Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting
Hospital Boardroom
Chair: Prof. Sir Christopher Edwards
Date: 13 September 2012 Time: 3pm

Agenda

'Starred' items will not be discussed unless an advance request is made to the Chairman.

	PLEASE NOTE THE EARLIER START AT 3PM	**Lead**	**Time**
1	**GENERAL BUSINESS**		
1.1	Welcome & Apologies	CE	3.00
1.2	Declaration of Interests	CE	
1.3	Minutes of Previous Meeting held on 12 July 2012 (attached)	CE	3.05
1.4	Matters Arising (attached)	CE	3.10
1.5	Chairman's Report (oral)	CE	3.15
1.6	Chief Executive's Report (oral)	TB	3.25
2	**ITEMS FOR DISCUSSION/DECISION/APPROVAL**		
	QUALITY		
2.1	Quality Awards – paper and presentation of certificates (attached)	MvL	3.35
2.2	* Quality Sub-Committee report (draft minutes of 21 August 2012 meeting attached)	CM	
	GOVERNANCE		
2.3	Shaping a Healthier Future – consultation update (attached) *Presentation by Dr Mike Anderson, Medical Director*	MA	3.45
2.4.1	Constitution changes required as a result of the Health and Social Care Act 2012 – to come into effect on 1 October 2012 (attached)	CM	4.15
2.4.2	Constitution review – other changes required as a result of the Health and Social Care Act 2012 and next steps (to follow)	CM	4.20
	COUNCIL OF GOVERNORS		
2.5	*Governors' Questions (attached) - Dress code for staff and patients (A-HP)	TD	
2.6	Care Quality Commission Engagement Project (attached)	CM	4.55
2.7	*Council of Governors Funding Report (attached)	CM	
2.8	* Governor/Senior Nurse Patient Rounds Update (attached)	TP	
	MEMBERSHIP		
2.9	* Membership Sub-Committee report (draft minutes of 26 July 2012 meeting attached)	ML	
2.10	* Membership Engagement and Communication – update (attached)	MAk	
2.11	* Membership Report (attached)	TP	
3	**ITEMS FOR INFORMATION**		
3.1	Finance Report – July 2012 (attached)	LB	
3.2	Performance Report – July 2012 (attached)	DR	
4	**ANY OTHER BUSINESS**		5.00
5	**DATE OF THE NEXT MEETING – 6 December 2012**		

PLEASE NOTE THAT THE ANNUAL MEMBERS' MEETING WILL FOLLOW AFTERWARDS AT 5.30pm

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 13 September 2012

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

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting Minutes, 12 July 2012
Draft

Prof. Sir Christopher	Edwards	Chairman		CE
Chris	Birch	Patient		CBir
Christine	Blewett	Public	Hammersmith and Fulham 2	CBle
Anthony	Cadman	Patient		ACad
Cass. J	Cass-Horne	Patient		CC-H
Edward	Coolen	Patient		EC
Samantha	Culhane	Public	Hammersmith and Fulham 1	SC
Carol	Dale	Staff	Management	CD
Brian	Gazzard	Staff	Medical and Dental	BG
Anna	Hodson-Pressinger		Patient	AH-P
Melvyn	Jeremiah	Public	Westminster 2	MJ
Martin	Lewis	Public	Westminster 1	ML
Kathryn	Mangold	Staff	Nursing and Midwifery	KM
William	Marrash	Patient		WM
Susan	Maxwell	Patient		SM
Wendie	McWatters	Patient		WMW
Henry	Morgan	Public	Wandsworth 1	HM
Cyril	Nemeth	Appointed	Westminster City Council	CN
Sandra	Smith-Gordon	Public	Kensington and Chelsea 2	SS-G
Frances	Taylor	Appointed	Royal Borough of Kensington and Chelsea	FT
Maddy	Than	Staff	Support, Admin & Clerical	MT
Alison	While	Appointed	King's College	AW

IN ATTENDANCE:

Sir John Baker	Non-executive Director	JB
Jeremy Loyd	Non-executive Director	JL
Sir Geoffrey Mulcahy	Non-executive Director	GM
Dr Mike Anderson	Medical Director	MA
Lorraine Bewes	Director of Finance	LB
David Radbourne	Interim Chief Operating Officer	DR
Mark Gammage	Director of Human Resources	MG
Catherine Mooney	Director of Governance and Corporate Affairs	CM
Matt Akid	Head of Communications	MAk
Axel Heitmueller	Director of Strategy and Business Development	AH
Anthony Pritchard	Deputy Chief Nurse	AP
Vida Djelic	Foundation Trust Secretary	VD
Patricia Gani	LINk representative	PG
Ben Sheriff	Deloitte LLP	BS
Helen Elkington	Head of Estates and Facilities	HE

1 GENERAL BUSINESS

1.1 Welcome & Apologies — CE

CE welcomed Ben Sheriff of Deloitte LLP to the meeting who will be presenting the papers from the auditors on behalf of Heather Bygrave.

Apologies were received from Nicky Brown, Alan Cleary, Fergus Cass, Rosie Glazebrook and Jenny Higham.

Apologies were also received from Karin Norman, Non-executive Director and Therese Davis, Chief Nurse.

CE informed the Council of Governors of the reason for FC's absence which was due to a potential conflict of interest.

1.2 Declaration of Interests — CE

None.

1.3 Minutes of Previous Meeting held on 3 May 2012 — CE

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

- P5 EU patients should read 'non-EU patients'

SS-G sought clarification of the last para on p.2, ref the Board Governance Assurance Framework.

1.4 Matters Arising — CE

Re 2.6 the Chairman wrote to the Health Secretary regarding the timeline for implementation of the private patient income cap provision of the Health and Social Care Act 2012. The Foundation Trust Network also lobbied. There was a subsequent positive response that it would take effect as of October 2012.

Re remote access to hospital email: VD said that Greg Hewitt, Acting Assistant Director of IT had provided information to CBir, ML and MJ who are currently testing the new solution. Once they are happy all governors will be issued the chelwest email account and addresses will be published on the website. VD reassured governors that she tested the new solution and it is user friendly. CBir said he agreed with this assessment.

It was noted that MAk would address the survey under the Open Day item.

1.5 Chairman's Report (oral) — CE

CE said he was delighted that CBir was present considering the fall he suffered recently. CBir said he had received a brilliant service in A&E.

CE said it was very important that the implications of the Health and Social Care

Act are discussed and that the Board and Council worked together and he proposed that this was addressed in a joint Away Day in the autumn. This was agreed.

2 ITEMS FOR DISCUSSION/DECISION/APPROVAL

2.1 Presentation of Annual Accounts & Annual Report 2011/12 LB/CE

LB presented the highlights of the annual accounts which are from page 123 onwards in the annual report. She described the key points outlined in the executive summary.

BG said that there must be a point when the surplus is excessive compared with the Cost Improvement Programme (CIP) and reducing costs is very painful for staff. It is a difficult situation to manage with staff when they are required to make savings of 10% and then be advised that there is a surplus of £13m.

LB acknowledged this and confirmed that an appropriate level of surplus was agreed by the Board.

CE said that to be able to have funds to invest is key to our future success. He assured the Council of Governors that patient care has not been affected. He referred to the recent visit of the Health and Social Care Scrutiny Committee and said that they were very impressed by the visit to the pediatric ward but not so by the visit to A&E. It highlights the fact that to have a world class facility we have to invest in the services.

LB commented that 9% is an overall figure and relates to approx 5% income and is within Monitor's guidelines. The scale of the Trust development would reduce if we cut back on CIPs.

BG suggested that this should be explained to staff and the benefits of the surplus emphasised.

CE said that an example might be that we have invested £9 million in modernising the infrastructure and this will lead to savings of £600k per year and will decrease our carbon production.

CE congratulated LB and said that the CIP is at a level that is impossible to be achieved at other Trusts and that we are more viable compared with our competitors. This is valuable for patients and for staff.

SM asked about the significant development in IT and whether this was just patient records? She had been told that LastWord is out of date.

LB replied that the LastWord is the patient administration system and is a legacy system, although was more advanced than the national IT programme.

CE commented that we were very much ahead of the time when it was put in to the Trust but we now recognise that this system needs to be replaced.

DK who is the Non-executive Director lead on IT, commented that the Trust has a

strong IT department and we are still advanced. As a part of the IT Strategy we are going to replace the system over the next few years and we are implementing the first phase of Electronic Document Management at the moment and the second phase will be completed in spring 2013.

CN referred to a recent incident where a hospital had lost records and there was potential adverse clinical consequences and he asked for assurance about the situation at Chelsea and Westminster Hospital. DR replied that this had been checked and he assured CN that it was unlikely to happen here.

In response to a question re savings, LB said that the Trust is working collaboratively with the Royal Brompton and Royal Marsden Hospitals as part of the Fulham Road Collaboration. She said that by having a joint contract with the three Trusts with ISS there were savings of £38 million over 3 years. We are also looking at pooling resources for IT.

ML queried if there is a system in place to charge foreign nationals who are outside of the EU. LB replied that we are exploring options to take credit card swipes for private patients. Non-EU patients who use A&E services do not get charged.

LB referred to a recent development involving the UK Border Agency which is allowed to hold details of people who have outstanding bills with the NHS and refuse them admission to the country. This was successful for the Trust recently as an American visitor was refused entry, and as a result paid his bill.

CE congratulated Matt Akid, Head of Communications and others who had worked extensively on the Annual Report.

CBir said that it is a magnificent report with a beautiful photograph on the front page cover and congratulated MAk for producing it. He commented that 'Terrence Higgins Trust' was misspelt and that some governors' terms of office are stated when they originally joined, and some when they were re-elected. He noted that on page 103 of the Annual Report, where the criteria for membership of the Trust are listed, the criterion of being a volunteer had been omitted.

ML said that he would like to record thanks to CM and Melanie Van Limborgh for the Quality Report.

2.2 External Auditors' Report on the Annual Accounts 2011/12 **BS**

BS presented the external auditors report on the annual accounts. He said that Deloitte had issued a clean opinion and there were no items they required to be reported by exception. He described the principal risks that Deloitte had covered.

ML queried if there were two systems for Payment by Results and BS clarified that there was one process but two types of checks.

LB confirmed that the figures disclosed do not show VAT.

2.3 Report on the external assurance audit of the Quality Report year ended 31.03.2012 **BS**

BS said that it is a legal requirement to produce an annual report about the quality of services delivered as an NHS service provider.

The audit includes a review of the content of the Quality Report and testing three performance indicators, two mandated by Monitor and one agreed locally. Deliotte had provided a private opinion last year and this year it has provided a public opinion on *C.difficile* and 62 day cancer wait. The limited assurance refers to the scope of the review rather than an opinion.

BS said that their opinion was that the Quality Report is user friendly and consistent. There were some issues in the data relating to the 62 day wait but this did not affect the breaches. There were more issues with the emergency surgery indicator but this was a less well established indicator. The overall conclusion was 'required improvement'.

2.4 Audit Committee Annual Report 2011/12 **JB**

Sir John said that this report notes the work of the Audit Committee for the last year and its important assurance that the committee gives to the Board. The assurance is in three areas: governance, control, and process improvement.

In relation to process improvement, KPMG look across a wide range of activities. The Audit Committee decides the priorities. KPMG provide audit services to a large number of trusts and so we gain from the experience of others. There was only one high risk recommendation re Freedom of Information requests and the speed of responses. KPMG were content to sign off their report and were also content with the improvements we are making.

There are few cases of fraud that come to the attention of the Audit Committee, either because we cannot find it or because we have good deterrents in place. The value of money saved is not very large but the deterrent value is unquantifiable.

Pages 6 and 7 report on a coding issue identified by KPMG which the Trust will address.

Overall there is reasonable assurance on the systems of control in place.

2.5 Shaping a Healthier Future – consultation update **MA**
& **&**
2.6 Shaping a Healthier Future – communication and engagement plan **MAk**

MA noted that the details have been published of the NWL 'Shaping a Healthier Future' consultation which proposes major changes to hospitals in the area including closing some A&E units. The consultation will run for 14 weeks from 2 July 2012 to October 8. The Response Form has 35 questions which may cause some difficulties and we will need to develop a plan to help people. Meetings are being organised with various parties including local MPs.

WM referred to a question asked of the Prime Minister by a Labour MP regarding 4 hospitals out of 9 closing their A&E units and the impact it will have on other

hospitals. There is also a risk of unemployment. MA responded that the consequences will be different in each Trust but no hospital closure is intended. An important point in the case of Charing Cross Hospital is that 70% of the people who attend A&E there now would still get care locally through the Urgent Care Centre there.

CBir said that A&E is an important local resource and asked if we are successful could not Charing Cross Hospital retain its A&E for its 'walking wounded'? MA replied that Charing Cross Hospital would keep the Urgent Care Centre 24/7 and 365 days a year.

WMW said some politicians have asked if the Trust would be able to cope with the additional number of patients. MA replied that we have to fully separate the UCC from A&E which would need to be bigger. We would have to deal with additional adult admissions and need extra bed capacity. We would achieve this by reducing length of stay and admissions.

CBle queried how the Trust would manage without the UCC. MA replied that the Trust would keep an UCC but at present it is integrated within the A&E and we would have to separate it to increase the space for A&E. Part of the overall proposal is to improve primary care so that the call on A&E services reduces. The risk is that primary care improvements do not occur and we need to take this into account when planning.

MA highlighted that the Trust will have to consider its capacity and potential to develop. Some research indicates that treating patients in hospital is very expensive and that the care could be delivered in the community.

CN queried if we have sufficient number of consultants. MA replied that the Trust has an appropriate establishment and that it could employ more consultants if there is demand. We also have an appropriate number of surgeons to deal with capacity.

ML suggested we involve the Westminster MP.

MA invited governors' views on how to help people answer questions in the consultation. Some model answers will be prepared.

EC said he doubted whether the consultation would achieve anything and referred to the closure of his local GP surgery and added that unless there is a powerful lobby group it will go ahead regardless of the consultation outcome results.

MA suggested providing help with submitting responses which could be via volunteers and governors and if not this is not workable we could pay for assistance.

CE noted that the communications department produced a communication and engagement plan offering a variety of proposals on how to do this.

MJ said he had looked at the electronic form and it is more extensive than simple options. MA responded that Ipsos Mori conducted the consultation and they had followed the brief they were given.

SM queried if we can present comparable quality data such as MRSA rates. MA said that Imperial cannot give separate data for each hospital and the assumption is made that quality is the same in the different Trusts although we have the best patient experience results and that is part of the reason we are preferred option.

MAk said they are encouraging people to provide responses electronically and he circulated a paper which outlined ways in which governors can contribute. The key messages we would wish to get across are described in the paper.

MA will find out whether it is possible to e mail and simply say what option is preferred.

CBle commented that it is important to deal with people's emotional attachments.

WMW suggested leaflets be issued which explains the issues simply and which could be handed out by volunteers.

EC said that following the consultation he attended he had heard that there could be 20% redundancies. MA confirmed this was not correct and if there were less beds, less staff would be employed in hospitals but more would be employed in the community.

JB said that the crucial element is care and MA cited how care had been improved in trauma, stroke and cardiac services through centralisation of services.

SC commented that naturally people are inclined to save their own local hospital.

CE summarised the following points:

The Council is supportive of the idea of using volunteers to help people complete the responses to the consultation. There may be a cost element to this and we may ask the governors to fund this.

The consultation is not just about A&E but will impact on other services e.g. we would lose pediatrics, emergency 24/7 anesthetic cover and maternity, obstetrics.

MAk suggested leaflets be available in A&E as most people will not know that this consultation is going on and we need to access the people who live locally.

AH-P suggested that an important point was that this was about saving money and we have the money to expand A&E which Charing Cross Hospital does not. CE said that part of the response should include what we will do if we succeed.

GM suggested that we announce that we are making an investment in A&E. There is a group looking at how we can improve the facilities currently.

BG suggested that as part of the consultation we advertise our new pediatric A&E and the Children's Hospital.

JL agreed with GM and that we should make a firm commitment to having a world

class A&E and if we are to win this argument we need to make quick changes which will involve both estates and level of services we provide.

SS-G suggested that MAk's department was too small and suggested that there was a temporary increase in staff especially as Renae McBride had left. CE said this will be considered.

WMW said we must be very careful not to have a negative campaign against Charing Cross Hospital.

ML asked that governors should be invited to join any MP visits.

CE concluded that the Council of Governors fully supports the Preferred Option A to retain the A&E within the Chelsea and Westminster Hospital.

2.7 Health and Social Care Act 2012 – briefing and review of constitution **CE/CM**

The Council of Governors noted the paper.

CE said that we will organise a joint Away Day with the Board to address the issues. The working groups will be put in place and will report back to the away day.

The Council of Governors agreed with the proposed approach.

2.8 Membership Recruitment, Engagement and Communications Strategy 2012/13 **MAk/TP**

MAk outlined the Membership Recruitment, Engagement and Communications Strategy and the main points. He noted that this was considered in detail by the Membership Sub-Committee at its meeting on 1 June.

ML highlighted the need to target black minority and ethnic groups and that Priti Bhatt, Equality and Diversity Manager will be the key to help with this.

MJ said that the membership sub-committee will discuss the option of an opt-out Membership system for the patient constituency as presently applies to the staff constituency.

CE highlighted the value of 15,000 members and the support they can give us in relation to the NWL consultation.

2.9 Council of Governors Quality Sub-Committee Terms of Reference* **CM**

This item was starred and therefore approved as read.

2.10 Annual Members' Meeting Proposal **MAk**

MA outlined the proposal and highlighted that the new Chief Executive will attend.

The first part of the meeting will consist of a presentation by a governor and will focus on the role of members and governors in supporting the Trust during the

consultation on ‘shaping a healthier future’.

The second part will consist of a presentation by clinicians and a couple of topics were suggested e.g. dementia

BG highlighted the important work of the volunteers and how they help on the wards. This might also attract more volunteers.

CBir commented on ‘Medicine for Members’ seminars and the proposal to repeat the recent Dementia seminar led by Dr Morgan. MAk said that the communications department could provide help with any slides.

MAk invited governors to express interest in presenting at the Annual Members’ Meeting.

Governors interested in presenting at the Annual Members’ Meeting to let MAk know. **All**

2.11 Governors’ Questions

In response to a question from ML if the Trust plans to redecorate some of the clinics and corridors MA responded that any big refurbishment is usually done during the summer season.

Helen Elkington, Head of Estates and Facilities said that over £1m of capital has been allocated for refurbishment of some clinical areas and noted that replacing of some floors, patient bathrooms and general repair of the hospital building has recently been done. She recognised that the Medical Day Unit and transport area need refurbishing.

ML commented that the transport area needs redecorating and a reception desk in the area needs to be of proportionate size (very high currently).

SM suggested that the transport waiting area should be extended to something like the Macmillan departure lounge. She felt the area needed developing and suggested some refreshments to be available and a desk where pharmacy could hand out prescribed medication instead of patients waiting for it on the ward. HE responded that this will be considered.

CE said he recognised that certain parts of the Trust need updating and various options for upgrading will be explored and this will be part of the Estates Strategy.

A further question was ‘May we please have a report explaining in simple terms and relating specifically to our Foundation Trust the system described under the heading "Accountability and Governors" in the Paper "Accountability in Action" recently circulated? (ACle)

In response to this question CM tabled information on risk management within the Trust and apologised for not circulating it to the governors in advance of the meeting which was due to a misinterpretation of the question that was being asked.

CM highlighted section 3.1 which demonstrates how the Board of Directors

manages risk and drew attention to the Risk Strategy and Policy a copy of which is available on request.

She explained the committee structure and the involvement of Non-executive Directors and governors.

She provided some examples of where the Board had intervened to deal with issues of performance. These included *C.difficile* and a special review of maternity which resulted in significant improvements.

Regarding reliability of past performance CM noted that we have not incorrectly predicted our performance since we became a Foundation Trust which indicated that our past performance was a reliable indicator of future performance.

VD to send the tabled paper to Alan Cleary. **VD**

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

TP said the wrong paper was circulated and he tabled a copy of the correct paper reporting on the visit of ML to the Emergency Department during the evening of 5 May. ML met with the Charge Nurse and observed the work of the team.

ML commented that staff were very professional but that some areas needed upgrading.

HM visited Nell Gwynne ward and the Stroke Unit and met with the coordinator of the Stroke Unit on 29 June. He was content with the unit and the way it operates.

TP invited governors to join regular Wednesday Clinical Rounds and also if any governors are interested in individual visits to advise him so that he can arrange it.

CE thanked TP for organising governors' visits to wards.

2.13 Council of Governors Funding Report **CM**

The Council of Governors noted the funding report.

CBir commented on the proposal for additional funding for the September recruitment session was higher by £40 otherwise he supported the request.

The Council of Governors agreed the additional funding of £1,260 for recruitment sessions in September 2012.

2.14 The tenth FTGA National Development Day 23 May & 27 June 2012 – feedback* **SM/ACle**

This item was taken as read.

2.15 Quality Sub-Committee report* **CM**

This item was taken as read.

2.16 Membership Sub-Committee report* **ML**

This item was taken as read.

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

This item was taken as read.

2.18 Membership Report* **TP**

This item was starred and therefore taken as read.

2.19 Open Day 12 May 2012 – Evaluation Report **MAk**

MAk highlighted that more than 2,100 visitors came to the May Open Day which was a new record for the event.

Question 6 of Appendix 1 presents information on how people heard about the Open Day. 10% of respondents said they received information via letter drop and 5% said via newspaper advertisement.

MAk highlighted that the Careers Event attracted a lot of interest and was well attended.

ML added that he received fantastic feedback from some people who attended.

ML expressed his thanks to MAk and Renae McBride on the successful organisation of the Open Day event.

MAk outlined a proposal for Open Day 2013 funding.

The Council agreed to support funding of the Open Day 2013 for £20,000 from the 2013/14 allocation. More information on organisation of the event to be provided at a future meeting.

3 ITEMS FOR INFORMATION

3.1 Finance Report – June 2012 **LB**

This item was taken as read.

3.2 Performance Report – June 2012 **DR**

This item was taken as read.

3.3 Monitor Code of Governance – compliance **CM**

This item was taken as read.

3.4 Wayfinding Project Update **TD**

This item was taken as read.

3.5 Director-Governor interaction in NHS Foundation Trust **CE**

This item was taken as read.

4 ANY OTHER BUSINESS **CE**

None.

5 DATE OF THE NEXT MEETING

The next meeting of the Council of Governors will be held on 13 September 2012 at 3pm and will be followed by the Annual Members meeting.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 13 September 2012

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

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

MATTERS ARISING
Council of Governors Meeting
Hospital Boardroom
Chair: Prof. Sir Christopher Edwards
Date: 12 July 2012
Time: 4:00 – 6:30 pm

Ref	Description	Lead	Subsequent Actions or Outcomes
2.10/Jul/12	**Annual Members' Meeting Proposal**		
	Governors interested in presenting at the Annual Members' Meeting to let MAk know.	**All**	Susan Maxwell volunteered.
2.11/Jul/12	**Governors' Questions**		
	VD to send the tabled paper to Alan Cleary.	**VD**	Completed.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 13 September 2012

AGENDA ITEM NO.	2.1/Sep/12
PAPER	Council of Governors Quality Awards 2012
AUTHOR	Melanie van Limborgh, Head of Quality and Assurance
LEAD	Catherine Mooney, Director of Governance and Corporate Affairs
EXECUTIVE SUMMARY	The Council of Governors Quality Awards led by the governors from the Council of Governors Quality Sub Committee is awarded for Patient Safety, Patient Experience and Clinical Effectiveness. The awards have been in operation in the Trust since January 2011. The awards are led and winners selected by members of the Council of Governors Quality Sub-Committee. The recent award winners were agreed at the August Council of Governors Quality Sub-Committee Meeting. 4 winning teams have been chosen for their work contributing to improvement for quality patient care. A new commended category was introduced from the Spring award cohort. 10 applications also obtained a commendation for their application. The award winners will attend the September Council of Governors Meeting to be presented by key governors and will receive their awards from the Trust Chairman.
DECISION/ ACTION	This report is for information only – the Council of Governors is asked to note the content of this paper for an overview of the Quality Award and the winners/commendees from the Spring 2012 nominations.

