ donation exists within the department. • A department policy was created in September 2014, including a pathway based on the CEM (College of Emergency Medicine) guideline for the Management of Lone Acute Severe Headache 2009.
National Lung Cancer Audit	Cancer Services	• The Trust participated in the National Lung Cancer Audit and has seen great improvements in the levels of data completeness over the past 12 months, and this has been formally recognised by the London Cancer Alliance. Furthermore, 100% of lung cancer patients with NHS numbers were successfully uploaded to LUCADA in the year in question. The trust has achieved joint highest compliance in the Cancer Network within two key areas: • 1) Patients undergoing a bronchoscopy receive a CT (CAT) scan prior to procedure. • 2.) SCLC (Small Cell Lung Cancer) patients receiving chemotherapy.
Heart Failure National Audit	Respiratory Service	• This audit was reviewed by The Respiratory Service and identified good practice in two areas. All Heart Failure admissions with a primary diagnosis of heart failure are recorded; and there are good prescribing rates for LVSD (Left Ventricular Systolic Dysfunction) patients, ensuring patients are offered treatment in line with the NICE clinical guideline.

Audit Title	Dept Leading Review	Actions Agreed
National Pain Audit	Pain Service	• The Pain Service took part in the National Pain Audit and identified two areas of good practice. Whereby specialised pain services need to work in an integrated fashion across a wide geographical area, Musculoskeletal Services are offered at St. Charles Hospital, along with high level meetings with the Royal Marsden and Royal Brompton Hospital to offer clinical care network for complex pain. Similar arrangements are also being considered for spinal pain management with the Imperial Neuro Surgical and Spinal Orthopaedics. This is further strengthened with the knowledge that Information Governance and other consultants are members of the Specialist service clinical reference group.
National Emergency Laparotomy Audit	General Surgery	• The General Surgery department reviewed this audit and identified 11 out of 12 areas of good practice. It was identified that the management of sepsis was incorporated into the routine care of all EGS (Emergency General Surgery) patients increasing the level of care received by patients. It was also identified that all consultants and juniors attended relevant Mortality and Morbidity meetings ensuring all relevant staff were aware of the progress of patients under their care. There is a structure handover of care in place in addition to daily handovers between members of the team. 24 hour theatre access is in place to ensure operating procedures can take place at any given time.
National Joint Registry Audit	Orthopaedics	• The Orthopaedics Service reviewed the National Joint Registry Report and developed and implemented a protocol outlining a detailed process to improve the consent rate and data quality. Adherence to this process was initially piloted for three months, with the review of the data since reporting considerable improvement.
National Care of Dying Audit	Palliative Care Team	• The Palliative Care Service reviewed this audit and identified 5 areas of care where the Trust has met its target. This ranged from continuing to offer clear, sensitive and timely, verbal and written information to the patient and family whereby the patient had passed away or was terminally ill. Education and training in care of the dying has also been made mandatory for all staff caring for dying patients. This includes communication skills training, skills for supporting families, and those close to dying patients. • The Trust has a designated board member and a lay member with specific responsibility for care of the dying.
National Inpatient Diabetes Audit	Diabetes Service	• The Diabetes Service participated in the National Inpatient Diabetes Audit. The service identified two areas of good practice. All Diabetes Specialist Nurses were found to have a dedicated in-patient care time in their job plans to provide referral service to patients in hospital. The department also has a clear referral pathway in place with integrated community and hospital based podiatry teams.
National Bowel Cancer Audit	Cancer Services	• This audit was reviewed by the Cancer Services Team. Four areas of best practice were identified. Currently, staff ensure that patient cases are discussed at the General Surgery Mortality & Morbidity and Clinical Governance meetings. In line with the current national (NICE) guidelines, Laparscopic surgery is considered in all suitable cases, with suitable patients offered the opportunity laparscopic resection. The team seeks to ensure accurate and complete data collection is submitted to the audit by ensuring that not only data is recorded on the relevant database, but that the lead clinician signs off on the data.
National Oesophago Cancer Audit	Cancer Services	• This audit was reviewed by Cancer Services and considered at the Trust Executive Quality Committee. All areas that were relevant to the Trust have been met. These include ensuring investigations are readily available at Chelsea and Westminster/Royal Marsden Hospital and used appropriately. Furthermore, all patients with SCC (Squamous-cell carcinoma) oesophagus are being seen and usually treated by medical/clinical oncologists. All patients being considered for curative treatment undergo a EUS (endoscopic ultrasound scan) or staging laparoscopy; whilst all patients with oesophageal SCC (Squamous-cell carcinoma) being considered for curative treatment are discussed with a clinical oncologist and a surgeon.
National Dementia Audit	Elderly Medicine	• The National Dementia Audit was reviewed and considered at the Trust Executive Quality Committee. On review of the results, it was recognised that the trust achieved compliance in 14 key areas. This included ensuring the 90% target set by CQUIN (Commissioning for Quality and Innovation). Furthermore, full day dementia training for trust staff commenced in September 2013, and have continued on a monthly basis offering training on both clinical and non-clinical staff, as well as volunteers. Protected mealtimes are enforced on all wards, with physical and verbal support provided to patients where appropriate. The trust ensures people with dementia admitted to hospital receive a standardised or structured assessment of functioning based on activities of daily living.
Neonatal Intensive and Special Care Audit (NNAP)	Neonatology	• The nurse education team and medical team reviewed this Gap analysis and in regards to temperature a new ITU chart was introduced to improve time entry and information provided for temperature to be taken immediately on arrival in NICU with guidelines modification were done. Contemporaneous direct entry of ROP data on Badger Net neonatal database by the ophthalmologist are in good practice and further actions taken to improve the local standards by providing clarification of fields for “SEND” data extraction and internal record keeping for comparison/documentation where screening cannot be timely carried out for clinical indications. Breast milk at discharge home and continue to do extremely well in promotion of use of breast milk and this was discussed at network/NNAP feedback. There was a network issue identified and it was discussed at the network board meeting. A reminder was given at medical staff induction programme on blood stream infections on NNU due to central line b care.

Audit Title	Dept Leading Review	Actions Agreed
Child Health Review Summary report	Paediatrics	• The Gap analysis was reviewed by divisional nurse and presented at the quality committee. Children, who access the shared care service, introduced a checklist for General Paediatric clinics. Children are discussed at monthly meeting who involve the Tertiary Neurology team and the Consultant Neurophysiologist. C&W do not have the resources to develop 'epilepsy passports' for all our children but we do ensure that all clinic letters with relevant clinical information and advice are copied in to school nurses and head teachers. All inpatients are discussed with the local Consultant in charge of the child's overall care
UK Paediatric Inflammatory Bowel Disease Audit	Paediatrics	• This Gap analysis was reviewed by the clinician and nursing staff. A biological nurse was introduced to support IBD Clinic and data collection. The service has moved from 80% to 100% compliance following introduction of NICE guideline. However, sustainability will be confirmed in the long term, since there is a bed capacity pressure. Infliximab guideline to reflect screening requirements was updated.

Local Clinical Audits

The reports of **61** local clinical audits were reviewed by Chelsea and Westminster Hospital NHS FT in 2014/15 and Chelsea and Westminster Hospital NHS FT intends to take the following actions to improve the quality of healthcare provided (as detailed below).

Please note rather than include details of all 61 audits a sample of 10 has been included below. Further details are available on request from Ms Zoe Penn, Trust Medical Director and Director of Quality at zoe.penn@chelwest.nhs.uk.

Table 7 Details of local Clinical Audits

Audit Title	Dept Leading Review	Audit Summary with Actions Agreed
An audit into appropriateness of CT pulmonary angiograms to investigate pulmonary embolisms in AAU	Acute and General Medicine	**The original clinical audit project planner submitted reflected an intention to re-audit in 2 months' time, the re-audit registration document which was submitted in April 2015 confirms that this re-audit will now take place during May 2015 with a projected end date of July 2015.** • 48 patients in total were audited. Based on Trust 'Suspected Pulmonary Embolism' and Royal College of Radiology Guidelines, the CTPA indicated the following: 13 out of 48 (28%) of CTPAs were not indicated. Out of the 13 identified, none had a Wells score documented in the notes. In 6 cases patients with a Wells score <4, a D-dimer was not ordered. Had this been negative, these patients would not have required CTPA and notably, none of these patients actually had a PE. All 48 patients had a CXR prior to CTPA. Of those 48 patients, 20 were reported as abnormal with findings such as (i) Pleural Effusion; (ii) Consolidation; (iii) Interstitial Lung Disease; (iv) Pulmonary Oedema. 16 out of 47 patients had not had an ABG done prior to CTPA. Out of these 5 out of 16 had PEs. There were only 9 radiologically proven PEs during this period, meaning that less than half had an ABG to assess their degree of hypoxia. • The findings from this audit were presented at the AAU departmental meeting and actions taken as a result of the findings included placing a sticker in the notes to prompt better documentation and guide junior doctors to remind them to fill in the Wells score, and finally to re-audit in 2 months to measure if the actions taken has had the desired outcome.
Urgent Care Centre Minor Ailments Audit	Emergency Department & Urgent Care Centre	• 24 patients were audited in total and it was found that 2 patients should have been streamed into the minor injury stream rather than the minor illness stream. All presentations were found to be suitable for the Urgent Care Centre (UCC) and no cases should have been seen in the main Emergency Department. • There were 2 episodes of prescribing differing from guidelines: (i) Penicillin used for 7 days not 10 days and (ii) co amoxiclav prescribed rather than amoxicillin. There was one episode of treatment in the streaming room by a nurse for a superficial wound with tissue glue which may have been more appropriate for review by an Emergency Nurse Practitioner or Doctor in order for them to document the findings of a neurovascular examination. • There was no evidence of over investigation or incorrect treatment. • Standard of compliance with the streaming and prescribing guidelines was found to be good and overall management in the minor illness stream of the UCC was also good. • The results of the audit were reassuring and the actions taken following completion all revolved around feedback to individual members of staff regarding how their practice may be improved.
Analysis of disease activity and its management in patients with	Rheumatology	• DAS28 scores were recorded in 71 of 101 patients and disease activity was assessed informally in the majority of the remaining patients. • Of those assessed, 67% were in remission/low disease activity and 26.5% had moderate disease activity and 6.5% had high disease activity. This should not be taken as an overall assessment of disease activity in the Callan patient cohort as patients in remission/low

Audit Title	Dept Leading Review	Audit Summary with Actions Agreed
established rheumatoid arthritis attending a hospital based rheumatology service		disease activity will tend to be seen less often within the medical clinics (reviews are offered monthly – annually depending on disease stage/activity). • Where disease activity was moderate then patients were advised to increase DMARDS and/or provided with IM or intra-articular corticosteroid injections unless the clinician judged the disease to be inactive despite the high DAS28 score or the patient had just increased treatment or declined to do so. In line with national guidance patients were not offered oral prednisolone to manage established rheumatoid arthritis. • Where disease activity was high and patients were not on a biologic agent then patients were advised to increase DMARDS and process was put in place to apply for biologic treatment. One patient declined treatment escalation as they were breastfeeding. As part of the learning from this audit staff have been asked to ensure that DAS 28 scores are recorded for all patients with RA attending Consultant clinics unless this has been done within the last month. If ESR and CRP are not available then the three other components of the score should be recorded. A re-audit will be undertaken in 2015/16 to assess the effectiveness of the measures implemented.
Audit of Intra Uterine Devices at West London Centre for Sexual Health	Sexual Health	**Note – this audit is based on all data for the calendar year Jan-Dec 2013. The report itself was completed during FY 2014/15 based on this collected data.** • The aim of this audit was to assess the standard of clinical practice in IUD/IUS (intrauterine device/intrauterine system) insertions within West London Centre for Sexual Health from 1st Jan 2013 – 31st Dec 2013 against Faculty good practice points and recommendations to review the complication rates following IUD/IUS insertion and review the reasons why women had their device removed. • The audit included all suitable women who opted for a Cu-IUD with higher efficacy as their first line choice. The Faculty suggests a follow-up visit 3-6 weeks post insertion, the Trust achieved this in 68% of all patients included in the audit. There were no known uterine perforations, and a 3% possible expulsion rate. 13% of devices were removed within 6 months. • Staff now keep a diary of all women post IUD/IUS insertion to ensure improved follow up rates with an 8 and 10 week text reminder if not the patient has not attended for 3-6 week follow-up. In addition, measures have been put in place to ensure clearer documentation on thread length if sending patients for an ultrasound scan to ascertain if incorrectly inserted device or expulsion. • Better counselling for patients pre-insertion on realistic changes in bleeding patterns to prevent early removal of device are also in place and all insertions to have clear documentation of device used in electronic patient record.
Audit of the management of Febrile Neutropenia in paediatric oncology patients	Paediatrics	• Children with cancer are at increased risk of infection as a result of their disease and/or its treatment. Fever with neutropenia is the commonest manifestation of infection in children with cancer; such infection is potentially fatal. • Febrile neutropenia is a medical emergency requiring urgent investigation and the administration of intravenous empirical antibiotic therapy within 1 hour. • Aggressive use of inpatient intravenous antibiotic therapy has reduced morbidity and mortality rates and reduced the need for intensive care management. The purpose of this audit was to demonstrate whether we are following the national guidelines in management of febrile neutropenia in oncology patients and at the same time looking oncology patients who were admitted febrile but not neutropenic. • The results show that all febrile patients were admitted, assessed and managed as per guidelines none of the low risk stratifications forms were filled and followed. This would of prompt early discharge for those patients as per national guidelines. To further improve care for these patients regular teachings and presentations to medical and nursing staff regarding the importance of identifying low risk patients on admissions and the new changes to the definition of neutropenia, stickers will be attached to the notes of all patients who will have to be on standard risk protocol on admission and risk stratification forms are now available on wards.
Enoxaparin post regional anaesthesia in obstetric patients	Anaesthetics/ Maternity	• The purpose of this audit was to assess whether the initial dose of low molecular weight heparin (LMWH) is being prescribed appropriately within 4-6hrs post-op and also to demonstrate whether or not subsequent doses of LMWH are prescribed at the agreed times of 07:00 and 18:00. • Following completion of the audit the following actions were implemented: All Specialist Trainee anaesthetic doctors working within labour ward were personally contacted to explain the optimal timing of LMWH prescribing, the optimal timing of LMWH prescribing information printed and attached to each anaesthetic machine on labour ward so clear for all anaesthetists to see and information has been produced for locum doctors including the standard prescription times for enoxaparin.
A review of patients referred with abnormal smear results – was a biopsy taken within 2 years?	Gynaecology	• The NHS Cervical Screening Programme published "Colposcopy and Programme Management" as part of 'Publication 20' in May 2010. The document states that women who are referred to colposcopy with a high grade abnormality on a smear test should have a biopsy taken at their first visit, target 90%. It also states that women referred with a low grade abnormality on a smear test should have a biopsy taken within 2 years, target >90%. The result of biopsies will help determine onward management including whether a patient should be offered treatment. • Patients who were kept under the care of the colposcopy department were adequately followed up. Those who were discharged to the GP would be adequately followed up by the National Cervical Screening Programme and reminded to attend for smear tests. 6 patients

Audit Title	Dept Leading Review	Audit Summary with Actions Agreed
		were not appropriately followed up due to appointments not being made. This may have been the patient choosing not to book an appointment, or an error on the clinic's part by not booking an appointment. • As a result of the audit it was recommended that the patient is informed of whether they are due to be followed up before leaving the clinic. If an appointment is needed, the patient is advised to book this at reception before leaving the clinic. To limit the numbers of patients who are not seen again incorrectly, all colposcopy staff were reminded of the process of ensuring patient's book their own appointment before leaving the department. 'Publication 20' was being updated by Public Health England at the time of this report due to the implementation of HPV triage for referral and management within colposcopy. Therefore, the need for a re-audit will be assessed once this document is published.
Audit of Patient Group Direction for Nurse Supervised Pharmacological Stress during Radionuclide Myocardial Perfusion Imaging	Radiology/ Medicine	• To aim of the audit was to ensure that all patients have received appropriate care and all the records have been recorded in line with the Trust Medicine policy and the PGD (Patient Group Direction) and to improve its care delivery to patients. • The audit results revealed that patients had received appropriate care and the records had been recorded in line with the Trust Medicine policy and the current PGD. However, there were a few points in patient documentation that required improvement, therefore feedback was delivered to all relevant staff to ensure that any additional patient history is clearly documented in the appropriate section, to always document that the J&A has been checked and stressing the importance of always documenting the date/time of each drug given.
Audit of follow up of patients treated for testicular cancer at Chelsea and Westminster Hospital between April '13 and April '14	Urology	• All patients that attended the Tuesday morning (testicular only) or afternoon (uro-oncology clinic) clinics for follow-up of their testicular tumours were recorded in a paper database between January and March 2014. The database was updated each time the patient attended the clinic. The year of follow-up from their primary diagnosis was noted, together with their tumour type and whether they had received adjuvant therapy or chemotherapy for relapsed / stage II + disease. • The majority of patients are being followed up according to the agreed Cancer Network / Urology Supra-Network Testicular cancer surveillance protocols at Chelsea and Westminster Hospital. • The majority of CT scans were booked according to protocol however, breaches arose due to patient related events and a failure to arrange one scan by the clinical team. • Actions included the continued use of the oncology database to follow up patients with cancer and consider the use of a computer database as an add-on to the aria chemotherapy system to follow up patients with testicular cancer which is now being implemented.
Enhanced Recovery for Hips Surgery Patients	Trauma & Orthopaedics/ Anaesthetics	• Enhanced recovery guidelines for all elective Hips and Knees were introduced Nov 2013. Aim was to reduce length of stay (LOS). • An assessment carried out in March 2014 confirmed low awareness and engagement amongst staff with the process put in place. • It was felt that additional education was required, and this was delivered via a presentation to Orthopaedic and Anaesthetic Department on referral guidelines and the recommendations from the audit project. • A further snap shot audit of elective Hip surgery was undertaken in September 2014 addressed gaps in compliance with guidelines, clinical pathways and complications that delayed discharge and highlighting the underlying issues that were resulting in increased length of stay, and complications associated with medication.

2.2.2. Research approved by a Research Ethics Committee

The number of patients receiving relevant health services provided or sub-contracted by Chelsea and Westminster Healthcare NHS FT in 2014/15 that were recruited during that period to participate in research approved by a research ethics committee was 3377.

We recruited 3377 patients to ethically approved, NIHR Portfolio adopted studies in FY 2014/15.

2.2.3. Goals agreed with commissioners (CQUINs)

A proportion of Chelsea and Westminster Hospital NHS FT's income in 2014/15 was conditional upon achieving quality improvement and innovation goals agreed between Chelsea and Westminster Hospital NHS FT and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2014/15 and for the following 12 months period are available electronically by contacting Leigh.Marsh@chelwest.nhs.uk .

The **Commissioning for Quality and Innovation (CQUIN)** payment framework enables commissioners to reward excellence, by linking a proportion of the Trust's income to the achievement of local quality improvement goals.

In 2014/15, income equal to 2.5% of the value of our main contract, which covers most of our NHS services, was conditional on achieving CQUIN goals agreed with our main commissioner, the North West London Clinical Commissioning Collaborative. Some of these schemes were nationally mandated, whilst the rest were developed locally. The schemes covered the following areas:

Table 8 Coverage of CQUINS

National	• Expansion of Friends & Family Test (FFT): timely feedback around patient experience. • Ensure hospitals deliver high quality care to people with dementia • Improving collection of data for the NHS Safety Thermometer and reducing harm caused by Pressure Ulcers
Local	• Improving timeliness of information given to GPs, shared patient records and information systems • Improving the effectiveness of emergency care and supporting care for patients outside hospital • Improving the effectiveness of planned care and supporting improved pathways • Planning and implementation of seven day services • Improving access to services and advice for GPs and Patients
Specialised Services	• Improving clinical reporting of specialised services through dashboards • Identification and improved reporting of specialised endocrinology • Increase in retinopathy of prematurity screening • Development of a specialised Orthopaedics Network • Identification and improved reporting of burns and reducing the length of stay for burns patients • Improving timeliness of obtaining a tertiary level fetal medicine opinion • Planning and implementation of seven day services • Increasing the availability of and recruitment of patients to clinical studies for HIV • Improved pathway for stable HIV patients and the development of telemedicine.

We achieved 86% of our Local and National CQUIN-related goals in 2014/15 for which we received a payment of £3.3m out of a maximum of £3.9m and we achieved 92% of our Specialist Commissioning CQUIN-related goals in 2014/15 for which we received a payment of £1.4m out of a maximum of £1.5m.

Overall, we achieved 88% of our CQUIN-related goals in 2014/15 for which we received a payment of £4.7m out of a maximum of £5.4m.

This information is subject to final confirmation by the North West London and NHS England commissioners and is expected by June 2015.

2.2.4. Care Quality Commission

Chelsea and Westminster Hospital NHS FT is required to register with the Care Quality Commission (CQC) and its current registration status is complete.

Chelsea and Westminster Hospital NHS Foundation Trust has no conditions on registration.

The Care Quality Commission has not taken enforcement action against Chelsea and Westminster Hospital NHS Foundation Trust during 2014/15.

Chelsea and Westminster Hospital NHS Foundation Trust has not participated in any special reviews or special investigations by the CQC during the reporting period.

2.2.5. Secondary Uses Service information (SUS)

Chelsea and Westminster Hospital NHS FT submitted 787,916 records during April 2014 to January 2015 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The % of records in the published data which included the patient's valid NHS number was	• *95.2%* for admitted patient care • 90.3% for out- patient care and • 88.1% for accident and emergency care
The % of records in the published data which included the patient's valid NHS number was	• *98.3% for admitted patient care;* • *99.1% for out-patient care; and* • *98.8% for accident and emergency care.*

2.2.6. Information Governance Assessment Report

The Chelsea and Westminster Hospital NHS FT Information Governance Assessment Report overall score for 2014/15 was 85% and was graded Green – Satisfactory.

2.2.7. Clinical Coding Audit

Chelsea and Westminster Hospital NHS FT was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were 3.2% for the Immunology, infectious diseases, poisoning, shock, special examinations, screening and other healthcare contacts HRG group and 1.0% for the Musculoskeletal disorders HRG group.

The results should not be extrapolated further than the actual sample audited. The sample was 190 Finished Consultant Episodes (FCEs) — 94 FCEs from the Immunology, infectious diseases, poisoning, shock, special examinations, screening and other healthcare HRG group and 96 FCEs from the Musculoskeletal disorders HRG group.

2.2.8. Improving Data Quality

Chelsea and Westminster Hospital NHS FT will be taking the following actions to improve data quality:

- Introduce further improvements to the patient administration system to improve recording of the patient pathway. Those to be undertaken early in the financial year are relevant to 18 weeks, Cancer, Planned Procedures with a Threshold (PPwT) and outpatient bookings.
- Audit data quality of key quality and performance indicators early in the financial year as part of the internal audit programme. The areas to be covered are Cancer, A&E waiting times, 18 weeks, C.Diff/ MRSA and Learning Difficulties indicators.
- Standardise processes for routine local auditing of key indicators.
- Agree a mechanism for reporting to Trust Board on the data quality of each key indicator.

- Formalise the sign-off procedure for all reports issued externally; focusing on reports and KPIs issued to our regulators (Monitor and CQC), followed by other indicators or reports that the Board receive on a regular basis. The second phase will cover all other external reporting i.e. local contract KPIs. The review will include assessment of the sign off process to ensure this is both timely and appropriate.
- Formalise the sign-off procedure for internal reports by proposing roles to sign-off the relevant reports. Once this is agreed, it will be documented as part of the production process.

2.3. Reporting against core indicators

The following data outlines the Trust performance on a selected core set of Indicators. Comparative data shown is sourced from the Health and Social Care Information Centre where available.

