Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting

Hospital Boardroom
Chair: Prof. Sir Christopher Edwards
Date: 14 February 2013
Time: 4pm

Agenda

		Lead	Time
1	**GENERAL BUSINESS**		
1.1	Welcome & Apologies	CE	
1.2	Declaration of Interests	CE	
1.3	Minutes of Previous Meeting held on 6 December 2012 (attached)	CE	
1.4	Matters Arising (attached)	CE	4.05
1.4.1	Lead Governor – announcement (oral)	CE	
1.5	Chairman's Report (oral)	CE	4.10
1.6	Chief Executive's Report (oral)	APB	4.20
2	**ITEMS FOR DISCUSSION/DECISION/APPROVAL**		
	STRATEGY		
2.1	Strategy Update (oral)	APB	4.30
2.2	High Quality Planning 2013/14 – update (attached)	AH	4.45
	GOVERNANCE		
2.3	Notes from 13 December 2012 Away Day and next steps (attached)	CM/CE	5.00
2.4.1	Terms of Reference of the Nominations Committee of the Council of Governors for the Appointment of NEDs (attached)	CE	5.10
2.4.2	Nominations Committee of the Council of Governors for the Appointment of NEDs – expression of interest (attached)	CE	5.15
	COUNCIL OF GOVERNORS		
2.5	Governors' Questions (attached) - West London Clinical Commissioning Group Out of Hospital Strategy (TY) - Hospital Signage (ML) - Organisation chart (ACle) - Trust view on the report on the role of local authority in end of life care published by LGiU (ACle) - Ron Johnson (CBir)		5.20
2.6	Council of Governors Performance Evaluation (attached)	CM	5.40
2.7	Open Day 2013 – update (attached)	KD-D	5.50
2.8	Council of Governors Funding Report (attached)	VD	5.55
2.9	Chelsea and Westminster Star Awards 2013 (oral)	MG	6.00
2.10	*Governor/Senior Nurse Patient Rounds Report (attached)	TP	
	QUALITY		
2.11	*Quality Sub-Committee report (draft minutes of 29 January 2013 meetings attached)	CM	
2.12	*Quality Account 2012/13 (attached)	CM	
2.13	A Framework for Senior Team Members, Non-Executives and Governors to undertake visits to clinical areas (attached)	TD	6.05
2.14	Francis Inquiry Report (oral)	APB	6.10

	MEMBERSHIP		
2.15	*Membership Sub-Committee report (draft minutes of 24 January 2013 meetings attached)	ML	
2.16	Membership Engagement and communication – update (attached)	KD-D	6.25
2.17	*Membership Report (attached)	SN	
3	**ITEMS FOR INFORMATION**		
3.1	Finance Report – December 2012 (attached)	LB	
3.2	Performance Report – December 2012 (attached)	DR	
4	**ANY OTHER BUSINESS**		
5	**DATE OF THE NEXT MEETING – 23 May 2013**		

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 14 February 2013

AGENDA ITEM NO.	1.3/Feb/13
PAPER	Draft Minutes of Council of Governors Meeting – 6 December 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, 6 December 2012
Draft

Prof. Sir Christopher	Edwards	Chairman		CE
Julie	Armstrong	Staff	Contracted	JA
Walter	Balmford	Patient		WB
Chris	Birch	Patient		CBir
Christine	Blewett	Public	Hammersmith and Fulham 2	CBle
Nicky	Browne	Appointed	The Royal Marsden NHS Foundation Trust	NB
Tom	Church	Patient		TC
Alan	Cleary	Patient		ACle
Samantha	Culhane	Public	Hammersmith and Fulham 1	SC
James	Dennis	Staff	Allied Health Professionals, Scientific and Technical	JD
Jenny	Higham	Appointed	Imperial college	JH
Anna	Hodson-Pressinger		Patient	AH-P
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
Tera	Younger	Patient		TY

IN ATTENDANCE:

Sir John Baker	Non-executive Director	JB
Jeremy Loyd	Non-executive Director	JL
Sir Geoffrey Mulcahy	Non-executive Director	GM
Karin Norman	Non-executive Director	KN
Tony Bell	Chief Executive	TB
Catherine Mooney	Director of Governance and Corporate Affairs	CM
Matt Akid	Head of Communications	MAk
Katie Drummond-Dunn	Communications Manager	KD-D
Axel Heitmueller	Director of Strategy and Business Development	AH
Melanie van Limborgh	Head of Quality and Assurance	MvL
Vida Djelic	Foundation Trust Secretary	VD
Patricia Gani	LINk representative	PG
Carol Dale (in part for item 2.1)	Former Staff Governor – Management	CD
Dr Sarah Cox (in part for item 2.2)	Consultant Palliative Care	SC

1 GENERAL BUSINESS

1.1 Welcome & Apologies — CE

Apologies were received from Anthony Cadman, Fergus Cass, Brian Gazzard, Rosie Glazebrook, Melvyn Jeremiah, Martin Lewis, Alison While and Steve Worrall.

CE noted that both Fergus Cass and Rosie Glazebrook have refrained from attending due to a potential conflict of interest.

Apologies were also received from Mike Anderson, Lorraine Bewes and Richard Kitney.

It was noted that Mike Anderson was attending the JCPCT Board meeting and was therefore unable to attend the Council of Governors meeting. CE said it would have been Mike's last Council of Governors meeting as he is leaving the Trust Board of Directors at the end of January 2013. He said we were fortunate to have such an excellent Medical Director who has the confidence of the staff, governors and the Board. He expressed his gratitude on behalf of the Council of Governors and wished him well for the future.

1.2 Announcement of election results

CE said he was delighted to hear that some governors were re-elected and welcomed newly elected governors.

A governor suggested that the number of votes for each governor should be published. — **VD**

VD to publish.