1.0 Introduction and background

The aim of the Trust's Quality Award is to recognise and reward contributions to quality initiatives in the Trust from an individual or team who have made a contribution to quality for patients under three categories (*Safety, Clinical Effectiveness and Patient Experience*).

This award is open to Chelsea and Westminster Trust employees as all staff have the potential to directly (or indirectly) improve quality through improving the patient's experience. The award can be received for a project, an initiative or a change in the work of staff that as a result provide benefit to quality care. The applicants are required in their application documentation to provide information on key themes that are listed in Appendix A (Application criteria):

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

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

The Council of Governors Quality Awards has been in operation from January 2011, supported and directed by the governors from the Council of Governors Quality Sub-Committee. The Quality Awards have traditionally followed a quarterly programme of applications. The Director of Governance and Corporate Affairs is Executive lead for the award. The award is administered and developed by the Head of Quality and Assurance working with the governors from the Council of Governors Quality Sub-Committee.

2.0 Recent developments

The Quality Award continues to develop and there has been several improvements.

The improvements have included (as noted in the Application criteria, Appendix 1) how the award application meets the Trust values Safe, Excellent, Kind and Respectful. To recognise high quality applications that do not qualify as winners, but deserve the recognition of a high quality application, a new commended category has been developed as part of the Quality Award.

A dedicated Quality Award governor to work closely with the Head of Quality and Assurance to continue the development of this award portfolio. This governor is confirmed as Sandra Smith Gordon.

At the time of writing there are plans underway to identify governors (as part of the Council of Governors Quality Sub Committee) to work with individual divisions in identifying areas of high quality work where the potential applicants could be encouraged to apply or be nominated for the Quality Awards.

The numbers of applications and the quality of the awards have risen over recent cohorts.

The awards will be held bi-annually during Spring and Autumn of this year with the frequency being reviewed. This will ensure they fit with the Trust's new Star Awards that are currently planned to be launched in the early part of the year and conclude in the Spring. This will mean the Quality Awards will be launched after Star Awards have concluded and then again, in the Autumn. This should allow the optimal exposure for both of these important Trust awards.

3.0 The Quality Award winners

The latest winners and commendations from the first cohort of awards for 2012, was agreed at the August 2012 meeting of the Council of Governors Quality Sub-Committee governors. 4 winners and 10 commendations were agreed.

The Council of Governors awarding panel comprises Mike Anderson, Medical Director, Cathy Mooney Director of Governance and Corporate Affairs, Therese Davis, Chief Nurse and Director of Patient Experience, Deputy Chief Nurse Anthony Pritchard, Maddy Than and Carol Dale, (Staff Governors) and Trust Governors Melvyn Jeremiah, Martin Lewis, Susan Maxwell, Wendie McWatters and Sandra Smith Gordon.

The winners for these awards are as follows:

3.1 Decontamination Services Department

Olga Sleigh, Decontamination Services Manager and the Decontamination Services Department Team

This department combined the work of several departments: endoscopy, the Treatment Centre, main theatres, maternity theatres, intensive care and the paediatric theatres into a new service for the Trust. All of these clinical areas were formerly using and cleaning flexible endoscopes during patient investigations and treatment.

When decontaminating these scopes after use, however, the facilities in question were inadequate and did not comply with required standards to ensure patients' safety. Several changes were required:

- Segregation for clean-dirty areas to prevent cross infection in any area
- Comprehensive maintenance and testing on machines
- Improvement in downtime of the old decontamination machines
- Replacement of old machines in several hospital venues
- Quality control of decontamination procedures
- Nursing staff who were not traditionally comprehensively trained in decontamination activities to be released from this role to be able to undertake patient care procedures
- An on call decontamination service for endoscopes
- Prevention of notable cancellations to patient services due to machines failing on a regular basis
- An overall improvement to endoscope decontamination facilities
- Prevention of health and safety risks to staff with faulty machines

.

After a successful business case was approved by the Trust Board for funding, the decontamination services team led a project to centralise endoscope decontamination in one department under one management team within the existing Sterile Services Department.

The approved business case provided allocated space to be added to the 'footprint' of

the Decontamination Department for the new decontamination unit. To facilitate these negotiations took place to re-allocate hospital radio to its new site. The new endoscopy decontamination unit building plans were approved

Decommissioning of the old machines started after procurement of the new compliant machines. Specially 'HEPA' filtered storage cabinets to provide safe and secure storage of expensive endoscopes and procurement of new endoscopes was included and firm maintenance contracts established

A new tracking and tracing system to attain national standards was introduced and a team of existing and newly recruited decontamination staff were trained in the use of the new systems. To add to this, a Quality Management System was introduced to monitor all compliance.

The new centralised decontamination unit robustly improved infection control concerns, maintenance and expansion of Endoscopy services improvement patient's safety and experience. This solution has proved a sustainable Endoscopy service to meet key targets. There is capacity for endoscopy unit growth well into the future and meeting clinical governance requirements.

A new on call service was established to provide emergency cover service for patient endoscopy services and new staffing structures for the unit were agreed which comprised of sterile services staff and not nurses. This released nurses to be able to undertake their patient care duties and for the decontamination services team to take over.

This proposal allowed the Trust to establish and implement the Quality Management System to demonstrate compliance with the European Medical Devices Directive and national standards and thereby the Healthcare Commission Standards and the Health Act. It also ensured current Department of Health infection control directives are met in this area.

The decontamination services offer one service of instrument and endoscope decontamination in one are and protocols and procedures are in place to meet customers' demands. Since the opening of the new unit productivity has increased from 6000 procedures per year in Endoscopy to 13000. In conclusion, it is notable that since the opening of the new unit, other healthcare organisations from the UK, Europe and other countries have visited the unit to gain learning for commissioning units of their own. This places the Endoscopy Decontamination Unit at Chelsea and Westminster as a 'world class' and well known unit for its quality and innovation.

3.2 Infrastructure Power Works Team

Catherine Sands, Emergency Planning Officer and Helen Elkington, General Manger Estates and Facilities (Executive Lead Thérèse Davis)

The Infrastructure works were part of an extensive £9.5m project, designed to make the hospital self-sufficient in power needed to keep services running smoothly and to reduce its carbon footprint.

It was anticipated that this project would also significantly enhance resilience to any future mains power loss and there would no longer be the need for the movement of patients across from one side of the hospital to the other to reach a safe power supply

In addition to the works taking place the project also involved the training and exercising of the new Incident Control Room and the first deployment of a full command and control

structure, including the use of the communication area or ‘pod’ and full use of radio system.

To ensure smooth running of the hospital and to manage contingencies in case of problems, the emergency management system, known as the command and control system was utilised. This means that 3 levels of management command are used, (Gold, Silver and Bronze levels of staff. In addition to this structure that is used during major incidents, additional ‘Bronze’ operational managers or commanders were located in the high risk areas of Acute admissions unit and the neonatal intensive care unit.

The command and control operated on every day of works where there was a significant risk. These works were of the highest risk especially as the hospital had to be removed from the National Grid supply in October 2011 and the works continued into March 2012.

Due to the nature of the work and the necessity to ensure that the whole hospital was centrally controlled, the updated incident control room was opened with staff working weekends and long into the week day evenings. Unfortunately, the hospital did experience a power loss during the October works but as a result of a thorough risk assessment and subsequent contingencies in place (including hired back up external generators) and experienced staff onsite, an evacuation was prevented.

The work that was completed successfully ensured those patients were managed safely during high risk infrastructure work. This was planned to a level of extensive detail and involved many departmental areas. Much detailed work needed dealt with critically dependent patients such as intensive care, neonatal intensive care, the emergency department, theatres, maternity, the acute admissions unit as some key examples. The project also required extensive communication with many internal leads and external agencies to ensure safety for patients in the planning of the work.

The project provided significant learning from the infrastructure works that has contributed to the greater resilience in the Trust and a large team of Trust staff have enhanced skills and knowledge of running Trust services during an emergency. There are many themes from this high risk work that can provide valuable patient safety lessons for all healthcare organisations and this initiative has provided a skilled team of Trust staff to respond to emergencies in the future.

3.3 Medihome

Andrea Fernandes, MediHome Clinical Manager and the Medihome Team at Chelsea & Westminster Hospital

This project addressed many challenges and introduced many changes to benefit patient care in the Trust.

Notably, the number of patients who are admitted to hospital is generally more than the capacity available and that waiting times, access and patient flow throughout the hospital can be affected. This is heightened over the winter where traditionally a seasonal increase in admissions is seen and financial positions are such that capacity must be used as efficiently as possible and managed within a budget.

Patients may also experience secondary complications or problems whilst in hospital, for example, remaining in hospital can increase the risk of contracting a hospital acquired infection and for elderly patients in particular may have an impact on their level of independence, making it harder for them to return home without additional support.

The Medihome Team have met these distinct challenges in their work by to providing a

pilot for up to 20 virtual beds to support medically stable patients to continue their treatment and care in the comfort of their own home. The pilot was initially commissioned to support winter pressures and has since been extended.

MediHome provide nurses, physiotherapists and healthcare assistants in the service and patients can be seen up to 4 times a day by one or more MediHome staff. There are a number of different treatments available which include:

- administering intravenous therapies including the management of Hickman and peripherally inserted central catheters (PICC) lines
- cannulation and blood tests
- monitoring
- wound care
- medication prompts
- packages of care and rehabilitation etc.

Care is always tailored to each patients needs and in discussion with the hospital and referring clinician. All patients are assessed by MediHome and asked to consent to continue their treatment at home prior to transfer to MediHome and all patients transferred to MediHome remain under the care of the hospital consultant. Finally, any change to the patients planned treatment is discussed and reviewed between MediHome and the patients' consultant.

Over the past 5 months MediHome are able to demonstrate that the overall length of stay for patients referred has reduced. This in addition to the patient satisfaction results is evidence that patients receiving treatment at home has a positive impact. MediHome actively liaise with the hospital microbiologists to ensure IV therapy is appropriate and change to oral medication is implemented as appropriate. This not only helps to reduce length of stay further but improves patient satisfaction and value for money

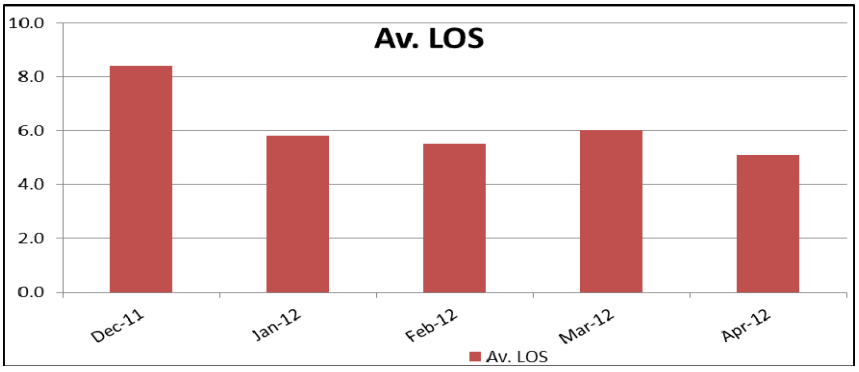


Table 1. Average Length of Stay (LoS)

To address quality and safety of services Medihome records and report all incidents that interrupt the patient pathway.

It can be reported that no serious untoward incidents have occurred. Over the past 5 months MediHome has saved Chelsea and Westminster over 2000 bed days and delivered over 2500 home visits and have no incidents of community acquired infection with the exception of a patient who continued to allow their dog to lick the IV site despite continued advice to the contrary.

The key lesson learned is to ensure that effective communication on the service and additional capacity to the hospital clinicians takes place in a timely manner. MediHome

and the trust worked effectively to ensure that the service was promoted through the issue of posters, attendance and presentations to junior doctors and information for patients. Information included how to refer and what to expect. The local operational team continue to meet every fortnight to review the service and highlight any areas for improvement.

This is in addition to daily ward rounds and bed management meetings where issues that may prevent a patient from being transferred are resolved in real time. Partnership working across organisational boundaries with parties from primary, secondary and third sector providers has played a key part in the success of this service.

The pilot has also provided the opportunity to identify other patient groups that could benefit from a hospital at home service and therefore reduce their length of stay and increase hospital inpatient capacity. These include routine surgical admissions where overnight admissions could reduce to day case as well as patients requiring occupational therapy input and opportunities in A&E to support admission avoidance initiatives.

Patients are also asked to provide comments on the care they have received and to indicate any area's that they would like to see improved. One particular improvement that has been introduced as a result of feedback from patients in 2011 is a service to contact patients the day before their visit to confirm the time they can expect the MediHome clinician to visit.

Over the past 5 months MediHome are able to demonstrate that the overall length of stay for patients referred has reduced. This in addition to the patient satisfaction results is evidence that patients receiving treatment at home has a positive impact. MediHome actively liaise with the hospital microbiologists to ensure IV therapy is appropriate and change to oral medication is implemented as appropriate. This not only helps to reduce length of stay further but improves patient satisfaction and value for money.

3.4 West London African Women's Service

Dr Rachael Jones and Miss Naomi Low-Beer and the West London African Women's Service (WLAWS) and the West London Centre for Sexual Health (WLCSH)

The West London African Women's Service (WLAWS) and the West London Centre for Sexual Health (WLCSH) has a joint service dedicated to improving the care of women living with female genital mutilation (FGM). The service represents an example of partnership between the Chelsea and Westminster (C&W), the departments of Obstetrics & Gynaecology, Sexual Health and a local outreach charity. In addition to care based at the WLCSH, WLAWS also offers a specialist service for pregnant women with FGM at Chelsea and Westminster Hospital.

An estimated 66,000 women in England and Wales have undergone female genital mutilation (FGM). FGM remains illegal in the UK.

FGM is associated with significant stigma, psychological distress, and long-term morbidity, including genitourinary infection, chronic pain, dyspareunia and obstetric complications. The WLAWS in combination with the WLCSH, delivered by Chelsea and Westminster NHS Trust, provides comprehensive accessible care for women living with FGM.

Having recognised the need for a dedicated FGM service, the WLCSH has worked in partnership with the department of Obstetrics and Gynaecology (Women's Services Directorate) to design a dedicated clinic to meet the complex needs of women living with

FGM. In the main, women are seen within the sexual health service initially and referred into the dedicated gynaecology clinic which is also located within the WLCSH. Engaging the services of a Somalian outreach worker, employed by the local charity 'Opportunity for all' (OfA) has led to extensive recruitment to the service. In parallel with this specialist gynaecology clinic based at the WLCSH, the care pathway for pregnant women with FGM has been significantly improved, and pregnant women with FGM are seen by a specialist FGM midwife, supervised by a consultant obstetrician with a specialist interest in FGM.

Given the stigmatising nature of this condition, many women living with FGM are lost to follow-up their care. Due to cultural boundaries, many find it difficult to discuss ensuing symptoms with primary care providers. Our combined service ensures that women seen within the WLCSH are able to have a subsequent review from the gynaecology team within the same centre, reducing lost to follow-up rates. Where appropriate, de-infibulation (surgical reversal) is performed at the WLCSH, under local anaesthetic.

Women with more complex gynaecology needs or requesting de-infibulation under general aneasthetic are referred to named gynaecology consultant with expertise in this area. Partnership working between the WLCSH, gynaecology and OfA has facilitated a more holistic approach to care ensuring that the women's sexual health, psychological and gynaecological needs are addressed.

Many of the women attending clinic originate from areas with high rates of HIV and hepatitis B. Contaminated instruments may be used to perform the FGM leading to further transmission of blood borne viruses. Unless these infections are identified, there is a high risk of transmission. Identification of FGM and underlying infection prior to sexual activity, pregnancy and delivery is clearly imperative and our service represents a safe and effective environment in which to address these issues. The presence of a culturally sensitive outreach worker further alleviates cultural boundaries and improves the patient experience.

For many of the attendees it is reported that it is the first time they have been able to discuss the physical and psychological ramifications of FGM. The service seeks to provide "kindness and compassion" and a unique service meeting the needs of a marginalised group who have frequently experienced barriers from alternative health providers. The presence of a culturally sensitive outreach worker further ensures sensitivity, respect and kindness.

Safety remains paramount. The partnership work is designed to reduce loss to follow-up; the holistic nature of the service ensures nothing is missed. The presence of health advisers within the service allows real term assessment and support of associated psychological issues. Evidence and patient feedback serves to highlight the excellent nature of the service.
Given that it is the only service of its kind in the UK, the lengthy waiting list is indicative of its excellence and popularity.

Continuity between this community based service and access to hospital maternity and gynaecology services is co-ordinated and overseen by a senior specialist midwife with expertise in this area. The specialist midwife who works closely with both the teams and the established hospital based FGM service ensures that this ethos and philosophy of care is seamless across the services. Over 90% of women attending gynaecology FGM service at WLCSH were of sub-Saharan African origin. Sexually transmitted diseases screening took place at the same centre.

HBsAg positive results were found in some patients, indicating current hepatitis B infection, late latent syphilis in four women, .a range of gynaecological complaints, and recurrent urinary tract infection.

This initiative is an example if partnership working across two major Directorates within the Trust. It has taken extensive planning and process mapping to become the success it is today. The team has identified a group of women living with FGM; there are large cohorts elsewhere in the UK. The service design could be easily adapted across the NHS, using the clinic as a template. This initiative has led to a new referral route and open access for this hard to reach group. Benefits have included engaging with this population, providing non-judgemental education and facilitating access to other services that are pertinent to this patient group, such as maternity services for pregnant women, direct referral to specialist gynaecology services for more complex gynaecology needs, and referral to associated specialities like psychosexual counselling, pelvic floor clinic, and urology or fertility services. The clinic is a firm example of partnership working between the NHS and a local charity. It represents the hard work and dedication of each individual involved in the service.

5.0 Commendations

As outlined, a commended category was introduced in August to recognise high quality applications and is endorsed by the Council of Governors Quality Sub Committee. Those teams recognised in this group are as follows:

- **Coffee morning drop in sessions for parents on the Neonatal Unit -** Revd Sharon Connell and members of the Chaplaincy Multi-Faith Team
- **Improving care for pregnancy related pelvic girdle pain -** Women's and Men's Health Physiotherapy team – Lucia Berry
- **Improving Medication Reconciliation at Discharge – Closing the Loop Project -** Shirley Kuo and the CLAHRC (Collaboration for Leadership in Applied Health Research and Care) Project Team
- **VTE Exemplar status -** VTE risk assessment development team, IT, Data warehouse and clinical representatives
- **Hand Therapy Service Improvements -** Hand therapy Team
- **Nutritional Screening -** Dietetics Team
- **Nutritional status of hospital patients -** Nutritional Screening Group
- **HIV Neurocognitive Screening -** HIV Neurocognitive Screening Team
- **Improved Birth experience -** Anne Steward Ward - Maternity
- **Hip fracture care improvements -** Orthopaedic Nurse Specialist and the Hip Fracture Multidisciplinary Team

6.0 Summary

The Quality Awards led by the governors from the Council of Governors Quality-Sub Committee, are awarded for Patient Safety, Patient Experience and Clinical Effectiveness.

This recent cohort of awards saw the highest number of nominations received for the Trust's Quality Award and a new development has included a commended category to recognise high quality applications.

The award winners were agreed in August 2012 Council of Governors Quality-Sub Committee meeting. 4 winners were chosen and their work will be presented at the Council of Governors Meeting on September 13th 2012 when the winners will be invited to attend to receive their awards form the Trust Chairman

The 2nd cohort of the Quality Awards for 2012 will be launched this month. Successful winners will receive their awards at the December Council of Governors Meeting.

7.0 Decision/action required

This report is for information. The Council of Governors are asked to note the content of this paper as an overview of the Quality Award and the winners and commendees from the Spring 2012 nominations.

Melanie van Limborgh
Head of Quality and Assurance
September 2012

Appendix 1

Application criteria for the Quality Award

Applicants must demonstrate evidence of the following information in their application:

- The context of the initiative that is being taken forward, e.g. where this work is done, the specific staff/patient groups that were involved and the specific problem or system dysfunction being addressed and how that was affecting patient care
- How the assessment of the problem and analysis of its causes is handled, how the applicants quantified the issue, how staff were involved, how the causes of the problem were addressed and what solutions/changes were needed to make improvements
- The applicants are required to describe the intervention employed and the strategy for implementing a proposed change and how the results were disseminated
- How plans for change to the groups involved with/affected by the planned change, the timetable for change and how improvement was measured, any analytical methods used if used any results obtained.
- Applicants are asked about the effects of changes, how far these changes resolved the problem that triggered the work, how this improved patient/client care and problems encountered with the process of changes or with the changes themselves.
- From the Spring 2012 award, applicants are required to demonstrate how their nomination meets the Trust values of Safe, Excellent, Kind and Respectful.
- Finally, the award application has to have note of lessons learnt from the work that could be applied elsewhere in the Trust or the NHS.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 13 September 2012

AGENDA ITEM NO.	2.2/Sep/12
PAPER	*Draft Minutes of the Council of Governors Quality Sub-Committee meeting held on 21 August 2012
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Mike Anderson, Chairman of the Quality Sub-Committee
EXECUTIVE SUMMARY	Draft minutes are enclosed.
DECISION/ ACTION	To note.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Quality Sub-Committee meeting, 21 August 2012

Draft Minutes

Attendees	Carol Dale	CD	Staff Governor – Management
	Melvyn Jeremiah	MJ	Public Governor – Westminster 2
	Anna-Hodson Pressinger	AH-P	Patient Governor
	Martin Lewis	ML	Public Governor – Westminster 21
	Susan Maxwell	SM	Patient Governor
	Wendie McWatters	WMW	Patient Governor
	Sandra Smith-Gordon	SS-G	Public Governor – Kensington & Chelsea 2
	Dr Oyejumoke Okubadejo	OO	NHS North West London Cluster representative
	Dr Mike Anderson	MA	
	Cathy Mooney	CM	Director of Governance and Corporate Affairs
	Therese Davis	TD	Chief Nurse
	Tony Pritchard	TP	Deputy Chief Nurse
	Patricia Gani	PG	LINk representative
	Melanie van Limborgh	MvL	Head of Quality and Assurance
	Debbie Basham	DB	PA to Director of Governance and Corporate Affairs
	Jamie Kitchenbrand (in part for item 6)	JK	Contracts Manager

1 Welcome and Apologies **MA**

Apologies were received from Therese Davis, Maddy Than and Vida Djelic.

2 Minutes of previous meeting held on 15 June 2012 **MA**

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

- CD sent apologies
- Page 6 item 9 SM reported on a patient who had had a bad experience with MRI and this had not been recorded in the minutes. **SM** **SM to email details to CM.**

3 Matters arising **MA**

3/Jun/12 Wayfinding group
TP confirmed that making the reception more welcoming is included in the workplan for the Wayfinding Group. It was noted that this is not just about presentation but also about people. A Concern was express that two meetings were cancelled. **TP to find out when the next meeting is.** **TP**

4/Jun/12 Quality Report – next steps
This is on the agenda.

5.1/June 12 M-PALS regular reports

This is on the agenda.

5.1/June 12 Information on information management and availability of patient records for consultants
It was agreed that Karen Baker, CRS Programme Manager would come to the next meeting of the sub-committee. She will also be presenting at the Council of Governors meeting in December.