Table 9 Performance against core indicators

Indicator	From local Trust data		From Health and Social Care Information Centre					
	2013/14	2014/15	Most recent results for Trust	Time period for most recent Trust results	Best result nationally	Worst result nationally	National average	Comments (This column still under development. Update to follow Thursday 14 May)
Summary hospital-level mortality indicator ("SHMI")	0.813 (3 – 'lower than expected')	N/A	0.811 (3 – 'lower than expected')	Oct13-Sep14	0.597 (3 – 'lower than expected')	1.198 (1 – 'higher than expected')	1	The Chelsea and Westminster Hospitals NHS FT considers that this data is as described for the following reasons: The Trust has consistently shown good performance with regards to mortality. The Chelsea and Westminster Hospital NHS FT [intends to take/has taken] the following actions to improve this [indicator/percentage/score/data/rate/number], and so the quality of its services, by ……..']
Patient deaths with palliative care coded	26.8%	N/A	33.2%	Oct13-Sep14	N/A	N/A	25.3%	The Chelsea and Westminster Hospitals NHS FT considers that this data is as described for the following reasons: the trust has put in staff and processes to focus on providing excellent end of life care The Chelsea and Westminster Hospital NHS FT [intends to take/has taken] the following actions to improve this [indicator/percentage/score/data/rate/number], and so the quality of its services, by ……..']
Patient reported outcome measures scores for groin hernia surgery	Adjusted Average Health Gain: EQ-5D index 0.051; EQ VAS -5.791	N/A	Adjusted Average Health Gain:	Apr14-Sep14	Adjusted Average Health Gain: EQ-5D index	Adjusted Average Health Gain: EQ-5D index	Adjusted Average Health Gain: EQ-5D index	The Chelsea and Westminster Hospitals NHS FT considers that this data is as described for the following reasons: the trust The Chelsea and Westminster Hospital NHS FT [intends to take/has taken] the following actions

Indicator	From local Trust data		From Health and Social Care Information Centre					
	2013/14	2014/15	Most recent results for Trust	Time period for most recent Trust results	Best result nationally	Worst result nationally	National average	Comments (This column still under development. Update to follow Thursday 14 May)
			Not available because of low volumes		0.125; EQ VAS 3.237 [18]	0.009; EQ VAS -4.070 [18]	0.081; EQ VAS -0.397 [18]	to improve this [indicator/percentage/score/data/rate/number], and so the quality of its services, by ……..']
Patient reported outcome measures scores for varicose vein surgery	Adjusted Average Health Gain: Not available because of low volumes	N/A	Adjusted Average Health Gain: Not available because of low volumes	Apr14-Sep14	Adjusted Average Health Gain: EQ-5D index 0.142; EQ VAS 3.955; Aberdeen Varicose Vein Questionnaire -4.567 [18]	Adjusted Average Health Gain: EQ-5D index 0.054; EQ VAS -2.799; Aberdeen Varicose Vein Questionnaire -16.762 [18]	Adjusted Average Health Gain: EQ-5D index 0.100; EQ VAS -0.465; Aberdeen Varicose Vein Questionnaire -9.479 [18]	The Chelsea and Westminster Hospitals NHS FT considers that this data is as described for the following reasons….. The Chelsea and Westminster Hospital NHS FT [intends to take/has taken] the following actions to improve this [indicator/percentage/score/data/rate/number], and so the quality of its services, by ……..']
Patient reported outcome measures scores for hip replacement surgery	Hip Replacement Primary Adjusted Average Health Gain: EQ-5D index 0.483; EQ VAS 15.927; Oxford Hip Score	N/A	Adjusted Average Health Gain: Not available because of low volumes	Apr14-Sep14	Hip Replacement Primary Adjusted Average Health Gain: EQ-5D index 0.501; EQ VAS 16.537; Oxford Hip Score 25.418 [20]	Hip Replacement Primary Adjusted Average Health Gain: EQ-5D index 0.350; EQ VAS 5.380; Oxford Hip Score 18.537[20]	Hip Replacement Primary Adjusted Average Health Gain: EQ-5D index 0.442; EQ VAS 12.162; Oxford Hip Score 21.922 Hip Replacement Revision Adjusted	The Chelsea and Westminster Hospitals NHS FT considers that this data is as described for the following reasons….. The Chelsea and Westminster Hospital NHS FT [intends to take/has taken] the following actions to improve this [indicator/percentage/score/data/rate/number], and so the quality of its services, by ……..']

[18] Apr14-Sep14 Includes ISTCs

[20] Hip Replacement Revision Adjusted Average Health Gain: Not available because of low volumes Apr14-Sep14 Includes ISTCs

Indicator	From local Trust data		From Health and Social Care Information Centre					
	2013/14	2014/15	Most recent results for Trust	Time period for most recent Trust results	Best result nationally	Worst result nationally	National average	Comments (This column still under development. Update to follow Thursday 14 May)
	23.227 [19]						Average Health Gain: EQ-5D index 0.283; EQ VAS 4.048; Oxford Hip Score 13.091[21]	
Patient reported outcome measures scores for knee replacement surgery	Adjusted Average Health Gain: Not available because of low volumes	N/A	Adjusted Average Health Gain: Not available because of low volumes	Apr14-Sep14	Knee Replacement Primary Adjusted Average Health Gain: EQ-5D index 0.394; EQ VAS 12.508; Oxford Knee Score 20.440 [21 22]	Knee Replacement Primary Adjusted Average Health Gain: EQ-5D index 0.249; EQ VAS -0.665; Oxford Knee Score 14.416 [21 22]	Knee Replacement Primary Adjusted Average Health Gain: EQ-5D index 0.328; EQ VAS 6.369; Oxford Knee Score 16.702 Knee Replacement Revision Adjusted Average Health Gain: EQ-5D index 0.264; EQ VAS 1.947; Oxford Knee Score 11.731 [22]	The Chelsea and Westminster Hospitals NHS FT considers that this data is as described for the following reasons….. The Chelsea and Westminster Hospital NHS FT [intends to take/has taken] the following actions to improve this [indicator/percentage/score/data/rate/number], and so the quality of its services, by ……..’]

[19] Hip Replacement Revision Adjusted Average Health Gain: Not available because of low volumes

[21] Apr14-Sep14 Includes ISTCs

[22] Knee Replacement Revision Adjusted Average Health Gain: Adjusted Average Health Gain: Not available because of low volumes

Indicator	From local Trust data		From Health and Social Care Information Centre					
	2013/14	2014/15	Most recent results for Trust	Time period for most recent Trust results	Best result nationally	Worst result nationally	National average	Comments (This column still under development. Update to follow Thursday 14 May)
Readmitted to the trust within 28 days of being discharged from hospital (Age 0-15)	8.12% [23]	8.26% [23]	6.09% [24]	Apr11-Mar12 [24]	0% Apr11-Mar12 [24]	14.94% Apr11-Mar12 [24]	N/A Not calculated for Apr11-Mar12 [24]	The Chelsea and Westminster Hospitals NHS FT considers that this data is as described for the following reasons: The Chelsea and Westminster Hospital NHS FT [intends to take/has taken] the following actions to improve this [indicator/percentage/score/data/rate/number], and so the quality of its services, by ……..']
Readmitted to the trust within 28 days of being discharged from hospital (Age 16+)	12.90%[23]	9.99%[23]	11.05% [24]	Apr11-Mar12 [24]	0% Apr11-Mar12 [24]	41.65% Apr11-Mar12 [24]	11.45% Apr11-Mar12 [24]	The Chelsea and Westminster Hospitals NHS FT considers that this data is as described for the following reasons….. The Chelsea and Westminster Hospital NHS FT [intends to take/has taken] the following actions to improve this [indicator/percentage/score/data/rate/number], and so the quality of its services, by ……..']
Responsiveness to the personal needs of its patients	Not available	Not available	66.1[25]	Jul12-Jun13 [25]	84.4 Jul12-Jun13 [25]	57.4 Jul12-Jun13 [25]	68.1 Jul12-Jun13 [25]	The Chelsea and Westminster Hospitals NHS FT considers that this data is as described for the following reasons….. The Chelsea and Westminster Hospital NHS FT [intends to take/has taken] the following actions to improve this [indicator/percentage/score/data/rate/number], and so the quality of its services, by ……..']
Staff employed by, or under contract to, the trust who would	85%	76.9% (National	76.9% (2014 Staff Survey)	NHS National Staff Survey 2014	92.8% 2014 Staff Survey)	38.2% 2014 Staff Survey)	65.2% 2014 Staff Survey)	The Chelsea and Westminster Hospitals NHS FT considers that this data is as described for the following reasons…..

[23] Derived from Trust Qlikview Dashboard and Excludes: Non-PbR spells, Cancer, radiotherapy, chemotherapy, patients under 4 years, obstetric medicine, renal dialysis, gastro HIV, readmissions following self-discharge, A&E obs, rehab

[24] (Next publication expected early 2016)

[25] (Data no longer available from Department of Health)

Indicator	From local Trust data		From Health and Social Care Information Centre					
	2013/14	2014/15	Most recent results for Trust	Time period for most recent Trust results	Best result nationally	Worst result nationally	National average	Comments (This column still under development. Update to follow Thursday 14 May)
recommend the trust as a provider of care to their family or friends.		Survey) Jan15-Mar15						The Chelsea and Westminster Hospital NHS FT [intends to take/has taken] the following actions to improve this [indicator/percentage/score/data/rate/number], and so the quality of its services, by ……..']
Patients who were admitted to hospital and who were risk assessed for venous thromboembolism	95.9%	96.5%	95.8% February 2015 96.9% Quarter 3 2014/15	February 2015 (Month) Quarter 3 2014/15	100% February 2015 100% Quarter 3 2014/15	75.0% February 2015 81.2% Quarter 3 2014/15	96.0% February 2015 96.0% Quarter 3 2014/15	The Chelsea and Westminster Hospitals NHS FT considers that this data is as described for the following reasons….. The Chelsea and Westminster Hospital NHS FT [intends to take/has taken] the following actions to improve this [indicator/percentage/score/data/rate/number], and so the quality of its services, by ……..']
Rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over	7.41	6.31	7.0	April 2013-March 2014	0.0	37.1	14.7	*The Chelsea and Westminster Hospitals NHS FT considers that this data is as described for the following reasons…..* *The Chelsea and Westminster Hospital NHS FT [intends to take/has taken] the following actions to improve this [indicator/percentage/score/data/rate/number], and so the quality of its services, by ……..']*
Rate of patient safety incidents reported within the trust and the number and percentage of such patient safety incidents that resulted in severe harm or death.	35.02 incidents per 1000 bed days; 0.08% resulted in severe harm or death	35.07 incidents per 1000 bed days; 0.16% resulted in severe harm or death	50.77 incidents per 1000 bed days; 0.18% resulted in severe harm; 0.03% resulted in death (April 2014-September 2014)	(April 2014-September 2014) Please note HSCIC change from 'per 100 admissions' to 'per 1000 bed days'	0.24 incidents per 1000 bed days; 0.00% resulted in severe harm; 0.00% resulted in death (April 2014-September 2014)	74.96 incidents per 1000 bed days; 74.29% resulted in severe harm; 8.57% resulted in death (April 2014-September 2014)	Incidents per 1000 bed days not available; 0.37% resulted in severe harm; 0.12% resulted in death (April 2014-September 2014)	*The Chelsea and Westminster Hospitals NHS FT considers that this data is as described for the following reasons…..* *The Chelsea and Westminster Hospital NHS FT [intends to take/has taken] the following actions to improve this [indicator/percentage/score/data/rate/number], and so the quality of its services, by ……..']*

Part 3: Other information

3.1. Our performance

3.2.1. Our performance on key national priorities in 2014/15

The Trust met most of the national priority targets tracked by Monitor, the independent regulator of Foundation Trusts.

Table 10 Performance on key national priorities in 2014/15

Indicator	Performance 2013/14	Target 2014/15	Performance 2014/15
Incidence of *Clostridium difficile*	9	**8**	**8**
All cancers: 31-day wait from diagnosis to first treatment	98.6%	**96%**	**99.7% (Apr14-Feb15)**
All cancers: 31-day wait for second or subsequent treatment: surgery	100%	**94%**	**92.3% (Apr14-Feb15)**
All cancers: 31-day wait for second or subsequent treatment: anti-cancer drug treatments	100%	**98%**	**100.0% (Apr14-Feb15)**
All cancers: 62-day (urgent GP referral to treatment) wait for first treatment	92%	**85%**	**91.2% (Apr14-Feb15)**
Cancer: two week wait from referral to date first seen comprising all cancers	95.9%	**93%**	**94.9% (Apr14-Feb15)**
Referral to treatment waiting times <18 weeks — admitted	91.0%	**90%**	**86.0%**
• *Before process improvement (Apr 2014 – Nov 2014)*			***83.5%***
• *After process improvement (Dec 2014 – Mar 2015)*			***91.6%***
Referral to treatment waiting times <18 weeks — non-admitted	97.7%	**95%**	**95.9%**
Referral to treatment waiting times <18 weeks —Incompletes	92.1%	**92%**	**92.3%**
A&E: Total time in A&E ≤4hrs	98.3%	**95%**	**96.3%**
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability	Compliant	**Compliant**	**Non-Compliant**
All indicators in the above table are sourced from Trust's Access Dashboard with the exception of Incidence of Clostridium difficile which is sourced from the Trust's Patient Safety Dashboard; targets are national targets or have been set by DH			

Impact of Q3 validation exercise on reported RTT performance

CWFT undertook a validation exercise of the 'Incompletes' and 'No Future Activity' spells during the end of Q2 and Q3. The themes established from the validation exercise were addressed including creation of appropriate data quality applications in Qlikview, the Trust's performance reporting system. Issues were identified that required input of further processes that would provide improved assurance of the accuracy of the data.

As a result from Q4 the Trust is far more confident that the data is accurate and staff have undergone training to ensure appropriate practices and procedures are in place.

For clarity the Trust's reported performance pre and post the improvement in process is set out in the table above.

3.2.2. Our performance on local performance indicators

The table below sets out our performance on local quality indicators for 2014/15, grouped by the domains of Patient Safety, Clinical Effectiveness and Patient Experience.

Table 11 Performance on local performance indicators

Subject	2010/11	2011/12	2012/13	2013/14	Target 2014/15	Performance 2014/15	Target 2015/16	Commentary and Notes on Data Sources
Patient Safety (ALL INDICATORS ARE SOURCED FROM THE TRUST'S PATIENT SAFETY DASHBOARD UNLESS SPECIFIED)								
MRSA bacteraemia cases	6	2	1	5	0	0	0	MRSA policy to ensure all newly MRSA positive patients receive decolonisation treatment, and old MRSA patients who remain MRSA positive will have MRSA suppression therapy for the duration of their hospitalisation. Target as set by DH
C.difficile cases	73	17	15	9	8	8	7	These targets are those set by the Department of Health; 7 shown within NWL CCG Quality Schedule
Hand hygiene audit—% completion rates	89	94	96	91.1	100			All clinical areas (In and Outpatient) are required to complete hand hygiene audits i.e. completion target of 100%
Hand hygiene—% compliance rates	85	94	95	96.5	98	97.3	>90	98% is an internal target
Inpatient falls / occupied 1k bed days	-	3.19[26]	2.62	3.20	3	3.31	<3	This is an internal target
Patient safety incident reporting rate—incidents per 100 admissions	7.1	6.6	6.7	7.2	8.5	7.63	8.5	The target is an internal benchmark
Number and rate of patient safety incidents reported within Trust (number per 100 admissions)	-	Num= 4,998 Rate = 6.5	Num= 5,162 Rate = 6.7	Num= 5,133 Rate = 6.76	8.5	Num= 5,777 Rate= 7.57	>8.5	The target is an internal benchmark
Number of patient safety incidents resulting in severe harm or death and % of total incidents	-	2 (0.04% of total incidents)	3 (0.06% of total incidents)	1 (0.02% of total incidents)	0	9 (0.16% of total incidents)	0	
Never Events	0	5	3	2	0	0	0	N/A
% of adult inpatient (excluding maternity) observation charts scored accurately (CEWS/S)	81	89	Not measured	Not measured	N/A	N/A	N/A	N/A

[26] (Cumulative. rate reported at the end of 2011/12)

Subject	2010/11	2011/12	2012/13	2013/14	Target 2014/15	Performance 2014/15	Target 2015/16	Commentary and Notes on Data Sources
Resuscitation calls (cardiac arrest) due to failure to escalate	-	7	2	1	1	3	1	Sourced from Trust's portal – individual KPI; The target is an internal benchmark
% patients with International Normalised Ratio (INR) less than 5	97	97	97	97	N/A	N/A	N/A	Sourced from Trust's portal – individual KPI
Hospital acquired preventable cases of venous thromboembolism (VTE)	-	10[27]	13	5	7	6	0	The target is an internal benchmark; Our ultimate target will remain as zero and we plan to reduce our target by a further 25% in 2015/16 as part of our aim to have no hospital associated preventable VTE events
Clinical Effectiveness (MOST INDICATORS IN THE ABOVE SECTION ARE SOURCED FROM THE TRUST'S CLINICAL EFFECTIVENESS DASHBOARD UNLESS SPECIFIED**)**								
Mortality (Hospital Standardised Mortality Indicator—HSMR)	85	79	83	73%[28]	Top 10%[29]	88.2	Top 10%[29]	Sourced from Trust's Patient Safety Dashboard; Target to remain in 'Lower than expected banding' and top 10% in England
% urgent surgery cases operated on within 24 hours of booking	99[30]	95	98	96.2	100	94.8	95.0	While we will always work towards a target of 100% we have set ourselves a tolerance limit of greater than or equal to 90%. There is no national definition for this indicator
% expedited surgery cases operated on within 4 days of booking	95[30]	99	100	99.9	100	N/A	100	While we will always work towards a target of 100% we have set ourselves a tolerance limit of greater than or equal to 90%. There is no national definition for this indicator
Urinary catheters continuing care—% compliance with Care bundles	-	92	92	92.9	95	93.2	95.0	We aim to reach 95%
Central line continuing care—% compliance with Care bundles	-	90	94	96.6	95	99.1	95.0	We continue to work towards achieving 100% compliance having made much progress this year.
Peripheral line continuing care—% compliance with Care bundles	-	86	80	85.1	95	84.9	95.0	We continue to aim high in line with the other continuing care indicators
Numbers of hospital pressure ulcers —grade 2	120	47	70	79	59	109	1	
Numbers ulcers —grade 3	58 (grades 3 & 4)	31 (grades 3 & 4)	38 (grades 3 & 4)	11	8	17 (grades 3 & 4)	<3.6	Sourced from Trust's Patient Safety Dashboard; Prior to 2013/14 Pressure ulcers grades 3 and 4 were reported together, so previous years' figures reflect this. In 2013/14 we decided to monitor and report these separately; we have since reverted back
Numbers of hospital pressure ulcers —grade 4	-	-	-	2	0	See above	See above	See above

[27] (7 months data)

[28] (Dr Foster Jul '12 to Jun '13)

[29] …of all non-specialist acute providers with the lowest HSMR

[30] (Average Nov'10 to Mar'11)

Subject	2010/11	2011/12	2012/13	2013/14	Target 2014/15	Performance 2014/15	Target 2015/16	Commentary and Notes on Data Sources
Numbers of hospital pressure ulcers—unstageable	-	-	-	26	20	29	20	The target is an internal benchmark
% patients nutritionally screened on admission	80	95	85	91.7	90	80.2	90.0	The target is an internal benchmark
% patients in longer than a week who are nutritionally rescreened	30	60	71	78.4	90	66.8	90.0	The target is an internal benchmark
Patient Experience (THE INDICATORS IN THE ABOVE SECTION ARE SOURCED FROM THE TRUST'S PATIENT EXPERIENCE DASHBOARD**)**								
% complaints reopened	9	4	5	4	N/A	7.29	<5%	There is no national definition for this indicator. These are consistently low numbers and we will report performance monthly; the target is an internal benchmark.
Complaints upheld by the Ombudsman (PHSO)	-	0	0	3	1	8	0	All complaints upheld by the Ombudsmen will be monitored and reported. For2013/14, we started monitoring the number of complaints referred to the Ombudsman (see below).
No of complaints referred to Ombudsman	-	-	-	10	7	N/A	N/A	
% Complaints responded to within target time (formal complaints responded to in 25 working days)	83	80	81	82.2	N/A	62.5	1	We will monitor the initial contact with complainants. We monitor performance every week and month and we will be relentless in our focus on experience and feedback.
Complaints (type 1 and type 2)—communication	260	198	179	227	Personal: 90 Comms Process: 90[31]	237	161	
Complaints (type 1 and type 2)—discharge	108	49	34	23	N/A	25	27	
Complaints (type 1 and type 2)—attitude and behaviour	-	-	-	176	120	198	16	We will continue to report performance on these concerns and complaints and we will be relentless in our focus on experience and feedback.
PLACE Scores - Cleanliness	-	-	-	95.36%	97.25	98.96	-	Patient-Led Assessments of the Care Environment (PLACE) are a self-assessment of a range of non-clinical services which contribute to the environment in which healthcare is delivered. These assessments were introduced in April 2013 to replace the former Patient Environment Action Team (PEAT) assessments.
PLACE Scores - Food & Hydration				82.92%	88.79	93.38	-	
PLACE Scores - Privacy, Dignity & Wellbeing				90.72%	87.73	95.43	-	

[31] Target broken down into two individual areas

Subject	2010/11	2011/12	2012/13	2013/14	Target 2014/15	Performance 2014/15	Target 2015/16	Commentary and Notes on Data Sources
PLACE Scores - Condition Appearance & Maintenance				88.27%	91.97	93.28	-	The aim of PLACE assessments is to provide a snapshot of how an organisation is performing against a range of non-clinical activities which impact on the patient experience of care – cleanliness; the condition, appearance and maintenance of healthcare premises; the extent to which the environment supports the delivery of care with privacy and dignity; and the quality and availability of food and drink. Changes in the forthcoming 2015 assessment: dementia elements will be scored and the final score will also be provided on a ward/departmental basis. (please note targets for 2014/15 are the national average figures)

3.2. Review of quality performance

3.2.3. How the Trust identifies local improvement priorities

We are committed to understanding and responding to what our patients tell us about their experiences of care at the Trust and there are several ways in which we actively seek the views of our stakeholders to determine our priorities for quality improvement.

As a Foundation Trust, we have the benefit of a well-established and active Council of Governors. The Council represents the views of patients, public and staff to ensure that their views and experiences are heard. Governors hold frequent 'Meet a Governor' sessions for this purpose. Governors also take part in senior nurse and midwife clinical rounds to find out for themselves how care is delivered to patients. When things are not right they make a note of them and check to see what progress has been made to rectify them at subsequent visits. In their role as a critical friend the governors are consulted on many aspects of the hospital's activities and may participate in the work of teams set up to carry forward particular projects. The perspective they bring is invaluable.

The Council of Governors Quality Sub-Committee is an important source of views and feedback and has a specific remit to help identify priorities for quality and members advise on the content and focus of the Quality Account and plans for quality improvement.

Governors on the Quality Sub Committee oversee our Quality Priorities and Quality Indicators and a governor member sits on both the Patient Experience Committee and the Staff Experience Committee.

Members of the Council of Governors Quality Sub Committee include patients, a representative from Healthwatch Central West London and our commissioners (CWHH). They not only feedback the experiences of those they represent in and outside meetings, but also their own, where relevant. They have also contributed to the discussions on our Quality Account priorities for 2015/16 and chosen their own quality indicator which will be audited by external auditors.

We seek clinicians' and managers' views via the Quality Committee of the Trust Board. And we take an inclusive approach to business planning, ensuring that all staff have the opportunity to be involved in the process. The feedback from open meetings with staff and governors during business planning is considered in the content of the Quality Account.

We actively look at complaints, incidents and feedback from service users to identify trends and areas where we can improve our services.

The various patient forums in the Trust influence how we design and deliver our services with an emphasis on quality. They represent specific areas and include the Patient Led Assessment of the Care Environment (PLACE) HIV Patient Forum, the Joint Research Committees, Bariatric Patient Support, the Stroke Forum, the Ex-Intensive Care Unit Patients Forum and the Learning Disabilities Steering Group.

3.2.4. Quality performance indicators

This section provides an explanation about some of our key quality performance indicators. So we have grouped some of the key the indicators we measure into themes here and described how they contribute to quality.

Two groups of indicators are mandated by the Department of Health and our regulator Monitor - and one group we measure is local to our patient needs. We select our local indicators for monitoring to look at care that we consider important for us to measure in detail.

Care Quality Commission (CQC) visits and assessments

In July 2014 we had our CQC inspection, our first of the new style inspections, with 40 inspectors attending the Trust for 4 days. They visited all areas of the Trust to speak to staff and patients, as well as undertaking a robust interrogation of our data and policies. Listening events were held for staff and patient groups.

Our final report was received in October 2014 and the overall findings are shown in the table below.

Table 12 High level summary of CQC findings, October 2014

Urgent and Emergency Services	Requires Improvement
Medical Care	Requires Improvement
Surgery	Requires Improvement
Critical Care	Good
Maternity & Gynaecology	Good
Services for Children and Young People	Requires Improvement
End of Life Care	Requires Improvement
Outpatients and Diagnostic Imaging	Requires Improvement
HIV and sexual health services	Outstanding
Overall Finding	Requires Improvement

As a result of this, an action plan has been developed and implemented. Our aim has been to complete all the actions that can be completed at this stage, by the end of March 2015. There are a small number of exceptions to this – which need to be addressed over a longer period. These include:

- Emergency Department environment being addressed through the Trust's current Emergency Department build, which has commenced and will conclude in 2016
- Medical Staffing for the Emergency Department, in line with the above
- Addressing recommendations in relation to electronic medical record as part of the Electronic Patient record (EPR) being delivered as part of the WMUH integration
- Integration with mental health services through placement of patients with Central North West London NHS Foundation Trust.

We subsequently held a peer review exercise in early April 2015, and are awaiting the results at the time of writing.