5.1/June 12 Older people involvement in patient experience objectives
TP has invited patient volunteers to join the Falls Group.

5.1/June 12 CQUINs(Commissioning for Quality and Innovations)
This is on the agenda.

5.2/June 12 The Terms of Reference of the Patient and Staff Experience Committee
The Terms of Reference of the Patient and Staff Experience Committee were circulated. SM has volunteered to be a member.

9/Jun/12 Feedback from governors on patient experience
TP confirmed that outpatient department front of house training had been completed and he will check on the position with the emergency department.

9/Jun/12 Patients who reported call bell had been taken away
TP said that this occurred on David Erskine ward. The evening is not known, but TD has written to all Sisters and Charge Nurses on a number of matters, including information on night call bells.

CM asked for clarification on the item 9/Jun/12 'It was agreed where issues were raised previously and follow up was made it should be reported back to the committee' as this was the function of matters arising. It was felt that providing this worked well there is no need for an additional system. CM asked the committee members to highlight if they thought any matter arising was accidentally dropped.

Otherwise, all matters arising are as reported in the paper.

4 Report on Quality Objectives Q1 **CM**

CM explained that the monitoring framework for the quality objectives was very specifically designed to ensure that everything we said we would do in the Quality Account is being monitored.

She outlined the progress with the objective to have no hospital preventable VTE.

This was noted to be a very helpful report. The general impression was that there was a great deal of work going on but that there is a significant lack of data.

There was a particular concern that it had taken as long as since February 2012 to put alternative plans in place to address the lack of data from VTE.

Regarding priority 4 CM said that since this paper had been written all the data was available which confirmed that we were meeting the target as outlined. The delay in data collection was due to the development of an IT solution as the method for collecting the data which was paper based and

very time consuming.

CD outlined the achievement re patient and staff experience objective. She confirmed that appraisals occur once a year and they are not used for poor performance which was addressed under sickness and absence, capability and the disciplinary procedures.

It was noted that the achievement of this objective will be measured by the by staff survey and measuring the internal appraisal rate is a proxy. It was not clear why the Trust was reporting a higher rate than the staff survey but efforts have been made to make it clear to staff that they were undertaking appraisals and the terminology had been changed to reflect that used in the staff survey.

There was a delay in every member staff receiving written confirmation of the Trust values. It was thought it would be beneficial for these new values to come from the new Chief Executive. CD confirmed that there is no definition of 'well structured' and noted that we believe that the staff survey questions are changing and we are not sure whether this question will remain or the one relating to personal development plans.

MJ thought that the point of appraisal was to get hold of poor performance and felt that disciplinary policy was ignored. He noted that we were just about achieving our target and wondered whether there should be another measure. CD said that the Appraisal Form is being reviewed to be in two parts, looking forward and looking back. Everyone uses the same paperwork except for doctors who have their own paperwork as part of revalidation.

Objectives can be set at different times and it is the policy that appraisals are set at the anniversary of the individual's start date. CD confirmed that there had to be a record signed off by the manager and member of staff which is held locally but reported centrally. Last year there were two audits of documentation and advice was given back to the areas audited on improvement. The manager takes action on poor performance with guidance from the HR adviser.

TP outlined progress on the patient experience objective and the Patient and Staff Experience Committee. He confirmed that the discharge pathway had been reviewed. We know that the key issues are around coordination and communication. We are looking at predicting the length of stay and beginning discharge on admission. WMW highlighted that families are often not informed, for example a patient she knows was waiting for their discharge but the relative was not informed. TD noted that this was also about perception. Patients often think they can go home as soon as the doctor tells them without understanding that there is a paper work to be completed. We are working on communication to patients on this.

It was noted that volunteers at the Olympics were trained by John Lewis and it was very successful. The values and behaviours will address the problems with attitude that had been highlighted.

5 Monthly performance report indicators **CM**

The areas where there are amber or red ratings are discussed at the Quality Committee with the leads giving explanations. CM highlighted the main points of the paper.

6 CQUINs (Commissioning for Quality and Innovations) JK

Jamie Kitchenbrand, Contracts Manager attended for this item. He outlined the paper and asked for questions before moving onto a more detailed discussion. He explained that there would be a meeting next week regarding a number of CQUIN in particular, end of life care. The Trust is working to develop indicators for this. CQUINs need to be achievable. We need to agree them with the commissioners. It was noted that the Council of Governors attached some importance to end of life care. It was confirmed that 8.1 and 8.2 measure how many patients die and the CQUIN is a subsection of this. Patients are identified within the last year of their life and then put on the appropriate pathways. It was agreed that the last year of life is subjective and occasionally patients who were put on the Liverpool Care Pathway will die within a year but in some areas they will live long and comfortably. It is very important that links are developed and improved with the community. Historically, end of life care has focused around cancer, lots of people have a poor prognosis who do not have cancer and they need to be included. MA explained that patients are not always aware that they have been told and advising patients that they are on an end of life pathway needs to be a process rather than a single conversation as patients often do not remember what they were told. There was a concern that putting a patient on the pathway removes hope. It was agreed that this is a particularly difficult thing to have as a CQUIN. An important measure last year was that where patients chose to die at home that they did actually die at home. We have met that CQUIN and therefore are now developing a new CQUIN. It was agreed that Sarah Cox would be invited to come and talk to the group at the next meeting.
CM to invite Sara Cox to present to the sub-committee in November. CM

JK highlighted GP real time information. This is about sharing information as quickly as possible. Information is provided to GPs through a portal. It is the Clinical Quality Group's responsibility to ensure that GPs access that. The feedback has been very positive so far.

JK outlined the 12 hour consultant assessment. It was confirmed that the CQUIN relating to children was that once patients had been admitted that they were seen within 12 hours. The main driver is that there is more early senior involvement across London.

7 Survey results of MPALS quarterly reports TP

The satisfaction audit results were outlined. There was an away day to develop an action plan which was also presented. It was noted that this was very small sample size and there are plans to repeat it with a wider group. WMW feedback is that MPALS is not visible enough. It was noted that a new sign went up yesterday 'Advice and information – MPALS'. She reiterated that she does not believe that people know where to go and questioned how prominent the information was on the wards. TP agreed that patients were often directed to MPALS and then redirected to the ward and it is the ward that should be resolving a lot of these issues.

It was agreed that an update on these actions will be provided at the next meeting. **TP to provide an update. TP**

Re Quarter 1 Report MPALS it was confirmed that these go the Divisions and they are discussed at local level. This also feeds into the Patient and

Staff Experience Committee. It was confirmed that every issue will have been responded to.

8 Quality Account evaluation questionnaire **MvL**

MvL explained that a questionnaire survey will be undertaken based on the last year's Quality Account. Questionnaires will be collected when the Quality Account is represented at the September Annual Members' Meeting. It was agreed that this would include the choice of completing the survey at home.

9 Council of Governors funding report **CM**

This was for information as it was agreed that more information would be given to the governors via sub-committees in between the Council of Governors meetings.

10 Transformation – Improving Discharge **CE**

CM said that Debbie Richards, Divisional Director of Operations Medicine and Surgery would be attending the meeting in November. She had asked CM to present the key areas of work to ensure that the Transformation Project Group was working in the direction as the governors wished. She outlined the three workstreams. The governors confirmed that the timing of discharge was important and that social circumstances are taken into account when patients are discharged i.e that safe discharge is very important. There was a question whether the planned day of discharge process included considering social circumstances.

There was some discussion about the discharge lounge. WMW said she had been an inpatient several times recently and has never been told about the discharge lounge and had to sit on the bed with her plastic bags. It was confirmed that there was a Health Care Assistant cover there at all times.

JO asked about the overnight discharges. CM confirmed that the Out of Hours Discharge Policy was approved at the Quality Committee in July 2012 and the impact would be measured.

Another issue raised by the Quality sub-committee was an issue of waiting for transport.

11 Feedback from governors on patient experience **MvL**

AH-P noted volunteer problems with wheelchairs. This was linked to the patients support project where patients can ask for help in getting to outpatients. Often volunteers have problems in finding wheelchairs. There was some discussion whether it would be possible to have wheelchairs accessible but the problem is we have to maintain the stock. **TP to look at potential solutions.** **TP**

It was noted that the reception board does not include physiotherapy and that there are hundreds of requests at reception for physiotherapy location. There was a concern that this needed to be sorted before the Wayfinding Group and a temporary measure should be put in place. **TP to follow up.** **TP**

TP was thanked for arranging the sign for 'meet a governor' sessions time.

PG reported on a friend's mother who was treated for cancer UCH. She had a raised temperature and was admitted to C&W. She was very positive about A&E and the communication with the doctors at UCH. However, her chemotherapy which was two days late. **PG is to supply the name to TP to follow up.** **PG/TP**

SN reported on her personal situation with her baby and the delay in being able to get hold of antibiotics. She agreed that she would register this as a formal complaint so that this could be investigated. **SN to register a formal complaint.** **SN**

SS-G said that she had only positive comments from patients to report.

AH-P commented on patient and staff dressing when outside. Patients are half-dressed when smoking outside, sometimes with an IV stand. Staff may be seen outside with their theatre clothes on. It was noted this was not an infection control risk but the perception was important. The problem is that the solution may not be within our gift as we have no sections towards patients. It was suggested that guidance was written in the ward guidance for patients.

ML reported that Junior Doctors were not wearing white coats. **MA to follow up.** **MA**

12 Quality Award - Lead Governor – for information **MvL**

This item was noted.

13 Quality Award schedule – for information **MvL**

This item was noted,

14 Any other business

MJ raised the issue of the Terms of Reference. He believes that the Chair of the Quality sub-committee should be a governor as it is a sub-committee of the Council of Governors. He requested that this specific issue is resolved at the Council of Governors meeting in September. However it was noted that the agenda for the Council of Governors meeting had been agreed and it was too late to include it especially as this meeting needed to be finished promptly for the Annual Members' Meeting later. Some members of the committee noted that they were very happy with the status quo. It was agreed this would be raised at the Council of Governors meeting in December 2012. **VD to forward this request to the Council of Governors Agenda Sub-Committee.** **VD**

12 Date of next meeting – 13 November 2012

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 13 September 2012

AGENDA ITEM NO.	2.3/Sep/12
PAPER	*Shaping a healthier future* – Trust Communications & Engagement Plan update
AUTHOR	Matt Akid, Head of Communications
LEAD	Dr Mike Anderson, Medical Director
EXECUTIVE SUMMARY	The *Shaping a healthier future* public consultation on NHS service changes in North West London has major strategic implications for the Trust – it is due to end on 8 October. This paper updates Governors on progress in implementing the Trust's 'Safe in our hands' campaign of communications and engagement with internal and external stakeholders. The campaign has included a range of activities involving Governors and Foundation Trust members in supporting the Trust and advocating on behalf of the Trust.
DECISION/ ACTION	The Council of Governors is invited to comment on progress and to discuss its ongoing role in supporting and advocating for the Trust during the public consultation.

1.0 Introduction

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

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

The 'Safe in our hands' campaign being run by the Trust to keep A&E and other services at Chelsea and Westminster has 2 key aims:

- To encourage Foundation Trust members, patients, local residents, staff and other potential supporters to register their support for keeping A&E and other services at Chelsea and Westminster (Option A)
- To demonstrate this support publicly through media, social media, online (website), stakeholder engagement and other activity

A range of 'Safe in our hands' communications materials have been developed including a dedicated website www.safeinourhands.info, tickbox postcards, posters and T-shirts.

Governors have played a key role by working in partnership with the Trust's Communications team on the campaign.

2.0 Encouraging support for Chelsea and Westminster

Potential supporters of the 'Safe in our hands' campaign have been asked to register this support in 3 main ways.

2.1 Completing the 'official' public consultation response form

The response form is lengthy and requires people to cross-reference against the public consultation document and so the Trust has provided a range of support by:

- Setting up a rota of Governors, Volunteers, Friends etc to canvass people in the hospital and help them to complete the response form either in hard copy or online using iPads provided by the Trust IT Department – this is being co-ordinated by the Volunteers Manager
- Producing 'suggested answers' to make it easier for people to complete the response form in support of Chelsea and Westminster – these have been provided to canvassers in the hospital, to ward staff helping patients complete the form via the Hospedia bedside entertainment system (see below for details) and online at www.safeinourhands.info where there are also quick links to the response form
- Making the online response form available to patients via the Hospedia bedside entertainment system in the hospital – an alert comes up on the system at 2pm every day

2.2 Filling in 'Safe in our hands' campaign postcards

Recognising that the official public consultation response form is lengthy and many people may not have the time or inclination to complete it, the Trust came up with an alternative to encourage involvement in the consultation – a 'Safe in our hands' campaign postcard.

This is a simple tickbox card for patients and visitors to the hospital, local residents and staff with a facility for people to indicate they are happy for the Trust to submit a consultation response form on their behalf (answering just the key question in support of Option A to keep A&E at Chelsea and Westminster).

The Trust produced 2 versions of the hard copy card – 1 for use in the hospital (completed cards to be placed in collection boxes at M-PALS, Main Reception and A&E) and 1 for use outside the hospital (FREEPOST) – and an online version at www.safeinourhands.info.

Distribution to date has included:

- Handed out to patients and visitors at Main Reception, M-PALS, A&E and in other clinical areas from w/c 13 August
- Handed out by Governors in the hospital from w/c 13 August
- FREEPOST cards sent to c. 8,500 patient and public Foundation Trust members in membership mailing w/c 20 August
- FREEPOST cards distributed by Governors in their local areas w/c 20 August
- FREEPOST cards given to local shops and businesses w/c 20 August
- Attached to staff payslips 24 August
- Included in TTO bags given to patients in Pharmacy

As of 30 August, a total of **2,628** postcards had been completed and returned – 1,971 cards used in the hospital, 582 FREEPOST cards (mainly as a result of the membership mailing), and 75 online.

Importantly, the vast majority of respondents ticked the box authorising us to submit an 'official' consultation response on their behalf. Completed postcards are sent to an external company for data entry and conversion of postcards into official consultation responses.

As of 30 August, the total number of responses to the 'official' *Shaping a healthier future* consultation was only 849 and therefore Chelsea and Westminster support following conversion of postcards into official consultation responses should be strong.

Distribution of postcards in September will include:

- 25,000 FREEPOST postcards distributed via a leaflet drop to local residents w/c 10 September
- FREEPOST postcards distributed to local GPs
- FREEPOST postcards sent to local schools and libraries
- Postcards handed out to everyone attending the Annual Members' Meeting on 13 September

2.3 Signing the Council of Governors petition

The online petition had 13 co-signatories from the Council of Governors – elected Patient, Public and Staff Governors. Thank you to all Governors who agreed to participate and in particular to Patient Governors Chris Birch and Susan Maxwell, who gathered support from their fellow Governors and finalised the wording of the petition, and to Public Governor Melvyn Jeremiah who liaised with online petition organisation '38 Degrees' to make it live.

As of 30 August a total of **177** people had signed the petition online. Governors also plan to gather signatures using a hard copy petition face-to-face in the local community.

3.0 Demonstrating support for Chelsea and Westminster

In addition to activity to encourage people to register their support for the 'Safe in our hands' campaign in the 3 ways outlined above, a range of other communications and engagement activity is being undertaken.

3.1 Stakeholder engagement visits

The Trust sent letters of invitation to visit Chelsea and Westminster to local MPs, the 4 local council leaders, and other key councillors from the 4 local boroughs (especially those on the Joint Health Overview and Scrutiny Committee for the 8 boroughs in North West London, as well as neighbouring boroughs outside North West London whose residents will be affected by the changes proposed, set up to overview the consultation).

Public Governors have been invited to join visits by local council leaders and other key local councillors for the boroughs that they represent on the Council of Governors.

The key aims of these visits are to enable these stakeholders to see our A&E, Paediatrics and Maternity facilities, to meet senior clinical staff, and to facilitate discussion with the Chief Executive and Chairman about why Chelsea and Westminster should keep A&E and other key services – and how we are preparing our services to accommodate extra patients.

The value of this activity is demonstrated by the fact that, following a visit to the hospital by members of City of Westminster's Health Overview and Scrutiny Committee on 11 June, they have since registered with NHS North West London their support for Option A in the *Shaping a healthier future* consultation including keeping A&E at Chelsea and Westminster.

By the beginning of October, all 4 local council leaders will have visited the hospital, together with most key councillors from the 4 local boroughs, and Chelsea & Fulham MP Greg Hands.

3.2 Foundation Trust membership engagement

A public consultation meeting specifically for Foundation Trust members was held on 4 September and the 'Safe in our hands' campaign will be the key theme of the Annual Members' Meeting on 13 September – Governors have kindly agreed to help members attending the meeting to complete consultation response forms afterwards.

In addition, 'Safe in our hands' tickbox postcards were sent to all Patient and Public members in the membership mailing in August and the campaign has also been the main item in the most recent monthly *Members' News* email bulletins which are sent to all Patient and Public members who have given us their email addresses.

3.3 Staff engagement

A series of 3 public consultation meetings specifically for staff were held on 5 July and attended by approximately 130 staff. A further 3 staff consultation meetings are being held on 14 September.

In addition, 'Safe in our hands' postcards were sent to all staff with payslips in August and the campaign has been communicated regularly to staff through *Trust News* magazine, the monthly Team Briefing, Daily Noticeboard email bulletin etc.

Staff have proved to be willing and enthusiastic advocates for the 'Safe in our hands' campaign, specifically by handing out tickbox postcards to patients and visitors in the hospital and by completing postcards themselves.

3.4 Media/social media/online (website)/engagement of key patient groups (Maternity)

The Trust has supplemented its limited in-house resources and capacity in the Communications Department by working with an external PR company to support a range of activity including generating media stories, driving interest in the 'Safe in our hands' campaign via social media such as Twitter and Facebook, and engaging key groups of patients such as women who have either had a baby in our Maternity Unit or who are currently pregnant.

Examples of this activity include encouraging celebrity supporters for the hospital – ie the former Olympian Daley Thompson – which has generated media interest.

4.0 Future consultation events

These events taking place before the public consultation ends on 8 October may be of interest to Governors.

4.1 Joint Health Overview and Scrutiny Committee (JHOSC)

A Joint Health Overview and Scrutiny Committee (JHOSC) for all the 8 boroughs in North West London, as well as neighbouring boroughs outside North West London whose residents will be affected by the changes proposed, has been set up to overview the consultation – if Governors wish to attend future meetings of the JHOSC, please contact Matt Akid in the Communications Department for dates.

4.2 Public consultation 'roadshows'

The *Shaping a healthier future* programme has organised public consultation 'roadshow' events in September following similar events earlier in the consultation period.

Details of local roadshows are as follows:

KENSINGTON & CHELSEA
Saturday 15 September, 10am-4pm
Chelsea Old Town Hall
Kings Road
Chelsea
SW3 5EE

HAMMERSMITH & FULHAM
Wednesday 19 September, 2-8pm
Fulham Broadway Methodist Church
452 Fulham Road
Fulham
SW6 1BY

WESTMINSTER
Saturday 6 October, 10am-4pm
Hinde Street Methodist Church
19 Thayer Street
Westminster
W1U 2QJ

4.3 Public meeting in Hammersmith

The London Borough of Hammersmith & Fulham has been running a ‘Save our hospitals’ campaign to keep A&E at Charing Cross and Hammersmith hospitals.

The Borough has organised a public meeting to take place at 7pm on Tuesday 18 September at Hammersmith Town Hall, King Street, Hammersmith. W6 9JU.

5.0 Next steps

The Council of Governors is invited to comment on progress in implementing the ‘Safe in our hands’ campaign and to discuss its ongoing role in supporting and advocating for the Trust during the public consultation.

Matt Akid
Head of Communications
September 2012

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 13 September 2012

AGENDA ITEM NO.	2.4.1/Sep12 – revised
PAPER	Constitution changes required as a result of the Health and Social Care Act 2012 – to come into effect on 1 October 2012
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Cathy Mooney, Director of Governance and Corporate Affairs
EXECUTIVE SUMMARY	This version of the constitution incorporates 2012 Act amendments which will come into force on or before 1 October 2012 as a result of the first and second commencement orders (Statutory Instruments 2012/1319 and 2012/1831). The amendments have been made in blue in accordance with the Model Core Constitution. They concern: • The continuation of the body corporate known as Monitor – amended as stipulated by Monitor Model Core Constitution p.3 • Change from the 'Board of Governors' to the 'Council of Governors' – no change needs to be made • Requirement for the principal purpose (i.e. provision of goods and services for the health service in England) to be stated in the constitution – amended as stipulated by Monitor Model Core Constitution p.5 • Introduction of the new legal duty to ensure that income of NHS funded goods and services is greater than income from other sources – amended as stipulated by Monitor Model Core Constitution p.31-32 • Introduction of additional oversight and scrutiny by the Council of Governors over activities generating non-NHS income – amended as stipulated by Monitor Model Core Constitution p.32 • Replacement of HM Treasury with Secretary of State as regards giving guidance over FT accounts – amended as stipulated by Monitor Model Core Constitution p.31
DECISION/ ACTION	The Council is asked to agree the changes as outlined to be presented to the members at the Annual Members' Meeting on 13 September 2012.

Constitution changes required as a result of the Health and Social Care Act 2012 – to come into effect on 1 October 2012

1.0 Introduction

Certain sections of the Health and Social Care Act 2012 will come into effect on 1 October 2012. These changes will affect the constitutions of all foundation trusts. Monitor had provided a Model Core Constitution which shows in highlights the changes which now need to be made. This paper outlines these changes and seeks approval by a majority of members present and voting at a members meeting duly called by order of the Council of Governors.

2.0 Background

For the time being, it remains Monitor's duty to approve constitution amendments. Monitor therefore has requested that all foundation trusts carry out the following actions as soon as possible:

1. Make the relevant changes to their constitutions either using the Model Core Constitution wording or alternative wording which is compliant with the legislation;
2. Secure the internal approvals required for constitution changes
3. Submit to their Monitor Relationship Manager a 1) tracked changes and 2) clean version of their revised constitution; and
4. Submit to their Monitor Relationship Manager confirmation of the internal approvals, including confirmation that each of the relevant meetings was quorate.

3.0 Changes

The changes are as follows and explained in the attached revised constitution:

- The continuation of the body corporate known as Monitor – amended as stipulated by Monitor Model Core Constitution p.3
- Requirement for the principal purpose (i.e. provision of goods and services for the health service in England) to be stated in the constitution – amended as stipulated by Monitor Model Core Constitution p.5
- Introduction of the new legal duty to ensure that income of NHS funded goods and services is greater than income from other sources – amended as stipulated by Monitor Model Core Constitution p.31-32
- Introduction of additional oversight and scrutiny by the Council of Governors over activities generating non-NHS income – amended as stipulated by Monitor Model Core Constitution p.32
- Replacement of HM Treasury with Secretary of State as regards giving guidance over FT accounts – amended as stipulated by Monitor Model Core Constitution p.31

These changes appear in blue and tracked changes in the attached document.

4.0 Approval

According to our constitution section 22 the amendments will require approval of members. An extract from the constitution is enclosed:

‘22.1. No amendment shall be made to this constitution unless:

22.1.1. it has been approved by a majority of members present and voting at a members meeting duly called by order of the Council of Governors in accordance with this constitution; and

22.1.2. it has been approved by the Independent Regulator.’

5.0 Action/Decision

The Council is asked to agree the changes as outlined to be presented to the members at the Annual Members’ Meeting on 13 September 2012.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

CONSTITUTION OF

CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST

(A PUBLIC BENEFIT CORPORATION)

V2

Note: V2 prepared for the Council of Governors meeting on 13 September; amendments have been made as stipulated by the Monitor Model Core Constitution to the following pages: 3, 5, 31 and 32;

The Council is asked to agree the changes as outlined to be presented to the members at the Annual Members' Meeting on 13 September 2012.