Infection control

[DN – this section subject to final updates to align with year end position, Tuesday 12 May]

Patients are more vulnerable to infection when they are in hospital and reducing the risk of this is a top priority for us. There are some healthcare associated infections that we have a statutory responsibility to report on. These include *Methicillin Resistant Staphylococcus Aureus* (MRSA)) bacteraemia and *Clostridium difficile* (C.difficile).

The Department of Health sets targets to reduce the number of new cases of these infections each year. Whenever a patient becomes infected, we complete a detailed review to find out how it happened and see what changes to our practice we may need to make.

Last year the Department of Health MRSA target was for zero hospital cases. We had zero cases and next year we aim to have zero. The equivalent target for C.difficile was for a maximum of 8 hospital cases. We had 8 cases and aim to achieve the Department of Health target of less than 7 cases next year. We have shown that we can reduce the incidence of these infections by good infection prevention and control, making sure that everyone is involved in this.

Table 13 Number of instances of MRSA and Clostridium Difficile

Target Organisms	Number of cases
MRSA	0
Clostridium difficile	8

Thorough hand washing and good practice around the use of intravenous lines can help reduce the risk of infection. We train all our staff on hand hygiene and monitor compliance with this every month. Results are recorded in our online data management system, and all the information passed on to the Infection Prevention and Control Committee.

The completion rate for the monthly audit in 2014/15 was 91% (up to the end of January 2015) we want to achieve 100%.We will be looking to improve this compliance by making sure all areas have trained auditors around and by improving the timeliness of our reporting. We aim for 95% compliance with standards across all clinical areas. Our compliance rate for 2014/15 was 97.50% up to the end of January 2015.

Another initiative that we have continued this year which has had an impact on improving practice is the Saving Lives Care 'Bundles' which were designed by the Department of Health (DH) in 2007. These are audit tools that are used to monitor the effective management of intravenous lines and urinary catheters. The use of each care bundle is checked regularly and the results are reported to the Infection Prevention and Control Committee and clinical divisions.

Table 14 Compliance with Invasive device care bundles

Invasive Device Care Bundle	What is this?	Compliance to January 2015
Peripheral venous catheters (PVC)	Tubes placed in smaller veins, and often referred to as a drip	84%
Central venous catheters	small tubes or catheters placed in large veins in the neck, chest, or groin	96%
Urinary catheters	Tubes inserted into the bladder to help a person to pass urine.	92%

Compliance with the PVC target is below target due to lapses in documentation, most

commonly in the medical notes. An IV taskforce group has been set up in part to improve performance against this target.

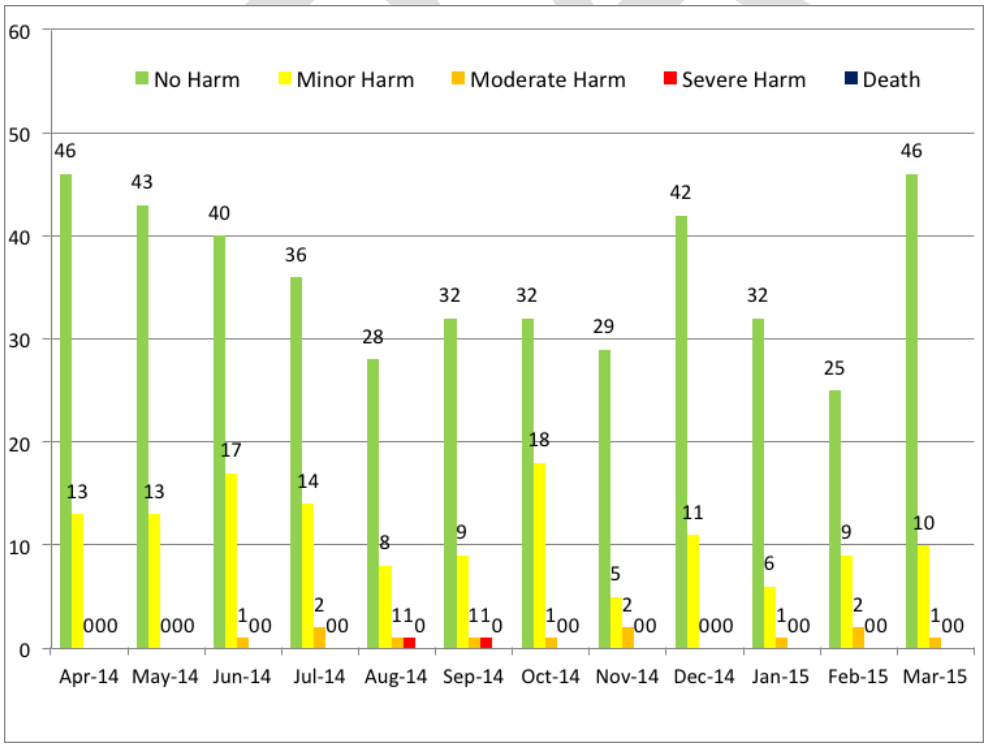
What has gone well this year?

- The Trust has invested in specialist software called ICNet designed to specifically help the Infection Control Team manage the infections around the hospital. This will be live from July 2015.
- The Emergency Planning Officer has rolled out training for key staff including the Infection Control Team on how to safely put on and remove personal protective equipment (PPE) when suspected or confirmed cases of Ebola enter our hospital.
- The Team have introduced 'Cdiff 'packs to improve ward staff compliance with the Trust *Clostridium difficile* policy. This ensures that patients with diarrhoea are medically assessed at an early stage. This also appears to have reduced the number of inappropriate specimens sent for testing in the lab and as such has contributed to reducing the number of C diff cases helping us to achieve our target.

Trips, slips and falls

A fall is the main cause of death from injury among the over-75s in the UK and can lead to loss of confidence and social isolation. Falls cost the NHS £2.3 billion a year. Inpatient falls are measured per occupied 1,000 bed days**.** Our target against this measure was 3 and we achieved 3.31. It remains an ongoing priority for us to continue to reduce the number of falls, particularly those that cause harm.

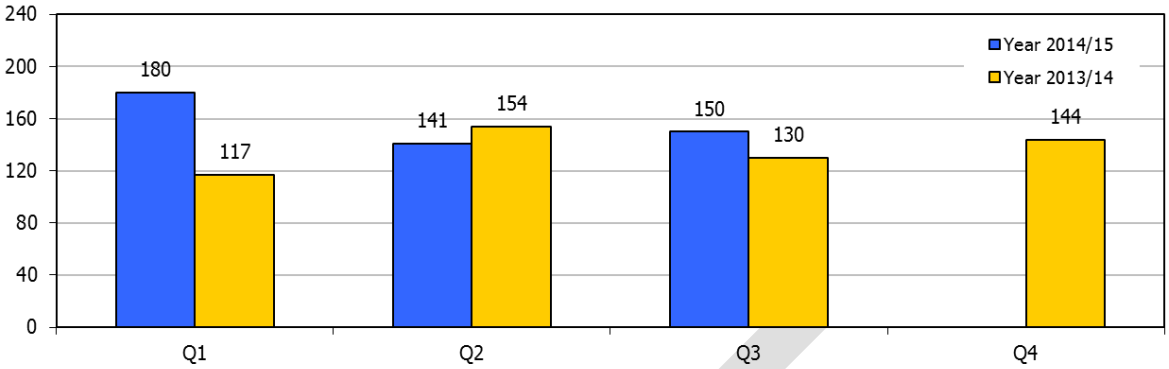
Figure 2 Patient Falls by Month by Degree of Harm, April 2014 – March 2015



Some of the risk factors for falls can be modified, and all patients who have had a fall are assessed for their risk of a subsequent fall and a care plan put in place. Both the risk assessment and care plan are electronic and readily available to patients, their carer's and all staff caring for the patient at the bedside.

Figure 3 Comparison of falls by quarter, 2014/15 – 2013/14

[DN – Q4 2014-15 data to be added to final draft]



A Preventing Harm Group is in place and comprises of a multidisciplinary clinical and non-clinical team. This group regularly monitors falls, ensures audit and oversees the process that patients are assessed for their risk of falls.

The group have secured equipment such as low beds and falls alarms and made recommendations about changes in practice to reduce both the number and impact of falls.

Recognising and Responding to Clinical Deterioration

The National Early Warning Score (NEWS) was introduced as a pilot in January 2013 on two wards. Following evaluation and adjustment it was rolled out across all adult inpatient areas with the exception of Maternity and Burns unit later that year.

In line with NHS recommendations and to move towards a 'common language' the NEWS assists ward based staff to recognise deterioration in a patient's condition, and to escalate and respond appropriately to deteriorating patients in a safe and consistent way. To improve the communication of deterioration between health care professionals the SBAR (Situation, Background, Assessment, Recommendations) communication tool was also introduced. This aims to promote a common language for communicating concerns, improve the transfer of clinical care by better handover of information.

An audit was undertaken was to measure the accuracy of the NEWS two months after the change from a previous system and assess adherence to the clinical escalation protocol. A second audit was conducted 8 months post rollout by the Critical Care Outreach Team (CCOT). The table below shows the improvement of the accuracy of NEWS scoring from 77% to 90%.

Table 15 Comparison of NEWS accuracy from 2013 and 2014 audits

Comparison of news observations performed correctly								
SEPTEMBER 2013 2 months post roll out of NEWS				**MAY 2014 8 months post rollout**				**OVERALL**
Number of patients episodes	All NEWS correct %	day accuracy %	night accuracy %	Number of patients episodes	All NEWS correct %	day accuracy %	night accuracy %	% + / -
438	**77**	**74**	**81**	**438**	**90**	**88**	**93**	**+ 13**
OVERALL 13% improvement in performing news observations with all elements performed correctly								

Failure to calculate NEWs scores accurately and or failure to escalate promptly or to the appropriate teams.

Over the last two years the number of adult in-patient cases where there has perceived to be a failure of either of the above criteria remains static at 18 cases per year excluding maternity and paediatrics. We are taking the following steps to improve this:

- Recognition Training: Ongoing multi-professional training with the acute life threatening emergencies and recognition course (ALERT) and Bedside emergency assessment course (BEACH) for health care and maternity support workers
- Ongoing local NEWS training for ward areas
- Development of innovative acute care course using sequential simulation for ward-based nursing teams to address communication and confidence issues amongst nursing and health care support workers
- Development and trial of e-observation charting system.

Improving Tracheostomy Care in Adults

With the introduction of the NCEPOD report (2014) "On the Right Trach?" we have reviewed the recommendations of the report and have instigated the following:

- Reconvened a short life multi-professional tracheostomy working group to improve care of the adult with a tracheostomy.
- Reviewed all tracheostomy related incidents during 2014 and identified gaps and learning
- Updated and enhanced current core competencies for nurses managing tracheostomies for ward-based patients
- Critical care outreach team continue to deliver local ward based training for nurses as required
- Utilised the information and posters supplied by trachestomy.org.uk
- Reviewed and updated the adult tracheostomy guidelines
- Reinstated the tracheostomy study day for ward nurses
- The nurse consultant is reviewing the feasibility of training suitable health care assistants from the stroke ward to provide tracheostomy care and support to long term patients.

Pressure Ulcers

The Quality Targets for the Trust aim to support a reduction in the number of hospital acquired pressure ulcer (HAPU). The aim for the year was to have no more than 59 Grade 2 hospital HAPUs and only 8 Grade 3 HAPUs.

During 2014/2015 there were 156 reported incidents of hospital acquired pressure ulcers. During the same period 491 incidents of admitted with pre-existing pressure ulcers were also reported.

Table 16 Pressure Ulcers by grade 2014-15

	Grade 2	Grade 3	Grade 4	Unstageable/ Unclassified	TOTAL
Community Acquired	304	84	26	77	491
Acquired during hospital admission	109	17	1	29	156
TOTALS	**413**	**101**	**27**	**106**	

We report all pressure ulcers, including those that are developed under a medical device.

All significant hospital acquired pressure ulcers (grade 3, 4 or unstageable) are investigated to try and establish and identify a root cause where there is one. We also review whether we think we did everything we could to avoid the pressure ulcer, and of the 47 incidents 18 were found to be unavoidable, 18 avoidable and the remaining 11 are still to be reviewed by the Trust's pressure ulcer standing panel.

Progress this year

We continue to work to reduce the incidents of harm for patients from pressure ulcers though we have some way to go to achieve our objective in significantly reducing pressure ulcer harm.

During 2014-15 the "Push off Pressure - POP" project was completed on our Acute Assessment Unit. This has seen an improvement in identifying pressure ulceration present on admission. In addition changes in equipment have been initiated as there had been a cluster of pressure ulcers as a consequence of facemasks and oxygen tubing, these changes have demonstrated positive results so far with no more incidents of mask/oxygen tubing pressure ulcers being reported.

We have now launched a further project on Lord Wigram ward to address the incidents of pressure ulcers associated with orthopaedic patients.

The Trust's Preventing Harm Group is developing a newsletter to share learning and themes from completed reviews to ensure that staff are aware of good practice.

Good Nutrition

The average estimated prevalence of malnutrition among patients admitted to hospital is 28%, and evidence shows this number increases by 5% once a patient has been an inpatient for 7 days, or longer. Good nutrition is therefore important for patient safety, clinical effectiveness, and the patient experience. To make sure that patients are eating properly, we provide screening for malnutrition within 24 hours of admission, and weekly thereafter, and then put in place nutritional care for any who are already malnourished or at risk of being so.

Nutritional screening is completed on the Electronic patient record (EPR) and the nutritional data is linked to the EPR and bed census so the Nutritional Care Plan follows the patient and is visible to all medical, nursing and catering staff. Most adult wards now have electronic screens for ward kitchens to display an up-to-the-minute accurate nutritional score, status and nutritional requirements for each patient.

If the patient is moved to another area within the Trust, the Nutritional Care Plan follows the patient and is visible to all medical, nursing and catering staff. Once the ward clerk updates the bed census, the screens update themselves every 3 minutes. These screens have allowed for a constant live communication system that is constantly updated to ensure the Nutritional Care Plan is clearly outlined for all at-risk patients. This is beneficial to all invested parties to improve not only patient safety (ensuring patients are receiving all aspects of the nutritional care pathway to prevent malnutrition) but also patient experience in receiving additional snacks, cooked breakfasts and nutritional supplements as promised by staff.

The nutritional care we provide is fully integrated; involving dieticians, ward and catering staff, and extends right through to discharge with various types of support provided. The number of patients who are screened within 24 hours of admission to within target, average for YTD

79.6% - range from 55.3%-89.6%(our target is 90%), and those who are rescreened within a week, average 68.2% - range from 56.5%-82.4% (target is 90%) These figures reflect a slight reduction on compliance from last year, so we will be working hard to improve these figures over the coming year, as we realise that good nutrition for patients is a fundamental element in providing excellent patient care

Learning from mistakes to improve safety

Our approach to reporting incidents are near misses

When things go wrong, or incidents are narrowly avoided, we need to find out why it happened so that we can take steps to avoid a recurrence and make the Trust an even safer environment for patients and staff. But we can only do that if we know about the things that might cause problems. That's why staff are constantly encouraged to report all mistakes (incidents) promptly, however minor they may seem. We believe it is just as important to know about the things that nearly happened as about those that did, and therefore we encourage the reporting of 'near misses' as well as 'actual' incidents.

The evidence shows that teams, departments, and organisations that report more safety incidents are more willing to learn from their mistakes and to promote a culture where patient and staff safety is a high priority. A reporting culture indicates an open and healthy organisation.

The number of patients treated at the hospital varies from day to day so rather than simply measuring the number of incidents reported we compare this figure with the proportion of patients treated to arrive at the incident reporting rate. This is a measure of the rates of patient safety incidents per 100 admissions at the hospital.

Experience in other industries shows that as an organisation's reporting culture becomes established, staff become more likely to report incidents. But we know that not all incidents are reported, particularly those regarded as trivial, so we constantly remind staff about the importance of reporting anything that could or did go wrong and encourage them to tell us about it.

It should be second nature for staff to report incidents (including those that led to no harm or that were 'near misses') as they have confidence in the investigation process and understand the value of reporting and learning from incidents.

We look at trends in all incidents but investigate the more serious ones (or those that could have been serious) in more detail using Root Cause Analysis, a way of understanding what went wrong. One of our objectives for 2015/16 is to continue to improve the speed at which we complete these investigations.

We make every effort to ensure that information relating to incidents reported is accessible, making sure that staff see how their incident reports are being used to improve patient safety and that patients and staff involved in incidents are treated fairly.

Our performance during 2014-15

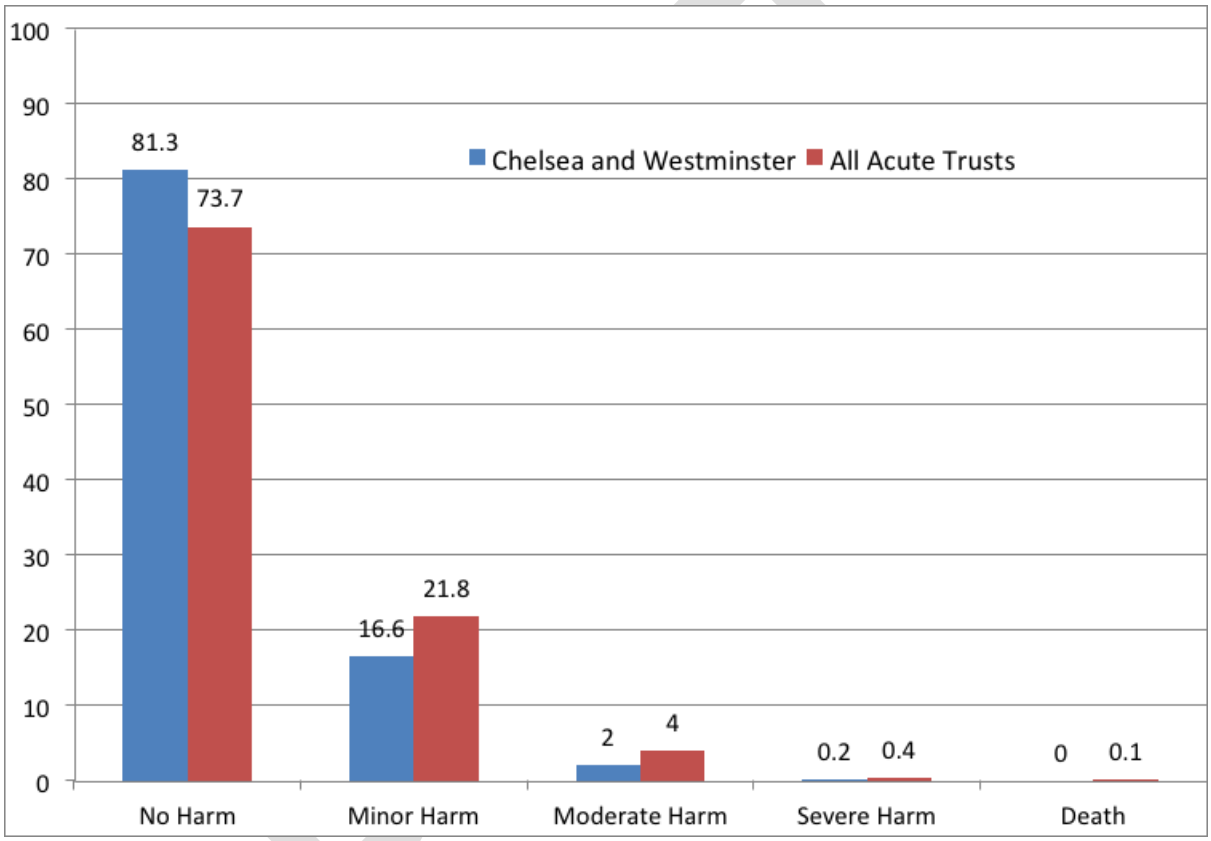
Proportionately, the Chelsea and Westminster Hospital have more incidents leading to 'no harm' (81.3%) to patients that those within our cluster of Acute Trusts report (73.7%). Similarly, there are fewer incidents leading to Severe Harm or Death at Chelsea and Westminster (0.2%) when compared to the same proportion in all Acute Trusts (0.5%).

Please see the table and chart below for the number and rate of patient safety incidents resulting in harm or death.

Table 17 Number & Percentage of Patient safety incidents reported by degree of harm

	No Harm		Low Harm		Moderate Harm		Severe Harm		Death	
	N	%	N	%	N	%	N	%	N	%
Chelsea and Westminster Hospital	2,694	81.3	549	16.6	65	2	6	0.2	1	0

Figure 4 Percentage of Patient safety incidents reported by degree of harm, comparing Chelsea and Westminster with Acute Non-Specialist Trusts.



How we respond to incidents and Near Misses

'Evidence tells us that in complex healthcare systems things will, and do, go wrong, no matter how dedicated and professional the staff. When things go wrong, patients are at risk of harm and there can be devastating emotional and physical consequences for patients and their families. For the staff involved too, incidents can be distressing, while members of their clinical teams can become demoralised and disaffected.' (National Patient Safety Agency, 2004)

Reporting incidents is essential but even more important is how we respond to and learn from them and that includes ensuring that changes happen to improve services for patients.

All incidents reported as resulting in moderate or severe harm, or death, are fully investigated and final classification may later be altered, depending on the outcome of the investigation. It

is rare that a death or severe harm incident is confirmed as avoidable and the outcome of an error.

The response to and learning from incidents is crucial. We feel that it is vital to both report and learn from incidents locally within teams, departments and divisions, and also across the organisation. Trends and themes are identified from reported incidents leading to, for example, the agreement of local changes in practice, provision of training or the strengthening of guidelines for safer practice. This helps teams to prevent the same type of incidents happening again locally or elsewhere.

Analysis of reported incidents in all departments relating to both safety and staff issues is shared via newsletters, reports and local action plans to ensure that lessons are learnt, solutions applied and we make changes.

Local action plans help our teams to develop a 'memory' – or a record – of changes that have been introduced or recommended, and actions taken to implement or work towards implementing safer systems.

With respect to the timely reporting and investigation of serious incidents, during 2014/15 we reviewed and revised our serious incident escalation, reporting and investigation processes, and have taken account of the regulatory requirements of the Duty of Candour.

The multidisciplinary attendees at the Trust's Risk Management Group, the Preventing Harm Group and the Health and Safety Group meets monthly and reviews incidents – those leading to actual harm and also no harm incidents.

These governance arrangements helps us to continue to protect our patients, staff and visitors from avoidable harm by ensuring that there are opportunities to review patterns and learn from incidents, particularly those where things go wrong. These groups use incidents reported by staff members to identify and take action to address emerging patterns and reduce the risk of harm. As a result, strategies are developed, which result in changes to practice, redesigned systems and processes to promote safety.

Duty of Candour

The Trust welcomed the Statutory Duty of Candour, which came into force in November 2014, and complimented our existing 'Being Open' policy and practices in relation to informing patients of mistakes which have led to significant harm or death.

This new duty emphasises the need for patient safety incidents to be investigated using a robust methodology; for investigation reports to be evidentially sound, accessible and focused on producing actionable and reasonable recommendations.

Candour is defined in Robert Francis' report as: "The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made."

The Duty of Candour is a legal duty on all hospital, community and mental health trusts. It aims to help ensure that patients receive accurate, truthful information about incidents which may have led to harm. The facts and outcome of investigations related to any incident helps patients understand what has happened to them and also assists staff in continually improving care, effectiveness and service delivery.

Table 18 Duty of Candour - the key elements

What is Candour? • Recognising when an incident occurs that impacts on a patient in terms of harm • Notifying the patient something has occurred • Apologising to the patient • Supporting the patient further • Following up with the patient as investigations evolve • Documenting the above discussions and steps	**What Triggers the Statutory Duty of Candour** • The death of a patient when due to treatment received or not received (not just an underlying condition) • Severe harm - in essence permanent serious injury as a result of care provided • Moderate harm - in essence non-permanent serious injury or prolonged psychological harm
When Might It Arise? • Whilst the patient is an in-patient, i.e. at the "bedside" • When a patient is back at home following discharge or via community based care • Following a patient's death	**What Does Candour Look Like?** • Open discussions between the patient and Trust staff when things go wrong • Recognition by staff that open conversations must take place at an early stage • Reduction in defensive approaches to information sharing about incidents in relation to the patient in question • Engaging the patient with the outcome of investigations; and • An apology in relation to the incident

Priorities for 2015/16 in relation to the Duty of Candour include ensuring that staff understand the incident reporting process and accurately and promptly report when an incident occurs, that staff understand what it means to be open and their role within the Trust's Duty of Candour regulatory requirements, and that staff are trained and supported on how to share information with patients when things go wrong.

When something has gone wrong, this can be devastating to the staff involved, therefore the Trust will also be undertaking work in 2015/16 to ensure that adequate support is available for staff members and that this is proactively provided/available to them.

Never Events

Never Events are a subset of Serious Incidents and are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'.

The list of Never Events published by the NHS England in 2013/14 consists of 25 types of events or categories and includes incidents such as surgery on the wrong part of the body or surgical instruments or swabs being left in the body after a procedure.

There were no never events at Chelsea and Westminster in 2014/15 (two were reported in 2013/14).

Like other serious incidents, these events are always explained to patients along with an offer of appropriate support, a full apology is given and the incident is thoroughly investigated with a report back to the patient.

In all high-risk activities, variation – in processes, protocols, technical language, training and team member status – leads to uncertainty and increases opportunity for error.

We have therefore continued to focus on developing reliable and resilient systems in order to reduce variation, promote the development of safe and cohesive teams, and supporting the exercise of clinical leadership and responsibility.

We are using our clinical simulation suite to focus on the human factors element of changing behaviours and habits in relation to safe practice, looking at how things work and how we can be confident that they do, in order to ensure that Never Events cannot happen.

The Chelsea and Westminster's response to incident reporting and investigation is open and inclusive. We value learning from staff, patients, carers, external stakeholders and respond to problems positively, encouraging questioning and challenge, to ensure that we continually learn from our mistakes.

(1)The never events list; 2013/14 update, 2013*, NHS England, Patient Safety Domain Team, NHS England website*

PALS and Complaints

The (PALS) and Complaints Teams manage all comments, plaudits and complaints that come into the Trust.

PALS

This section highlights issues raised by service users who have contacted the PALS Team either to raise a concern about a service, request information, advice, or to praise a service.

The total number of informal complaints (Type 1) for year 2014-15 was **1034**. This compares to **761** for year 2013-14.

In 2014-15:

- We received 505 compliments – the majority of compliments were forwarded by the staff members for log
- 67% of PALS complaints were answered within 10 working days, 70% of complaints were acknowledged within two working days by the department investigating.

The Top 3 complaints received in 2014-15 related to:

- Appointments, delay/ cancellation (outpatient) – **313**; in 2013-14 – **176**
- Attitude of staff – **161**; in 2013-14 – **93**
- Communication/information to patients (written and oral) – **189**; in 2013-14 – **141**

There was an increase in concerns throughout the trust in 2014-15. The most frequent concerns related to staff attitude, communication along with appointments cancellation or long waiting times for outpatient appointment. These issues remain consistent each year with slow tracking on actual improvement. Many of our patients that report to us directly expressed their dissatisfaction with lack of the Appointments Office for patients' access; it makes it harder to book/cancel an appointment. Patients also reported difficulties with calling the clinics as all phone calls are diverted to the Appointment Office.

Overall feedback demonstrates:

1) Patients felt that it was very difficult to call anyone within the hospital as the telephones were and currently are not answered or diverted to the answer machines.
2) Patients were not happy with the long queues when calling the Appointments line.

In last year there has been an overall increase in concerns related to staff attitude/behaviour. All concerns were sent to the appropriate managers for follow up with staffs involved ensuring cases were dealt with responsibly and to ensure the problem does not re-occur.

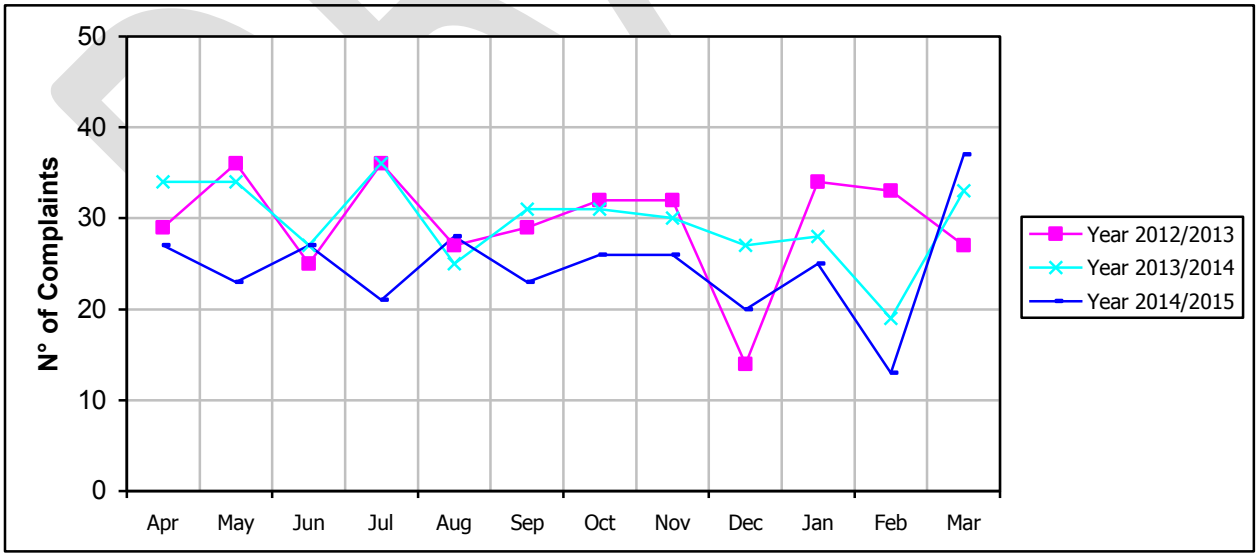
PALS has been working with trust staff to highlight the need for local resolution, and re-skilling staff to take ownership of patient's complaints before sending patients to PALS. PALS has distributed posters across the outpatient clinics with information about resolving concerns locally. This should raise (not only patients but also staff members) awareness of the correct process.

There is huge opportunity to improve and in particular in answering patients concerns in 'real time'. PALS works with Divisions to encourage a reduction of length of time to respond to patients. Such example can be demonstrated where by large number of patients had to wait several weeks for a response to an informal issue that should have been resolved locally in a timely manner.

Formal complaints

The Complaints Team manages all formal complaints. These provide an important mechanism by which we can assess the quality of service we provide; Trust wide initiatives have incorporated the learning from complaints to inform service development. The total number of formal complaints for year 2014/2015 is 299; 294 type 2 complaints, 5 type 3 complaints. This is consistent with the number of formal complaints received in the previous two years, 356 for year 2013/2014 and 377 for year 2012/2013.

Figure 5 Type 2 Complaints Received between April 2012 and March2014



Our performance target stipulates that complaints should be acknowledged in three working days and that a response should be provided within 25 working days or within a timescale agreed between the Trust and the complainant. Whilst all the complaints have been acknowledged in three working days, the performance for response times has been very disappointing. Of the Type 2 concerns received 69% were responded to and resolved by the Directorates within 25 days.

A summary of the breaches relating to each division is sent to the Trusts Executive Team every week for discussion with the Divisional Directors. The Divisional Directors are expected to account for the breaches and give assurance about when the response will be ready and any plans to improve performance.

During the year there have been a number of changes to senior staff in some of the divisions. This has meant that more junior staff have not always had the support they needed to investigate and complete more complex investigations. Some complaint investigations were not completed before the allocated investigating officer left; these had to be handed over to other staff to re start the process.

In a number of cases the response from the medical teams has been delayed. This has been addressed directly with the clinical leads; our expectation is that complaints are dealt with in a sensitive and timely manner to prevent re-occurrence or escalation of incidents.

Going forward we will continue to monitor the response time frame and the complaints team will continue to work closely with the Divisions to achieve the required turnaround time for responses.

Last year Niche Patient Safety Consultancy undertook an external review of the complaints and concerns processes looking at the speed, appropriateness and quality of responses to complaints and concerns. The review identified some excellent practice. However, some areas required improvement including the timeliness of formal responses. The Trust has refined the complaints policy, having a clearer process for sign off within the divisions.

Within the Surgical division a senior Service Manager will now be concentrating on the more complex complaints that are received and will liaise directly with the clinicians. It is anticipated that this will improve the quality of the investigations and the timeliness of the responses. This member of staff will also provide support to more junior team members in responding to complaints and in ensuring early contact with complainants.

The newly appointed Divisional Directors of Nursing will work with the Divisional teams to ensure appropriate level of senior personnel leads on investigation, response and action plan in response to clinical and non-clinical complaints and response

Reopening of complaints

At the point of reporting, of the 299 complaints received during the financial year 2014-2015, 20 complaints have been reopened. This represents 7% of the complaints received this year against a Trust target of 4%. Complainants who were unhappy with their responses felt that there were discrepancies between what was said in the response and their recollection of events. Some complainants felt that the investigation had been superficial and had not addressed the concerns raised. Others identified that they were unhappy with the tone of the response and that the Trust had failed to offer a sincere apology. A number of complainants wanted further information in order to help them understand the decisions made about their care.

All complainants received either a further written response or met with staff and issues have been resolved. Niche Patient Safety were asked to return to the Trust and work with staff to help to deliver improvements to help our response and handling of complaints. Niche Patient Safety delivered two training sessions for key staff involved in complaint handling. The training has been well received and there will be further training for Ward Sisters/Charge Nurses, Lead Nurse and Matrons and senior members each division. Amendments to the complaints policy will be made in response to the feedback from the teams. This will include more support and leadership from the Divisional Leads and clearer accountability.

Referral to the Parliamentary and Health Service Ombudsman

All complainants whose complaint relates to NHS funded care have the right to have their complaint reviewed by the Parliamentary and Health Service Ombudsman (PHSO). The Ombudsman is independent and is not part of government or the NHS. The Ombudsman considers the issues that each complaint raises, examines how the NHS trust responded, takes clinical advice if needed, and then reaches a decision on whether to uphold the complaint.

This year the Trust was informed that eight complaints have been referred to the PHSO However only one of the complaints referred this year was received by the Trust during this financial year. Seven of the complaints referred to the PHSO were received in previous years between 2011 and 2014.

The Trust received 7 reports in total this financial year from the PHSO, 6 of which were referred to the PHSO in the previous financial year. 3 complaints were not upheld and 4 complaints were partially upheld. The PHSO noted that in each case where the complaint had been partially upheld, the Trust had already acknowledged the service failing. The Trust was required to write to each complainant to apologise for the service failure. The Trust was required to write to the PHSO to describe what has been done to ensure that action had been taken to prevent a reoccurrence and to demonstrate how the learning has been shared with staff. This has been completed for all cases where the decision was to partially uphold the complaint; the PHSO has advised the Trust that no further action is required.

Learning and continuous improvement

As an organisation committed to improvement, it is important that lessons learned from complaints are shared across the Trust and used to enhance the quality of services for the future. The Trust ensures that complaints are used to learn lessons, and that this results in improved services. Below are some examples of service improvements that have been implemented during the reporting period as a result of complaints:

- A review of the dispensary staffing on the In-Patient and Out-patient late shift teams was undertaken to ensure more effective cross cover between the late shift teams in order to support discharge prescriptions.
- The Emergency Department has developed a consultant led hot clinic where patients who may not require admission, but would benefit from a surgical opinion, can be seen the next day.
- The Emergency Team are reviewing the process for escalation to ensure that decisions regarding appointments outside the requested time frame are made with the clinical teams.
- The Orthopaedic service has now set up 'Acute Knee Injury' clinics with a knee specialist available twice weekly. These clinics should ensure that patients with acute knee injuries are seen by the appropriate clinician or can be referred to be seen for expert advice.
- Maternity services have developed a tongue tie clinic with an agreed referral pathway between midwives, neonatal doctors, and paediatric surgeons.
- The Trust has recruited three nurses to the Palliative Care Team to enable the service to run seven days a week.

Valuing our Workforce

The results of the national staff survey 2014 show that Chelsea and Westminster remains in the top 20 per cent of acute trusts in the country as an organisation that staff would recommend as a place to work or to receive treatment.

Staff ability to contribute towards improvements at work ranked above average compared with other acute trusts. Also scoring well in the survey was staff felt they were able to make

valuable contributions to improve the work within their team and have frequent opportunities to show initiatives in their current role.

Our work against each of the seven staff pledges in the NHS Constitution (published in March 2013) helps to create and maintain a highly skilled and motivated workforce capable of improving the patient experience.

Pledge 1: To provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability

The Trust was in the top 20% of acute Trusts for the 2014 NHS staff survey in 5 out of 29 Key Findings. This related to: staff agreeing that feedback from patients/service users is used to make informed decisions in their directorate/department, staff reporting good communication between senior management and staff, staff recommendation of the trust as a place to work or receive treatment, having well-structured appraisals, receiving support from their immediate managers.

Pledge 2: To provide all staff with clear roles and responsibilities and rewarding jobs that make a difference to patients, their families and carers and communities The most recent

NHS Staff Survey results show that we are in the top 20% of acute Trusts for the quality of our staff appraisals (with 44% of staff reporting having a well-structured appraisal). However, it is unlikely that we will achieve our target of 85% of staff having had an appraisal in the last 12 months and we will be working hard next year to improve on this. The appraisal forms and process will be reviewed in 2015/16 in order to simplify the process and ensure that managers and jib holders get the most out of it. Reports of overdue and due appraisals are issued to managers monthly and included within the Divisional Board reports to ensure action is taken to complete appraisals within 12 months.

Pledge 3: To provide all staff with personal development, access to appropriate education and training for their jobs and line management support to enable them to fulfil their potential

The Trust offers a wide variety of training courses for professional and non-professional staff covering topics for basic administration to leadership and advanced clinical skills development.

Each year the Learning and Development (L&D) department consults with services and conducts a detailed training analysis to determine the priorities for the coming year.

The Trust is committed to its status as an outstanding teaching hospital, recognising the importance of investing in our future workforce to ensure quality and safety of care, and as a University teaching hospital we host over 150 medical students and 100 nursing and AHP students each year. The Trust also hosts in excess of 230 medical trainees as part of the pan London training rotation.

There is a well-established “Excellence of care” programme for developing the knowledge and skills of our Health Care Assistants (HCAs) and from April 2015 this programme will be replaced by the national care certificate. There are qualified staff, known as HCA leads in each ward/department who are responsible for overseeing their development in clinical areas, supported by the L&D team.

The Trust is also the host organisation for the HE NWL end of life care for the community Education Provider Network(CEPN) leading on a programme of development for HCAs

across the HC community. This gives the staff the opportunity to rotate through acute, community and hospice placements gaining knowledge and a wider understanding of the services available.

Healthcare assistants are one of the largest staff groups within the Trust. However, there is high level of turnover in this group. To tackle this, a survey was sent out to all HCAs in the organisation to understand what the issues were and a short-life working group was set up to tackle these head on. The lack of differentiation between band 2 and 3 HCAs was outlined as a major reason for the turnover. The group looked at both job descriptions and ensured differentiation between the two. Band 3 HCAs were also renamed Senior Healthcare Assistants

Pledge 4: To provide support and opportunities for staff to maintain their health, well-being and safety

Staff ability to contribute towards improvements at work ranked above average compared with other acute trusts. Also scoring well in the survey was staff felt they were able to make valuable contributions to improve the work within their team and have frequent opportunities to show initiatives in their current role.

We continue to provide the following services and benefits to staff: occupational health; cycle to work scheme, fast track physiotherapy, subsidised on-site exercise classes, subsidised childcare during school holidays and Schwartz Rounds.

All of these initiatives aim to improve and sustain the mental and physical health of our employees. We also continue to run the Benefits and Wellbeing Newsletter 'For Who You Are' which promotes the wide range of benefits and support available for staff. This includes discounts with many local shops and restaurants.

This year we ran several wellbeing events promoting the importance of mental and physical health for staff. These included:

- **National Work Life Week**. Massages, mindfulness sessions, stress management sessions, and a benefits roadshow.
- **National Stress Day**. We held a roadshow in the cafeteria which showcased the stress resources available in the Trust and free 'stress dots' to boost awareness. Previous feedback from the maternity wards showed that staff felt high levels of stress and also unable to leave the wards throughout the day so often missed out on wellbeing events. As a result, a few members of the HR team also took the resources up to the maternity wards along with healthy snacks to boost morale, stress awareness and knowledge of what benefits and resources are available to staff.
- **Carer's event**. Recent studies show 1/9 members of the workforce nationally have caring responsibilities. The Trust recognises that these members of the workforce may need extra support. As a result, the Trust has subscribed to Employers for Carers. As part of our membership we held a carers event for staff with caring responsibilities. The aim of this was to make staff feel supported, help staff to understand what they are entitled to, create a carers' network and, help managers to support staff with caring responsibilities.

The Trust encourages staff to be active. As part of this, we have sourced and communicated discounted gym memberships, continued the cycle to work scheme, held lunch time Nordic

walking classes, organised open weeks at Virgin Active Health Club, invited British Military Fitness into the Trust to discuss free classes and discounted membership with staff, and continued to subsidise exercise classes , including yoga classes, within the Trust.

As well as the cycle to work scheme, the Trust also offers staff the opportunity to take part in salary sacrifice schemes for electronic goods and cars.

The Trust has been named in the Top Employers for Working Families Awards from 2010 to 2014 inclusive.

Pledge 5: To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families

We have well-established methods of involving staff, including joint consultative frameworks and strong lines of communication. The NHS staff survey results show that the Trust's performance in both communication and staff engagement has improved every year for the past four years.

Pledge 6: To have a process for staff to raise an internal grievance

We have a Trust Grievance Policy and Procedure in place that is jointly reviewed and agreed with our staff side representatives on a regular basis.

Pledge 7: To encourage and support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Public Interest Disclosure Act 1998.

All our policies and practices are focussed on early resolution to providing the right environment for staff to be able to raise and address concerns early on.

We have a Policy for Raising Concerns (Whistleblowing) and actively encourage and engage with staff to discuss issues in an open environment for the safety and welfare of our patients, their care and our staff.

Listening to our Staff

Friends and Family Test (FFT) Staff Surveys

The National Friends and Family Test (FFT) for staff was launched in April 2014 and had a response rate of 20% (466 of 2,300 staff surveyed) in Quarter 1. Results showed 91% of staff were likely to recommend the trust as a place to receive care or treatment, and 75% would recommend this as a place to work.

For Quarter 2 a total of 245 paper based surveys were distributed to a specific staff group - Support Workers/HCA's. 42 staff responded to the survey and it was positive to note that from the responses received 76% were likely or extremely likely to recommend the trust as a place to receive care or treatment and would also recommend the trust as a place to work.

The National Staff Survey was issued to trust staff during Quarter 3 and they were encouraged to complete. We look forward to receiving the results from this more in depth review of what our workforce thinks.

The Trust recognises that there are direct links between an engaged workforce and the quality of patient experience. We have continued to focus on staff engagement through a range of activities. These include:

- Participation in Work Life Week and National Stress Day in response to staff identifying high levels of stress at work. This aimed to boost awareness amongst staff and promote the resources available to staff.
- Staff communications: The Chief Executive hosts monthly team briefings which all staff are encouraged to attend; The *Trust News* staff magazine is published monthly; Daily Noticeboard email bulletins are sent to all staff as well as a weekly 'For Who You Are' benefits newsletter.
- Schwartz Rounds which continue to run in the Trust. In total, 678 people attended the first 11 rounds. 96% of attendees rated these rounds to be good, excellent or exceptional. The rounds aim to support staff in the more emotional aspects of their roles.
- The Chelsea and Westminster Star Awards. This recognises the work of both clinical and non-clinical staff in relation to our Trust values. The Quality Awards (see section below) also recognise staff achievements.
- The Great Expectation training which took place last year was in response to feedback in the staff survey about perception of bullying and harassment. The training gave managers the tools to tackle difficult situations confidently and respectfully.
- Junior Doctors in some specialities held patient experience sessions where they invited patients to reflect on their hospital experience and then undertook structured and supported reflective sessions following this. This was found to be helpful and enabled the doctors to reflect on the patients comments and actively think about their practice.

The Council of Governors Quality Awards

The Council of Governors Quality Awards aim to recognise and reward contributions to quality initiatives in the Trust by an individual or team under the three quality areas that are key to delivering high quality care: patient safety; patient experience; and clinical effectiveness.

Applicants have to prove that they also meet the Trust values of safe, kind, excellent and respectful, and show how their initiative could be applied elsewhere in the Trust to enhance the quality of patient care.

The awards, which have been running since January 2011 are open to all staff as every employee has the potential to improve quality either directly or indirectly. The awards were established by the Trust's governors and are now led by a key group of governors from the Council of Governor's Quality Sub Committee.

Award winners have the opportunity to meet directly with key Trust directors and governors from the Council of Governors Quality Sub Committee to discuss their initiatives and highlight the value of their achievements that benefit the quality of patient services. The Quality Awards are awarded twice a year, in Spring and in Autumn.

Spring 2014 Quality Award winners

1. Dr Alan McOwan and Mr Leigh Chislett and their team - For their Revolutionary Sexual Health Screen Service at Dean Street Express
2. Alex Mancini and team – For their practical guidance document for palliative care on neonatal units
3. Mars Paediatric Burns Dressing & Scar Management Team - For their *Moving forwards for a Family Friendly Service* initiative
4. Kate Shaw Clinical Nurse Specialist in HIV associated haematological cancers
5. Sandra Howard - For turning around Phototherapy
6. Birth Centre Team - For several initiatives leading to continued quality of care improvements.

Plus two Highly Commended Awards:

- The One Stop Carpal Tunnel Clinic - Nominated by a patient for improved effectiveness leading to an excellent patient experience
- The Imaging Team - For the successful completion of the "Imaging Services Accreditation Scheme

Autumn 2014 Award winners

1. Sarah Bryan and team – For their Dementia Care Initiative
2. Miss Sheena Patel and team – For their Nuclear Medicine Department auditing of patient experience
3. Emma Bartlett and Infant Feeding team - For two years of Maternity Baby Friendly UNICEF accreditation.
4. Jane-Marie Hamill - For the Discharge booklet for ICU patients

Plus one Highly Commended Award

- The Pain Clinic for their initiative in creating a ***Survivors of Torture*** project.

Our Physical Environment

Chelsea and Westminster is a modern, well-designed hospital, but the physical environment needs to be able to respond to changes in service provision. The Trust is continuing its multi-million pound investment programme to maintain and improve its facilities and meet rising demand for services.

Recent developments include:

- The annual PLACE (Patient Led Assessment of the Care Environment) assessment is due to take place during March 2015, and an action plan will be developed on its conclusion in order to make on-going improvements to the patient environment, in addition a detailed score for each area will be provided. For the first time the dementia elements of the assessment will also be scored
- Improvement to the current 'wayfinding' and signage to improve the patient experience is ongoing. The Wayfinding Steering Group identified areas for improvement in regards to general wayfinding and signage in particular for those who have learning difficulties and dementia. To this end, a trial on the third floor has been undertaken whereby colour is used to identify which floor you are on e.g. coloured lift buttons and on the glass balustrades (the colour used was agreed by the Learning Disability and Mental Health leads). Once funding is secured the wayfinding strategy will be implemented Trust wide
- 'Medicinema', a small cinema in the Trust (sponsored the Hospital Charity) is currently under construction, due for completion this summer
- Upgrade of the existing lights to LED's within the Atria and wards was completed in 2014
- Refurbishment of ward wet rooms and bathroom facilities is ongoing throughout the Trust

- Replacement of the original flooring within the Trust is ongoing.
- Upgrade to the existing Nurse Call System throughout the Trust is ongoing.

There is a five-year development plan under way which will ensure that the Trust has state-of-the-art facilities to meet the needs of all its patients, and to accommodate Shaping a Healthier Future requirements. Plans include:

- An improved and expanded Emergency Department for both adults and children is under construction – this is a £12 million project commencing July 2014 and with completion by May 2016
- A new Children's Out Patients Department has been created on the first floor of the main hospital
- The main Outpatients Department on the lower ground floor has been extended and there are ongoing improvements to outpatient areas
- A new Patient transport lounge is currently under construction, due for completion April 2015
- A new Immunology Research laboratory has been completed
- Retail pharmacy facilitating in pharmaceutical savings in outpatient dispensing facility both in the Trust and in 56 Dean Street.

Health & Safety

The Trust are committed to providing and maintaining, so far as reasonably practicable, a safe and healthy environment for all employees, contractors, patients, visitors and those who may be affected by work related activities.

The Health, Safety and Fire Department in the hospital have been working hard to promote safe working arrangements and a safe environment for all. A programme of work is in place to support this continuous improvement.

This includes:

Training - Health, Safety & Fire training is a mandatory requirement for all staff and is included in all of the Trust's staff update programmes.

- There are 246 identified Fire Marshals who have all received an enhanced level of fire safety training.
- A network of health & safety leads for wards and departments are in place.
- There is a Managing Safely course run for Managers and their health & safety leads. The course includes developing local safe systems and risk assessment.
- Controls of Substances Hazardous to Health (COSHH) Assessors have been identified and trained for all risk areas.

Inspections - A programme of health & safety inspections is in place across the Trust. This identifies both good practice and shortfalls. The inspection supports managers in achieving satisfactory health & safety standards. The key themes/findings are reported to HSFC quarterly.

Equality and Diversity

We continued to make good progress towards meeting actions in accordance with the Equality Act 2010 and against key objectives. A brief account of progress through the year is highlighted below.