Approved October 2009

CONSTITUTION OF CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST

1 Definitions

1.1. Unless the contrary intention appears or the context otherwise requires, words or expressions contained in this constitution bear the same meaning as in the Health and Social Care (Community Health and Standards) Act 2003.

1.2. References in this constitution to legislation include all amendments, replacements, or re-enactments made.

1.3. Headings are for ease of reference only and are not to affect interpretation.

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

1.5. In this constitution:

"the 2003 Act" means the Health and Social Care (Community Health and Standards) Act 2003;

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

"the 1977 Act" means the National Health Service Act 1977;

"appointed Governors" means those Governors appointed by the appointing organisations;

"appointing organisations" means those organisations named in this constitution who are entitled to appoint Governors;

"areas of the Foundation means the eight areas specified in Trust" Annex 1 which are Royal Borough of Kensington and Chelsea (areas 1 and 2), the City of Westminster (areas 1 and 2), the London Borough of Hammersmith and Fulham (areas 1 and 2) and the London Borough of Wandsworth (areas 1 and 2);

"authorisation" means an authorisation given by the Independent Regulator;

"Board of Directors" means the Board of Directors as constituted in accordance with this constitution;

"carer" means a person who has attended any of the Foundation Trust's facilities as the carer of a patient in the last three years and is registered as a carer by the Foundation Trust, provided that such person is not providing care in pursuance of a contract (including a contract of employment), or as a volunteer for a voluntary organisation (being a body other than a public or local authority the activities of which are not carried on for profit);

"Director" means a member of the Board of Directors;

"elected Governors" means those Governors elected by the public constituencies, the patients' constituency and the classes of the staff constituency;

"external auditor" means any external auditor other than the financial auditor appointed under this constitution to review and report upon other aspects of the Foundation Trust's performance;

"financial auditor" means the person appointed to audit the accounts of the Foundation Trust, who is called the auditor in the 2003 Act;

"Financial year" means:

(a) the period beginning with the date on which the Foundation Trust is authorised and ending with the next 31 March; and

(b) each successive period of twelve months beginning with 1 April;

"Monitor" is the body corporate known as Independent Regulator of NHS Foundation Trusts, as provided by Section 61 of the 2012 Act.

Deleted: "Independent Regulator" means the regulator for the purposes of Part 1 of the 2003 Act; ¶

"Local Authority Governor" means a Governor appointed by one or more local authorities whose area includes the whole or part of one of the areas of the Foundation Trust;

"member" means a member of the Foundation Trust;

"Council of Governors" means the Council of Governors as constituted in accordance with this constitution, which has the same meaning as the board of governors in the 2003 Act;

"the NHS Trust" means Chelsea and Westminster Hospital NHS Trust which made the application to become an NHS foundation trust

"partner" means, in relation to another person, a member of the same household living together as a family unit;

"Partnership Governor" means a Governor appointed by a partnership organisation;

"patient" means a person who has attended any of the Foundation Trust's facilities as a patient in the last three years;

"patients' constituency" means (collectively) those members comprising the patients' constituency;

"Patient Governor" means a member of the Council of Governors elected by the patients' constituency;

"PCT Governor" means a Governor appointed by a Primary Care Trust for which the Foundation Trust provides goods or services;

"public constituency" means (collectively) those members living in one of the areas of the Foundation Trust;

"Public Governor" means a Governor elected by the members of one of the public constituencies;

"registered dentist" means a registered dentist within the meaning of the Dentists Act 1984;

"registered medical practitioners" mean a fully registered person within the meaning of the Medicines Act 1983 who holds a licence to practice under that Act;

"Secretary" means the Secretary of the Foundation Trust or any other person appointed to perform the duties of the Secretary, including a joint, assistant or deputy secretary;

"staff constituency" means (collectively) those members of the six classes comprising the staff constituency;

"Staff Governor"	means a Governor elected by the members of one of the classes of the staff constituency;
"University Governor"	means a Governor appointed by Imperial College, University of London.

2 Name and status

2.1. The name of the Foundation Trust is to be "Chelsea and Westminster Hospital NHS Foundation Trust". The Foundation Trust is a public benefit corporation authorised under the Health and Social Care (Community Health and Standards) Act 2003.

3 Principal Purpose

Deleted: 3.1 The Foundation Trust's purpose is to serve the community by the provision of goods and services for the purposes of the health service in England. ¶

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 Functions

4.1. The function of the Foundation Trust is to provide goods and services, including education and training, research, accommodation and other facilities, for purposes related to the provision of health care.

4.2. The Foundation Trust may also carry on other functions for the purpose of making additional income available in order to carry on the Foundation Trust's principal purpose better.

5 Powers

5.1. The Foundation Trust may do anything which appears to it to be

necessary or desirable for the purposes of or in connection with its functions.

5.2. In particular it may:

5.2.1. acquire and dispose of property,

5.2.2. enter into contracts,

5.2.3. accept gifts of property (including property to be held on trust for the purposes of the Foundation Trust or for any purposes relating to the health service),

5.2.4. employ staff.

5.3. Any power of the Foundation Trust to pay remuneration and allowances to any person includes the power to make arrangements for providing or securing the provision of pensions or gratuities (including those payable by way of compensation for loss of employment or loss or reduction of pay).

5.4. The Foundation Trust may borrow money for the purposes of or in connection with its functions, subject to any limit imposed by its authorisation or specified in the prudential borrowing code published by the Independent Regulator from time to time.

5.5. The Foundation Trust may invest money (other than money held by it as trustee) for the purposes of or in connection with its functions. The investment may include investment by:

5.5.1. forming or participating in forming bodies corporate.

5.5.2. otherwise acquiring membership of bodies corporate.

5.6. The Foundation Trust may give financial assistance (whether by way of loan, guarantee or otherwise) to any person for the purposes of or in connection with its functions.

6 Commitments

6.1. The Foundation Trust shall exercise its functions effectively, efficiently and economically.

6.2 Representative membership

6.2.1. The Foundation Trust shall at all times strive to ensure that taken as a whole its actual membership is representative of those eligible for membership. To this end:

6.2.1.1. the Foundation Trust shall at all times have in place and pursue a membership strategy which shall be approved by the Council of Governors, and shall be reviewed by them from time to time, and at least every three years,

6.2.1.2. the Council of Governors shall present to each annual

members meeting:

6.2.1.2.1. a report on steps taken to secure that taken as a whole the actual membership of its public constituencies, the patients' constituency and of the classes of the staff constituency is representative of those eligible for such membership;

6.2.1.2.2. the progress of the membership strategy;

6.2.1.2.3. any changes to the membership strategy.

6.3 Co-operation with health service bodies

6.3.1. In exercising its functions the Foundation Trust shall co-operate with Health Authorities, Special Health Authorities, Primary Care Trusts, NHS Trusts and NHS Foundation Trusts or any successor bodies.

6.4 Respect for rights of people

6.4.1. In conducting its affairs, the Foundation Trust shall respect the rights of members of the community it serves, its employees and people dealing with the Trust as set out in the Charter of Fundamental Rights of the European Union.

6.5 Openness

6.5.1. In conducting its affairs, the Foundation Trust shall have regard to the need to provide information to members and conduct its affairs in an open and accessible way.

6.6 Prohibiting distribution

6.6.1. The profits or surpluses of the Foundation Trust are not to be distributed either directly or indirectly in any way at all among members of the Foundation Trust.

7 Framework

7.1. The affairs of the Foundation Trust are to be conducted by the Board of Directors, the Council of Governors and the members in accordance with this constitution and the Foundation Trust's authorisation. The members, the Board of Directors and the Council of Governors are to have the roles and responsibilities set out in this constitution.

7.2 Members

7.2.1. Members may attend and participate at members meetings, vote in elections to, and stand for election to the Council of Governors, and take such other part in the affairs of the Foundation Trust as is provided in this constitution.

7.3 Council of Governors

7.3.1. The roles and responsibilities of the Council of Governors, which are to be carried out in accordance with this constitution and the Foundation Trust's authorisation, are:

7.3.1.1. at a General Meeting

7.3.1.1.1. to appoint or remove the Chairman and the other non-executive Directors;

7.3.1.1.2. to approve an appointment (by the non-executive Directors) of the chief executive;

7.3.1.1.3. to decide the remuneration and allowances, and the other terms and conditions of office, of the non-executive Directors;

7.3.1.1.4. to appoint or remove the Foundation Trust's financial auditor;

7.3.1.1.5. to appoint or remove any other external auditor appointed to review and publish a report on any other aspect of the Foundation Trust's affairs;

7.3.1.1.6. to be presented with the annual accounts, any report of the financial auditor on them and the annual report;

7.3.1.2. to provide their views to the Board of Directors when the Board of Directors is preparing the document containing information about the Foundation Trust's forward planning;

7.3.1.3. to respond as appropriate when consulted by the Board of Directors in accordance with this constitution;

7.3.1.4. to undertake such functions as the Board of Directors shall from time to time request;

7.3.1.5. to prepare and from time to time review the Foundation Trust's membership strategy and its policy for the composition of the Council of Governors and of the non-executive Directors;

7.3.1.6. when appropriate to make recommendations for the revision of this constitution.

7.4 Board of Directors

7.4.1. The business of the Foundation Trust is to be managed by the Board of Directors, who shall exercise all the powers of the Foundation Trust, subject to any contrary provisions of the 2003 Act as given effect by this constitution.

8 Members

8.1. The members of the Foundation Trust are those individuals whose names are entered in the register of members. Every member is either a member of one of the public constituencies, or a member of the patients' constituency, or a member of one of the classes of the staff constituency.

8.2. Subject to this constitution, membership is open to any individual who:

8.2.1. is over sixteen years of age,

8.2.2. is entitled under this constitution to be a member of one of the public constituencies, the patients' constituency, or one of the classes of the staff constituency, and

8.2.3. completes a membership application form in whatever form the Secretary specifies.

8.3. An individual who is entitled to be a member of one of the public constituencies and is also entitled to be a member of the patients' constituency shall be entitled to choose.

8.4. The Secretary shall make a final decision about the constituency of which an individual is eligible to be a member.

8.5 Public constituencies

8.5.1. There are eight public constituencies corresponding to the eight areas of the Foundation Trust specified in Annex 1. Membership of a public constituency is open to individuals who:

8.5.1.1. live in the relevant area of the Foundation Trust,

8.5.1.2. are not a member of another public constituency or the patients' constituency, and

8.5.1.3. are not eligible to be members of any of the classes of the staff constituency.

8.5.2. The minimum number of members of each of the public constituencies is to be four.

8.6 Patients' constituency

8.6.1. Membership of the patients' constituency is open to individuals who:

8.6.1.1. are or have been a patient of the hospital in the past three years; or

8.6.1.2. are or have been a carer for a patient of the hospital in the past three years; and

who are not members of a public constituency or eligible to be members of any of the classes of the staff constituency. Not more than one carer may be registered as a member in relation to each patient, with the exception of both parents of children who are

under 16 years of age.

8.6.2. The minimum number of members of the patients' constituency is to be four.

8.7 Staff constituency

8.7.1. The staff constituency is divided into six classes as follows:

8.7.1.1. Support, Administrative and Clerical staff

8.7.1.2. Allied Health Professionals, Scientific and Technical staff

8.7.1.3. Contracted staff

8.7.1.4. Medical and Dental staff

8.7.1.5. Nursing and midwifery

8.7.1.6 Management

8.7.2. Membership of one of the classes of the staff constituency is open to individuals:

8.7.2.1. who are employed under a contract of employment by the Foundation Trust and who either

8.7.2.1.1. are employed by the Foundation Trust under a contract of employment which has no fixed term or a fixed term of at least 12 months, or

8.7.2.1.2. who have been continuously employed by the Foundation Trust or the NHS Trust for at least 12 months; or

8.7.2.2. who are not so employed but who nevertheless exercise functions for the purposes of the Foundation Trust and who have continuously exercised the functions for the purposes of the Foundation Trust or the NHS Trust for at least 12 months.

8.7.3 A system of automatic membership by default will be limited to individuals who are employed by the Foundation Trust under a contract of employment. An individual who is:

8.7.3.1. eligible to become a member of the staff constituency under 8.7.2.1 above and has been invited by the Trust to become a member of the staff constituency shall become a member of the Trust staff constituency without an application being made, unless they inform the Trust that do not wish to do so;

8.7.3.2. eligible to become a member of the staff constituency under 8.7.2.2 above may do so on an application made to the Foundation Trust.

8.7.4. The Secretary shall make a final decision about the class of which an

individual is eligible to be a member.

8.7.5. A person who is eligible to be a member of one of the classes of the staff constituency may not become or continue as a member of any of the public constituencies or of the patients' constituency, and may not become or continue as a member of more than one class of the staff constituency.

8.7.6. The minimum number of members of each class of the staff constituency is to be four.

9 Termination of membership

9.1. A member shall cease to be a member if:

9.1.1. they resign by notice to the Secretary;

9.1.2. they die;

9.1.3. they are expelled from membership under this constitution;

9.1.4. they cease to be entitled under this constitution to be a member of any of the public constituencies, the patients' constituency, or any of the classes of the staff constituency;

9.1.5. if it appears to the Secretary that they no longer wish to be a member of the Foundation Trust, and after enquiries made in accordance with a process approved by the Council of Governors, they fail to demonstrate that they wish to continue to be a member of the Foundation Trust.

9.2. A member may be expelled by a resolution approved by not less than two-thirds of the Governors present and voting at a General Meeting. The following procedure is to be adopted.

9.2.1. Any member may complain to the Secretary that another member has acted in a way detrimental to the interests of the Foundation Trust.

9.2.2. If a complaint is made, the Council of Governors may itself consider the complaint having taken such steps as it considers appropriate to ensure that each member's point of view is heard and may either:

9.2.2.1. dismiss the complaint and take no further action; or

9.2.2.2. for a period not exceeding twelve months suspend the rights of the member complained of to attend members meetings and vote under this constitution;

9.2.2.3. arrange for a resolution to expel the member complained of to be considered at the next General Meeting of the Council of Governors.

9.2.3. If a resolution to expel a member is to be considered at a General Meeting of the Council of Governors, 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.

9.2.4. At the meeting the Council of Governors will consider evidence in support of the complaint and such evidence as the member complained of may wish to place before them.

9.2.5. If the member complained of fails to attend the meeting without due cause the meeting may proceed in their absence.

9.3. 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.

9.4. No person who has been expelled from membership is to be re-admitted except by a resolution carried by the votes of two-thirds of the Council of Governors present and voting at a General Meeting.

10 Members Meetings

10.1. The Foundation Trust is to hold a members meeting (called the annual members meeting) within nine months of the end of each financial year.

10.2. All members meetings other than annual meetings are called special members meetings.

10.3. Members meetings are open to all members of the Foundation Trust, Governors and Directors, and representatives of the financial auditor, but not to members of the public unless the Council of Governors decides otherwise. The Council of Governors may invite representatives of the media and any experts or advisors whose attendance they consider to be in the best interests of the Foundation Trust to attend a members meeting.

10.4. All members meetings are to be convened by the Secretary by order of the Council of Governors.

10.5. The Council of Governors may decide where a members meeting is to be held and may also for the benefit of members:

10.5.1. arrange for the annual members meeting to be held in different venues each year:

10.5.2. make provisions for a members meeting to be held at different venues simultaneously or at different times. In making such provision the Council of Governors shall also fix an appropriate quorum for each venue, provided that the aggregate of the quorum requirements shall not be less than the quorum set out below.

10.6. At the annual members meeting:

10.6.1. the Board of Directors shall present to the members:

10.6.1.1. the annual accounts

10.6.1.2. any report of the financial auditor

10.6.1.3. any report of any other external auditor of the Foundation Trust's affairs

10.6.1.4. forward planning information for the next financial year

10.6.2. the Council of Governors shall present to the members

10.6.2.1. a report on steps taken to secure that (taken as a whole) the actual membership of its public constituencies, the patients' constituency and of the classes of the staff constituency is representative of those eligible for such membership;

10.6.2.2. the progress of the membership strategy

10.6.2.3. any proposed changes to the policy for the composition of the Council of Governors and of the non-executive Directors

10.6.3. the results of the election and appointment of Governors and the appointment of non-executive Directors will be announced.

10.7. Notice of a members meeting is to be given:

10.7.1. by notice to all members;

10.7.2. by notice prominently displayed at the head office and at all of the Foundation Trust's places of business; and

10.7.3. by notice on the Foundation Trust's website at least 14 clear days before the date of the meeting. The notice must:

10.7.3.1. be given to the Council of Governors and the Board of Directors, and to the financial auditor;

10.7.3.2. state whether the meeting is an annual or special members meeting;

10.7.3.3. give the time, date and place of the meeting; and

10.7.3.4. indicate the business to be dealt with at the meeting.

10.8. Before a members meeting can do business there must be a quorum present. Except where this constitution says otherwise a quorum is

one member present from each of the Foundation Trust's constituencies.

10.9. The Foundation Trust may make arrangements for members to vote by post, or by using electronic communications.

10.10. It is the responsibility of the Council of Governors, the Chairman of the meeting and the Secretary to ensure that at any members meeting:

10.10.1. the issues to be decided are clearly explained;

10.10.2. sufficient information is provided to members to enable rational discussion to take place.

10.11. The Chairman of the Foundation Trust, or in their absence the Deputy Chairman of the Council of Governors, shall act as chairman at all members meetings of the Foundation Trust. If neither the Chairman nor the Deputy Chairman of the Council of Governors is present, the members of the Council of Governors present shall elect one of their number to be Chairman and if there is only one Governor present and willing to act they shall be Chairman.

10.12. If no quorum is present within half an hour of the time fixed for the start of the meeting, the meeting shall stand adjourned to the same day in the next week at the same time and place or to such time and place as the Council of Governors determine. If a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting, the number of members present during the meeting is to be a quorum.

10.13. A resolution put to the vote at a members meeting shall be decided upon by a poll.

10.14. Every member present and every member who has voted by post or using electronic communications is to have one vote. In the case of an equality of votes the Chairman of the meeting is to have a second or casting vote.

10.15. The result of any vote will be declared by the Chairman and entered in the minute book. The minute book will be conclusive evidence of the result of the vote.

11 Council of Governors

11.1. The Foundation Trust is to have a Council of Governors. It is to consist of Public Governors, Patient Governors, Staff Governors, PCT Governors, Local Authority Governors, a University Governor and Partnership Governors.

11.2. The aggregate number of Public Governors and Patient Governors is to be more than half of the total number of members of the Council of Governors.

11.3. The Council of Governors, subject to the 2003 Act, shall seek to

ensure that through the composition of the Council of Governors:

11.3.1. the interests of the community served by the Foundation Trust are appropriately represented;

11.3.2. the level of representation of the public constituencies, the patients' constituency and the classes of the staff constituency and the appointing organisations strikes an appropriate balance having regard to their legitimate interest in the Foundation Trust's affairs; and to this end, the Council of Governors:

11.3.3. shall at all times maintain a policy for the composition of the Council of Governors which takes account of the membership strategy, and

11.3.4. shall from time to time and not less than every three years review the policy for the composition of the Council of Governors, and

11.3.5. when appropriate shall propose amendments to this constitution.

11.4. The Council of Governors of the Foundation Trust is to comprise:

11.4.1. eight Public Governors from the following public constituencies:

11.4.1.1. Royal Borough of Kensington and Chelsea (area 1) - one Public Governor;

11.4.1.2. Royal Borough of Kensington and Chelsea (area 2) - one Public Governor;

11.4.1.3. City of Westminster (area 1) - one Public Governor;

11.4.1.4. City of Westminster (area 2) - one Public Governor;

11.4.1.5. London Borough of Hammersmith and Fulham (area 1) – one Public Governor;

11.4.1.6. London Borough of Hammersmith and Fulham (area 2) – one Public Governor;

11.4.1.7. London Borough of Wandsworth (area 1) – one Public Governor;

11.4.1.8. London Borough of Wandsworth (area 2) – one Public Governor;

11.4.2. ten Patient Governors;

11.4.3. six Staff Governors from the following classes;

11.4.3.1. Support, Administrative and Clerical staff – one Staff Governor;

11.4.3.2. Allied Health Professionals, Scientific and Technical staff – one Staff Governor;

11.4.3.3. Contracted staff – one Staff Governor;

11.4.3.4. Medical and Dental staff – one Staff Governor;

11.4.3.5. Nursing and midwifery – one Staff Governor;

11.4.3.6. Management – one Staff Governor

11.4.4. four PCT Governors, one to be appointed by each of: Kensington and Chelsea PCT, Hammersmith and Fulham PCT, Westminster PCT and Wandsworth PCT;

11.4.5. two Local Authority Governors to be appointed by Westminster City Council, and the Royal Borough of Kensington and Chelsea;

11.4.6 one University/Medical School Governor to be appointed by Imperial College, University of London;

11.4.6. three Partnership Governors to be appointed by partnership organisations.

11.5. The partnership organisations that may each appoint a Partnership Governor are:

11.5.1. the major nursing and midwifery education provider for the Trust which will be one of the following:
Buckinghamshire New University
Kingston University
London South Bank University
King's College London
University of Greenwich
City University
Middlesex University

11.5.2. the Royal Marsden NHS Foundation Trust;

11.5.3. the Royal Brompton and Harefield NHS Trust.

11.6. Elected Governors

11.6.1. Public Governors are to be elected by members of their public constituency, Patient Governors are to be elected by members of the patients' constituency and Staff Governors are to be elected by members of their class of the staff constituency. Each class/constituency may elect any of their

number to be a Governor in accordance with the provisions of this constitution.

11.6.2. If contested, the elections must be by secret ballot.

11.6.3. Elections shall be carried out in accordance with the rules set out in Annex 2. The Council of Governors will decide which of the two voting methods set out in Annex 2 is to be used.

11.6.4. A member of a public constituency or the patients' constituency may not vote at an election for a Public Governor or a Patient Governor (as the case may be) unless within twenty-one days before they vote they have made a declaration in the form specified by the Secretary that they are qualified to vote as a member of the relevant public constituency or patients' constituency. It is an offence to knowingly or recklessly make such a declaration which is false in a material particular.

11.7. PCT Governors

11.7.1. The Secretary, having consulted Kensington and Chelsea PCT, Westminster PCT, Hammersmith and Fulham PCT and Wandsworth PCT, is to adopt a process for agreeing the appointment of PCT Governors with those Primary Care Trusts.

11.8. Local Authority Governors

11.8.1. The Secretary, having consulted Westminster City Council and the Royal Borough of Kensington and Chelsea, is to adopt a process for agreeing the appointment of Local Authority Governors with those local authorities.

11.9. University Governors

11.9.1. The Secretary, having consulted Imperial College, University of London, is to adopt a process for agreeing the appointment of University Governors with Imperial College, University of London.

11.10. Partnership Governors

11.10.1. The Partnership Governors are to be appointed by the partnership organisations, in accordance with a process agreed with the Secretary.

11.11. Appointment of Deputy Chairman of the Council of Governors

11.11.1. The Council of Governors shall appoint one of the Governors to be Deputy Chairman of the Council of Governors.

11.12. Terms of office for Governors

11.12.1. Elected Governors:

11.12.1.1. shall normally hold office for a period of three years commencing immediately after the poll results are formally announced;

11.12.1.2. are eligible for re-election at the end of that period;

11.12.1.3. may not hold office for more than nine consecutive years, and shall not be eligible for re-election if they have already held office for more than six consecutive years.