Objective 1: Improve equality data collection and usage across all protected characteristics[32]

- A breakdown of equality and diversity workforce related data shows that 44.14% of staff are identified as White British (excluding other white categories) whilst 50.05% of staff are identified as BME (including non-British white). The total from any White background made up 59.93% of the workforce. 74.16% of the workforce is female which is similar to the national picture with the Health and Social Care Information Centre (HSCIC) reporting that female staff comprise of 77% of the NHS workforce.
- The percentage of staff who indicated that they are disabled is 1.81%, whilst the percentages that have declared that they do not have a disability is 51.31%, and those not declaring a disability is 46.88%. The average age of Trust employees is 38 ¾ years
- Only 42.32% of staff have disclosed their belief, and of these 27.25% have defined this as Christianity, which is the largest declared faith group.
- The records for sexual orientation indicate that the majority of staff at 52.31% are undefined. Heterosexuals account for 41.94% for the workforce.

Objective 2: Continue to develop and promote an organisational culture that support the principles of equality

- We participated in the Stonewall's 'Diversity Champions Programme' by undertaking a Workplace Equality Index questionnaire (2014/15). The results published in January 2015, showed that we had moved up a further 15 places in the rankings. We have also worked closely with our Stonewall representative to identify senior LGBT (Lesbian, gay, Bisexual and Trans) champions in the organisation with a view to re-launching our LGBT Network in 2015/16.
- The Faith network promoted the use of therapeutic meditation in the workplace and its success led to the trainer running meditation sessions in some departments for patients.
- We reviewed the equality and diversity training provided across the organisation and have adopted the online Core Learning Unit's Equality and Diversity training module for corporate induction and refresher training for all staff.
- We participated in a roundtable discussion with NHS Employers and a number of other Trusts to share potential interventions and good practice on reducing bullying and harassment in the workplace.
- We participated in the Employers Network for Equality and Inclusion e-quality questionnaire for the first time in 2014. The tool is designed to benchmark organisational performance in equality and diversity across different sectors and we were awarded a bronze award. We will use the results to help inform our equality and diversity work plan for 2015/16.

Objective 3: Effectively communicate with, engage, and involve all of our stakeholders in equality

[32] For more detailed analysis please go to http://www.chelwest.nhs.uk/about-us/equality-diversity/equality-information

- We were successful in our application for the Stonewall 'Health Champions Programme'. As a result we secured funding to help identify areas in our organisation that would benefit from tailored LGBT training to assist with delivering effective patient care and services to our LGBT community.
- The Way finding Steering Group has identified areas for improvement in regards to general way finding and signage in particular for those who have learning difficulties and dementia. To this end, a trial on the third floor of the hospital has been undertaken whereby colour is used to identify the floor e.g. colour lift buttons and on the glass balustrades (the colour utilised was agreed by the leads for Learning Disability and Mental Health). Once funding is secured the way finding strategy will be implemented Trust wide.
- We continued to focus on improving the experience of patients with learning disabilities through the Learning Disability Support Group. A Lead Nurse for Learning Disabilities and Transition was also appointed in November 2014 which will support the development of this agenda.
- Our Staff Faith Network, has continued to meet and the main focus in the past few months has been on how to improve the ambiance of the multi-faith chaplaincy prayer spaces once the Tent is reinstated as the permanent Muslim prayer space. The discussion continued in January at the Mica Gallery where Reedah El-Saie, the Director, facilitated an interactive session about the decoration of sacred spaces and the varied needs that can arise. Meanwhile the temporary removal of the Tent had led to a very practical example of sharing and hospitality as Friday Prayer has been taking place in the Chapel each week from late autumn 2014 until the Tent is reinstated in early May 2015.

Objective 4: Strengthen equality and diversity communications and resources across the Trust

- Following the success of the national stress awareness day in 2013, another event was organised in November 2014. This was in response to staff feedback through the 2013 Staff Survey. The day included promoting mental health well-being and a number of useful resources were made available from Mind and Occupational Health and received positive feedback from staff and manager
- Learning Disability Training sessions were held in 2014-2015 for all staff groups, including ISS and volunteers. These sessions equip staff with basic communication skills to meet the needs of our patients and clients with a learning disability and how to support their carers. Understanding the Mental Capacity Act and ways of 'making reasonable adjustments' for this group of patients are key components of this useful training.

A work plan for 2015/16 will be prepared and we will continue to make further progress against our equality objectives, particularly around the staff survey results for equality and diversity and bullying and harassment.

Good news stories from this year

Control and Restraint Training for Edgar Horne Ward (Staff Experience)

Going by the Physical Assaults Statistics for 2013/14 Edgar Horne Ward surprisingly had the highest number. The Assaults were more Clinical Assaults, however staff got injured and we needed to do something different from Conflict Resolution Training. With the backing of the Chief Executive Officer we created a Training Pack for the staff who had suffered an assault, where we looked at how they were assaulted and with the help of the experts Maybo (Training Organisation) we showed them safer ways to do their tasks like: Putting a pair of slippers on a Patient, Change the Sheets without being kicked or slapped, Controlling a Patient who is

trying to abscond. This made a huge difference to the staff, they felt safer going about their tasks and we still get positive feedback who attended the course and we have seen a significant reduction in Assaults.

Postage - Switch to Royal Mail (Patient Experience / Financial)

In 2014 it became evident that some of our patients were not receiving their appointment letters in adequate time, or in some cases not at all. This led to missed appointments, and an associated approximate cost of £180.00 per patient. The Trust switched from using TNT to Royal Mail, purchased a new more advanced Franking Machine that marks the mail in such a way that we are guaranteed a First Class Service at a Second Class Rate. The Mail Service has subsequently improved 100%, with very little complaints from Patients or Departments.

Waste Segregation and Recycling (Financial / Environmental)

The Directorate has instigated significant changes to the Trusts Waste Segregation which includes bailing all cardboard and shredding of all confidential Waste; this is then sold back to the industry. This has meant that we are being kinder to the environment by being Greener as a Trust and improved our recycling figures. In addition the Trust has changed the disposal route for 60% of our clinical waste which now goes as offensive waste and has kept the directorate on track for a cost improvement.

Lone Working Devices for Community Staff (Staff Experience)

The Directorate has been supporting the Maternity Department (Community Midwifes) Community TB Nurses, HIV/GUM Outreach Teams and our on-site Chaplains by rolling out the MySOS Lone Working Devices to 50 members of staff, which is a safety measure for protecting our staff and making them Safe. This was highly commended by the Council of Governors.

Service Track - Electronic Patient Meal Service (Patient Experience)

Each ward now orders all patient meals through the Saffron Electronic Patient Meal Service Device. For the patient this means that they will get the food they ordered, there is more interaction between the hostess and patient. The system is quicker for the staff and we have seen a significant reduction in food waste.

Scrubs Vending Machine (Scrubbex) (Staff Experience)

We now have six scrub suit vending machines (Scrubbex) based in all theatres, Emergency Department and maternity areas. This has been a huge success in terms of controlling scrubs across the Trust, complies with Infection control stipulations, and ensures that our patients are kept safe from potential infections. In addition staff are assured that scrubs are readily available.

Interpreting Services (Patient Experience)

In order to increase the accessibility of interpreting service for patients we have promoted the use of telephone interpreting services which are readily available, instantaneous and with 256 languages and dialects available. Nationally the utilisation rate of telephone interpreting is 19% and within London between 13- 15%; the Trust is currently in the top 2 in the country for providing telephone interpreting and operates at 36%. This has had a beneficial effect of

contributing to the patient experience and a secondary financial benefit to the Trust by reducing the face to face interpreting expenditure by approximately £50,000 per annum.

Annex 1: Statements from Commissioners, Healthwatch and Overview and Scrutiny Committees

Statement from Commissioners

[DN – Statement from lead commissioner CCG to follow]

Statement from Healthwatch

Healthwatch Central West London statement on the Chelsea and Westminster Hospital NHS Foundation Trust's Quality Account 2014/15

Healthwatch Central West London (Healthwatch CWL) welcomes the opportunity to comment on the Chelsea and Westminster Hospital NHS Foundation Trust (the Trust) Quality Account (QA) 2014/15.

We have been quite pleased with the quality of our working relationship with the Trust in recent years and although there have been a number of changes in recent months, we seek to continue our engagement through Dignity Champions, PLACE visits, the Quality Sub-committee, the Membership Sub-committee and through our work on nutrition and on learning disability.

We would like to commend the improvements made by the Trust on its priorities for 2013-2014, particularly in relation to the quality of end of life care. We also want to praise the Trust for their excellent work in sexual health and on their improvements to A&E services.

We would like to commend the efforts made in providing simple explanations of the Quality Account, as well as of the Trust's services and priorities. A one page summary of the quality report and a signposting of the main topics akin to the structure of last year's account would help the reader greatly. It would also be useful to have data tables and lists of national audits removed from the main text and added in to the appendix.

We strongly feel the recent Care Quality Commission inspection report should inform the content of the Quality Account much more than in the current draft provides for. The CQC highlighted a number of areas that require improvements and we look forward to see the Quality Account highlighting these in the introduction, as well as providing greater details in line with the CQC action plan in parallel with priorities throughout the QA.

Overall, we:

- Would like further clarification on the way the impact of the various initiatives implemented to improve patient experience are being monitored
- Continue to be disappointed with the reported performance on staff appraisals. Staff experience and motivation at a time of much change in the health landscape is critical to quality care provision including patient experience.
- Would also welcome further detail on the different discharge projects, in particular the reasoning for restricting this work to elective surgery, whereas non elective surgery is more problematic, as well as on how impact is being monitored.
- Are worried Chelsea and Westminster Hospital maternity services are missing the target on 12 week assessments, homebirths, non-elective caesareans, 1:1 midwife care in labour, and the midwife to birth ratio for the majority of 2014-2015. An explanation on how the Trust plans to meet these targets

seems particularly important considering the changes likely to happen in maternity services in the North West London area in the coming months.

- Are concerned about the quality of the paediatric dental services. Whilst we recognise this is a North West London concern, Chelsea and Westminster Hospital is the only specialist provider for this area. To the best of our knowledge, we understand 4 of the 5 paediatric dental specialists have been lost within the last year and there has been a consequential loss of capacity. The service is currently operating to highly restrictive referral criteria and is not serving the majority of referrals in North West London.
- Are most disappointed and concerned that despite the provisions of the Health and Social Care Act, the Hospital has not responded to our numerous requests for an action plan on Nell Gwynne.
- Are not fully aware of the recent changes in governance at the Hospital and as a result, we are not as engaged as we were previously.

2015-2016 Priorities

Priority 1- Reduction of acquired Pressure Ulcers both in Hospital and the Community

Pressure ulcers have been the main safety risk for a number of years now. Healthwatch is frustrated that more progress has not been made. Whilst we recognise the need for this work to be prioritised, we suggest clearer specific targets and actions must be included leading to measurable change going forward.

Priority 2- Embedding of the WHO checklist

We welcome this innovative approach to improving patient safety. We would like to have further clarification on the way this priority will be measured and how the impact will be communicated to patients and the public.

Priority 5- Friends and Family Test (FFT)

We welcome the Trust's efforts in taking the views of patients and families on board. However, our members feel that the FFT should not be seen as the only way to gather patient's views as it is quite limited in terms of what can be expressed. We are happy to re-visit this discussion at the Trust's convenience. In the interim, we would like to see greater emphasis on the way results are analysed and shared and actions plans are developed as a result.

Further issues:

Staffing

Is the high turnover of Healthcare Assistants still an issue? The number and percentage of agency and bank staff numbers should be reported in the final version of the QA.

Complaints

We commend the efforts to improve the way complaints are used for learning across the Trust. Our patient stories also flag concerns about the management of outpatient appointments and the quality of patient communication. We are aware that a lot has been done about staff attitudes, and we are keen to know how the Trust will take that work forward and how it will be evaluated.
The frequency and time period for redress is a concern. Whilst this is acknowledged by the draft QA, the data was not available at the time of writing.

We are disappointed the actions proposed for next year do not seem to map to the main concerns arising from the complaints. We would particularly welcome clarification on the way the Trust is planning to triangulate the findings from complaints, PALS and the Friends and Family Test to monitor and improve patient experience.

Patient safety

We welcome the change in organisational culture on the reporting of 'never events' and measures aimed at improving internal communication and openness. However and over the course of the last year, we have had concern about the speed and effectiveness of these processes.

In addition, we would welcome further detail on the level of safeguarding training provided to and completed by staff, including Mental Capacity Act compliance.

Going forward

In conclusion, we are keen to re-build our working relationship with the Trust and we hope progress can be on made on the issues raised in the coming year including a number of outstanding issues raised in previous years as detailed above.

Contact:

Luul Balestra, Borough Manager, Kensington and Chelsea
Healthwatch Central West London

Phone: 020 8964 1490

Email: luul.balestra@hestia.org

Date: 08/05/2015

Statements from Overview and Scrutiny Committees

Statement from Adult Services and Health Policy Scrutiny Committee, Westminster City Council

Chelsea and Westminster Hospital NHS Foundation Trust

Response to Quality Account 2014/2015

Introduction

We welcome the opportunity to comment on the Chelsea and Westminster Hospital NHS Foundation Trust's Quality Account 2014/15.

Merger with West Middlesex University Hospital Trust

The Chelsea and Westminster Hospital NHS Foundation Trust has been an efficient and high performing trust.

There are a number of risks to Chelsea and Westminster NHS Foundation Trust in any merger with West Middlesex University Hospital Trust.

There are risks to finance associated with this merger. We do not believe the Chelsea and Westminster NHS Foundation Trust should take on the significant legacy debt that West Middlesex University Hospital Trust owes the Department of Health.

There are risks to performance due to management distraction from a challenging merger taking away focus from providing care for our residents and of maintaining Chelsea and Westminster Hospital as a centre of excellence.

- We note a decline in service, highlighted by the England's Chief Inspector of Hospitals rating the services provided at the Chelsea and Westminster hospital as 'requires Improvement overall'[33], took place at the time this merger was being planned.
- We note a decline in service, highlighted by the England's Chief Inspector of Hospitals rating the services provided at the West Middlesex University Hospital Trust as 'requires Improvement overall'. The Care Quality Commission (CQC) report[34] said the 'protracted' merger process had led to a high use of interim senior managers and 'planning blight'. This had particularly affected surgery with an 'unstable management support'.

A firm eye needs to be kept on the core business to minimise performance risks. The Foundation Trust will need to ensure that new work (i.e. to take forward the merger, bring the different bodies together and resolving the issues at West Middlesex University Hospital) does not distract from the core work at the Fulham Road site.

[33] CQC inspection report (28 Oct 14): Chelsea and Westminster Hospital available at: http://www.cqc.org.uk/location/RQM01

[34] CQC inspection report (7 Apr 15): West Middlesex available at: http://www.cqc.org.uk/provider/RFW

Performance in 2014 / 2015

We recognise many improvements have taken place in many areas however issues in some areas still need to be addressed.

We are pleased:

- Nationally, the Trust consistently ranks as one of the best providers of high quality clinical care. For example, SHMI is 78.5 against a National Benchmark of 100 – statistically significantly lower than expected risk
- There were no 'never events' in 2014/15
- Chelsea and Westminster remains in the top 20 per cent of acute trusts in the country as an organisation that staff would recommend as a place to work or to receive treatment.
- The National Cancer Patient Survey 2013/14 has improved since the previous year, and the Trust recognised that there is still more that they can do to improve as identified in Dr Quinn's Action Plan.
- The Trust won two HSJ Value in Healthcare Awards 2014: (1) For 'Value and Improvement in Acute Service Redesign' Boundary less patient flow across acute and community emergency care pathway (2) For 'Value and Improvement in the use of Diagnostics' Dean Street Express. And then Dr Ann Sullivan, Consultant physician in HIV and genitourinary medicine was named an HSJ Innovator 2014

We note:

- Compliance of peripheral venous catheters was at 84%.
- Over the last two years the number of adult in-patient cases where there has perceived to be a failure to calculate NEWs scores accurately and/or failure to escalate promptly or to the appropriate teams has remained static at 18 cases per year (excluding maternity and paediatrics).

We were disappointed this year:

- England's Chief Inspector of Hospitals rated the services provided at the Chelsea and Westminster hospital as 'requires Improvement overall'.
- There were 7 cases of Clostridium difficile.
- There were 3.2 inpatient falls per occupied 1,000 bed days (the target was 3)
- There were 140 pressure ulcers acquired during hospital admission this year. 98 grade 2 (target 59), 14 grade 3 (tagret 8). We agree the hospital should have the reduction of acquired pressure ulcers in next year's priorities.
- From April 2014 - January 2015, the Trust identified 6 hospital associated preventable venous thromboembolisms (VTEs). The Trust set a target of 90% of adult patients to receive appropriate medication and compression stockings. We note only 87% of adult patients received compression stockings. We note the % of patients who were admitted to hospital and who were risk assessed for VTE during April 2014- February 2015 were 96.5% (not assessed 3.5%). To have no hospital associated preventable venous thromboembolism was a quality priority this year and it should remain a priority for next year.

Quality Account priorities 2015/16

The suggested priorities for 2015/16 will be:

1. Reduction of acquired Pressure Ulcers both in Hospital and the Community
2. Embedding of the WHO checklist
3. Early Identifying of the Deteriorating Patient
4. To Reduce Avoidable Admissions of Term Babies to the Neonatal Intensive Care Unit (NICU)
5. Friends and Family Test – in-patient responses

Related to these new priorities, we are disappointed the Trust has dropped as Quality Priorities: (1) Hospital associated preventable venous thromboembolism; (2) Discharge.

The priorities for 2014/15 were:

1. To have no hospital associated preventable venous thromboembolism (VTE)
2. Continue to focus on communication, discharge, and delivering safe and compassionate care to all our patients
3. Patient Experience (Staff Engagement) 2014/15
4. To improve choice and quality in End of Life Care

National clinical audits

Diabetes Audit

We note participation in this audit 'in 15/16 is a divisional priority.'

Child Health Review

We note the comment 'C&W do not have the resources to develop 'epilepsy passports' for all our children but we do ensure that all clinic letters with relevant clinical information and advice are copied in to school nurses and head teachers.'

UK Paediatric Inflammatory Bowel Disease Audit

We note the comment 'However, sustainability will be confirmed in the long term, since there is a bed capacity pressure.'

Local clinical audits

An audit into appropriateness of CT pulmonary angiograms to investigate pulmonary embolisms in AAU

Results from the 2 month re-audit should be presented in the Quality Account.

Urgent Care Centre Minor Ailments Audit

The statement '2 patients should have been streamed into the minor injury stream rather than the minor illness stream' doesn't make sense.

Audit of Intra Uterine Devices at West London Centre for Sexual Health

We note the data used relates to 2013.

A review of patients referred with abnormal smear results – was a biopsy taken within 2 years?

We note '6 patients were not appropriately followed up due to appointments not being made' and the inconclusive statement 'this may have been the patient choosing not to book an appointment, or an error on the clinic's part by not booking an appointment'.

Conclusion

We are entirely supportive of the work that Chelsea and Westminster NHS Foundation Trust undertakes. The hospital on the Fulham Road has been an outstanding facility, but it is now in need of improvement.

We were disappointed that this year England's Chief Inspector of Hospitals rated the services provided at the Chelsea and Westminster hospital as 'requires Improvement overall'. We hope that progress can be on made on all issues raised. Risks from the merger with West Middlesex University Hospital Trust will need to be kept to a minimum.

We are interested to find out how the priorities outlined in the Quality Account are implemented over the course of 2015/16.

We look forward to continuing our strong working relationship with Chelsea and Westminster Hospital NHS Foundation Trust in 2015/16.

Councillor David Harvey,
Chairman, Adult Services and Health Policy Scrutiny Committee,
Westminster City Council

Statement from Adult Services and Health Policy Scrutiny Committee, Adult Social Care and Health Scrutiny Committee, Royal Borough of Kensington and Chelsea

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A firm eye needs to be kept on the core business to minimise performance risks. The Foundation Trust will need to ensure that new work (i.e. to take forward the merger, bring the different bodies together and resolving the issues at West Middlesex University Hospital) does not distract from the core work at the Fulham Road site.

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- Over the last two years the number of adult in-patient cases where there has perceived to be a failure to calculate NEWs scores accurately and/or failure to escalate promptly or to the appropriate teams has remained static at 18 cases per year (excluding maternity and paediatrics).
- We note the reference to 'Understanding the Mental Capacity Act (MCA) and ways of 'making reasonable adjustments' for this group of patients [people with learning disabilities] are key components of this useful training.' We would add that staff needs appropriate knowledge of the MCA and awareness of the requirements of Deprivation of Liberty Safeguards (DoLS). The processes for patients in need of DOLS assessment or MCA assessment should always be prompt and appropriate.

We were disappointed this year:

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5. Friends and Family Test – in-patient responses

Related to these new priorities, we are disappointed the Trust has dropped as Quality Priorities: (1) Hospital associated preventable venous thromboembolism; (2) Discharge. The Trust needs to work to reduce all delayed transfers, both internal and external, and timeliness of discharge.

The priorities for 2014/15 were:

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Conclusion

We are entirely supportive of the work that Chelsea and Westminster NHS Foundation Trust undertakes. The hospital on the Fulham Road has been an outstanding facility, but it is now in need of improvement.

We were disappointed that this year England’s Chief Inspector of Hospitals rated the services provided at the Chelsea and Westminster hospital as ‘requires Improvement overall’. We hope that progress can be on made on all issues raised. Risks from the merger with West Middlesex University Hospital Trust will need to be kept to a minimum.

We are interested to find out how the priorities outlined in the Quality Account are implemented over the course of 2015/16.

We look forward to continuing our strong working relationship with Chelsea and Westminster Hospital NHS Foundation Trust in 2015/16.