11.12.2. Appointed Governors:

11.12.2.1. shall normally hold office for a period of three years commencing immediately after the Council of Governors meeting at which their appointment is announced;

11.12.2.2. are eligible for re-appointment at the end of that period;

11.12.2.3. may not hold office for longer than nine consecutive years, and shall not be eligible for re-appointment if they have already held office for more than six consecutive years.

11.13. Eligibility to be a Governor

11.13.1. A person may not become a Governor of the Foundation Trust, and if already holding such office will immediately cease to do so, if:

11.13.1.1. they are under sixteen years of age;

11.13.1.2. they are a Director of the Foundation Trust, or a governor or director of a health service body (unless they are appointed by an appointing organisation which is a health service body);

11.13.1.3. they are the spouse, partner, parent or child of a member of the Board of Directors of the Foundation Trust;

11.13.1.4. they are a member of a local authority's Overview and Scrutiny Committee covering health matters

11.13.1.5. being a member of one of the public constituencies or the patients' constituency, they refuse to sign a declaration in the form specified by the Secretary of particulars of their qualification to vote as a member of the Foundation Trust, and that they are not prevented from being a member of the Council of Governors;

11.13.1.6. if they are subject to a sex offender order;

11.13.1.7. they have been adjudged bankrupt or their estate has

been sequestrated and in either case they have not been discharged;

11.13.1.8. they have made a composition or arrangement with, or granted a trust deed for, their creditors and have not been discharged in respect of it;

11.13.1.9. they have within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed;

11.13.1.10. they have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

11.13.1.11. they are 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 their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

11.13.1.12. they are a member of the Foundation Trust's Patients' Forum.

11.14. Termination of office and removal of Governors

11.14.1. A person holding office as a Governor shall immediately cease to do so if:

11.14.1.1. they resign by notice in writing to the Secretary;

11.14.1.2. they fail to attend three consecutive meetings, unless the other Governors are satisfied that:

11.14.1.2.1. the absences were due to reasonable causes; and

11.14.1.2.2. they will be able to start attending meetings of the Council of Governors again within such a period as the other Governors consider reasonable;

11.14.1.3. in the case of an elected Governor, they cease to be a member of the constituency or class of the constituency by which they were elected;

11.14.1.4. in the case of an appointed Governor, the appointing organisation terminates the appointment;

11.14.1.5. they have refused without reasonable cause to undertake any training which the Council of Governors requires all Governors to undertake;

11.14.1.6. they have failed to sign and deliver to the Secretary a statement in the form required by the Secretary confirming acceptance of the code of conduct for Governors;

11.14.1.7. they are removed from the Council of Governors under the following provisions.

11.14.2. A Governor may be removed from the Council of Governors by a resolution approved by not less than three-quarters of the remaining Governors present and voting on the grounds that:

11.14.2.1. they have committed a serious breach of the code of conduct, or

11.14.2.2. they have acted in a manner detrimental to the interests of the Foundation Trust, and

11.14.2.3. the Council of Governors consider that it is not in the best interests of the Foundation Trust for them to continue as a Governor.

11.15. Vacancies amongst Governors

11.15.1. Where a vacancy arises on the Council of Governors for any reason other than expiry of term of office, the following provisions will apply.

11.15.2. Where the vacancy arises amongst the appointed Governors, the Secretary shall request that the appointing organisation appoints a replacement to hold office and serve for a three-year term.

11.15.3. Where the vacancy arises amongst the elected Governors, the Council of Governors shall be at liberty either:

11.15.3.1. to allow the seat to remain open until the next scheduled election or

11.15.3.2. to invite the next highest polling candidate for that seat at the most recent election, who is willing to take office, to fill the seat and serve for a three-year term.

11.15.4. Two elections shall be scheduled each year, but shall only be executed if needed at the request for the Council of Governors to fill one or more vacancies.

11.16. Expenses and remuneration of Governors

11.16.1. The Foundation Trust may reimburse Governors for travelling and other costs and expenses incurred in carrying out their duties at such rates as the Board of Directors decides.

11.16.2. Governors are not to receive remuneration.

11.17. Meetings of the Council of Governors

11.17.1. The Council of Governors is to meet at least four times in each

financial year. Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give at least fourteen days written notice of the date and place of every meeting of the Council of Governors to all Governors. Notice will also be published in a local newspaper or newspapers circulating in the area served by the Foundation Trust, and on the Foundation Trust's website.

11.17.2. Meetings of the Council of Governors may be called by the Secretary, or by the Chairman, or by ten Governors (including at least two elected Governors and two appointed Governors) who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all Governors as soon as possible after receipt of such a request. The Secretary shall call a meeting on at least fourteen but not more than twenty-eight days' notice to discuss the specified business. If the Secretary fails to call such a meeting then the Chairman or ten Governors, whichever is the case, shall call such a meeting.

11.17.3. All meetings of the Council of Governors are to be General Meetings open to members of the public unless the Council of Governors decides otherwise in relation to all or part of a meeting for reasons of commercial confidentiality or on other proper grounds. The Chairman may exclude any member of the public from a meeting of the Council of Governors if they are interfering with or preventing the proper conduct of the meeting.

11.17.4. Twelve Governors including not less than four Public and/or Patient Governors, not less than one Staff Governor and not less than two appointed Governors shall form a quorum.

11.17.5. The Chairman of the Foundation Trust or, in their absence, the Vice Chairman of the Board of Directors, or in their absence one of the non-executive Directors is to preside at meetings of the Council of Governors. If the person presiding at any such meeting has a conflict of interest in relation to the business being discussed, the Deputy Chairman of the Council of Governors will chair that part of the meeting.

11.17.6. The Council of Governors may invite the Chief Executive or any other member or members of the Board of Directors, or a representative of the financial auditor or other advisors to attend a meeting of the Council of Governors.

11.17.7. The Council of Governors may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

11.17.8. Subject to this constitution and the following provisions of this paragraph, questions arising at a meeting of the Council of Governors shall be decided by a majority of votes.

11.17.8.1. In case of an equality of votes the person presiding at or chairing the meeting shall have a casting vote.

11.17.8.2. No resolution of the Council of Governors shall be passed if it is opposed by all of the Public Governors present.

11.17.9. The Council of Governors may not delegate any of its powers to a committee or sub-committee, but it may appoint committees consisting of its members, Directors, and other persons to assist the Council of Governors in carrying out its functions. The Council of Governors may, through the Secretary, request that advisors assist them or any committee they appoint in carrying out its duties.

11.17.10. All decisions taken in good faith at a meeting of the Council of Governors or of any committee shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of the Governors attending the meeting.

11.18. Disclosure of interests

11.18.1. Any Governor who has a material interest in a matter as defined below shall declare such interest to the Council of Governors and:

11.18.1.1. shall withdraw from the meeting and play no part in the relevant discussion or decision

11.18.1.2. shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

11.18.2. Any Governor who fails to disclose any interest required to be disclosed under the preceding paragraph must permanently vacate their office if required to do so by a majority of the remaining Governors.

11.18.3. Subject to the exceptions below, a material interest is

11.18.3.1. any directorship of a company;

11.18.3.2. any interest or position held by a Governor in any firm or company or business which, in connection with the matter, is trading with the Foundation Trust, or is likely to be considered as a potential trading partner with the Foundation Trust;

11.18.3.3. any interest in an organisation providing health and social care services to the National Health Service;

11.18.3.4. a position of authority in a charity or voluntary organisation in the field of health and social care;

11.18.3.5 any connection with any organisation, entity or company considering entering into a financial arrangement with the Foundation Trust including but not limited to lenders or banks.

11.18.4. The exceptions which shall not be treated as material interests are as follows:

11.18.4.1. shares not exceeding 2% of the total shares in issue held in any company whose shares are listed on any public exchange;

11.18.4.2. an employment contract held by a Staff Governor;

11.18.4.3. an employment contract with their PCT held by a PCT Governor;

11.18.4.4. an employment contract with, or a position of authority in, a local authority held by a Local Authority Governor;

11.18.4.5 an employment contract with, or a position of authority in, a university held by a University Governor;

11.18.4.6. an employment contract with, or a position of authority in, a partnership organisation held by a Partnership Governor.

11.18.5. The Council of Governors is to adopt its own standing orders for its practice and procedure, in particular for its procedure at meetings.

11.19. Declaration

11.19.1. An elected Governor may not vote at a meeting of the Council of Governors unless, before attending the meeting, they have made a declaration in the form specified by the Secretary of the particulars of their qualification to vote as a member of the Foundation Trust and that they are not prevented from being a member of the Council of Governors. An elected Governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Council of Governors, and every agenda for meetings of the Council of Governors will draw this to the attention of elected Governors.

12 Board of Directors

12.1. The Foundation Trust is to have a Board of Directors. It is to consist of executive and non-executive Directors.

12.2. The board is to include:

12.2.1. the following non-executive Directors:

12.2.1.1. a Chairman, who is to be appointed (and removed) by the Council of Governors at a General Meeting;

12.2.1.2. five other non-executive Directors who are to be appointed (and removed) by the Council of Governors at a General Meeting;

12.2.1.3. in each case subject to the approval of a majority of the Council of Governors (in the case of an appointment) present and voting at the meeting, and three-quarters of all of the members of the Council of Governors (in the case of a removal) voting at the meeting;

12.2.2. the following executive Directors:

12.2.2.1. a Chief Executive (who is the accounting officer), who is to be appointed (and removed) by the non-executive Directors, and whose appointment is subject to the approval of a majority of the members of the Council of Governors present and voting at a General Meeting;

12.2.2.2. a Finance Director, a registered medical practitioner or a registered dentist, a registered nurse or registered midwife, and one other executive Director, all of whom are to be appointed (and removed) by a committee consisting of the Chairman, the Chief Executive and the other non-executive Directors.

12.3. The Board of Directors shall elect one of the non-executive Directors to be Vice-Chairman of the Board of Directors. If the Chairman is unable to discharge their office as Chairman of the Foundation Trust, the Vice-Chairman of the Board of Directors shall be acting Chairman of the Foundation Trust.

12.4. Only a member of one of the public constituencies, or the patients' constituency, or an individual exercising functions for Imperial College, University of London is eligible for appointment as a non-executive Director.

12.5. Non-executive Directors are to be appointed by the Council of Governors using the following procedure.

12.5.1. The Council of Governors will maintain a policy for the composition of the non-executive directors which takes account of relevant Trust strategies, and which they shall review from time to time and not less than every three years.

12.5.2. The Board of Directors will work with an external organisation recognised as expert at appointments to identify the skills and experience required for non-executive Directors.

12.5.3. Appropriate candidates (not more than five for each vacancy) will be identified by a Nominations Committee through a process of open competition, which take account of the policy maintained by the Council of Governors and the skills and experience required;

12.5.4. The Nominations Committee will comprise the Chairman of the Foundation Trust (or the Vice Chairman unless they are standing for appointment, in which case another non-executive director, when a Chairman is being appointed), two elected Governors and one Appointed Governor. Another person nominated by the Nominations Committee will be invited to act as an independent assessor to the Nominations Committee.

12.6. The removal of the Chairman or another non-executive Director shall be in accordance with the following procedures.

12.6.1. Any proposal for removal must be proposed by a Governor and seconded by not less than ten Governors including at least two elected Governors and two appointed Governors.

12.6.2. Written reasons for the proposal shall be provided to the non-executive Director in question, who shall be given the opportunity to respond to such reasons.

12.6.3. In making any decision to remove a non-executive Director, the Council of Governors shall take into account the annual appraisal carried out by the Chairman.

12.6.4. If any proposal to remove a non-executive Director is not approved at a meeting of the Council of Governors, no further proposal can be put forward to remove such non-executive Director based upon the same reasons within 12 months of the meeting.

12.7. Terms of Office

12.7.1. The Chairman and the non-executive Directors are to be appointed for a period of office in accordance with the terms and conditions of office, including remuneration and allowances, decided by the Council of Governors at a General Meeting. Any re-appointment of a non-executive Director by the Council of Governors shall be subject to a satisfactory appraisal carried out in accordance with procedures which the Board of Directors has approved.

12.7.2. The remuneration committee of non-executive Directors shall decide the terms and conditions of office including remuneration and allowances of all the executive Directors.

12.8. Disqualification

12.8.1. A person may not become or continue as a Director of the Foundation Trust if:

12.8.1.1. they are a member of the Council of Governors, or a governor or director of a health service body;

12.8.1.2. they are a member of the Foundation Trust's Patient's Forum;

12.8.1.3. they are the spouse, partner, parent or child of a member of the Board of Directors of the Foundation Trust;

12.8.1.4. they are a member of a local authority's Overview and Scrutiny Committee covering health matters.

12.8.1.5. they have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;

12.8.1.6. they have made a composition or arrangement with, or granted a trust deed for, their creditors and have not been discharged in respect of it;

12.8.1.7. they have within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed;

12.8.1.8. they are the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

12.8.1.9. in the case of a non-executive Director, they are no longer a member of one of the public constituencies or the patients' constituency or no longer exercising functions for Imperial College, University of London;

12.8.1.10. they are a person whose tenure of 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, for non attendance at meetings, or for non-disclosure of a pecuniary interest;

12.8.1.11. they have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

12.8.1.12. in the case of a non-executive Director they have refused without reasonable cause to fulfil any training requirement established by the Board of Directors; or

12.8.1.13. they have refused to sign and deliver to the Secretary a statement in the form required by the Board of Directors confirming acceptance of the code of conduct for Directors.

12.9. Committees and delegation

12.9.1. The Board of Directors may delegate any of its powers to a committee of Directors or to an executive Director.

12.9.2. The Board of Directors shall appoint a committee of non-executive

Directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.

12.9.3. The Board of Directors shall appoint a remuneration committee of non-executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the executive Directors.

12.10. Meetings of the Board of Directors

12.10.1. Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give to all Directors at least fourteen days written notice of the date and place of every meeting of the Board of Directors.

12.10.2. Meetings of the Board of Directors shall be held in private.

12.10.3. Meetings of the Board of Directors are called by the Secretary, or by the Chairman, or by four Directors who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all Directors as soon as possible after receipt of such a request. Save in an emergency, the Secretary shall call a meeting on at least fourteen but not more than twenty-eight days' notice to discuss the specified business. If the Secretary fails to call such a meeting then the Chairman or four Directors, whichever is the case, shall call such a meeting.

12.10.4. Six Directors including not less than three executive Directors (one of whom must be the Chief Executive [or the Deputy Chief Executive], and not less than three non-executive Directors (one of whom must be the Chairman or the Vice-Chairman of the Board) shall form a quorum.

12.10.5. The Board of Directors may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

12.10.6. The Chairman of the Foundation Trust or, in their absence, the Vice-Chairman of the Board of Directors, is to chair meetings of the Board of Directors.

12.10.7. Subject to the following provisions of this paragraph, questions arising at a meeting of the Board of Directors shall be decided by a majority of votes.

12.10.7.1. In case of an equality of votes the Chairman shall have a second and casting vote.

12.10.7.2. No resolution of the Board of Directors shall be passed if it is opposed by all of the non-executive Directors present or by all of the executive Directors present.

12.10.8. The Board of Directors is to adopt Standing Orders covering the proceedings and business of its meetings. The proceedings shall not however be invalidated by any vacancy of its membership, or defect in a Director's appointment.

12.11. Conflicts of Interest of Directors

12.11.1. Any Director who has a material interest in a matter as defined below shall declare such interest to the Board of Directors and:

12.11.1.1. shall withdraw from the meeting and play no part in the relevant discussion or decision and

12.11.1.2. shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

12.11.2. Details of any such interest shall be recorded in the register of the interests of Directors.

12.11.3. Any Director who fails to disclose any interest required to be disclosed under the preceding paragraph must permanently vacate their office if required to do so by a majority of the remaining Directors and (in the case of a non-executive Director) by the requisite majority of the Council of Governors.

12.11.4. A material interest is

12.11.4.1. any directorship of a company;

12.11.4.2. any interest (excluding a holding of shares in a company whose shares are listed on any public exchange where the holding is less than 2% of the total shares in issue) or position held by a Director in any firm or company or business which, in connection with the matter, is trading with the Foundation Trust, or is likely to be considered as a potential trading partner with the Foundation Trust;

12.11.4.3. any interest in an organisation providing health and social care services to the National Health Service;

12.11.4.4. a position of authority in a charity or voluntary organisation in the field of health and social care;

12.11.4.5 any connection with any organisation, entity or company considering entering into a financial arrangement with the Foundation Trust including but not limited to lenders or banks.

12.12. Expenses

12.12.1. The Foundation Trust may reimburse all Directors travelling and other costs and expenses incurred in carrying out their duties at such rates as the remuneration committee of non-executive Directors decides. These are to be disclosed in the annual report.

12.12.2. The remuneration and allowances for Directors are to be disclosed in bands in the annual report.

13 Secretary

13.1. The Foundation Trust shall have a Secretary who may be an employee. The Secretary may not be a Governor, or the Chief Executive or the Finance Director. The Secretary's functions shall include:

13.1.1. acting as Secretary to the Council of Governors and the Board of Directors, and any committees;

13.1.2. summoning and attending all members meetings, meetings of the Council of Governors and the Board of Directors, and keeping the minutes of those meetings;

13.1.3. keeping the register of members and other registers and books required by this constitution to be kept;

13.1.4. having charge of the Foundation Trust's seal;

13.1.5. acting as returning officer in any elections;

13.1.6. publishing to members in an appropriate form information which they should have about the Foundation Trust's affairs;

13.1.7. preparing and sending to the Independent Regulator and any other statutory body all returns which are required to be made.

13.2. Minutes of every members meeting, of every meeting of the Council of Governors and of every meeting of the Board of Directors are to be kept. Minutes of meetings will be read at the next meeting and signed by the Chairman of that meeting. The signed minutes will be conclusive evidence of the events of the meeting.

13.3. The Secretary is to be appointed and removed by the Board of Directors, subject to the approval of the Council of Governors.

14 Registers

14.1. The Foundation Trust is to have:

14.1.1. a register of members showing, in respect of each member, the constituency and (where relevant) the class of a constituency to which they belong;

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

14.1.3. a register of Directors;

14.1.4. a register of interests of Governors;

14.1.5. a register of interests of the Directors.

14.2. The 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.

14.3. The Secretary is to send to the Independent Regulator a list of persons who were first elected or appointed as Governors and Directors.

15 Public Documents

15.1. The following documents of the Foundation Trust are to be available for inspection by members of the public free of charge at all reasonable times, and shall be available on the Foundation Trust's website:

15.1.1. a copy of the current constitution;

15.1.2. a copy of the current authorisation;

15.1.3. a copy of the latest annual accounts and of any report of the financial auditor on them;

15.1.4. a copy of the report of any other external auditor of the Trust's affairs appointed by the Council of Governors;

15.1.5. a copy of the latest annual report;

15.1.6. a copy of the latest information as to its forward planning;

15.1.7. a copy of the Foundation Trust's membership development strategy;

15.1.8. a copy of the Foundation Trust's policy for the composition of the Council of Governors and of the non-executive Directors;

15.1.9. a copy of any notice given under section 23 of the 2003 Act (regulator's notice to failing NHS Foundation Trust).

15.2. The registers shall be made available for inspection by members of the public, except in circumstances prescribed by the Public Benefit Corporation (Register of Members) Regulations 2004 (SI 2004 no.539) as amended by the Public Benefit Corporation (Register of Members) Amendment Regulations 2006 (SI 2006 no.361); and so far as they are required to be available they are to be available free of charge at all reasonable times.

15.3. Any person who requests it is to be provided with a copy or extract from any of the above documents or registers. The Foundation Trust may impose a reasonable charge for providing the copy or extract, but a member is entitled to a copy or extract from the registers free of charge.

16 Financial Auditor and Other External Auditors

16.1. The Foundation Trust is to have a financial auditor and is to provide the financial auditor with every facility and all information which he may reasonably require for the purposes of his functions under Part 1

of the 2003 Act.

16.2. A person may only be appointed as the financial auditor if they (or in the case of a firm each of its members) are a member of one or more of the bodies referred to in paragraph 23 (4) of Schedule 1 to the 2003 Act.

16.3. An officer of the Audit Commission may be appointed as financial auditor with the agreement of the Audit Commission. Where an officer of the Audit Commission is appointed as auditor, the Commission is to charge the Foundation Trust such fees for their services as will cover the full cost of providing them.

16.4. The Council of Governors at a General Meeting shall appoint or remove the Foundation Trust's financial auditor.

16.5. The financial auditor is to carry out their duties in accordance with Schedule 5 to the 2003 Act and in accordance with any directions given by the Independent Regulator on standards, procedures and techniques to be adopted.

16.6. The Board of Directors may resolve that external auditors be appointed to review and publish a report on any other aspect of the Foundation Trust's performance. Any such auditors are to be appointed by the Council of Governors.

17 Accounts

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

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

17.3 The accounts are to be audited by the trust's auditor.

17.4 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.

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

18 Annual reports, forward plans and non-NHS work

18.1 The trust shall prepare an Annual Report and send it to Monitor.

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

18.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

Comment [DV1]: Monitor stipulation

Comment [DV2]: Monitor stipulation

Comment [DV3]: Chosen to change in line with Monitor Model Core Constitution

Comment [DV4]: Monitor requirement is to name the Secretary of State; remainder has been changes as per Model Core Constitution

Comment [DV5]: Chosen to change in line with Monitor Model Core Constitution

Deleted: 17.1 . The Board of Directors shall cause the Foundation Trust to keep accounts in such form as the Independent Regulator may with the approval of the Treasury direct. ¶
17.2. The accounts are to be audited by the Foundation Trust's financial auditor. ¶
17.3. The following documents will be made available to the Comptroller and Auditor General for examination at his request: ¶
17.3.1. the accounts; ¶
17.3.2. any records relating to them; and ¶
17.3.3. any report of the financial auditor on them. ¶
17.4. The accounting officer shall cause the Foundation Trust to prepare in respect of each financial year annual accounts in such form as the Independent Regulator may with the approval of the Treasury direct. ¶
17.5. In preparing its annual accounts, the accounting officer shall cause the Foundation Trust to comply with any directions given by the Independent Regulator with the approval of the Treasury as to: ¶
17.5.1. the methods and principles according to which the accounts are to be prepared; ¶
17.5.2. the information to be given in the accounts; ¶
¶
and shall be responsible for the functions of the Foundation Trust as set out in paragraph 25 of Schedule 1 to the 2003 Act.¶
17.6. The annual accounts, any report of the financial auditor on them, and the annual report are to be presented to the Council of Governors at a General Meeting. ¶ ... [1]

Deleted: and

Comment [DV6]: Chosen to change in line with Monitor Model Core Constitution

Deleted: <#>18.1. The Foundation Trust is to prepare annual reports and send them to the Independent Regulator. ¶
<#>18.2. The reports are to give: ¶
<#>18.2.1. information on any ste ... [2]

Comment [DV7]: Chosen to change in line with Monitor Model Core Constitution

Comment [DV8]: Chosen to change in line with Monitor Model Core Constitution

18.4 In preparing the document, the directors shall have regard to the views of the Council of Governors.

Comment [DV9]: Chosen to change in line with Monitor Model Core Constitution

18.5 Each forward plan must include information about –

18.5.1 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

18.5.2 the income it expects to receive from doing so.

Comment [DV10]: Monitor stipulation

18.6 Where a forward plan contains a proposal that the trust carry on an activity of a kind mentioned in sub-paragraph 18.5.1 the Council of Governors must –

18.6.1 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

18.6.2 notify the directors of the trust and its determination.

Comment [DV11]: Monitor stipulation

18.7 A trust which 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 health service in England may implement the proposal only if more than half of the members of council of governors of the trust voting approve its implementation.

Comment [DV12]: Monitor stipulation

19 Indemnity

19.1. 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 Foundation Trust. The Foundation Trust may purchase and maintain insurance against this liability for its own benefit and for the benefit of the Council of Governors and the Board of Directors and the Secretary.