Councillor Robert Freeman,
Chairman, Adult Social Care and Health Scrutiny Committee,
Royal Borough of Kensington and Chelsea

Statement from Our Governors

[DN – to follow]

Annex 2: Statement of Directors' responsibilities for the Quality Report

[DN – to be completed at the end of the process]

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2014 to [the date of this statement]
  - papers relating to Quality reported to the board over the period April 2014 to [the date of this statement]
  - feedback from commissioners dated XX/XX/20XX
  - feedback from governors dated XX/XX/20XX
  - feedback from local Healthwatch organisations dated XX/XX/20XX
  - feedback from Overview and Scrutiny Committee dated XX/XX/20XX
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XX/XX/20XX
  - the [latest] national patient survey XX/XX/20XX
  - the [latest] national staff survey XX/XX/20XX
  - the Head of Internal Audit's annual opinion over the trust's control environment dated XX/XX/20XX
  - CQC Intelligent Monitoring Report dated XX/XX/20XX
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- The Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the

standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board
NB: sign and date in any colour ink except black

.....Date.....Chairman

.....Date.....Chief Executive

Council of Governors Meeting, 14 May 2015

AGENDA ITEM NO.	11/May/15
REPORT NAME	Performance and Quality Report
AUTHOR	Virginia Massaro, Assistant Director of Finance
LEAD	Karl Munslow-Ong, Chief Operating Officer
PURPOSE	To report the Trust's performance for February 2015, highlight risk issues and identify key actions going forward as presented to the April Quality Committee.
SUMMARY OF REPORT	The Trust met all key performance indicators for Monitor in February, with the exception of the compliance with requirements regarding access to healthcare for people with learning. - The Trust is currently not fully compliant will all 6 of the learning disabilities indicators, but working to achieve compliance in 2015/16. This is also part of our CQC Action Plan. - All three RTT indicators were achieved in February and A&E performance against the 4 hour waiting time indicator of 97.2% was achieved in February, which is a further improvement on January's performance. - Patient Safety: There has been a reduction in the prevalence of pressure ulcers in February, but still above the challenging target, with the Q4 achievement now at risk. Screening of elective patients for MRSA has improved in February following actions put in place earlier in the year. - Clinical Effectiveness: There has been a reduction in the % of patients nutritionally screened on admission in February and actions have been put in, with improvements seen at the beginning of March. Maternity caesarean section rates continue to be above target, but have reduced in February to 30.9% overall. - Patient experience: Response rates have improved for the Friends and Family Test in the month. Training will be delivered during March to improve access to departmental results, analyse the feedback so that they can improve patient experience based on the feedback for individual areas. - Access and Efficiency: There were two 60 minute handover breaches

	during the busy period on 1 day in February. Further improvement in discharge summaries sent in real time in February, though the Trust remains behind the challenging 80% target.
KEY RISKS ASSOCIATED	As outlined above.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	As outlined above.
EQUALITY & DIVERSITY IMPLICATIONS	NA
LINK TO OBJECTIVES	Improve patient safety and clinical effectiveness Improve the patient experience Ensure Financial and Environmental Sustainability
DECISION/ ACTION	For information.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Performance and Quality Report

Performance to 28th Feb 2015

At a Glance Performance – February

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Patient Safety Domain

- Hospital Associated VTE: 0
- Harm Free Score: 95.3%
- Cdiff Infections: 0
- Mortality SHMI: 79.5
- Never Events: 0
- Med. Related Safety Incidents: 7.0

Clinical Effectiveness Domain

- Time to Theatre Urgent Surgery: 94.6%
- 12hr consultant assessment: 0.00%
- Dementia Case Finding: 91.1%
- Emergency Re-admissions: 2.89%
- Caesarean Section Rate: 30.4%

Patient Experience Domain

- FFT Local Positive: 90.5%
- Hospital Cancellations: 11.0%
- FFT Response Rate: 25.7%
- Formal Complaints: 33.33%
- Staff FFT - To receive care: n/a
- Staff FFT - Place to Work: n/a

Access & Activity Domain

- A&E Waiting Times: 97.2%
- 18 weeks RTT Admitted: 90.7%
- Choose & Book Slot Issues: 6.0%
- EL & DC Activity: 3428
- DTOCs: 2.73%

Process Efficiency Domain

- Avg Wait New OP Appt: 6.3
- Theatre Conversion rate: 88.5%
- OP Letters sent <7 working days: 71.1%
- Theatre Active Time: 73.1%
- DSUM sent before Disch.: 70.2%

External Compliance Domain

- Monitor Compliance: 100%
- CQUIN Compliance: 93.6%

Work Force Domain

- Sickness Rate: 3.2%
- Turnover Rate: 17.1%
- Appraisal Completion: 69.5%
- Vacancy Rate: 10.7%
- Avg Days for Recruitment: 48 days

Finance Domain

- I&E Surplus: £1.7m
- EBITDA: 7.5%
- CIP Identified: £12.9m
- COSRR: 3
- Cash: £18.9m

Trust Headlines – 2015

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Monitor Compliance – Feb 2015

Sub Domain	Trust Level Monthly Data @ 11/03/2015 XL				YTD XL
	MonthYear	Dec 2014	Jan 2015	Feb 2015	YTD
Harm	Clostridium difficile infections (Target: < 0.67)	2	1	0	7
	MRSA Bacteraemia (Target: < 0)	0	0	0	0
Cancer	Cancer diagnosis to treatment waiting times > 31 Days (Target: > 96%)	100.0%	100.0%	N/A	99.7%
	Cancer diagnosis to treatment waiting times > Subsequent Surgery (Target: > 94%)	50.0%	100.0%	N/A	91.7%
	Cancer diagnosis to treatment waiting times > Subsequent Medicine (Target: > 98%)	100.0%	N/A	N/A	100.0%
	Cancer urgent referral GP to treatment waiting times (62 Days) (Target: > 85%)	97.6%	92.6%	N/A	90.8%
	Cancer urgent referral Consultant to treatment waiting times (62 Days) (Target: > 90%)	100.0%	N/A	N/A	96.0%
	Cancer urgent referral to first outpatient appointment waiting times (2WW) (Target: > 93%)	97.4%	93.2%	N/A	94.7%
RTT	18 week referral to treatment times Admitted Patients (Target: > 90%)	91.2%	91.1%	90.4%	85.3%
	18 week referral to treatment times Non Admitted Patients (Target: > 95%)	95.9%	95.0%	95.0%	95.9%
	18 week RTT incomplete pathways (Target: > 92%)	92.1%	93.0%	92.9%	92.3%
A&E	A&E waiting times (Target: > 98%)	95.7%	96.9%	97.2%	96.4%
LD	Self-certification against compliance with requirements regarding access to healthcare for pe...	Non-Compliant	Non-Compliant	Non-Compliant	Non-Compliant

Self certification against compliance with requirements regarding access to healthcare for people with learning difficulties:

The Trust is currently not fully compliant will all 6 of the learning disabilities indicators, but working to achieve compliance in 2015/16. This is also part of our CQC Action Plan. The main actions to achieve compliance are:

- Launch of a new LD flag in May 2015. Until then, the CSI log is being used.
- Development of easy read information for patients
- LD training program for staff is in place. To be expanded to include obstetric staff and improve training at Clinical Trust Induction
- Improvement of protocols to regularly audit its practices for patients with learning disabilities and to demonstrate the findings, as currently our only audits are of the use of CSI log for LD. Plan to report bi-annually to the Quality committee/CQG.

*The Monitor MRSA de minimus target is 6 cases, however we measure against a stretch target of 0
*The Monitor A&E target is 95% under 4hr wait, however we measure against an internal stretch target of 98%

Performance Headlines

Improvements

- All Monitor indicators were achieved in February, with no further Cdiff cases and a further improvement in A&E waiting times.
- There was a significant improvement in the turnaround times for outpatient letters within 7 days, following focussed work on reducing the backlog in Surgery.
- Elective screening for MRSA has improved following actions put in place to check all elective lists for screening.
- Friends and Family Test results reported a higher net local positive score in February and also an increased response rate.

Challenges

- The prevalence of pressure ulcers rate remained high in February, despite continued work to reduce pressure ulcers. The Trust is now unlikely to achieve the Q4 stretch target, however most other CQUIN schemes are on target.
- There were two 60 mins ambulance handover breaches in February following high demand and capacity constraints within the department on 1 day in the month.
- Staff turnover remains high in February, with actions underway to target specific areas of concern.

Sub Domain	Trust Level Monthly Data @ 11/03/2015 XL				YTD XL
	Month Year ▼	Dec 2014	Jan 2015	Feb 2015	YTD
Harm	Incidence of newly acquired category 3 and 4 pressure ulcers (Target: < 3.6)	2	2	2	19
	Safety Thermometer - Harm score (Target: > 90%)	96.0%	93.9%	95.3%	94.6%
	Safety Thermometer - Prevalence of Pressure Ulcers (Rate) (Target: < 3.45%)	2.8%	5.5%	4.9%	4.2%
HCAI	C Diff rate per 100k bed days pts aged >=2 (Target: < 14.7)	104.7	52.3	0.0	33.3
	Clostridium difficile infections (Target: < 0.67)	2	1	0	7
	Hand Hygiene Compliance (trajectory) (Target: > 90%)	97.2%	97.4%	97.2%	97.3%
	Methicillin Sensitive Staphylococcus Aureus Target < 3.9)	0	1	1	10
	E.Coli bloodstream infections Target < 11.9)	5	3	1	59
	MRSA Bacteraemia (Target: = 0)	0	0	0	0
	Screening all elective in-patients for MRSA (Target: > 95%)	95.3%	93.3%	96.6%	92.8%
	Screening Emergency patients for MRSA (Target: > 95%)	98.5%	97.8%	97.1%	97.7%
Incidents	Incident reporting rate per 100 admissions (Target: > 8.50)	7.91	7.23	6.29	7.53
	Inpatient falls per 1000 Inpatient bed-days (Target: < 3.00)	3.01	2.34	3.42	3.36
	Never Events (Target: = 0)	0	0	0	0
	Medication related safety incidents per 1000 admissions Target < 89.4)	7.7	4.7	7.0	7.1
	Rate of patient safety incidents per 100 admissions (Target: < 2.9)	7.26	6.91	5.87	7.14
	Rate of pt. safety incidents resulting in severe harm - death per 100 admissions (Target: = 0.00)	0.02	0.00	0.02	0.01
Mortality	Mortality (HSMR) (2 months in arrears) (trajectory) (Target: < 104)	N/A	N/A	N/A	74.4
	Mortality SHMI *TRUST ONLY* (Target: < 82)	79.5	79.5	79.5	80.2
	Number of In-hospital Deaths (Adults	40	41	30	339
	Number of in-hospital deaths (Paed	0	0	0	0
	Number of in-hospital deaths (Neonatal)	1	5	4	36

Safety Thermometer - Pressure ulcers:

Work continues to focus on hospital acquired pressure ulcers. The Preventing Harm Group have reviewed information requirements relating to pressure ulcers so that effort can be targeted appropriately.

Progress has been made on the presentation of pressure ulcers with a particular focus on Lord Wigram Ward where a project "Lift Off" has commenced. This has involved changing practice along the pathway including recovery and theatres, clinicians discussing skin assessments on ward rounds, new guidelines for cast management and letters to all staff regarding their responsibility and accountability in Pressure Ulcer Management. The project will continue in 15/16. At the time of writing this report there has been no pressure ulcer on Lord Wigram ward for 50 days.

Inpatients falls per 1000 inpatient bed days:

The Preventing Harm Group continue to focus on falls, particularly those with harm. The falls with moderate harm remain less than 1 per month for the last 6 months and falls with minor harm average about 9 the number of overall falls is variable each month. A review of the information required for the Preventing Harm Group has also been agreed so that the group are clear where they need to target effort.

Safe Nursing and Midwifery Staffing

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Ward Name	Average fill rate registered nurses/midwives (%) day shift	Average fill rate care staff (%) day shift	Average fill rate registered nurses/midwives (%) night shift	Average fill rate care staff (%) night shift
Maternity	78.6%	77.4%	71.0%	57.1%
Annie Zunz	107.3%	190.0%	135.0%	190.0%
Apollo	96.4%	53.6%	96.4%	-
Jupiter	90.8%	75.0%	137.5%	-
Mercury	109.5%	89.3%	106.5%	70.4%
Neptune	94.6%	85.7%	102.4%	92.9%
NICU	92.4%	-	94.6%	-
AAU	93.6%	94.4%	119.4%	103.6%
Nell Gwynne	103.3%	99.6%	126.8%	100.0%
David Erskine	105.7%	107.1%	105.4%	123.2%
Edgar Horne	110.7%	100.9%	133.9%	100.0%
Lord Wigram	100.0%	100.0%	100.0%	100.0%
Rainsford Mowlem	98.5%	98.8%	100.0%	101.8%
David Evans	108.9%	90.2%	137.5%	111.4%
Chelsea Wing	101.3%	96.4%	100.0%	100.0%
Burns Unit	94.7%	121.4%	101.2%	234.4%
Ron Johnson	92.5%	91.7%	93.3%	91.7%
ICU	98.2%	-	101.2%	-

National Quality Board Report – Hard Truths expectations:

The February fill rate data (table 1) is presented in the format as required by NHS England.

Definition – Fill rate:

The fill rate percentage is measured by collating the planned staffing levels for each ward for each day and night shift and comparing these to the actual staff on duty on a day by day basis. The fill rate percentages presented are aggregate data for the month and it is this information that is published by NHS England via NHS Choices each month.

Trusts are also required to publish this information on their own web sites, a recent survey has revealed that very few Trusts receive enquiries on the back of their fill rate data. The concern from the outset is that data aggregated at this level provides little or no meaning to the public.

Summary for February:

February has been a particularly difficult month with an increasing number of unwell and highly dependent patients with complex needs. Nell Gwynne and Edgar Horne Ward needed to increase their night staffing levels to 3 registered nurses to safely manage their patients. Investment in night time staffing levels has been approved as part of business planning. Jupiter ward had a need for a significant number of RMN shifts. David Evans have a local agreement to have 3 registered nurses on at night.

Annie Zunz and AAU fill rates relates to additional capacity and trollies being open overnight.

Burns unit excessive fill rate for health care assistants requires further investigation as it is not clear what was driving this level of demand.

Clinical Effectiveness

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Sub Domain	Trust Level Monthly Data @ 16/03/2015 XL				YTD XL
	MonthYear	Dec 2014	Jan 2015	Feb 2015	YTD
Admitted Care	Elective LoS - Long Stayers (Target: < 46)	52	51	51	577
	Elective Length of Stay (Target: < 3.7)	3.7	2.9	3.3	3.2
	Emergency Care Pathway - Discharges (Target: N/A)	185.9	190.6	175.0	2104.3
	Emergency Care Pathway - Length of Stay (Target: < 4.5)	5.35	5.00	5.08	4.69
	Emergency Re-Admissions within 30 days (adult and paed) (Target: < 2.8%)	2.57%	3.08%	2.89%	2.96%
	Non-Elective Long Stayers (Target: < 488)	437	455	416	4811
	Non-Elective Length of Stay (Target: < 3.9)	4.6	3.9	4.2	4.0
	VTE Assessment (Target: > 95%)	96.4%	96.8%	95.8%	96.5%
Best Practice	% Patients Nutritionally screened on admission *TRUST ONLY* (Target: > 90%)	81.5%	89.6%	75.3%	79.6%
	% Patients in longer than a week who are nutritionally re-screened *TRUST ONLY* (Target: > 90%)	74.4%	72.7%	59.8%	68.2%
	12 Hour consultant assessment - AAU Admissions (Target: > 90%)	80.7%	67.9%	67.8%	65.5%
	Central line continuing care—compliance with Care bundles (Target: > 90%)	100.0%	88.9%	100.0%	98.8%
	Peripheral line continuing care—compliance with Care bundles (Target: > 90%)	90.0%	94.4%	100.0%	89.5%
	Urinary catheters continuing care—compliance with Care bundles (Target: > 90%)	90.0%	87.5%	100.0%	95.6%
	Fractured Neck of Femur - Time to Theatre < 36 hrs for Medically Fit Patients (Target: = 100%)	84.6%	81.8%	N/A	87.2%
	Safeguarding adults - Training Rates (Target: >)	tba	tba	tba	tba
	Safeguarding children - Training rates (Target: >)	tba	tba	tba	tba
	Stroke: Time spent on a stroke unit *TRUST ONLY* (Target: > 80%)	100.0%	100.0%	100.0%	100.0%
Best Practice	Dementia Screening Case Finding (Target: > 90%)	90.5%	93.3%	94.2%	94.6%
	Appropriate referral Dementia specialist diagnosis *TRUST ONLY* (Target: > 90%)	100.0%	100.0%	100.0%	100.0%
	Dementia Screening Diagnostic Assessment (Target: > 90%)	100.0%	100.0%	100.0%	100.0%
Theatres	Procedures carried out as day cases (basket of 25 procedures) (Target: > 85%)	84.3%	83.8%	81.1%	81.7%
	Theatre Active Time - % Total of Staffed Time (Target: > 70%)	73.9%	71.1%	73.7%	73.4%
	Time to theatre for urgent surgery (NCEPOD recommendations) (Target: > 95%)	95.6%	96.3%	94.6%	94.7%

Elective LOS – Long stayers: The majority of long stay patients in February were on David Evans ward, which is consistent with the complex surgery associated with patients on the ward. The number is also consistent with the previous month's performance and has reduced from previous months. Two wards had a higher number of patients staying longer than expected but these numbers were 4 patients on Ron Johnson ward and 5 patients on Mercury ward. These relatively low numbers point to complications in individual cases rather than significant themes.

Nutritional Screening on Admission: Initial screening has reduced by 15% from 90% to 75%, rescreening after 7 days dropped by 12% to 60%. Both are well below the target of 90%.

All Wards are now be monitored weekly on Wednesdays and ward sisters notified of performance by Friday to enable weekly senior nurse presence to monitor and promote screening. The results for the first two weeks of March show an improvement to 84% for initial screening and 65% for rescreening.

Ward sisters have been trained to access live nutritional screening information and nutrition screening will be discussed at the Chief Nurses cabinet, the specialist nurse forum and the lead nurse and matron forum.

12 hour consultant Assessment: The divisions are working on the visibility of this metric with attending consultant teams and making the electronic solution to recording consultant review a reality by using the "computers on wheels" on ward rounds to record this metric contemporaneously. The acute assessment unit is achieving over 90% on some days, demonstrating that this metric is achievable and we now need to capture and embed good practise in this regard. Work is ongoing.

NCEPOD: In February there were 462 patients who required emergency surgery. Of these patients 437 (94.6%) had their surgery within the Trusts locally adapted more stringent waiting times for emergency surgery and 25 did not. 439 patients (95.02%) had their surgery within the national waiting times for emergency surgery.
All cases have been reviewed by a clinician and for those that did not meet the target there were no serious clinical consequences.

Procedures carried out as Day cases: February performance has deteriorated compared to January although there has been a continued improvement in hernia and cholecystectomy procedures carried out as day-cases. Hernia is currently at 62% against a target of 65%. Cholecystectomies performed as a day case have risen from 20% last month to 46% in February meeting the Trusts target of 40%. Paediatric tonsillectomy procedures low performance in this area is due to operating on afternoon lists which impedes the ability to discharge on the day. Discussions are taking place to change the SLA and move these lists to the morning.

Clinical Effectiveness – Maternity

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

	Indicator	Measure	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	YTD Total
Activity in Month	NHS Deliveries	Benchmarked to 5042 per annum	416	417	405	422	412	433	462	464	427	432	463	398	4,735
	Private Deliveries	Benchmarked to 840 per annum	72 per month	62	76	71	73	63	70	71	53	60	85	50	734
	Trust Deliveries	Total Maternities (Mother)		479	481	493	485	496	532	535	480	492	548	448	5,469
	Births	Birth Centre (excludes transfers)	No. of patients	83	67	79	65	65	65	59	64	48	66	47	708
		BC maternities rate of Trust total SVD	%	37.4%	31.6%	36.1%	30.2%	30.5%	28.3%	28.8%	28.2%	24.7%	28.1%	25.1%	
		Home births - rate of NHS maternities	% NHS Dels	1.2%	1.2%	1.2%	0.7%	0.5%	0.9%	0.6%	0.2%	1.6%	0.6%	1.3%	
	Norm. Vaginal Deliveries	SVD (Normal Vaginal Delivery)	No. of patients	222	212	219	215	213	230	205	227	194	235	187	2,359
		Maintain normal SVD rate	52%	53.2%	52.3%	51.9%	52.2%	49.2%	49.8%	44.2%	53.2%	44.9%	50.8%	47.0%	
	C- Section	Total C/S rate overall	<27%	29.3%	32.3%	28.4%	28.9%	31.6%	30.1%	33.2%	27.9%	35.0%	31.5%	30.9%	
		Emergency C Sections	No. of patients	59	66	66	64	85	77	69	58	77	84	64	769
			<12%	14.1%	16.3%	15.6%	15.5%	19.6%	16.7%	14.9%	13.6%	17.8%	18.1%	16.1%	
		Elective C Sections	No. of patients	63	65	54	55	52	62	85	61	74	62	59	692
			<15%	15.1%	16.0%	12.8%	13.3%	12.0%	13.4%	18.3%	14.3%	17.1%	13.4%	14.8%	
	Assisted Deliveries	Ventouse, Forceps Kiwi	No. of patients	73	62	83	78	83	93	105	81	87	82	88	915
			10-15% (SD)	17.5%	15.3%	19.7%	18.9%	19.2%	20.1%	22.6%	19.0%	20.1%	17.7%	22.1%	
	Total CS Rate Based on Coded Spells		<27%	29.0%	32.5%	29.2%	29.2%	31.9%	31.2%	32.7%	27.9%	34.2%	31.5%	30.4%	
Clinical Indicators	PP Heamorrage	Blood loss >2000mls	<10	11	3	5	11	7	8	9	4	6	8	4	76
		Blood loss >4000mls	No. of patients	1	0	0	1	0	0	2	0	0	1	1	
	Perineum	3rd/4th degree tears	<5% (RCOG)	7	10	9	6	8	8	18	12	13	14	10	115
				2.4%	3.6%	3.0%	2.0%	2.7%	2.5%	5.8%	3.9%	4.6%	4.4%	3.6%	
	Stillbirths	Number of Stillbirths		3	2	4	1	4	3	3	2	1	3	2	28
	Sepsis	GBS - NHS maternities		32	31	35	30	23	33	27	26	36	32	27	332
		Pyrexia in labour	≥38°C	8	16	12	4	13	16	12	9	5	11	13	119
	Readmissions	Neonatal < 28 days of Birth (Feeding)		4	5	2	7	7	2	3	8	1	5	n/a	44
		Of which were born at C&W		2	5	4	7	6	2	3	6	1	3	n/a	39
PbR	Pathways	Antenatal Bookings completed	509	463	539	492	524	476	471	498	495	430	465	431	5,284
		Ref by 11w		351	377	383	406	356	341	354	361	306	327	321	3,883
		% Ref by 11w		76%	70%	78%	77%	75%	72%	71%	73%	71%	70%	75%	
		KPI: % Ref by 11w and seen by 12+6w	95%	92.9%	91.8%	95.8%	97.3%	95.8%	96.8%	95.2%	96.4%	95.4%	91.1%	90.3%	
		Breaches (11w ref and booked > 12+6w		25	31	16	11	15	11	17	13	14	29	31	213
	Postnatal discharges		221	222	214	238	228	249	223	235	254	213	230	n/a	2,306
Risk	Maternal Morbidity	Maternal Death	Incident Form	0	0	0	0	0	0	0	1	0	0	0	1
		ITU Admissions in Obstetrics	In 2 mths < 6	1	1	0	1	1	0	1	1	1	0		7
	VTE	Assessments	95%	97.2%	98.0%	97.6%	96.5%	97.2%	96.3%	98.6%	97.2%	96.3%	97.2%	94.7%	
KPI	Trust Level Indicators	NBBS - offered and discussed	100%	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	
		Maternity Unit Closures	LSA Db	0	0	0	0	0	0	0	0	0	0	0	0
		1:1 care	100%	93.5%	93.2%	96.5%	93.6%	93.4%	93.0%	97.9%	98.4%	94.4%	96.5%	95.6%	
		Breastfeeding initiation rate	90%	89.9%	91.9%	93.4%	89.8%	88.5%	89.8%	88.8%	89.7%	90.3%	88.8%	87.4%	
		Women smoking at time of delivery	<10%	1.2%	0.7%	0.9%	1.5%	1.4%	1.7%	0.9%	2.1%	1.6%	1.3%	2.5%	
		Midwife to birth ratio - Births per WTE	1:30	1:33	1:32	1:31	1:33	1:32	1:36	1:37	1:30	1:34	1:36	1:28	
		DSUMs complete & sent in 24hrs	80%	71.6%	50.0%	50.5%	50.0%	59.8%	69.5%	54.4%	67.0%	61.2%	67.4%	54.3%	

Activity: NHS deliveries were lower than prior months at 398 in February in line with the lower number of days in the month. Community midwifery teams are in an early phase of trailing a new tablet based app which will facilitate paper-free postnatal visits and real time capture of activity in the field.

C-Section: February section rates improved against the target for emergency and overall c-sections. The elective section rate was within target for the second successive month. Clinical indicators for blood loss and 3rd degree tears were within a normal range and below ceiling targets.

DSUMs: Ongoing work with the Information team to validate and set appropriate exclusions within our local reporting. From the initial validation we are confident in achieving the DSUM target for Q4 following these developments.

Breastfeeding Initiation: The Infant Feeding Team are auditing patients across Q4 to date to validate the CMiS (maternity system) records in comparison to the paper notes to confirm correct indication of initiation. The Trust is expecting to achieve each month of Q4 against the target of 90% following these audit results. Training is ongoing in record keeping within the electronic CMiS system.

12+6 Access: February saw a second consecutive month below the 95% target for women referred by 11w gestation to be seen by 12 wks and 6 days. Staff sickness absence within the antenatal booking team has now been addressed to improve the timely processing of referrals and reception cover across the clinical areas. We are also progressing a 'prospective view' app with the Information team to provide clear signposting of those appointments booked outside of 12+6 so that they may be reviewed and brought forward as appropriate.

Sub Domain	Trust Level Monthly Data @ 11/03/2015 XL Month/Year	Dec 2014	Jan 2015	Feb 2015	YTD XL YTD
Complaints	Breach of Same Sex Accommodation *TRUST ONLY* (Target: = 0)	0	0	0	0
	Complaints (Type 1 and 2) - Communication (Target: < 13)	16	22	9	214
	Complaints (Type 1 and 2) - Discharge (Target: < 2)	1	3	1	21
	Complaints (Type 1 and 2) - Attitude / Behaviour (Target: < 16)	20	10	14	182
	Complaints Re-opened (Target: < 5%)	5.56%	0.00%	N/A	6.97%
	Complaints upheld by the Ombudsman *TRUST ONLY* (Target: = 0)	1	1	0	6
	Formal complaints responded in 25 working days (Target: = 100%)	50.00%	60.00%	N/A	65.16%
	Total Formal Complaints	18	25	12	244
Friends & Family	Friends & Family Test - A&E response rate (Target: > 20%)	22.0%	21.7%	21.3%	21.3%
	Friends & Family Test - Inpatients response rate (Target: > 30%)	27.6%	30.5%	30.8%	30.4%
	Friends & Family Test - Local +ve score (Trust) (Target: > 90%)	87.3%	89.6%	90.5%	89.7%
	Friends & Family Test - Net promoter score (Target: > 62)	59.6	59.8	64.2	61.1
	Friends & Family Test - Total response rate (Target: > 30%)	24.8%	25.4%	25.7%	24.5%

Friends and Family:

The Trust is focussing on how we can improve our FFT response rate, particularly in those areas where the response rate is low and working to determine the most appropriate feedback mechanism; for some areas this may include a mix of call centre, paper and text as the mechanism for obtaining feedback.