20 Execution of documents

20.1. A document purporting to be duly executed under the Foundation Trust's seal or to be signed on its behalf is to be received in evidence and, unless the contrary is proved, taken to be so executed or signed.

20.2. The Foundation Trust is to have a seal, but this is not to be affixed except under the authority of the Board of Directors.

21 Dispute Resolution Procedures

21.1. Every unresolved dispute which arises out of this constitution between the Foundation Trust and:

21.1.1. a member; or

21.1.2. any person aggrieved who has ceased to be a member within the six months prior to the date of the dispute; or

21.1.3. any person bringing a claim under this constitution; or

21.1.4. an office-holder of the Foundation Trust

21.2. is to be submitted to an arbitrator agreed by the parties or in the absence of agreement to be nominated by the Strategic Health Authority. The arbitrator's decision will be binding and conclusive on all parties.

21.3. Any person bringing a dispute must, if required to do so, deposit with the Foundation Trust a reasonable sum (not exceeding £250) to be determined by the Council of Governors and approved by the Secretary. The arbitrator will decide how the costs of the arbitration will be paid and what should be done with the deposit.

22 Amendment Of The Constitution

22.1. No amendment shall be made to this constitution unless:

22.1.1. it has been approved by a majority of members present and voting at a members meeting duly called by order of the Council of Governors in accordance with this constitution; and

22.1.2. it has been approved by the Independent Regulator.

22.2. No amendment shall be made to the provisions of this constitution concerning the public constituencies unless it has also been approved by a majority of the members of all of the public constituencies as may have voted at a members meeting.

22.3. No amendment shall be made to the provisions of this constitution concerning the patients' constituency unless it has also been approved by a majority of the members of the patients' constituency as may have voted at a members meeting.

22.4. No amendment shall be made to the provisions of this constitution concerning the staff constituency or the classes of the staff constituency unless it has also been approved by a majority of the members of all of the classes of the staff constituency as may have voted at a members meeting.

23 Mergers

23.1. The Foundation Trust may in accordance with section 27 of the 2003 Act apply to the Independent Regulator jointly with another NHS Foundation Trust or an NHS Trust for authorisation of the dissolution of the Foundation Trust and the transfer of some or all of their property and liabilities to a new NHS Foundation Trust established under that section. Such application shall only be made if a majority of those

members of the Foundation Trust voting at a meeting of the members shall have approved the making of such an application.

24 Dissolution Of The Foundation Trust

24.1. The Foundation Trust may not be dissolved except by order of the Secretary of State for Health, in accordance with the 2003 Act.

25 Head Office

25.1. The Foundation Trust's head office is at Chelsea and Westminster Hospital, 369 Fulham Road, London SW10 9NH or such other place as the Board of Directors shall decide.

26 Notices

26.1. Any notice required by this constitution to be given shall be given in writing or shall be given using electronic communications to an address for the time being notified for that purpose. "Address" in relation to electronic communications includes any number or address used for the purposes of such communications.

26.2. Proof that an envelope containing a notice was properly addressed, prepaid and posted shall be conclusive evidence that the notice was given. A notice shall be treated as delivered 48 hours after the envelope containing it was posted or, in the case of a notice contained in an electronic communication, 48 hours after it was sent.

Page 31: [1] Deleted	Djelic, Vida	07/09/2012 14:33:00

17.1 The Board of Directors shall cause the Foundation Trust to keep accounts in such form as the Independent Regulator may with the approval of the Treasury direct.

17.2. The accounts are to be audited by the Foundation Trust's financial auditor.

17.3. The following documents will be made available to the Comptroller and Auditor General for examination at his request:

17.3.1. the accounts;

17.3.2. any records relating to them; and

17.3.3. any report of the financial auditor on them.

17.4. The accounting officer shall cause the Foundation Trust to prepare in respect of each financial year annual accounts in such form as the Independent Regulator may with the approval of the Treasury direct.

17.5. In preparing its annual accounts, the accounting officer shall cause the Foundation Trust to comply with any directions given by the Independent Regulator with the approval of the Treasury as to:

17.5.1. the methods and principles according to which the accounts are to be prepared;

17.5.2. the information to be given in the accounts;

and shall be responsible for the functions of the Foundation Trust as set out in paragraph 25 of Schedule 1 to the 2003 Act.

17.6. The annual accounts, any report of the financial auditor on them, and the annual report are to be presented to the Council of Governors at a General Meeting.

17.7. The accounting officer shall cause the Foundation Trust to:

17.7.1. lay a copy of the annual accounts, and any report of the financial auditor on them, before Parliament; and
17.7.2. once it has done so, send copies of those documents to the Independent Regulator.

Page 31: [2] Deleted	alex	10/09/2012 11:31:00

18.1. The Foundation Trust is to prepare annual reports and send them to the Independent Regulator.

18.2. The reports are to give:

18.2.1. information on any steps taken by the Foundation Trust to secure that (taken as a whole) the actual membership of its public constituencies, patients' constituency and of

the classes of the staff constituency is representative of those eligible for such membership; and

18.2.2. any other information the Independent Regulator requires.

18.3. The Foundation Trust is to comply with any decision the Independent Regulator makes as to:

18.3.1. the form of the reports;

18.3.2. when the reports are to be sent to him;

18.3.3. the periods to which the reports are to relate.

18.4. The Foundation Trust is to give information as to its forward planning in respect of each financial year to the Independent Regulator. The document containing this information is to be prepared by the Directors, and in preparing the document, the Board of Directors must have regard to the views of the Council of Governors.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 13 September 2012

AGENDA ITEM NO.	2.4.2/Sep12
PAPER	Constitution review – other changes required as a result of the Health and Social Care Act 2012 and next steps
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Cathy Mooney, Director of Governance and Corporate Affairs
EXECUTIVE SUMMARY	An update on progress on revision of the constitution and next steps are outlined in the paper.
DECISION/ ACTION	For information.

Constitution review – other changes required as a result of the Health and Social Care Act 2012 and next steps

1.0 Introduction

It has been indicated that most of sections of the Health and Social Care Act 2012 will come into effect on 1 April 2013. These changes will affect the constitutions of all foundation trusts. This paper outlines progress to date on revising the constitution.

2.0 Background

Monitor had provided a Model Core Constitution which has been revised to take the Act 2012 into account.

3.0 Constitution Review Task Force – progress on revision

The Council of Governors Constitution Review Task Force has met on 21 August and 7 September 2012. The membership includes:

Chris Birch	Patient Governor
Melvyn Jeremiah	Public Governor – Westminster 2
Martin Lewis	Public Governor – Westminster 1
Susan Maxwell	Patient Governor
Anna Hodson-Pressinger	Patient Governor

The constitution has been amended following the Monitor Model Constitution using tracker. Each amendment has been reviewed and either agreed as non-controversial (e.g. reflecting the Act) or been logged for further discussion. This document forms the basis for further work and approval by the Council of Governors.

4.0 Next Steps

4.1 Workshop for the Council of Governors

A workshop will be organised on 17 October which will consist of a presentation by Ray Tarling, Legal Adviser from Beachcroft on the implications of the Health and Social Care Act 2012 followed by a discussion on issues identified from this and from the review of the constitution. Views of the governors on issues will be sought.

4.2 Workshop for the Board of Directors

A similar workshop for the Board of Directors will be organised on 25 October which will take the form of a presentation by Ray Tarling, Legal Adviser from Beachcroft followed by discussion on issues identified. Where possible agreement will be sought on issues agreed from the Council of Governors meeting held on 13 September 2012.

4.3 Board of Directors/Council of Governors Away Day

A joint review combining the discussions of the governors and directors to date at the Board of Directors/Council of Governors Away Day to agree on changes to be made to the constitution to date and focus on areas where there is not agreement so that we can agree.

4.4 Further meetings will be organised in the period January to March 2013 as required.

5.0 Action/Decision

For information.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 13 September 2012

AGENDA ITEM NO.	2.5/Sep12
PAPER	*Governors' Questions
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Therese Davis, Chief Nurse and Director of Patient Experience and Flow
EXECUTIVE SUMMARY	The issue raised by Anna Hodson-Pressinger: Dress code for patients 1. That they are completely covered at all times and the matron doesn't let them out of the ward unless they are covered and these are rules of the hospital. Our aim is to maintain our patient's privacy and dignity throughout their stay in the hospital. We also aim to support individuals rights, choices and decisions As a Trust, we have no powers to prevent a patient leaving the ward unless legally detained under the mental health act. Not all patients tell the nurse when they are leaving the ward. We will add a paragraph to our patient information booklet which will ask patients to let their nurse know if they are leaving the ward. This will enable the nurses to ensure that the patient is appropriately dressed and is safe to leave the ward. Not all patients have suitable outdoor clothing with them when admitted, so we have supplies of dressing gowns and blankets to offer to those patients who wish to leave the hospital. We will ensure there is a supply held at front reception so if staff see patients outside uncovered they can easily obtain one to give to the patient. 2. Plus no patient should be allowed to wander outside and smoke. There must be a smoking area at the back where they could go. It is awful to see half dressed patients who are smoking and are seen walking around with breathing equipment or drips etc. It looks so unprofessional and untidy and as though we are in a third world, when we should be setting the standard.

	As a trust, we actively support smoking cessation for patients. However, some patients may choose to continue smoking during their hospitalisation, particularly during times of stress. Similarly patient's visitors who smoke may be present for significant periods of time during the patient's admission. We have an obligation as a public service not to permit smoking within the hospital premises. The pavement to the front of the hospital is a public thoroughfare and as such, we have no jurisdiction over the patient and public use of this space. The area at the back of the hospital may present risks to patients as this is a delivery and storage area with significant flow of traffic and storage of medical gases. It may also be difficult to access for those with limited mobility. For these reasons we would actively discourage patients from entering these areas. The trust has explored the possibility of a smoking shelter to the side of the hospital, but this is not possible as the thoroughfare is public as opposed to private space. Our Facilities department ensure the front of the hospital is swept clean on a regular basis throughout the day. As of 5/9/2012 we have started a nightly jet clean at the front of the hospital. 3. Dress code for theatre staff that none are allowed outside the hospital in shops etc in their green outfits with shoe covers which looks so unhygienic and messy and unprofessional. We have recently revised our clinical staff uniform and dress code policy. The purpose is to support effective infection prevention and control and to uphold the professional image of our staff. The policy provides clear guidance to staff and managers on appropriate dress as follows *The wearing of visible uniform (including scrub suits) in public places outside of the Trust is not permitted. This includes any staff leaving the main hospital or other hospital buildings. All staff must either change out of uniform when leaving the hospital premises or ensure that it is completely covered. The public often perceive that there is a risk of infection and it may undermine their confidence in the Trust.* Having revised our policy we will be ensuring it is communicated and adhered to by all of our clinical staff.
DECISION/ ACTION	To note.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 13 September 2012

AGENDA ITEM NO.	2.6/Sep12
PAPER	Care Quality Commission Engagement Project
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Cathy Mooney, Director of Governance and Corporate Affairs
EXECUTIVE SUMMARY	The FTGA and the Care Quality Commission (CQC) have joined forces on a new project focussed on developing the relationship between the CQC and foundation trust councils of governors. This is outlined in the paper attached.
DECISION/ ACTION	The Council of Governors is asked to confirm that the Trust is interested in becoming part of this project. An initial expression of interest has been made. If selected, a lead governor will be required. Interested governors should send their expression of interest to Vida Djelic by Friday, midday Friday, 14 September.

Care Quality Commission Engagement Project

1.0 Introduction

The FTGA and the Care Quality Commission (CQC) have joined forces on a new project focussed on developing the relationship between the CQC and foundation trust councils of governors.

2.0 Background

The CQC is the independent regulator for health and social care in England ensuring that care in hospitals, ambulances and care homes meets government standards of quality and safety.

The new CQC project aims to improve how CQC and councils of governors can work together and share information about their work.

The outcome will be to develop best practice models to share with the wider foundation trust community.

3.0 CQC Project

The project will be recruiting up to eight foundation trusts across the acute, mental health and ambulance trust sectors, with a range of experience from newly established foundation trusts to trusts that have previous relations with the CQC.

We have expressed interest in participating in this project and would like to discuss the attached CQC engagement project paper with the Council of Governors.

With some guidance from the FTGA the Trust will need to create the Council of Governors plan for developing the relationship with and use of information from the CQC. The project will run for six months. The plan should be created with the Chairman of the Trust and governors who sit on the committee which addresses quality and safety governance. A governor will can act as the main point of contact for the duration of the project.

4.0 Action

The Council of Governors is asked to confirm that the Trust is interested in becoming part of this project. An initial expression of interest has been made. If selected, a lead governor will be required.

Interested governors should send their expression of interest to Vida Djelic by Friday, midday Friday, 14 September.

Foundation Trust Governors' Association
Debate | Exchange | Learn

Care Quality Commission

CQC Engagement Project Information Paper

Joint project between the CQC and FTGA

Introduction

The Care Quality Commission (CQC) Engagement Project aims to develop best practice models for how CQC and foundation trust councils of governors can work together. Those models can be used by councils of governors to improve how they relate to CQC and use CQC information in their internal procedures for dealing with safety and quality governance.

The CQC is the independent regulator for health and social care in England and ensures that care in hospitals, ambulances and care homes meets government standards of quality and safety.

To deliver the project the CQC has joined forces with the FTGA and will work closely with up to eight selected foundation trusts during the six month project.

Aims

The aims of the project are to:

- Develop and share best practice models of working together
- Improve information sharing channels at a local level
- Capture what information governors need from the CQC
- Provide FTs with the opportunity to mould the way the CQC communicates with governors

Recruitment

The project will recruit up to eight foundation trusts across the acute, mental health and ambulance trust sectors, with a range of experience from newly established foundation trusts to trusts that have previous relations with the CQC.

If you want to be involved but are not one of the eight participating trusts, you can join a wider interest group. We will share updates with this group during the project.

5th Floor, Skipton House, 80 London Road, London, SE1 6LH
Telephone 020 7972 5173 Fax 020 7972 1707
Email governors@ftga.org.uk
www.ftga.org.uk

Registered office:
71 Victoria Street, Westminster, London, SW1H 0XA
Registered Charity No: 1144152
Registered Company No: 7751344

Foundation Trust Governors' Association
Debate | Exchange | Learn

Care Quality Commission

Council of Governor Plan

Each participating trust will be asked, with the help and guidance of the FTGA, to create their own council of governor plan for developing their relationship with and use of information from CQC. This document will outline what the governors want to achieve over the six month project. As well as working with the FTGA, the plan should be created with the trust chair and governors who sit on the committee which addresses quality and safety governance.

Suggestions for the council of governors plan will depend on the level of knowledge and contact your council of governors already has with CQC.

For example:

- develop governors understanding of CQC
- testing out the guide for Foundation Trust Councils of Governors on working with CQC – and identify the learning from this
- explore and agree how councils of governors can use the government standards for quality and safety that CQC monitors
- develop a local protocol for working with and exchanging information with CQC
- exploring how governors can inform CQC inspections of the trust

Trust Contact Person

We would like to establish one governor at each participating trust who can act as the main point of contact for the duration of the project. Most communication will be between that nominated trust representative and the FTGA. The representative would be expected to attend the teleconference meetings and the face to face event.

Observation, interaction and engagement throughout the project

We would like to provide governors with a platform to speak directly with the CQC and local inspectors as well as governors from different trusts about their shared interest of quality and patient safety.

The following events will be scheduled at the beginning of the project and it is advised that the trust representative participates in these meetings to get the maximum benefit for their council of governors development plan

Trust Visit

The FTGA and CQC would like to attend and observe one quality and patient safety governance committee meeting to a get a real grasp of the work of the council of

5th Floor, Skipton House, 80 London Road, London, SE1 6LH
Telephone 020 7972 5173 Fax 020 7972 1707
Email governors@ftga.org.uk
www.ftga.org.uk

Registered office:
71 Victoria Street, Westminster, London, SW1H 0XA
Registered Charity No: 1144152
Registered Company No: 7751344

governors, meet the governors, perhaps meet the chair and establish a strong working relationship going forward.

Teleconferences
We will hold at least two teleconference meetings for governors to dial into and discuss the progress of the project. Governors may also wish to discuss recent achievements in relation to their development plan, how they are progressing and compare notes on how other trusts function.

Face to Face Event
One face to face event will be held on 8 November in London. This will be an opportunity for governors participating in the study to come together for the first time and discuss procedures and practices for working with CQC and using CQC information in their own trust.

Email
Participants are welcome to email the FTGA throughout the project and we will endeavour to answer your queries or put you in touch with the right person.

Final report

The FTGA and CQC will work jointly to produce a set of case studies based on the eight participating trusts. It is envisaged that the CQC will write and publish a final report to be launched at the FTGA National Development Day on 14 March 2013. However dependent on the progress of the project there may be scope for further work and a final report may be published at a later date.

Schedule of the Project

Date	Activity
August	Initial telephone conversation with FTGA – establish contact person
September	Create development plan with CQC and FTGA
September	Teleconference 1
Sep – Nov	Trust visit
November	Face to face event

December	Teleconference 2
January	Draft report
March	Final report launched at FTGA National Development Day

Apply to Participate

If after reading this document you are still interested in this project but have some questions then please call Molly Musgrave on 0207 972 5173 or 07557 202 887.

Alternatively if you need more time to discuss the project with your foundation trust chairman and the council of governors before you can make a decision then please email governors@ftga.org.uk expressing an interest to participate in the project.

Please include the following information in your email:

- Name of foundation trust
- Type of foundation trust
- Trust contact person
- Trust contact person email and telephone number
- When it is likely your trust will decide whether to participate.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 13 September 2012

AGENDA ITEM NO.	2.7/Sep/12
PAPER	*Council of Governors Funding Report
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Cathy Mooney, Director of Governance and Corporate Affairs
EXECUTIVE SUMMARY	The report provides an overview of the use of the Council of Governors budget to Month 4 of FY 2012/13.
DECISION/ ACTION	The Council of Governors is asked to note the report

Council of Governors Funding Report

1.0 Background

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

2.0 Update

At the last meeting the Council of Governors agreed the additional funding of £1,260 for the recruitment sessions in September (lead Tony Pritchard).

At the last meeting the Council of Governors also agreed to support funding of the Open Day 2013 for £20,000. NB. 2013/14 allocation (lead Matt Akid)

3.0 Funding Overview for 2012/13

Of the £80k circa £54k has been committed to the activities listed in the table below which were approved by the Council of Governors. It leaves circa £26k available for the remainder of the 2012/13 FY.

4.0 Use of funds FY 12/13

TABLE 1

Date Presented	Projects	Amount Committed	Decision	Spent to date
June 2010 and recurring	Quality Awards	£2,000	Agreed 2012/13 FY	£1,000
December 2011	Open Day 2012	£15,000	Agreed 2012/13 FY	£12,904.22
December 2011	Engagement Activity - Membership mailing (Jan 2013)	£10,000	Agreed 2012/13 FY	
December 2011	Engagement Activity - 12 Members' News monthly emails (April 2012-March 2013)	£2,520	Agreed 2012/13 FY	£648
December 2011	Engagement Activity - Annual Members' Meeting + 2 associated events (Sept 2012)	£5,000	Agreed 2012/13 FY	
December 2011	Engagement Activity - 5 'Medicine for Members' events	£5,000	Agreed 2012/13 FY	£283
December 2011	Engagement Activity - Christmas event (Dec 2012)	£5,000	Agreed 2012/13 FY	
February 2012	Small Membership branded gifts for the Open Day May and Annual Members' Meeting September 2012	£1,500	Agreed 2012/13 FY	£150.60
February 2012	Members Recruitment Campaign for Open Day May 2012	£2,340	Agreed 2012/13 FY	£1,800
May 2012	Open Day 2012 advertising via letterbox drop and in the local press	£4,793	Agreed 2012/13 FY	£4,093
May 2012	Giggle Doctors	£4,600	Declined	-
July 2012	Membership recruitment session September – additional funding	£1,260	Agreed 2012/13 FY	
July 2012	Open Day 2013	£20,000	Agreed 2013/14 FY	
	TOTAL	**£54,413**		**£20,878.82**

6.0 Progress report re projects for FY 2012/13

6.1 For an update on projects re membership engagement approved by the Council of Governors for FY 2012/13 see paper 2.10.

6.2 For an update on projects re the Members Recruitment Campaign see paper 2.11.

6.3 Quality Awards – see paper 2.1.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 13 September 2012

AGENDA ITEM NO.	2.8/Sep/12
PAPER	*Report on Senior Nurse/Governor Rounds
AUTHORS	Tony Pritchard, Deputy Chief Nurse
LEAD	Therese Davis, Chief Nurse and Director of Patient Experience and Flow
EXECUTIVE SUMMARY	This report provides a summary Governor visits that were conducted during July and August 2012. The paper provides details of forthcoming senior Nursing and Midwifery clinical rounds in which we assess the Care Quality Commission essential standards of quality and safety.
DECISION / ACTION	For information.

Report on Senior Nurse / Governor Rounds

1.0 Introduction

1.1. This report provides a summary of Governors visits during July and August 2012 and provides details of future Senior Nursing and Midwifery clinical rounds during the forthcoming months.

1.2. Governors are welcome to arrange visits to find out more about clinical services or to complete Governors rounds to discuss the experience of patients and families. Governors are also invited to join the senior Nursing and Midwifery clinical rounds that take place on alternate Wednesday afternoons each month, in which we assess the Care Quality Commission essential standards of quality and safety in clinical areas.

2. Governor Visits

2.1. A number of Governors expressed an interest in visiting the Clinical Skills Unit within the Trust, and 2 dates were arranged for these visits during August.

2.2. On Tuesday August 7th, Governor Cass – Horne visited the unit during the afternoon, and was accompanied by Lisa McMillan.

2.3. On Monday August 20th, Governors Melvyn Jeremiah, Susan Maxwell and Wendie McWatters visited the Clinical Skills Unit accompanied by Mr David Bushby and Ms Lisa McMillan.

2.4. Wendie McWatters considered that this was a fascinating visit and was not too technical. She commented that the staff were very enthusiastic about their work. Mannequins that blinked & breathed were extraordinary and there were high technical levels of simulation. There was a good description of the medical student course whilst the interaction between theatre & consultants was interesting.

2.5. Susan Maxwell found the visit extremely interesting, particularly as the service appears to operate on a minimal budget. An annual budget of just £5,000 plus pennies from which they manage to run the undergraduate student teaching AND exams (from which annual catering costs take up £1,000). During the exam period there are three circuits three times a day (120 students a day). Susan was amazed at how they managed on such a low annual expense budget. Susan found it impressive that they also manage to teach using antediluvian equipment, which technician Alan Luker manages to keep operating. Susan noted that the department has submitted capital bids for a new audio visual system costing £80,000 and a new Meti simulator mannequin costing £120,000. Susan is strongly supportive of this badly needed new equipment and views that this should be a priority. Susan noted that there is £12m allocated by SHA for educational purposes, and since the Centre for Clinical Practice department generates income through tutorial fees, and views that they should have state-of-the-art equipment to help them continue their good work.

...

3. Clinical Rounds

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

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

4. Future Clinical Rounds and Visits

Governor Wendie McWatters is currently organising a series of visits to the maternity service which will commence in September

A calendar of future dates for rounds, and the associated CQC standards is attached in appendix 1. We would welcome Governors to join the Senior Nursing and Midwifery team on any of these dates. Planning for these is coordinated by the Deputy Chief Nurse.

6. Summary

This report has provided a summary of Governor visits conducted during July and August 2012. The Details of future Senior Nursing and Midwifery Clinical Rounds have been provided.

Tony Pritchard
Deputy Chief Nurse
August 2012

Appendix 1

Senior Nursing & Midwifery Clinical Rounds – Assessment of CQC Standards

September 19th 12	**October 3rd 12**	**Oct 17th 12**	**Nov 7th 12**	**Nov 21st 12**	**Dec 5th 12**
2. Consent to care and treatment 21. Maintaining records of peoples care	10. Safety & suitability of premises 11. Safety, availability & suitability of equipment	16. Assessing, monitoring and improving the quality of service provision 17. Complaints	8. Cleanliness and infection control	7. Safeguarding people from abuse 9. Safe and appropriate management of medicines	1. Respecting & involving service users
Dec 19th 12	**Jan 9th 13**	**Jan 23rd 13**	**Feb 6th 13**	**Feb 20th 13**	**March 6th 13**
4. Care & welfare of people who use the service	12, 13 & 14. Workers, Staffing and supporting staff	5. Meeting peoples nutritional needs 6. Co-operation with other providers	2. Consent to care and treatment 21. Maintaining records of peoples care	10. Safety & suitability of premises 11. Safety, availability & suitability of equipment	16. Assessing, monitoring and improving the quality of service provision 17. Complaints

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 13 September 2012

AGENDA ITEM NO.	2.9/Sep/12
PAPER	*Draft Minutes of the Council of Governors Membership Sub-Committee meeting held on 26 July 2012
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Martin Lewis, Chairman
EXECUTIVE SUMMARY	This is a draft of proceedings at the meeting held on 26 July 2012
DECISION/ ACTION	The meeting is asked to agree the minutes as a correct record of proceedings.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Membership Sub-Committee, 26 July 2012
Draft

Attendees	Martin Lewis	ML	Chairman
	Chris Birch	CB	Patient Governor
	Cass J Cass-Horne	CC-H	Patient Governor
	Melvyn Jeremiah	MJ	Public Governor, Westminster 2
	Susan Maxwell	SM	Patient Governor
	Wendie McWatters	WMW	Patient Governor
	Maddy Than	MT	Staff Governor – Support, Admin and Clerical
In attendance	Matt Akid	MA	Head of Communications
	Priti Bhatt	PB	Equality and Diversity Manager
	Christopher Collister	CC	PALS Manager
	Vida Djelic	VD	Foundation Trust Secretary

1. Welcome & Apologies **ML**

Apologies were received from Sam Culhane and Mel Christodoulou.

VD conveyed TP's sincere apologies for being unable to attend due to an unannounced visit of the Care Quality Commission (CQC).

2. Minutes of previous meeting held on 1 June 2012 **ML**

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

- P.5, 3rd para, 2nd line insert 'if there are any other areas it could cover'.
- P.6, 2nd para remove 'as' before the full stop.

3. Matters arising **ML**

4/Jun/12 Membership Recruitment, Engagement and Communication Strategy
CC confirmed that TP followed up with Capita re membership forms from the Open Day May 2012 to go on the membership database.

VD said she has not yet circulated the future dates of meet a Governor sessions to the Council of Governors and asked the sub-committee what they felt would be appropriate text.

ML said we should send an email to all governors encouraging them to participate in future 'Meet a Governor' sessions.

WMW commented that she was enthusiastic when these sessions were introduced but later on felt that she did not achieve much either for herself or for hospital

visitors. She also felt that if more governors were involved in these sessions she would be more confident to join again.

SM expressed the view that Meet a Governor sessions were a means of making Governors accessible and that it didn't matter if some sessions proved non-productive. It was important that people knew we were there if needed.

MJ said he agreed that it is important that governors are available should any hospital visitor want to talk to them and it is still better to keep the current arrangements than not to have any. He commented that at his last session three people came forward to talk to him.

CC-H commented that when he attends a 'Meet a Governor' session in the Information Zone he tends to stand up and flag up the membership leaflet in order to attract hospital visitors to come forward for informal talk. He observed that the zone gets untidy at times. In response to WMW's question he said that people come to talk to him.

CB noted that it is important to differentiate between recruiting new members and engaging with the current members. He said he had done some sessions and intends to do some more in August. He stressed that it is important to encourage all governors to join in, especially in the light of the 'Shaping a Healthier Future' consultation.

ML pointed out that governors have responsibility to their constituents and should make themselves available.

VD to encourage all governors to join 'Meet a Governor' sessions and to highlight that their constituents would benefit from having the opportunity to contact them especially during the launch of the 'Shaping a Healthier Future' consultation. **VD**

<u>9/Jun/12 Information Zone racks</u>
CC said that TP is looking into ordering some suitable size racks.

CB commented that two more actions should be added to the list.

Action 1: MA said that he would ask Capita to add all governors to email distribution list for Members' News and other electronic membership communications. MA responded that he made a request to Capita.

Action2: BME Health Forum meetings. PB recalled that she had asked the sub-committee via email if the Trust should host one of the BME quarterly meetings. She highlighted that this would give the Trust the opportunity to recruit diverse members and to promote the hospital. She suggested that the Trust could host the December meeting.

In response to ML's query PB replied that a number of representatives from the local community groups with BME focus have been invited to attend the September BME Health Forum. PB said that TP emailed a contact from the Sickle Cell Society and Capita representatives for help with recruiting members.

It was proposed to have a governors' stand at the September BME Health Forum. **Governors to confirm who will volunteer to man the stand (by email to PB and AP by 24th August 2012)**. **All**

It was agreed that the December BME Health Forum should be hosted by the Trust.

ML observed that the Info Zone looks untidy on occasions and queried who was responsible for looking after it. CC responded that it is the ISS. After some discussion it was agreed that VD should email the General Manager of ISS to request that since the nearby toilet gets cleaned every half an hour the Information Zone should be cleaned at the same time. **VD to email the General Manager of ISS with the request on behalf of the sub-committee.** **VD**

4. Shaping a Healthier Future Consultation **MA**

MA noted that some governors have already expressed interest in running a petition in relation to the consultation. Chelsea and Westminster Health Charity and Friends are also interested.

'Shaping a Healthier future' is a public consultation document and it has a response form which contains 40 questions. The questions can be completed either online or as a hard copy. It is important that as many people as possible complete the questionnaire which would be available as of 27 July. Suggested answers to the questionnaire will be also published on the website. There will be a PR company in the hospital to help people complete the questions. It has been recognised that some people would be put off by a lengthy document and the communications department has produced a draft card asking people to support option A i.e to keep A&E at the Chelsea and Westminster Hospital NHS Foundation Trust. A copy of the card was circulated. MA said that this has been accepted by the NHS NWL. The post card will also be available on the website and we will collate responses. We are considering sending this card with each appointment letter.

MA noted that he had presented to the Board earlier this afternoon and the Board was supportive of the idea of a petition supported by governors.

MA said that also Chelsea and Westminster Health Charity and volunteers are interested in supporting the petition. MA highlighted that it was to be confirmed whether the charity is the right stakeholder to lead the petition.

The sub-committee discussed the consultation and the possibility of charity leading the petition and involving 1 representative from each stakeholder group i.e Friends, St Stephen's Centre volunteers, governors etc.

CB commented that the Hammersmith and Fulham Council have already launched a petition Save Charing Cross Hospital.

In relation to CB's question on the steps taken by the Kensington and Chelsea Council MA responded that their position is complex as not all residents come to the C&W for treatment.

SM said that she saw a leaflet of Save Charing Cross Hospital petition and there was no mentioning of the Chelsea and Westminster hospital.

SM suggested that the post card should not be printed on a glossy paper as it is not very good for writing.

WMW suggested that governors should distribute the post card between their friends and neighbours. She also suggested that the card should contain reasons why we would keep A&E at the C&W.

In response to a question from WMW how the petition works MA said that there are two sides to it; one is online and there is also a hard copy so that people can insert signature.

CB queried who organises the roadshow at Hammersmith on Saturday. MA responded that it is organised by the NHS North West London.

ML queried if staff members can sign the petition.

SM suggested that each inpatient gets a card.

WMW suggested that the post cards are given to GPs.

CC-H queried when the post cards will be ready. MA responded that they would be ready the week after and said that he will inform all governors once the post cards are available.

ML queried if MPs have been invited. MA responded that we invited the MPs to come so we can explain the implications for other services we provide. We will also have a visit by the joint local authority Scrutiny Committee. ML suggested that a governor is invited to this meeting.

ML confirmed he and SM will liaise with the Charity regarding the petition.

MA said that the Trust made a request to the NHS North West London to have a representative presenting to the Council of Governors on 13 September and to organise a public meeting for trust members. We hope to be able to get a date from them shortly and to publish it in the Trust News.

ML said he and SM will provide feedback on petition to the governors.

MJ emphasised that the consultation is broad and it covers reconfiguration of wider health services not just A&E. We need to encourage people to fill in the questionnaire and to choose option A. CB agreed that we need to emphasise that we support the proposal for NWL reconfiguration as a whole and suggested that this is summarised in the post card.
The sub-committee agreed.

5. M**embership engagement and communication calendar of events** **MA**

MA noted that the August membership mailing will focus on publicising the Annual Members' Meeting and the 'Shaping a Healthier Future' consultation on changes to the NHS services in North West London.

MA highlighted the main changes to the calendar and noted that two seminars will be organised during the week of the Annual Members' Meeting, one on topic of dementia and the other on musculoskeletal problems.

The sub-committee discussed who should chair the seminar on dementia and whether it should be a governor.

CB commented that in his view the membership engagement and communication calendar of events does not need to include events organised in the previous period but the most recent updates and the future events.

SM suggested a possibility of having one seminar a month as these are very popular and also suggested the following might be of interest: pharmacy, roles of governors, etc. MJ added that the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) may also be interested in promoting their work.

ML said he would like to encourage more governors to attend these seminars.

6 Membership recruitment – update **TP**

This item was not discussed due to Tony Pritchard being unable to attend.

7 Annual Members Meeting – proposal

MA outlined the format of the Annual Members' Meeting and noted that SM will present the membership report on behalf of the Council of Governors.

MA said that there were suggestions on topics for the presentations which included the work of volunteers as well as the introduction of 'wellbeing rounds' on inpatient wards which have enhanced the care of older patients, especially those who suffer from dementia.

MA noted that a presentation on a topic of the Trust's work to reduce preventable venous thromboembolism (VTE) may not be the most appropriate and suggested alternative topics such as Chronic obstructive pulmonary disease (COPD) and CLAHRC.

CB said he was delighted that SM will present the membership report on behalf of the Council of Governors.

CB queried if it would be possible to suggest to the Chairman to announce at the beginning of the meeting that the supplementary questions are not allowed so that as many members as possible can ask a question. MA responded that the meeting will start with the Q&A session first to allow enough time for members to ask questions.

CB noted that it would be unlikely that we propose any amendments to the constitution by September.

8 Governors Stand at the Annual Members meeting **ML**

ML queried if governors could have their own stand. MA responded that this will be arranged.

9 Council of Governors Funding Report **VD**

This item was for information.

10 Membership Sub-Committee Terms of Reference – review **VD**

VD introduced the papers and noted that the changes were outlined in blue.

The sub-committee discussed the Terms of Reference and the following provisionally agreed:
- Ref 1.1 accept proposed change
- Ref 2.1 c) replace Membership Development and Communications Strategy and Membership Development Action Plan with Membership Recruitment, Engagement and Communications Strategy, Membership Engagement and Communication calendar of events and Membership Recruitment Calendar of Events
- Ref 3.1 accept proposed change
- Ref 3.2 b) accept proposed change
- Ref 4.1 (2) change 3 to 2
- Ref 7.5 accept proposed change

CB queried why three Trust's staff were required for the quorum and the requirement for meeting attendance. He also queried why the terms are now reviewed annually.

VD explained that the NHS Litigation Authority (NHSLA) requires that we comply with the standards and we have adopted the standard template for the Trust-wide terms of reference. VD said she would send out some information on the NHSLA to the sub-committee.

The sub-committee agreed that further discussion of the terms of reference should be deferred to the next meeting of the sub-committee. VD to put on the September agenda. **VD**

12. Any other business

Engagement
WMW expressed the view that she does not particularly feel engaged and queried if the mobile health bus could help here. WMW said she was involved in launching the mobile health bus at the Chelsea FC and was very optimistic regarding the success of the whole project. MJ replied that the bus can be used by any part of the hospital as it happens the major user is the sexual health service. At the last Membership sub-committee meeting there was a discussion about the difficulty of recruiting new members when the bus was in use by this service. The mobile clinic steering group would welcome use by other hospital services, but they would have to contribute to the costs from their budget. MJ also noted that the mobile health bus had more success in recruiting when taken to the shopping venues as opposed to sporting

venues.

Membership Sub-Committee future meeting dates
VD said that draft dates have been circulated internally for agreement before sending on to the sub-committee.

Rolling Screen
CC noted that the rolling screen is no longer under warranty and the manufacturer would not help with any repair. SM said she found a company which can mend it but it would be costly.

CC said the call charge is £90 and the repair would cost £200.

After discussion the sub-committee agreed that MPALS should continue to monitor whether it is working or not and discussion should be resumed at the next sub-committee meeting. VD to put on the September agenda. **VD**

Governors' chelwest email account
MJ recalled that the idea of governors' chelwest email accounts was initiated by ML so that each governor could have a chelwest email address at which they could be contacted. This was originally done after a lengthy delay by allowing governors access to the hospital e-mail system via the remote access which was available to some staff. Some governors used it and others did not. Those who used it found it burdensome to go via the two sets of log in with a generated number. In further discussion at the Council of Governors meeting in December 2011 it was agreed the IT would look at improving the email system to make it easier to access and user friendly.

The new system had been introduced recently. Three governors had been asked to test it before rolling out to other governors and they had now been asked to report their conclusions.

The solution presented by IT had been to adopt an external commercial e-mail package but using the address @governors.chelwest.nhs.uk This required a single log-in of username and password but the username had to be the user's full e-mail address instead of a shortened version of their name as under the "remote access" system. It always took MJ at least three attempts and sometimes more before getting it right – the system would not accept the "Remember me" instruction. This was very irritating. More serious, though, was that because it was not within the main hospital system there was no access to the invaluable hospital e-mail address book. This had been taken up with IT, who had said the only way it could be overcome was to copy the whole address book to the commercial package server, which would be a major task and very costly. MJ observed that this was enough on its own to persuade him that the new package should be dropped and governors encouraged to use the main system through remote access as a number of them were doing successfully already.

After discussion the sub-committee agreed to keep the previous "remote access" email system to which they had got used and that all governors should be encouraged to use it.

VD to email all governors with this conclusion. **VD**

13. Date of next meeting – 20 September 2012

Note: The next meeting has been rearranged to 27 September 2012.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 13 September 2012

AGENDA ITEM NO.	2.10/Sep/12
PAPER	*Membership Engagement and Communication – update
AUTHOR	Matt Akid, Head of Communications
LEAD	Therese Davis, Chief Nurse and Director of Patient Experience and Flow
EXECUTIVE SUMMARY	Appendix 1 (Membership Engagement and Communications calendar of events 2012 – updated September 2012) is an update on progress in implementing an enhanced programme of membership engagement and communications activity following the approval of funding at the Council of Governors meeting on 1 December 2011.
DECISION/ ACTION	Governors are invited to note this update and to provide their feedback on the proposed activity and future plans.

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

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

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

Date/Month	Event/Activity	Existing or new activity?	Lead	Cost/Funding source
Weds 6 Jun	Members' News Issue 5	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
July				
Fri 6 Jul	Members' News Issue 6	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
Mon 2 Jul-Mon 8 Oct	*Shaping a healthier future* public consultation by NHS North West London on changes to NHS services – Communications & Engagement Plan including the involvement of members and Governors approved by Trust Board on 28 May and by Council of Governors on 12 July	New activity	Head of Communications with Directors	Not from Council of Governors budget
August				
Fri 3 Aug	Members' News Issue 7	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
w/c Mon 13 Aug	Membership mailing (including covering letter from Chairman, Trust News, Annual Members' Meeting invitation and A5 flyers about 2 'Medicine for Members' events in September	Existing activity	Head of Communications	£10,000 (Foundation Trust budget) - funding already budgeted for in Trust budget as part of our membership 'offer' of 2 mailings/year
September				
Tues 4 Sep	'Medicine for Members' 3rd event – *Shaping a healthier future* public consultation meeting for Foundation Trust members	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
Fri 7 Sep	Members' News Issue 8	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011

Date/Month	Event/Activity	Existing or new activity?	Lead	Cost/Funding source
Thu 13 Sep	Annual Members' Meeting	Existing activity	Head of Communications	£5,000 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
Thurs 27 Sep	Medicine for Members 4th event – Management of Shoulder Pain seminar	New activity	Communications Dept	£2,000 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
October				
Fri 5 Oct	Members' News Issue 9	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
November				
Fri 2 Nov	Members' News Issue 10	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
Date TBC	Medicine for Members 5th event (seminar topic TBC)	New activity	Communications Dept	£1,000 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
December				
Fri 7 Dec	Members' News Issue 11	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
Mon 17 Dec	Christmas 'open house' event (mini Open Day)	New activity	Communications Dept	£5,000 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011

Other activity not included in calendar

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

Council of Governors Meeting, 13 September 2012

AGENDA ITEM NO.	2.11/Sep/12
PAPER	*Council of Governors Membership Report
AUTHOR	Sian Nelson, Membership and Engagement Manager
LEAD	Therese Davis, Chief Nurse and Director of Patient Experience and Flow
EXECUTIVE SUMMARY	This paper presents an overview of Foundation Trust membership and provides an analysis of trends for the period June and July 2012. Current total public, patient and staff membership is 15,069. During June and July, 241 new members joined, whilst 115 left, providing an overall gain of 126 in membership during the 2 month period.
DECISION/ ACTION	For information.

Membership Report

1.0 Membership size and movements

Table 1 below shows the size and movement of membership for the year 2011-2012, and for June and July of the current year. This shows a total membership of 15,069.

Table 1. Size and movement of membership

1.0 Membership size and movements

OVERALL MEMBERSHIP OVERVIEW	Last Year 1 Apr 11 – 31 Mar 12	Current Situation 31 July 12
As at start	**14,501**	**14,858**
New Members	1,512	444
Members leaving or changing constituency	1,210	233
TOTAL	**14,803**	**15,069**
PUBLIC MEMBERSHIP OVERVIEW	**Last Year 1 Apr 11 – 31 Mar 12**	**Current Situation 31 July 12**
As at start	**5,737**	**5,942**
New Members	659	95
Members leaving or changing constituency	454	122
TOTAL	**5,942**	**5,915**
PATIENT MEMBERSHIP	**Last Year 1 Apr 11 – 31 Mar 12**	**Current Situation 31 July 12**
As at start	**5,591**	**5,685**
New Members	487	345
Members leaving or changing constituency	393	107
TOTAL	**5,685**	**5,923**
STAFF MEMBERSHIP	**Last Year 1 Apr 11 – 31 Mar 12**	**Current Situation 31 July 12**
As at start	**3,173**	**3,231**
New Members	508	4
Members leaving or changing constituency	450	4
TOTAL	**3,231**	**3,231**

2.0 Membership Joiners and Leavers June - July 2012

2.1 Public Membership

Table 2 below shows public membership joiners and leaves during June and July 2012. There were 49 public who joined and 59 who left membership during this period

Month	June	July	Total
Joiners	43	6	49
Leavers	58	1	59

Table 2. Public Membership joiners and leavers June and July 2012

2.2 Patient Membership

Table 3 below shows patient membership joiners and leavers during June and July 2012. There were 192 new joiners and 56 who left membership during this period.

Month	June	July	Total
Joiners	190	2	192
Leavers	54	2	56

Table 3. Patient membership joiners and leavers June and July 2012

3. Membership Demographics

3.1. Public Membership Ethnicity July 2012

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

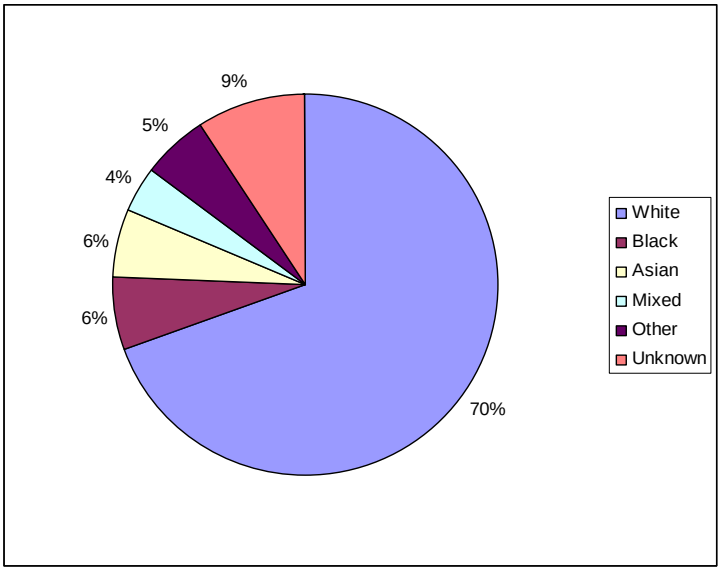
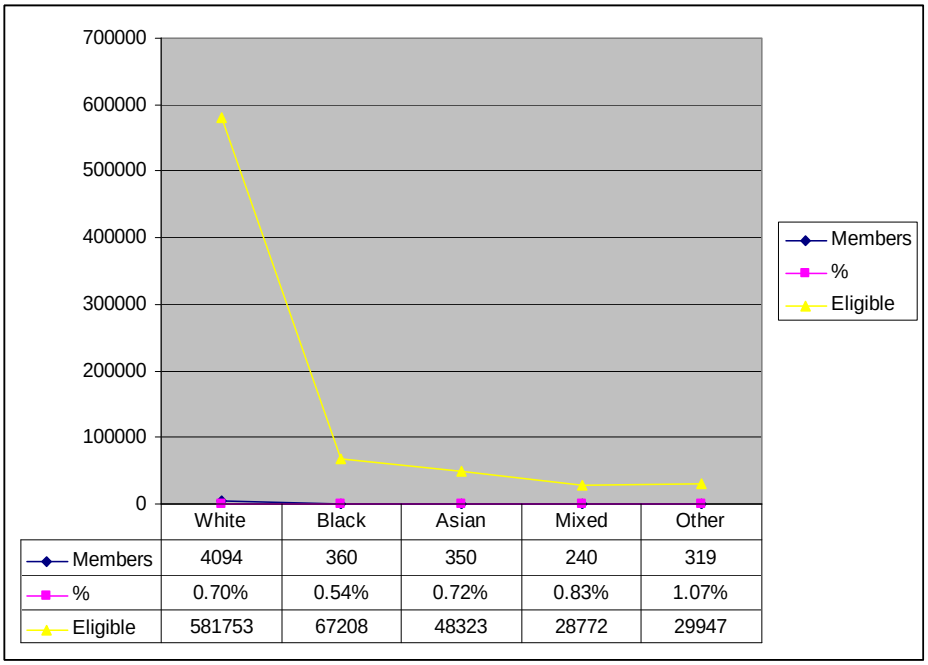


Figure1. Public Membership Ethnicity May 2012

3.2. Public Membership Ethnicity – comparison against local eligible population

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



	White	Black	Asian	Mixed	Other
Members	4094	360	350	240	319
%	0.70%	0.54%	0.72%	0.83%	1.07%
Eligible	581753	67208	48323	28772	29947

Figure 2. Public Membership ethnicity comparison against local eligible population