FFT training will be delivered to all ward and department leaders during March so that they understand how to access their results, analyse the feedback and get into the detail so that they can improve patient experience based on the feedback for their areas.

Access and Efficiency (1)

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Sub Domain	Trust Level Monthly Data @ 16/03/2015 — MonthYear	Dec 2014	Jan 2015	Feb 2015	YTD
A&E	A&E Time to Treatment (Target: < 60)	01:09	01:02	01:04	01:07
	A&E waiting times (Target: ≥ 98%)	95.7%	96.9%	97.2%	96.4%
	A&E: Unplanned Re-attendances (Target: < 5%)	6.92%	6.85%	6.43%	6.69%
	LAS Patient Handover Times - 30 mins (KPI2) *TRUST ONLY* (Target: < 0)	70	40	41	759
	LAS arrival to handover more than 60mins (KPI 3) *TRUST ONLY* (Target: < 0)	0	5	2	25
Cancer	Cancer Consultant Upgrade (Target: ≥ 85%)	100.0%	N/A	N/A	96.0%
	Cancer diagnosis to treatment waiting times - 31 Days (Target: ≥ 96%)	100.0%	100.0%	N/A	99.7%
	Cancer diagnosis to treatment waiting times - Subsequent Medicine (Target: ≥ 98%)	100.0%	N/A	N/A	100.0%
	Cancer diagnosis to treatment waiting times - Subsequent Surgery (Target: ≥ 94%)	50.0%	100.0%	N/A	91.7%
	Cancer urgent referral Consultant to treatment waiting times (62 Days) (Target: ≥ 90%)	100.0%	N/A	N/A	96.0%
	Cancer urgent referral GP to treatment waiting times (62 Days) (Target: ≥ 85%)	97.6%	92.6%	N/A	90.8%
	Cancer urgent referral to first outpatient appointment waiting times (2WW) (Target: ≥ 93%)	97.36%	932%	N/A	94.69%
OP	Average Wait – Referral to First Attendance (Weeks) (Target: < 6 weeks)	5.7	6.8	6.3	6.0
	Choose and Book slot issue % *TRUST ONLY* (Target: < 2.0%)	7.7%	8.0%	6.0%	6.7%
	Number of patients waiting longer than six weeks for a diagnostic test (Target: = 0)	0	0	0	0
	Rapid access chest pain clinic waiting times (Target: ≥ 98%)	100.0%	100.0%	100.0%	100.0%
RTT	18 week referral to treatment times Admitted Patients (Target: ≥ 90%)	91.4%	91.2%	90.8%	85.4%
	18 week referral to treatment times Non Admitted Patients (Target: ≥ 95%)	95.9%	95.0%	95.0%	95.9%
	18 week RTT incomplete pathways (Target: ≥ 92%)	92.1%	93.0%	92.9%	92.3%
	RTT Incomplete 52 Wk Patients @ Month End (Target: = 0)	0	0	1	2
IP	Average Wait – Decision to admit to Admission (Weeks) (Target: < 6 weeks)	6.9	9.1	7.3	8.6

Choose and Book slot issues:
Slot issues remain in Paediatric Cardiology & Community Dermatology, with Thoracic Medicine a more recent issue. Trauma & Orthopaedic choose and book slots are no longer polling because of changes to the MSK triage process , which is under review.

Choose and Book slot issues will also be looked as part of the Trust's outpatient efficiency programme for 2015-16.

A&E Performance: waiting times:
February saw an improvement in A&E performance compared with January. January saw 6504 attendances with 264 breaches, and February 6201 attendances with 245 breaches. Adult attendance and acuity in particular remain key themes.

LAS Handovers:
Both 60 minute breaches relate to the 11th February when the Trust experienced high demand for ED services, in particularly impacted by acuity of admissions and majors resus space .

RTT Incomplete 52 Wk Patients:
This related to a plastics patient that was incorrectly encountered as having treatment in March 2014. Further validation work in February has identified that this patient had not had treatment. This is a complex patient that is a joint case and one of the consultants was not available at the end of February. The patient has now been booked for the end of March.

In order to ensure that the risk of this happening again is minimised, the Trust will ensure that when patients are added to the waiting list the encountering is correct and the clock is started from the correct date. All outpatient staff have been reminded of the importance of encountering correctly and an ongoing process of validation of the waiting list will continue to identify any further patients with an incorrect clinic outcome.

In addition, the Trust will set up more routine regular audits of activity to provide greater assurance around Data Quality. This will also form part of our internal audit work that has been commissioned.

Access and Efficiency (2)

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Sub Domain	Trust Level Monthly Data @ 16/03/2015 XL				YTD XL
	MonthYear	Dec 2014	Jan 2015	Feb 2015	YTD
Admitted	Delayed transfers - Patients affected *TRUST ONLY* (Target: < 2.00%)	3.28%	1.94%	2.73%	2.00%
	Delayed transfers of care days lost (Target: < 644)	426	360	367	3318
DQ	Coding Levels complete - 7 days from month end (Target: > 95%)	98.7%	99.0%	98.6%	98.6%
	Total NHS Number compliance (Target: > 98%)	96.9%	96.8%	96.8%	96.8%
GP Real Time	Discharge Summaries Sent < 24 hours (Target: > 70%)	76.1%	79.0%	80.7%	79.5%
	Discharge Summaries Sent In Real Time (Target: > 80%)	64.9%	68.2%	70.2%	65.3%
	GP notification of an A&E-UCC attendance < 24 hours (Target: > 70%)	99.92%	99.87%	99.95%	99.77%
	GP notification of an emergency admission within 24 hours of admission (Target: >)	99.83%	99.66%	99.82%	99.84%
	GP Notification of discharge planning within 48 hours for patients >75 (Target: > 70%)	63.85%	75.30%	68.37%	68.30%
Outpatients	OP Letters Sent < 7 Working Days (Target: > 70%)	58.4%	63.6%	71.0%	71.9%
	Average PICs per patient (Target: < 0.64)	0.59	0.62	0.60	0.62
	DNA Rate (Target: <11.1%)	10.4%	10.2%	11.6%	11.0%
	First to Follow-up ratio (Target: < 1.5)	1.66	1.70	1.60	1.69
	Hospital cancellations \ reschedules of outpatient appointments % of total attendances (Target: < 8.00%)	9.6%	9.9%	11.0%	10.0%
	Hospital cancellations made with less than 6 Weeks Notice (Target: < 3%)	4.6%	5.0%	5.8%	5.3%
	Patient cancellations \ reschedules of outpatient appointments % of total attendances (Target: < 8%)	8.4%	9.5%	9.6%	9.4%
Theatres	No urgent op cancelled twice (Target: = 0)	0	0	0	0
	On the day cancellations not rebooked within 28 days (Target: = 0)	1	2	0	4
	On the day cancelled operations (non clinical) % total elective admissions (Target: < 0.80%)	0.27%	0.33%	0.65%	0.33%
	Theatre booking conversion rate (Target: > 80%)	89.3%	86.4%	88.1%	87.9%

NHS Number Compliance:

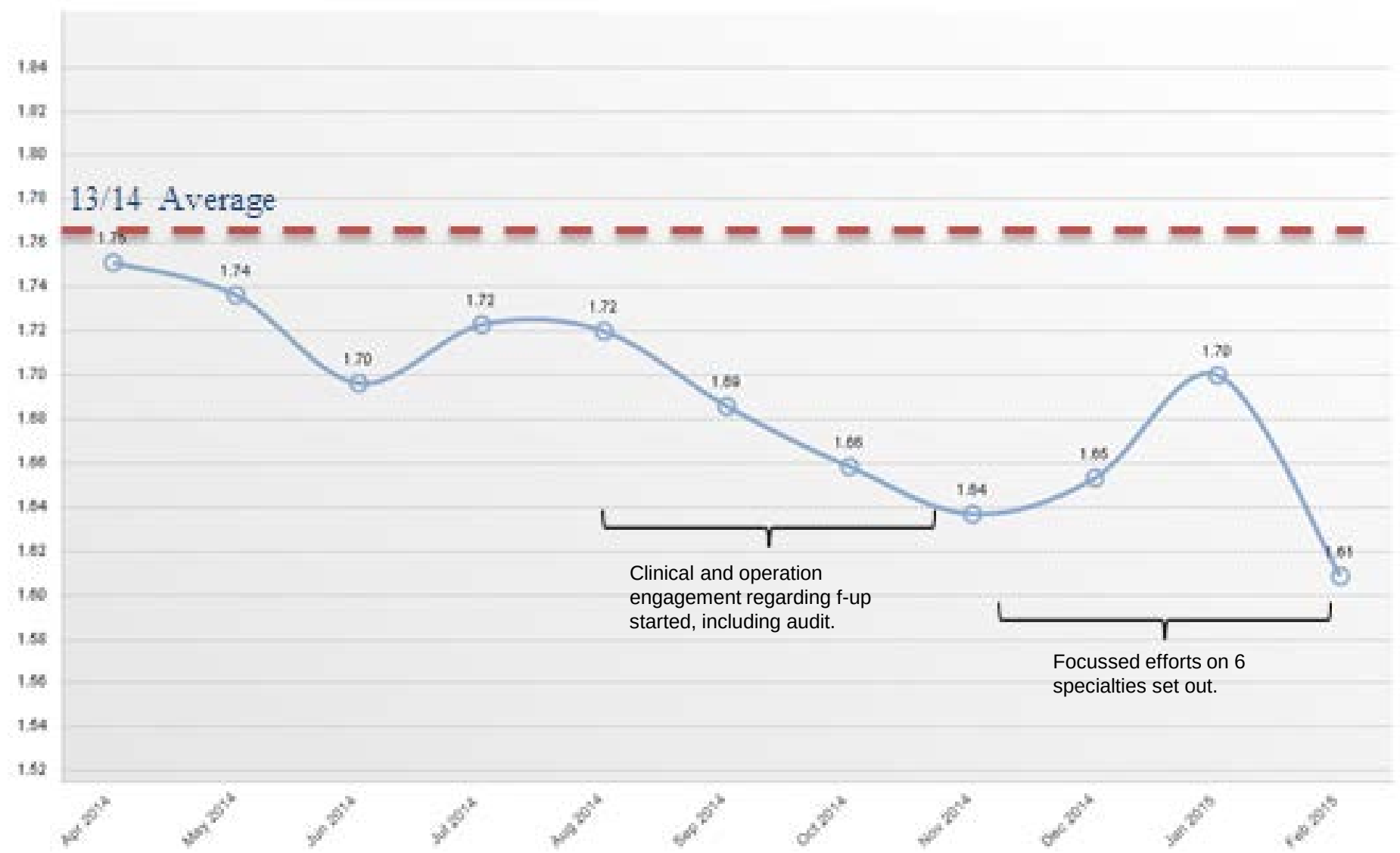
Staff continue to be issued with smartcards and trained in looking up missing NHS numbers on the spine. The overall position remains consistent however, Paediatric Dentistry is an area identified for improvement to target NHS number inclusion in referrals.

Discharge Summaries sent in real time:

While performance continues to improve on Discharge summaries, the figure has not improved sufficiently to meet the 80% target. Areas of improvement who were over 80% for February included Diagnostics, Surgery and HIV. There are still some high volume areas where completely discharge summaries in a timely manner has proved extremely difficult, most notably on AAU and the Emergency Observation Unit.

Access and Efficiency (3)

First to Follow-up ratio: Through mutli-disciplinary engagement and team work the Trust has successfully enabled the reduction of the follow up ratio. This has been a key priority of the outpatient transformation programme supported by the Trust central Service Improvement team.



CQUINs

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Domain	Indicator Detail	Q1 Total	Q2 Total	Oct-14	Nov-14	Dec-14	Q3 Total	Jan-15	Feb-15	Q4	YTD
FFT	Friends & Family Test - Inpatients response rate (Target: >30.0% in Q4)	33.30%	30.40%	33.10%	27.30%	27.60%	29.40%	30.50%	30.80%	30.60%	30.40%
	Friends & Family Test - A&E response rate (Target: >20.0% in Q4)	17.40%	23.30%	23.60%	22.80%	22.00%	22.80%	21.70%	21.30%	21.50%	21.30%
	Friends & Family Test - Staff FFT	-	-	-	-	-	-	-	-	-	-
Safety Thermometer	Safety Thermometer Data Collection (Target: =100%)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Safety Thermometer - Prevalence of Pressure Ulcers (Rate) (Target: <3.45%)	4.00%	4.80%	2.20%	4.70%	2.80%	3.20%	5.50%	4.90%	5.20%	4.20%
Dementia	Dementia Screening - Case Finding (Target: >90%)	97.20%	91.70%	92.50%	95.20%	88.00%	92.80%	91.50%	91.10%	91.50%	92.90%
	Dementia Screening - Assessment (Target: >90%)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Dementia Screening - Appropriate Referral (Target: >90%)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
GP Communication in Real Time	DSUMS Before Discharge 80% Target	63.80%	65.20%	63.40%	65.10%	65.00%	64.50%	68.24%	70.30%	69.20%	65.30%
	GP Notification Of Emergency Admission withing 24 hours	99.86%	99.88%	100.00%	99.75%	99.83%	99.86%	99.66%	99.82%	99.74%	99.84%
	GP Notification of A&E & UCC Attendance	99.30%	99.95%	99.96%	99.96%	99.92%	99.95%	99.83%	99.95%	99.91%	99.77%

The Trust continued to achieve the national CQUIN schemes of Friends and Family Test, Safety Thermometer data collection and Dementia Screening in February and is on track to achieve these for quarter 4, despite an increased target for Friends and Family test response rates in the last quarter (30% for inpatients and 21% for A&E).

The performance in February against the national CQUIN scheme to reduce the prevalence of pressure ulcers was 4.9% against a target of 3.45% and therefore the CQUIN scheme is now unlikely to be achieved.

The other key CQUIN scheme that is now unlikely to be achieved is the local CCG scheme to send 80% of discharge summaries to GPs within real time in quarter 4. There has been a significant improvement in January and February, with 70.3% of discharge summaries sent in real time in February, but this remains 10% behind target. There are a number of large volume areas that are underperforming, such as emergency medicine. Work is continuing with the clinical teams to target underperforming wards and improve the timely completion of discharge summaries, including weekly monitoring.

Mandatory Training

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Division	Total	Corporate Division	Emergency & Integrated Care Division	Planned Care Division	Womens, Childrens and Sexual Health Division
Fire	61%	74%	56%	67%	55%
Moving & Handling	72%	71%	70%	71%	74%
Safeguarding Adults Level 1	100%	100%	100%	100%	100%
Slips Trips and Falls	85%	87%	82%	88%	83%
Harrassment & Bullying	87%	87%	91%	89%	84%
Information Governance	55%	61%	54%	61%	50%
Hand Hygiene	75%	77%	75%	74%	75%
Health & Safety	84%	88%	79%	87%	85%
Child Protection Level 1	100%	100%	100%	100%	100%
Innoculation Incident	89%	90%	88%	94%	85%
Basic Life Support	74%	78%	72%	72%	76%
Health Record Keeping	78%	76%	76%	77%	80%
Medicines Management	93%	88%	96%	96%	90%
VTE	81%	76%	78%	77%	88%
Blood	78%	73%	79%	77%	79%
Safeguarding Children Level 2	81%	87%	83%	82%	75%
Safeguarding Children Level 3	71%	100%	78%	66%	71%
Corporate Induction	89%	90%	88%	94%	85%
Local Induction	*Reporting of local induction is under review*				
Mandatory Training Compliance %	78%	80%	77%	80%	77%

Mandatory Training:

Mandatory training figures in Feb 2015 were 78%, which is 16% below target for the month. The ambitious target of reaching 95% compliance by the close of 2014/15 is highly aspirational and will require a review of our policy and processes in relation to mandatory training. However our rate is above the average for LATTIN Trusts which is 75%. These are the London Area Teaching Trusts.

It was pleasing to note that Health & Safety training stands at 84% (compliance rate of staff trained within the two year refresher period across all staff groups).

A fundamental review of statutory and mandatory training is now taking place and this will be overseen by the new People and Organisational Development Committee. A report will go to the May meeting of that Committee.

We are also taking part in the London HR Streamlining programme which is improving policies and processes on statutory and mandatory training across all London Trusts.

Workforce

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

HR Metric		Monthly Target	Feb 15	~2013/14 Out-turn	2014/15 Annual Target	Average 12 month Rolling YTD
Turnover rate***		13.67%	**19.12%**	14.83%	13.50%	**17.83%**
Vacancies	Total	8.14%	**11.04%**	8.60%	8%	**10.80%**
	Active	3.25%	**5.75%**	3.02%	3.25%	**4.35%**
Time to Recruit	Authorisation to pre-employment checks completed	<55 days	**48 days**	-	<55 days	****52.25 days**
Sickness rate		3.50%	**3.23%**	2.92%	3.00%	**2.83%**
Agency % of WTE		3.15%	**3.30%**	3.82%	3.15%	**3.40%**
Appraisals	Non-Med	84.35%	**74%**	85%	85%	**81.00%**
	Medical	84.35%	**78.60%**	70%	85%	**81.00%**
Mandatory training*		95.00%	**77%**	77%	95%	**78.25%**

Vacancies: The total Trust vacancy rate for Feb 2015 was 11.04%, which is a increase of 0.31% on last month and 2.90% above the monthly target set for Feb. It is important to recognise that not all vacancies are being actively recruited to, and a large proportion of these vacancies are held on the establishment to support the Cost Improvement Programme (CIP).

A truer measure of vacancies is those posts being actively recruited to, based on the WTE of posts being advertised through NHS jobs throughout Feb 2015. The active vacancy rate for Feb was 5.75% which is 1.03% above the monthly target of 2.50%.

The average time to recruit (between the authorisation date and the date that all pre-employment checks were completed) for Feb starters was 48 days.

The average 12 months rolling YTD position remains on target.

Average vacancies across LATTIN Trusts = 12.02% (latest data available)

Red – below/worse than both monthly target and 2013/4 **Amber** – below/worse than either monthly target or 2013/4 **Green** – above/better than monthly target and 2013/4
*Mandatory training represents % of completed relevant training within refresher period. ** As this is a new KPI measurement, the figure quoted is current financial YTD rather than 12 month rolling YTD.
***Turnover rate is calculated in line with the CQC Intelligent Monitoring Report.
The Monthly Target has been agreed and set internally.
~ Figures quoted for 2013/14 are the mean of the 12 month financial year period NB: **Rolling YTD** is the average of the most recent 12 months data e.g. Jan-Dec)

Appraisals & Training: The non-medical appraisal rate decreased in Feb to 74% which is below both the monthly and yearly targets set. Reports of overdue and due appraisals are issued to managers monthly and included within the Divisional Board reports to ensure action is taken to complete appraisals within 12 months. This data was also discussed in Feb with Execs for urgent remedial action and then March SOG for direct operational action to remedy per area. Consultant appraisal rates currently stands at 78.60% which is an increase of 4.50% on last month.
The Medical Revalidation Team is working collectively with all consultants to ensure the completion of all appraisals that are currently outstanding.

Average (Appraisal rate) across LATTIN Trusts = 74% (latest data available)

Turnover: Unplanned staff turnover (i.e. resignations) has increased from 15.36% in Feb 2014 to 19.12% in Feb 2015. This is 5.45% above the monthly target of 13.67% set for Feb 2015. Nursing and Midwifery, Support staff and Admin and Clerical make up over half of the Trust's total establishment and accounted for 63.13% of voluntary resignations in Feb. ESR Analysis shows the main reasons staff leave the Trust is for 'Work Life Balance', Promotion and 'Relocation'. In response to the increase in leavers, Human Resources have conducted further in-depth analysis on turnover, leaving reasons and the length of service of leavers. Areas of most concern have been identified action plans developed and a turnover paper was taken to the Jan Board. This will be monitored on an ongoing basis by new People and Organisational Development Committee.

Finance Balanced Scorecard

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Financial Performance

Financial Position (£000's)

	Full Year Plan	Plan to Date	Actual to Date	Mth 11 YTD Var
Income	(368,981)	(337,341)	(341,914)	4,574
Expenditure	335,144	306,286	316,146	(9,860)
EBITDA	(33,837)	(31,055)	(25,769)	(5,286)
EBITDA %	9.2%	9.2%	7.5%	-1.7%
Surplus/(Deficit) from Operations bef	**33,837**	**31,055**	**25,769**	**(5,286)**
Interest	1,429	1,310	729	581
Depreciation	13,948	12,748	13,116	(368)
PDC Dividends	11,400	10,450	10,242	208
Retained Surplus/(Deficit) excl impair	**7,060**	**6,547**	**1,682**	**(4,865)**
Impairments			0	
Retained Surplus/(Deficit) incl impairr	**7,060**	**6,547**	**1,682**	**(4,865)**

Comments

Impact 5 – Loss of over £5.0m. Likelihood 3 – possible. **Red**

The YTD position is a surplus of £1.7m (EBITDA of 7.5%) which is an adverse variance of £4.9m against the budg
February is a surplus of £0.8m (EBITDA of 9.1%) against the February budget of £(0.9)m deficit, which is a favoura
of £1.7m.

Please see below for the key reasons for the £4.9m overspend.

The year end forecast remains a surplus of £2.2.

Risk Rating (year to date)

COSR Rating	Weighting	M11 Planned Rating	M11 Actual Rating
Capital Servicing Capactity	50%	3	2
Liquidity	50%	3	4
Total Rating		**3**	**3**

Comments

The Trust recorded a Continuity of Service Rating (COSR) of 3 year to date at quarter 3 compared to a plan of 3. The capital service cover rating is a 2 (against a planned 3) and the liquidity rating is a 4 (against a planned 3).

Cost Improvement Programme

Division	YTD Identified	YTD Actual	YTD Variance	2014/15 Identified	Forecast Delivery	Forecast Variance
Total Planned Care	2,793	2,471	-322	3,060	2,709	-351
Total Emergency Care	1,266	926	-340	1,418	1,050	-371
Total W&N, C&Y, HIV & SH	4,292	3,150	-1,142	4,956	3,605	-1,351
Total Facilities	2,559	2,559	0	2,794	2,794	0
Total ICT	258	258	0	284	284	0
Total Chief Nurse	287	287	0	315	315	0
Total HR & Education and Trair	170	149	-21	182	161	-21
Total Procurement/Commercia	857	857	0	961	961	0
Total Finance	428	427	-1	491	490	-1
Unidentified	0	0	0	10,407	0	-10,405
2014/2015 CIP Total	12,910	11,084	-1,826	24,868	12,369	-12,500

Comments

The original CIP target was £24.9m (£18.9m in 14/15 + £6.0m brought forward from 13/14).

The year to date achievement is £11.1m (against the year to date identified schemes of £12.9m
The forecast achievement is £12.4m (against identified schemes of £14.5m)
The forecast CIP achievment is 3.3%.

Key Financial Issues

Performance against control totals

In February the Trust reported a surplus of £0.8m bringing the year to date surplus to £1.7m. The Trust had planned to deliver a surplus of £0.8m in February based on the control total, and is therefore on plan in month and remains £0.2m behind year to date.

Primary Reasons for Current Month Position (against the control total)

There were £1.9m of central mitigations released into the position.

NHS clinical income and local authority income (excluding drugs) is behind the month 9 forecast by £0.7m mainly in outpatients and elective income.

Clinical and corporate divisions are behind the month 8 forecast by £1.0m, however this has been offset against a favourable variance in central budgets, and therefore on target overall in month.

Key drivers behind the £6.5m overspend against the original budget

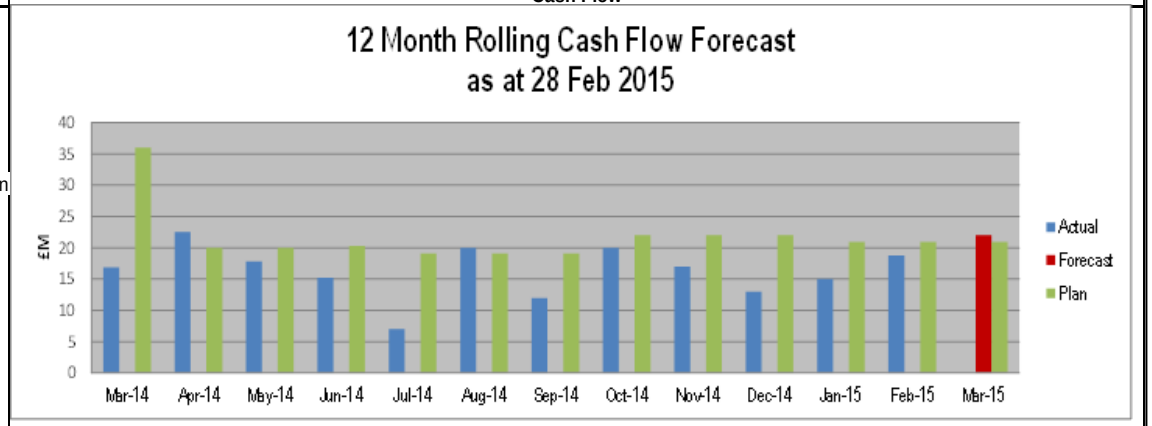
- Unidentified CIPS (£10.3m)
- Private patient income under performance (£3.0m)
- Pay overspend, primarily due to high temporary staff usage in certain areas (£2.0m)
- Offset by over-performance on NHS clinical income (£4.9m)

Forecast

-The year end forecast remains a **£2.2m surplus**.

The main risk in the year end forecast relates to the recovery of the Planned Care division year to date adverse va

Cash Flow



Comments

The cash position at M11 is £18.9m. The principal causes are the level of debt which is yet to be recovered and the Trust has a surplus of £1.7m against a planned surplus of £7.4m. Financial Control and Contracting/ activity staff meet on a daily basis to review the aged debt and to target specific debts for recovery action.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 14 May 2015

AGENDA ITEM NO.	12/May/15
REPORT NAME	Membership Engagement and Communication Calendar of events – update
AUTHOR	Layla Hawkins, Head of Communications and Marketing
LEAD	Layla Hawkins, Head of Communications and Marketing
PURPOSE	To update the Council of Governors on the schedule of membership engagement & communications events.
SUMMARY OF REPORT	The schedule of membership engagement events up until September 2015 enclosed.
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	NA
LINK TO OBJECTIVES	NA
DECISION/ ACTION	For information

Membership Engagement & Communications Calendar of Events 2015

Date/Month	Event/Activity	Lead	Cost/Funding source
May 2015			
Saturday 9 May	Open Day	Events Officer	£20,000 (Council of Governors)
Tuesday 12 May	Members' News	Events Officer	£216 (Council of Governors)
TBC	Medicine for Members seminar	Events Officer	£700 (Council of Governors)
Tuesday 19 May	Wandsworth Constituency Event	Vida Djelic	Project Management Office (integration budget)
Wednesday 20 May	Clinical Summit	Events Officer	Project Management Office (integration budget)
June 2015			
TBC	Burns Unit Opening	Events Officer	Not from Council of Governors budget (Funded by Burns)
Tuesday 9 June	Members' News	Events Officer	£216 (Council of Governors)
Tuesday 16 June	Hammersmith and Fulham Constituency event	Vida Djelic	Project Management Office (integration budget)
July 2015			
Tuesday 14 July	Members' News	Events Officer	£216 (Council of Governors)
TBC	Medicine for Members seminar	Events Officer	£700 (Council of Governors)

Date/Month	Event/Activity	Lead	Cost/Funding source
TBC	Constituency Meeting	Vida Djelic	Project Management Office (integration budget)
August 2015			
TBC	Constituency Meeting	Vida Djelic	Project Management Office (integration budget)
September 2015			
TBC	Medicine for Members seminar	Events Officer	£700 (Council of Governors)
TBC	Constituency Meeting	Vida Djelic	Project Management Office (integration budget)

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 14 May 2015

AGENDA ITEM NO.	13/May/15
REPORT NAME	Council of Governors Funding Report
AUTHOR	Vida Djelic, Board Governance Manager
LEAD	Layla Hawkins, Head of Communications and Marketing
PURPOSE	To keep the Council of Governors updated on the governor spend.
SUMMARY OF REPORT	This report provides an update on the Council of Governors budget.
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	NA
LINK TO OBJECTIVES	All
DECISION/ ACTION	For information

2014/15 Financials for Projects

Project Name	Estimated Spend	Actual Spend to Date	Expected Expenditure Period	Lead	Approved by the Council of Governors
Open Day 2014	£ 20,000.00	£ 18,434.33	May/June 14	Katie Drummond-Dunn	17 July 2013
12 Members' E-News	£ 2,600.00	£ 1,944.00	Monthly	Katie Drummond-Dunn	17 July 2014
Xmas at C&W 2014	£ 8,000.00	£ 9,442.98	Nov/Dec14	Katie Drummond-Dunn	17 July 2014
5 Medicine for Members seminars 2014/15	£ 4,167.00	£ 171.00	Quarterly	Katie Drummond-Dunn	17 July 2014
Annual Members' Meeting 2014	£ 5,000.00	£ 1,967.24	Aug/Sep14	Katie Drummond-Dunn	17 July 2014
1 membership mailing per year (Feb 15)	£ 10,000.00	£ 4,269	Mar 15	Katie Drummond-Dunn	17 July 2014
Membership Recruitment Campaign for Open Day	£ 1,500.00	£ 1,500.00	June 14	Sian Nelson	17 July 2013
Quality Awards	£ 3,000.00	£ 2,150.00	Jul/Dec 14	Vanessa Sloane	17 July 2014
Council of Governors election	£ 7,177.00	£ 8,945.33	Dec 14	Susan Young	18 September 2014
Equipment for governor engagement with members	£ 800.00	£ 180.92	Dec 14	Layla Hawkins	4 December 2014
Christmas gifts to adult inpatients	£ 1,000.00	£ 1,000.00	Dec 14	Anna Hodson-Pressinger	4 December 2014
TOTAL FOR 14/15	**£ 63,244.00**	**£ 50,004.80**			

2015/16 Financials for Projects

Project Name	Estimated Spend	Actual Spend to Date	Expected Expenditure Period	Lead	Approved by the Council of Governors
Open Day 2015	£ 20,000.00			Caroline Pooley	17 July 2014
NHS Providers Membership Subscription 2015/16	£ 7,687			Susan Young	
TOTAL FOR 15/16	£ 27,687.00				

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 14 May 2015

AGENDA ITEM NO.	14/May/15
REPORT NAME	Draft Minutes of the Council of Governors Quality Sub-Committee meeting held on 4 March 2015
AUTHOR	Vida Djelic, Board Governance Manager
LEAD	Zoe Penn, Chair
PURPOSE	To provide a record of any actions and decisions made at the meeting.
SUMMARY OF REPORT	This paper outlines a record of the proceedings of the Council of Governors Quality Sub-Committee meeting held on 4 March 2015
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	None.
LINK TO OBJECTIVES	NA
DECISION/ ACTION	For information.

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Minutes of a Meeting of the Council of Governors Quality Sub-Committee
Held on 4 March 2015

Attendees	Zoe Penn	ZP	Chair
	Melvyn Jeremiah	MJ	Public Governor - Westminster Area 2
	Martin Lewis	ML	Public Governor - Westminster Area 1
	Susan Maxwell	SM	Patient Governor
	Anna Hodson-Pressinger	AHP	Patient Governor
	Christine Blewett	CB	Public Governor – Hammersmith & Fulham 2
In attendance	Vanessa Sloane	VS	Director of Nursing
	Mathew Guys	MG	Healthwatch representative
	Sonia Richardson	SR	Patient Representative on the West London CCG
	Susan Luce	SL	Director of Clinical Governance and Quality
	Vida Djelic	VD	Board Governance Manager

1.	**Welcome & Apologies**	
a.	Apologies were received from Wendie McWatters and Sharon Connell.	
2.	**Minutes of previous meeting held on 13 November 2014**	
a.	Minutes of the previous meeting were accepted as a true record of the meeting.	
3.	**Matters Arising & Action Log**	
a.	The sub-committee noted that most of matters arising were complete.	
b.	In relation to action ref. feedback from governors on patient experience ZP said that GPs decide whether a specialist referral is necessary; hospital referrals to another specialist are not common occurrence, however, an onward referral can be made as part of an established patient pathway. She highlighted that in the case MJ raised the Trust would require more information from patient in order to be able to assist. ZP added that she is a member of the Clinical Quality Group which considers integrated care pathways not working well for patients or staff.	
c.	In relation to the action relating to AHP and SM to be invited to attend the Preventing Harm Group VS noted that she will ask the Chair, Lucy Connolly, to invite AHP and SM to attend the Preventing Harm Group. **Action: LC to invite AHP and SM to attend the Preventing Harm Group.**	**LC**
4.	**Complaints Report Q3 and PALS Report Q3**	
a.	<u>Complaints Report</u> VS noted that a lot of work has been done on ensuring compliance with the timely responses to complaints. An external company undertook review of the internal processes. A two day training sessions was provided to relevant staff about how to respond to complaints and writing letters. The aim is to amend the Complaints Policy and Procedure taking into consideration feedback following the review undertaken and to provide training.	
b.	Top three complaints subjects remain the same as in previous quarters: aspects of clinical care, staff	

	attitude/behaviour and information.	
c.	ML noted that for some time he has been emphasising the need for the customer service training for the receptionists in outpatients areas. VS commented that this is being looked into. SR queried if there is an issue of staff recruitment and retention in this area. VS responded that this staff group does not have a particularly quick turnover. The staff should feel the ownership of their work area and this is likely to impact on staff behaviour. SR queried if this group of staff have been asked about the job satisfaction. ZP confirmed that it was done as part of the process.	
d.	SR referred to the section 5 on p.3 relating to complaints upheld by the Parliamentary and Health Service Ombudsman and said that from reading the report and at the same report being considered at the recent CCG meeting she was unclear what measures the Trust put in place in response to complaints and what improvements were made. ZP said that in response to any issues arising from complaints the Trust generates those in five primary subject areas and deeper underneath we give examples i.e processes, clinical care etc. SR said she still was not clear about actions the Trust has taken in order to improve. ZP suggested that assurances as to what actions the trust has taken in response to complaints upheld by the Parliamentary Ombudsmen can be picked up outside the meeting with CCG. **Action: VS to find out from CCG assurance required in relation to complaints upheld by the Parliamentary Ombudsmen.**	**VS**
	<u>PALS Report Q3</u>	
e.	Top three PALS complaints relate to staff attitude and appointments delay/cancellation (outpatients) and communication/information to patients.	
f.	SR referred to section 6 summary on p.8 of the report regarding the access to an appropriate person when calling the appointments line. VS responded that the number of people answering the calls is increased. ZP highlighted that the Trust has been working on redesigning the system of booking appointments. Medical departments are encouraged to make a direct contact with patients.	
g.	In relation to a query relating to type 2 complaints ZP responded that some cases are complex, require more time to review and therefore difficult to respond to within two weeks time as stipulated.	
h.	CB queried if the Trust received feedback on complaints about patients satisfaction. ZP responded that one way to measure this is when patient comes back to complain. VS noted that the Trust has improved in the area of cancelling appointments, however, rebooking an appointment proves difficult.	
i.	In response to a question from ML re the future plans for managing the PALS VS responded that the team will be restructured and West Middlesex University Hospital PALS structure have been considered.	
j.	In response to a question from AHP regarding the booking appointments VS clarified that inpatients cancellations are separate from outpatients cancelations.	
5.	**Quality Accounts**	
a.	SL outlined the timescales for production and publication of the Quality Accounts.	
b.	ZP noted that the priorities for 2014/15 Quality Accounts have been identified through the development of the Quality Strategy.	
c.	It was noted that the draft Quality Accounts will be taken to the Board meeting in April and the Council of Governors meeting in May.	

	Quality Priorities Q3 update	
d.	**Priority 1 (Patient Safety): To have no hospital associated preventable venous thromboembolism (VTE)** The sub-committee noted that the priority for the hospital is to work on hospital-associated VTE events. To date, there have been 6 preventable hospital associated VTE events compared with the target to have no more than 7. The Trust performs in-depth root cause analysis to find out what happened so that it can prevent it happening again.	
b.	**Priority 2: To continue to focus on communication, discharge and delivering safe and compassionate care to all our patients** Patient Experience VS noted that due to change in leadership the current Patient and Staff Experience Group will split up into two committees, Patient Experience Group and Staff Experience Group which will be launched in April. The PLACE meetings continue and the annual PLACE audit is taking place later this month.	
c.	The friends and family test is offered by text or paper copy to inpatients, outpatients, day cases and Emergency Department attendees. From April 2015 this will be rolled out to paediatric patients. However, the satisfaction results remain below the expected level. Overall, most of wards are doing well and those that are not we are addressing issues. An external company, Healthcare Communications is assisting the Trust with improving results and are providing training sessions to ward sisters. At the recent walkabout we received a positive feedback from patients and staff following this.	
d.	The transport lounge is being remodelled at present and the aim is to make the environment more attractive to patients. There is some work undertaken on nurse led discharge on David Evans and it has been rolled out to Edgar Horne.	
e.	In response to a question from ML, VS responded that there is an issue with prescribing medication in a timely manner; this is a complex issue and it impacts on patient flow.	
f.	Staff engagement C&WFT remains in the top 20% of acute trusts nationally for staff engagement; it also remains in the top 20% of acute trusts in the country as an organisation that staff would recommend as a place of work or to receive treatment.	
g.	The quality of appraisals in relation to staff having a well-structured appraisal has improved and it has put the Trust in the top 20% of acute trusts nationally. However, the appraisal rate has decreased. Some work will be undertaken to improve the appraisal rate linked to incremental progression and reward in 2015/16.	
h.	In response to a question from AHP in relation to usage of agency nurses VS responded that numbers are high and the Trust will focus on staff retention and filling vacant posts.	
i.	**Priority 4: To improve choice and quality in End of Life care** The End of Life Care Committee lead on delivering the end of life care strategy. The Trust has six day palliative care nursing service and is moving to seven days service. The Trust provides educational and training programmes to staff i.e rotational programmes for health care assistants and junior nurses, end of life care training for senior members of staff, improving leadership of care at the end of life etc.	
j.	Governor chosen indicator A governor selected indicator is one of the requirements set by Monitor for the Quality Accounts. The indicator of choice is then audited by external auditors. The sub-committee discussed options for the governors indicator for the Quality Account 2015/16. A list of quality indicators considered by the sub-committee included: - Dementia Screening	

	- Nutritional Screening - Learning Disability: identification and "flagging" - Pressure Ulcers - Friends and Family Test (in relation to In-patients response rate) - Discharge - Medication management training - Sepsis bundle	
k.	The Quality Sub-Committee agreed the Friends and Family Test – in-patient responses.	
6.	**Performance and Quality Dashboard**	
a.	ZP presented at a glance performance for January 2015 and explained that where target met it was colour coded green and for targets not being met it was colour coded red.	
b.	The sub-committee noted that the Trust continues to meet all key performance indicators for Monitor, with the exception of 1 case of clostridium difficile in January 2015, though performance for the year to date is still within target.	
7.	**COG Quality Awards schedule – Spring 2015**	
a.	SM provided an overview of Spring schedule of the Council of Governors Awards. The awards will be presented to the winning teams by the lead governors and the Chairman at the May Council of Governors meeting.	
b.	ML emphasised the importance of the Council of Governors Quality Awards to governors and suggested that this is kept within the sub-committee's remit.	
c.	SM noted that an area requiring improvement relates to ensuring clarity as to how staff can collect their money awarded. VD responded that this is being discussed with the finance team with a view of making the permanent arrangement of having voucher system in place.	
8.	**Feedback from governors on patient experience**	
a.	SM reported on an elderly couple she met who could not afford any refreshments when they came to C&W for an appointment. She spoke to ISS Manager who generously offered to provide them with a free coffee on their next visit to the hospital.	
b.	MJ reported on an issue with booking appointments in the dermatology department. He passed the issue to the PALS office to resolve.	
c.	SM noted that she had asked the Hospital Charity, CW+, if it could sponsor water fountain to be installed in the hospital area as it gets very hot in the summer and some patients cannot afford to buy a bottle of water.	
d.	ML reported that he and Marie Courtney visited a staff uniform room and he observed that there was a number of uniforms uncollected. He added that Vanessa Sloane will follow up with the appropriate staff.	
9.	**Funding Report**	
a.	The report was noted.	
10.	**Any Other Business**	
a.	MJ noted that the new Board committee, Quality Committee, has been established and its Terms of Reference have been set up, which include in its membership CB and himself. He suggested it would	

	be useful to consider their terms of reference in order to establish its own terms of reference.	
11.	**Date of next meeting**	
	07 May 2015	

15.20 close

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 14 May 2015

AGENDA ITEM NO.	15/May/15
REPORT NAME	Draft Minutes of the Council of Governors Membership Sub-Committee meeting held on 3 March 2015
AUTHOR	Vida Djelic, Board Governance Manager
LEAD	Walter Balmford, Chair
PURPOSE	To provide a record of any actions and decisions made at the meeting.
SUMMARY OF REPORT	This paper outlines a record of the proceedings of the Council of Governors Membership Sub-Committee meeting held on 3 March 2015
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	None.
LINK TO OBJECTIVES	NA
DECISION/ ACTION	For information.

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Minutes of a meeting of the Council of Governors Membership Sub-Committee
Held on 3 March 2015 in the Boardroom, Verney House

Attendees	Walter Balmford	Chairman	WB
	Chris Birch	Patient Governor	CB
	Martin Lewis	Public Governor - Westminster Area 1	ML
	Philip Owen	Public Governor – Kensington and Chelsea Area 2	PO
In attendance	Thomas Lafferty	Trust Secretary	TL
	Caroline Pooley	Events Officer	CP
	George Vassilopoulos	Website Communications & Graphic Design Manager	GV
	Vida Djelic	Board Governance Manager	VD

The sub-committee noted that the meeting was not quorate due to the Head of Communications not being able to attend. It was decided to proceed with no formal decisions to be made.

CB pointed out a need for review of the sub-committee's Terms of Reference which passed the review date.

TL noted that he looked the Membership Sub-Committee Terms of Reference in the context of a potential acquisition of West Middlesex University Hospital.

1.	**Welcome and Apologies**	
a.	WB welcomed TP, GV and CP to the meeting.	
b.	Apologies were received from Layla Hawkins, Sam Culhane, Tom Pollak and Steve Worrall.	
2.	**Minutes of previous meeting held on 13 November 2014**	
	Draft minutes of the previous meeting were approved as a true and accurate record of the meeting.	
3.	**Matters Arising & Action Log**	
a.	The sub-committee noted that all actions were complete.	
b.	GV updated the sub-committee on the cost of the banner for governor engagement with members and noted that the total cost is considerably lower than originally estimated due to some savings being made.	
c.	ML referred to the FTN/FTGA membership subscription item requiring costing and suggested that that governors are encouraged to attend the training courses and asked for a list of available courses to be circulated to all governors. **Action: VD to email all governors with a list of GovernWell training courses available to governors.**	**VD**
4.	**Council of Governors election – November 2014**	
a	CB noted that the paper provided was comprehensive and that the aim was to discuss it. He queried the status of some of aims re the election communication where it states that no funding was agreed. **Action: LH to provide response to the sub-committee.**	**LH**

b.	CB noted that the response provided in relation to his query relating to the number of ballot papers that were returned to the Returning Officer either online or by post in each constituency in the November 2014 election was not satisfactory. **Action: TL to confirm with ERS whether the number of members who voted correspond to the number of ballot papers returned.**	**TL**
5.	**Membership report Q3**	
a.	CB queried how far in the process the Trust was in relation to appointing a new membership services provider. **Action: LH to confirm the progress with appointing a new membership services provider.**	**LH**
b.	TL noted that as a part of the post-acquisition process the Trust will review the membership services provider. We are in the process of writing a membership plan for West Middlesex public areas: Hounslow and Richmond. The priority should be getting a membership base fully representative of wider population and an election will be conducted in due course. The membership services provider will be reviewed under these new arrangements.	
c.	In response to a query from ML, TL responded that he will find out if West Middlesex University Hospital (WMUH) had their members' demographic information of their membership; this will help the Trust establish the necessary membership activities. **Action: TL to find out if WMUH had their members' demographic information.**	**TL**
d.	CB suggested that where it read 'All' in headings of pie charts to be removed. GV clarified that unknown is as valid category as black and white. It was agreed that 'withheld' is more suitable term to use to describe the 'unknown' category.	
e.	PO noted that he had raised with TL a possibility of having a proxy vote or sealed vote for acquisition. TL responded that unlike voting on other matters there is a specific requirement in relation to mergers and acquisitions that more than half of the governors present and voting agree. The current constitution does not allow for proxy vote, email or latter. However, the new constitution will have a provision to participate via a teleconference, email or latter on other constitutional matters. TL confirmed that the Health and Social Care Act 2012 does now allow proxy voting.	
6.	**Constituency meetings proposal**	
a.	PO suggested that a short SWOT (strengths, weaknesses, opportunities, threats) analysis is produced for governors. This information from this analysis could be used for constituency meetings. TL clarified that the transaction prospectus for governors covers most of elements of the analysis, including key advantages, strengths, risk and threats.	
b.	PO expressed a concern about the length of time it might take to implement EPR at Chelsea and Westminster, which in his view would take approx 4 years.	
c.	TL emphasised that as a FT, Chelsea and Westminster governors should have regular constituency meetings. It provides both the Trust and governors with the opportunity to engage with members on key issues and developments and it addresses concerns governors have regarding representing members' views. This should be done regardless the potential acquisition.	
d.	TL noted that Caroline Pooley, Events Officer will be assisting with organising meetings. There will be 1 constituency meeting a month in each of the public areas i.e the Royal Borough of Kensington and Chelsea, City of Westminster, Hammersmith and Fulham and Wandsworth.	
e.	CB said that the paper was very detailed and useful and queried if a similar engagement events are planned for other 2 elected constituencies (i.e patient and staff).	

f.	WB expressed that in his opinion it would be difficult for patient governors to engage with patients considering that they come from other parts of the country. Governor representatives should be trusted in making decision.	
g.	TL said that as most of patient governors live in the local boroughs and that they will be invited to the future constituency meeting. ML noted that a way of engaging with members is via meet a governor session and visiting patient wards. He queried the mobile health bus and if it would be useful to use it for engagement events. ML referred to p.2 last para of the paper should read 'elected and appointed'.	
h.	ML suggested that a mobile health bus could be used for further engagement purposes considering that it was used in the past.	
i.	The sub-committee agreed in principle with the proposal for constituency meetings.	
7.	**Membership engagement and communication calendar of events – update**	
a.	The sub-committee noted the updated list of events planned up until the end July.	
b.	ML confirmed that he will chair the Medicine for Members event on Tuesday, 10 March 2015.	
8.	**Chelsea and Westminster Star Awards 2015**	
a.	CP noted that the deadline for receiving nominations for the Star Awards has been extended to Friday, 13 March in order to allow more time for receiving nominations.	
b.	The sub-committee noted that the deadline for CP to receive governor preferred choice is Friday, 20 March.	
c.	GV noted that he has withdrawn from the judging panel due to a potential conflict of interest since he works in the communications department.	
9.	**Governors stand for Open Day 2014 – suggestions**	
a	The following highlights were provided: • Open Day will be held on 9 May • The theme of the day is safety • GV has created a logo • ML will lead on the governor stand and volunteers for the stand are welcome as well as suggestions for goodies to go in a prospective member bag.	
b.	The sub-committee discussed the items to go in the prospective member bag and it was agreed to include balloons, mugs and pens.	
c.	CB highlighted a need to concentrate on engaging with the members rather than recruiting. ML responded that the active recruitment is important in order to keep the membership number balanced between leaver and joiners and the Open Day provides the opportunity for both engaging and recruiting new members.	
d.	TL noted that the benefits to being a member of the Trust should be considered at a future sub-committee meeting. GV responded that the membership benefits feature in the Trust News and on the website.	
10.	**Council of Governors Funding Report**	

a.	The sub-committee noted the funding position. VD highlighted that the correct position regarding invoices received is circa £43k not £34k as stated on the cover sheet of the paper.	
b.	**Action: LH to ensure that money which remains in the budget is accrued for the first constituency meeting.**	**LH**
c.	**Action: To accrue money in the 2015/16 budget for expected cost of the constituency meetings in 2015/16.**	**LH**
d.	CB thanked VD for adding column 6 to the report stating when each project was approved by the Council of Governors.	
e.	CB queried if all money accrued for Christmas presents to patients £1,000 has been spent. **Action: VD to check if all money accrued for presents to patients project has been spent.**	**VD**
11.	**Feedback from members**	
a.	ML reported to the sub-committee on a patient he met at the last meet a governor session who had a complaint. He has forwarded the patient to the PALS.	
12.	**Any other business**	
	Information Zone	
a.	ML commented on a recent communication regarding the touch screen terminal in the Information Zone and proposed it gets removed considering that it has been working irregularly. CB disagreed with the proposal based on the fact that the touch screen terminal is a valuable tool for patients and hospital visitors and it provides variety of useful information. It was funded from the Council of Governors budget and he felt that it is worth keeping it providing it can be repaired. WB added that most of the time the touch screen terminal is not working and when it does it provides out of date information.	
b.	CB noted that the fundamental issue to be resolved is whose responsibility is looking after the Information Zone. TL responded that all departments are under review in the context of a potential acquisition of WMUH and that in interim Layla Hawkins's responsibility and if necessary issues can be escalated to him.	
13.	**Date of next meeting** To be confirmed	

Meeting closed at 17.00.