3.3. Public Membership Age

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

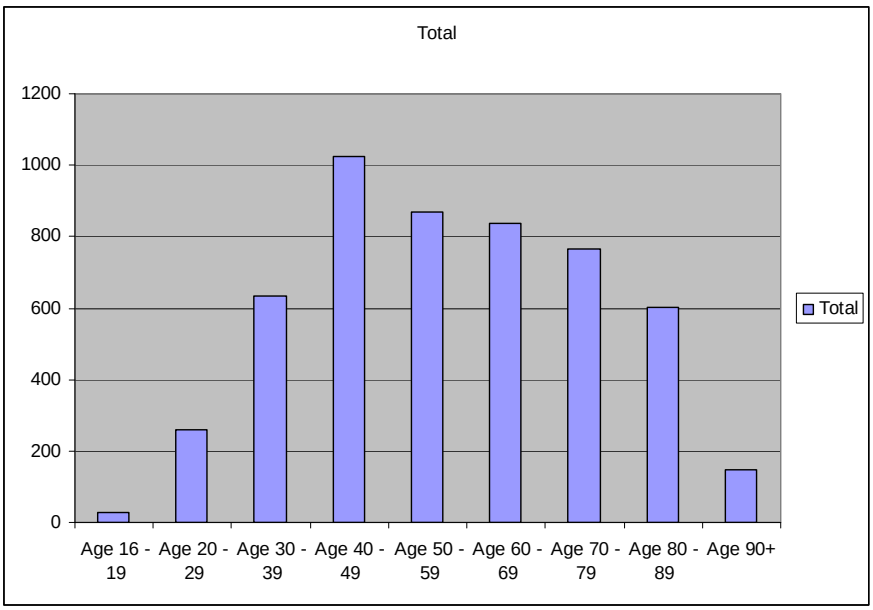
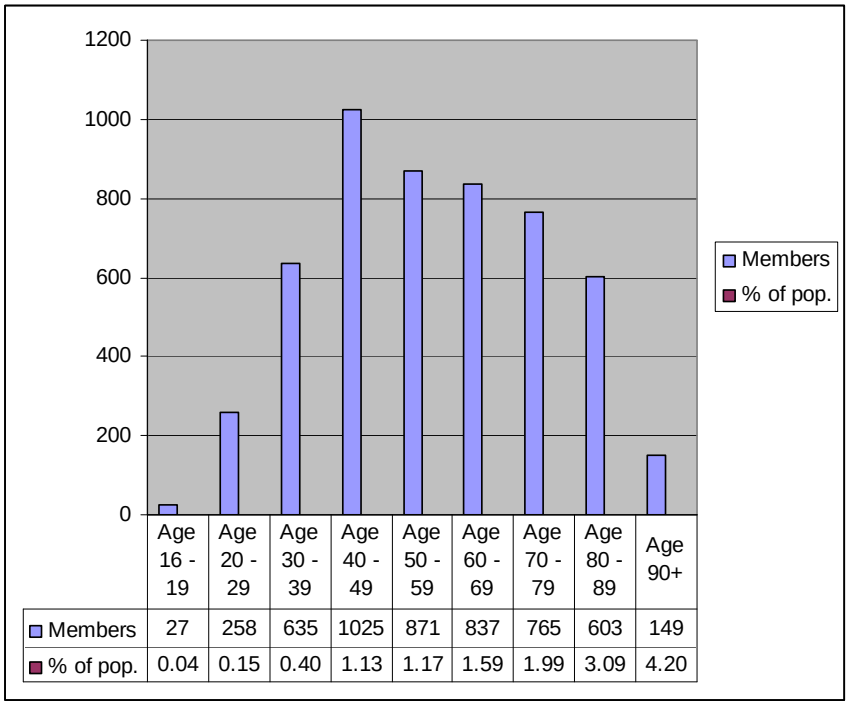


Figure 3. Public Membership Age

3.4. Public Membership Age – Comparison against local eligible population

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

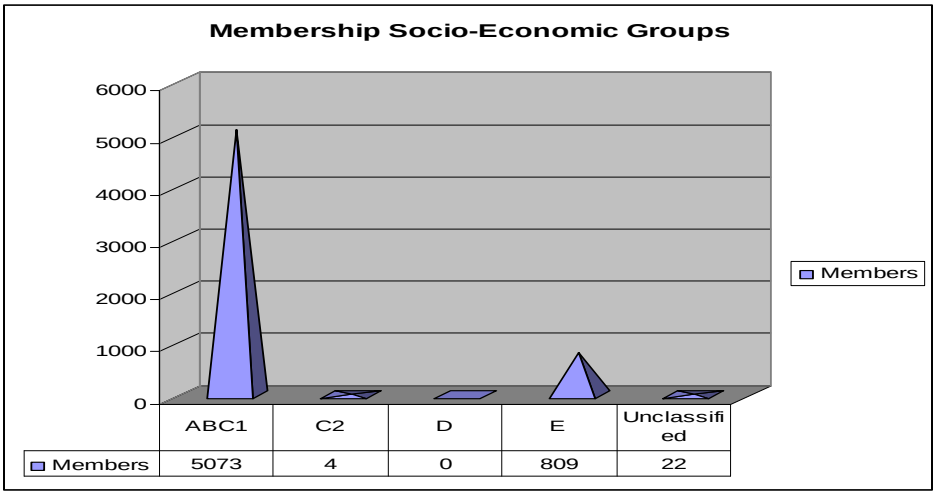


	Age 16 - 19	Age 20 - 29	Age 30 - 39	Age 40 - 49	Age 50 - 59	Age 60 - 69	Age 70 - 79	Age 80 - 89	Age 90+
Members	27	258	635	1025	871	837	765	603	149
% of pop.	0.04	0.15	0.40	1.13	1.17	1.59	1.99	3.09	4.20

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

3.5. Public Membership - Socio-economic grouping

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



	ABC1	C2	D	E	Unclassified
Members	5073	4	0	809	22

`

Figure 5. Public Membership - Socio-Economic Groups*

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

4.0 Membership Recruitment

4.1 At the start of 2012/13 there were 14,858 members. During June and July there was a net gain of 126 new members. Membership at the end of month 7 was 15, 069.

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

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

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

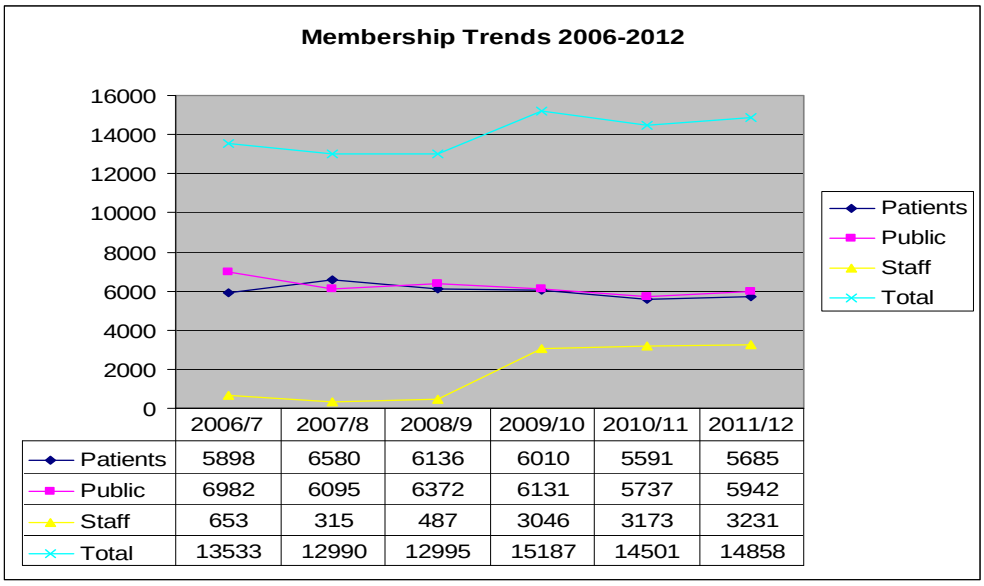
4.6. A Governor now attends the Mobile Health Steering Group. The group plan activities and decide how Governors can link with Trust activities in the community (especially where membership is underrepresented) and decide on appropriate outreach services for these areas.

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

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

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

4.9. Figure 6 shows the trends in Trust membership from 2006-2012.



	2006/7	2007/8	2008/9	2009/10	2010/11	2011/12
Patients	5898	6580	6136	6010	5591	5685
Public	6982	6095	6372	6131	5737	5942
Staff	653	315	487	3046	3173	3231
Total	13533	12990	12995	15187	14501	14858

Figure 6. Membership trends 2006-2012

5. Recruitment Campaigns

5.1. In the current year, we have commissioned Capita, our recruitment providers, to run 2 recruitment events in May and a divided campaign during September and November.

5.2. The first event took place within the Trust in May and the objective was to recruit 300 new members whilst also promoting the Trust Open day on Saturday May 12th. A total of 355 members were recruited against a target of 300.

5.3. During the Trust open day on May 12th, a further 64 members were recruited

5.4. A further 3 day recruitment event is planned for September which will also promote the annual general meeting, whilst recruitment in November will promote the Council of Governors elections. Through both events, we will aim to recruit a further 300 new members.

5.5. An initial annual budget of £2,340 was agreed. The cost for recruitment events will be £3,600 and a request for additional funding was approved by the Council of Governors.

5.6 We are awaiting developments to the Trust letter distribution system so that initial appointment letters can include a membership application form.

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

6.0 Developing a Representative Membership

6.1 Analysis of the membership database by age, gender and ethnicity ensures we work towards representative memberships within the communities we serve.

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

6.3. In the past year, we sought opportunities to hold membership recruit events within local GP practices in North Wandsworth, where a significant proportion of patients use this hospital, but to date we have been unsuccessful in gaining support for this.

6.4. We will now explore further options to recruit from local community groups as a part of our strategy to develop a representative membership. This includes attendance at a Black, Minority and Ethnic (BME) Health Forum in September and hosting a future forum within the Trust.

7.0 Summary

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

7.2. We need to continue our focus on recruitment to maintain our membership numbers whilst also seeking a representative membership. Beyond this, we have introduced initiatives such as 'Medicine for members' to actively encourage the engagement of members in the work of our hospital.

8. Membership Recruitment Achievements 2012/13

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

Month	Event	Total Recruited
April 2012	No events	
May	Trust Open Day	64
May	Capita Trust Recruitment	355
September 7th, 10th 11th **19th**	To promote AGM Black, Minority Ethnic Group Health Forum	Plan for 300 over 6 days including November
November	To promote the Governor Elections	

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 13 September 2012

AGENDA ITEM NO.	3.1/Sep/12
PAPER	Finance Report – July 2012
AUTHOR	Mike Fox, Chief Management Accountant
LEAD	Lorraine Bewes, Director of Finance
EXECUTIVE SUMMARY	For the 4 months to the end of July 2012/13 the Trust has achieved an EBITDA of £11.4m (£0.8m behind plan) and a net surplus of £4.0m (£0.9m behind plan). The Trust financial performance to date has been driven by income under-performance relating to RTAs and amenity beds and increased costs relating to clinical supplies and utilities which have been partially offset by lower provisions for bad debts. The Trust has been successful in controlling pay costs and has continued to monitor the use of temporary staffing through the use of quotas. departments have been managing the use of temporary staff flexibly in line with activity led demands to ensure where increased costs are incurred they are as a result of increased demand which leads to increased income for the Trust. Year to date the Trust pay spend is broadly in line with budget. Non pay costs are overspent by £0.6m for the year to date. The most significant element of this over-spend is due to the costs of clinical supplies relating to clinical activity as well as increased costs for utilities which has been partially offset by the release of provisions made during 2011/12 for potential bad debts which are no longer required. The Trust has set a CIP target for 2012/13 of £16.2m. To date the trust has identified schemes with a value of £16.5m and is forecasting to implement schemes in year which will release £16.5m of efficiency savings with a recurrent value of £16.1m. The Trust is currently forecasting a year end surplus of £11.7m, £1.0m behind the agreed annual plan. The Trust will continue to work on identifying further income and savings in order to improve the forecast and ensure the Trust meets its financial plan for the year and is able to continue to fund the agreed capital investment programme.
DECISION / ACTION	The Council is asked to note the financial position for the financial year to date July 2012/13.

Glossary of Terms

AAU: Acute Assessment Unit

BPPC: Better Payment Practice Code

CIP: Cost Improvement Programme

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

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

Monitor: Regulatory body for NHS Foundation Trusts.

PBL: Prudential Borrowing Limit (established by Monitor)

PPI: Private Patients' Income

PDC: Public Dividend Capital

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

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 13 September 2012

AGENDA ITEM NO.	3.2/Sep/12
PAPER	Performance Report Commentary – July 2012
AUTHOR	Matthew Dooley, Interim Head of Performance Improvement
LEAD	David Radbourne, Interim Chief Operating Officer
EXECUTIVE SUMMARY	There was no Trust Board in August, therefore we have provided a summary performance report for the September Council of Governors meeting. Subsequent meetings will receive the fuller reports as previously undertaken. This report provides information on performance using most recent data up until the end of July. In overall terms the Trust has performed well to month 4 (July), achieving the required performance level in all Monitor indicators. Positive Performance headlines of note are: • With regard to core access targets, all RTT targets were achieved, as were cancer access targets and the Trust maintained its positive performance on A&E • The Trust has continued to improve on discharge letter completion and outpatient letter turn around, in preparation for the forthcoming CQUINs targets • The Trust has maintained its priority focus on achieving very low levels of HCAI with performance to end of July at 0 and 5 for MRSA and CDif respectively • Positive performance on VTE assessment has been maintained and, • Our performance on cancelled operations, diagnostics within 6 weeks and access to GUM remains good • The Trusts' resilience plans for the core Olympic period were implemented successfully and the Trust performed well during the period The Trust aspires to operate at the highest levels of performance in order to provide exemplary services to the people who use our services. We have therefore been focussing attention in a number of areas to improve performance. • The number of issues patients and GPs face in booking through Choose and Book remain higher than wished. In order to reduce these levels new processes have been employed to achieve short term improvements, alongside proposals which will be reported to the September Board to improve access in a number of services to better meet demand. • During July the Trust experienced some spikes in demand which challenged our ability to respond to patients brought by ambulance in a timely way. A full review of our escalation procedures has occurred and updated ones are

	in place. This coupled with our additional estates and workforce investment in A&E will ensure moving forward greater overall resilience to manage peaks in demand effectively. During the summer a significant amount of attention has been given to ensuring the Trust is well placed to achieve the CQUINs goals set out in this year's contract. To date our progress indicates Q1 and Q2 compliance which primarily centred on the establishment of action plans and technological improvements to facilitate the CQUIN achievement. The most significant changes are seen from Q3 onwards where the Trust is required to ensure that GPs receive notification in real time of patients attending the Trust, outpatient letters within 5 days and discharge summaries within 24 hours of discharge, amongst others. Plans are in hand with divisions to ensure from October onwards the Trust is well placed to achieve the standards. The dashboard appended gives an at a glance record of performance. Further information can be obtained by contacting David Radbourne, Interim Chief Operating Officer or Matt Dooley, Interim Head of Performance Improvement.
DECISION/ ACTION	The Council of Governors is asked to note this report.

Quality Account Actuals

Clincial Effectiveness	Target	Jun	Jul	YTD	Trend
% General and acute patients with a urinary catheter	12.5%	18.94%	N/A	15.24%	-
Income lost due to first to follow-up ratio	£0.0	£72k	N/A	£116k	100.0%
Maternity Access 12 weeks + 6 Days	90.0%	94.1%	95.9%	94.5%	1.8%
Breastfeeding initiation rates	95.0%	91.0%	92.0%	92.0%	1.0%
Caesarean section rate	29.0%	31.2%	28.2%	29.6%	-3.0%
Percentage of A& E attendances for cellulitis that end in admission	40.0%	18.6%	21.7%	19.9%	-3.1%
Non-Elective average length of stay (Last month target: < 576 long stays)	<576	391	411	1694	-7.3%
Stroke: % High risk TIA patients assessed and treated within 24 hours	75.0%	83.3%	100.0%	89.5%	16.67%
Incidence of newly-acquired category 3 and 4 pressure ulcers	0	0	1	11	-100.0%
Stroke: Patients who had a stroke who spend at least 90% on a stroke unit	80.0%	81.3%	92.3%	92.5%	11.1%
% Rapid access chest pain clinic patients seen within 2 weeks	98.0%	100.0%	100.0%	98.1%	0.0%
Elective average length of stay (Last month target: < 52 long stays)	<52	51	61	206	-7.7%
Daycase rate (Basket 25 procedures YTD Target = 84.1%)	84.1%	81.3%	77.6%	81.3%	-3.7%

Process Effectiveness	Target	Jun	Jul	YTD	Trend
Delayed transfers of care (% Beds effected - snapshot)	2.0%	0.8%	0.5%	2.9%	0.3%
% Outpatients waiting longer than 13 weeks	0.03%	0.000%	0.000%	0.000%	0.000%
Did Not Attend Rate - Outpatients	< 8.77%	10.61%	10.56%	10.39%	0.05%
Call Centre Hang Up %	9.5%	9.9%	7.9%	9.3%	2.0%
DNA Rate Treatment Centre	3.0%	2.9%	3.8%	3.4%	-0.9%
Inpatients waiting longer than the 26 week standard	0.0%	0.0%	0.0%	0.0%	0%
2 week wait for appointments for newly diagnosed HIV	100.0%	94.6%	97.4%	96.8%	2.8%
Fracture Neck of Time to Theatre for Medically Fit Patients	100.0%	100.0%	100%	92.3%	0%
Outpatients NHS Number Completion	95%	96.0%	96.1%	96.1%	0.1%
Inpatient NHS Number Completion	95%	96.5%	95.8%	96.1%	-0.3%
A&E NHS Number Completion	90%	88.9%	88.7%	88.62%	-0.2%
Smoking cessation	90%	100%	100%	100%	0%
LAS Patient Handover Times - 15 mins	85.0%	89.1%	90.3%	90.3%	-1.2%
LAS Patient Handover Times - 30 mins	95.0%	98.9%	98.8%	98.7%	0.1%
LAS arrival to handover more than 60mins	0.0	3	0	3	3

Safety	Target	Jun	Jul	YTD	Trend
Hand Hygiene Completion	100%	98.0%	98.2%		0.2%
Hand Hygiene Compliance	90.0%	94.2%	95.0%		0.8%
Incident reporting rate per 100 discharges	0.8	8.2	8.8	8.0	6.8%
Never events	0.0	0	0	1	0.0%
Patient falls resulting in moderate or major harm	2.3	1	2	3	-100.0%
PEAT Audit (Composite score 1 month behind)	95.0%	95.0	96.5	94.7	1.4
Hospital Associated VTE	0.0	0	0	0	0.0%
Ratio of midwives to deliveries	TBC	34.09	33.78	33.40	2.65%
3/4th degree perineal tears	5.0%	2.8%	3.3%	2.9%	-0.8%
1:1 care of women in established labour	100.0%	100.0%	100.0%	25.0%	0.0%
Emergency MRSA screening rate	95.0%	79.3%	80.6%	80.8%	1.3%
Elective MRSA screening rate	95.0%	83.9%	85.5%	86.2%	1.6%
NICU Nurse: Patient ratio vs. BAPM compliance	85.0%	94.0%	104.0%	98.0%	10.0%
MSSA Reduction of Incidences	TBC	1	1	9	0.0%

Patient Experience	Target	Jun	Jul	YTD	Trend
Complaints upheld by the Ombudsman (1Mth Delay)	0	0	0	0	0
Breach of same sex accomodation	0.0%	0	0	0	0.0%
Staff job satisfaction	60.0%	60.0%	60.0%	60.0%	0.00%
Slot issues on Choose and Book	4.0%	4.7%	7.1%	4.4%	-2.4%
Access to GUM clinics	100.0%	100.0%	100.0%	100.0%	0.0%
Rebooking cancelled operations	0%	0%	0%	0%	0%
Six week diagnostic test wait	0	0	0	0	0
ACU - Medical Pregnancies per cycle - Q3 & Q4	> 30%	30.5%	29.19%	29.19%	-1.31%
Pulmonary TB - Two week wait	-	100.0%	-	100.0%	-
Choice of named consultant led team	90.0%	97.1%	96.5%	96.8%	-0.6%

Key Commissioner Priorities

Trend - Last 12 Months

NHS Year Figures

MonthYear	Apr 2011	May 2011	Jun 2011	Jul 2011	Aug 2011	Sep 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Apr 2012	May 2012	Jun 2012	Jul 2012	2011-2012	2012-2013
VTE Assessment	93.0%	92.1%	91.9%	91.9%	94.6%	92.5%	91.3%	91.3%	91.7%	92.1%	90.8%	90.6%	90.9%	90.2%	91.0%	91.5%	92.0%	90.9%
OP Letter Turnarounds	-	-	-	-	-	5.83	8.00	6.68	6.78	10.01	8.01	8.78	7.24	5.99	3.98	3.91	7.58	5.60
Discharge Summary Completion	70.8%	77.3%	75.9%	78.7%	85.5%	91.2%	90.8%	94.6%	93.2%	93.0%	93.9%	94.3%	93.0%	90.2%	91.9%	95.5%	87.4%	92.9%
Emergency Re-admissions Following a Non-elective spell	3.0%	2.5%	2.6%	2.4%	2.6%	2.2%	2.5%	2.5%	2.5%	2.8%	2.6%	2.6%	2.6%	2.7%	2.6%	2.6%	2.8%	2.6%
Emergency Re-admissions Following a Elective spell (Target 0)	1.3%	1.0%	1.5%	1.6%	1.3%	1.3%	1.4%	1.3%	1.5%	1.1%	1.3%	1.3%	1.2%	1.0%	0.8%	0.9%	1.5%	1.0%
NCE POD Recommendations (One month in arrears)	-	96.6%	98.6%	93.7%	97.0%	94.9%	92.9%	95.5%	92.2%	94.0%	97.1%	97.4%	86.2%	97.4%	99.7%	98.3%	95.4%	95.5%
HSMR	66.04	71.43	61.11	71.66	75.60	85.53	81.97	56.48	68.68	76.19	74.25	69.33	69.59	81.21	93.37	-	71.50	80.80
LAS Handover - 90% HAS Data Completeness	66.0%	70.0%	79.0%	81.0%	82.0%	73.0%	72.0%	71.0%	77.0%	76.0%	82.2%	84.8%	90.4%	88.3%	89.9%	85.6%	76.2%	88.5%
GP Referrals	5916	7102	7261	6416	5923	6189	6609	6827	5284	6573	6405	6202	5738	6629	5880	6408	76707	24655

Monitor Indicators

Quarter Name	YTD	Apr-Jun 2012	Jul-Sep 2012	Expected Score
Clostridium difficile cases	5	5	0	0
MRSA objective	0	0	0	0
All cancers: 31-day wait from diagnosis to treatment	100.0%	100.0%	100.0%	0
All cancers: 31-day wait for second or subsequent treatment Surgery	100.0%	100.0%	100.0%	0
All cancers: 31-day wait for second or subsequent treatment anti cancer drug treatments	100.0%	100.0%	100.0%	0
All cancers:62-day wait for first treatment from urgent GP referral to treatment	95.1%	93.8%	100.0%	0
All cancers:62-day wait for first treatment from consultant screening referral	100.0%	100.0%	100.0%	0
Cancer: Two Week Wait from referral to date first seen comprising all cancers	97.0%	96.7%	98.3%	0
Referral to treatment waiting times < 18 Weeks - Admitted	93.61%	93.24%	94.55%	0
Referral to treatment waiting times < 18 Weeks - Non-Admitted	99.33%	99.31%	99.38%	0
Referral to treatment waiting times < 18 Weeks - Incomplete Pathways	92.93%	92.97%	92.83%	0
A&E: Total time in A&E < 4hrs	98.7%	98.8%	98.6%	0
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability	Compliant	Compliant	Compliant	0
		Green	Green	