1.3 Declaration of Interests — CE

None.

1.4 Minutes of Previous Meeting held on 13 September 2012 — CE

Minutes of the previous meeting were accepted as a true and accurate record of the meeting with the following changes:
- Add JH and NB to the list of attendees
- p.3 re Chelwest email account replace 'tree' with 'three'
- p.6 re CQC an unannounced inspection – July 2012, 3rd line should read 'patients' instead of 'patient'.

1.5 Matters Arising — CE

A&E estate

It was noted that a plan had been agreed for short term work to refurbish A&E. A bigger capital plan is waiting for the outcome of the Shaping a Healthier Future Review.

FTGA/CQC project

It was noted that the main criteria used for the selection process for the FTGA/CQC

project was based on having a balance of acute and mental health foundation trusts as well as an even spread across the strategic health authorities. The project intended to work with 8 trusts and it was extended to 10 to try to accommodate more trusts as the interest in the project was great.

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

CE thanked all governors who took part in the 'Shaping a Healthier Future' consultation and highlighted how appreciative the Trust is of governors' support.

Governors noted that a joint Board/Council of Governors Away Day will be held on 13 December from 9.30-4.30pm in the President Room of the Queen's Club.

CE informed governors that the Trust has made an expression of interest in the West Middlesex University Hospital and we have been invited to present the bid to the West Middlesex University Hospital Board.

1.7 Chief Executive's Report **TB**

TB highlighted the recent media attention in relation to the Liverpool Care Pathway and the results of the survey re the 'Shaping a Healthier Future' consultation which were presented by Ipsos MORI at a public meeting on 28 November 2012.

TB emphasised that emergency admissions continue to increase and this is concerning as winter approaches. The UCC is a great benefit. The need to refurbish A&E was recognised.

TB highlighted that the Trust has set up a clinical engagement process and a meeting is taking place on 14 December to consider the future clinical strategy and to get clinicians' view on how to develop future of Chelsea and Westminster Hospital NHS Foundation Trust.

TB also highlighted that there would be the opportunity to get governors perspective on the key objectives for the future at a joint Board/Council Away Day to be held on 13 December.

One governor asked whether something could be done about the front of the hospital. CE responded that Jeremy Loyd, a Non-executive Director has a particular interest in this and the Trust has instituted a regular programme of cleaning. It was noted that the responsibility of the front of the hospital is with the Royal Borough of Kensington and Chelsea.

2 ITEMS FOR DISCUSSION/DECISION/APPROVAL

2.1 Quality Awards **MvL**

The six team winners were welcomed and the high quality of services they provide noted. This is an opportunity to thank people publically and the Council of Governors fund a small reward.

Governors noted an appendix circulated prior to the meeting which provided details of each award.

The Council of Governors received a report from governors who visited each winner's area and representatives received a Quality Award certificate from the Chairman.

The winners were:

- Rapid discharge pathway for terminally ill patients who wish to die at home.
- The Friends Patient Support Project
- Excellent Patient Experience in the Emergency Department
- Maternity Team initiative
- Rapid Access Occupational Health Physiotherapy Service
- Excellence in Clinical Education

The three teams commended for their work were:
- Carpal Tunnel Clinic Team
- Medical Day Unit Team
- Acute Admissions Unit

2.2 Liverpool Care Pathway (LPC) **SC**

Dr Sarah Cox gave a presentation on end of life care linking it to the recent media publicity, public concerns about end of life care initiatives and the Trust's response. She highlighted the impact this has had on the patient experience.

It was noted that the public was concerned that some relatives did not believe patients put on the LPC were close to the end of life and that some patients on the LPC died because of the lack of food supply or dehydration, which was incorrect.

SC was of opinion that the LCP was very valuable and that the recent blog from the Chief Executive was very educating and helpful. There is also an article in the December Trust News to members and it is planned that the LPC is a topic of the upcoming medicine for members' event.

The importance of understanding the LPC was highlighted and noted that doctors record decisions rather than making decision; this is done in communication with patient and family. Should the patient or family object to a patient being put on the LPC this is recorded and respected.

One governor expressed the view in relation to the BBC programme which was to be broadcasted in the evening re some hospitals failing financially and believes that hospitals have to deal with death and should not attempt to be social services.

A governor said patients potentially might be at disadvantage. SC responded that the LPC brings together lot of things which otherwise might be forgotten i.e. free parking for family, next of kin, etc.

One governor expressed the view that there is a perception that in relation to end of life care there is a target of patients being on the LCP and the media are not particularly helpful.

One governor suggested that the LPC document circulated is not easily readable

for an ordinary person and suggested the use of simple language and a shorter version. SC responded that that the document presented to governors is for clinical professionals and emphasised that it contains what is required to achieve a good death.

The governor also noted that in the USA half of expenditure on medical treatment is in the last six months. SC noted that patients and family should be involved in the advanced care planning at an early stage.

A governor said that at the Royal Marsden Hospital NHS Foundation Trust they have been trying to work early with patient and family and noted that getting family involved helps both patients and relatives. SC responded that the Trust has recently been focusing on the advance care planning.

2.3 *Quality Sub-Committee report **CM**

This item was taken as read.

2.4 Health and Social Care Act 2012 implications **CE**

CE highlighted the key issues and noted that implications of the Act 2012 will be presented by Ray Tarling, Governance Adviser at DAC Beachcroft at a joint Board/Council of Governors Away Day.

It was noted that the main focus will be on the Non-executive Director accountability and director/governor interaction and the governors representing interest of the members as a whole and the interest of the public. This is part of a longer piece of work reviewing the implications of the Act.

Governors noted that positive and negative quotations will be provided to enable workshop discussions.

The afternoon session will focus on strategy and understanding the strategy issues and how governors will influence strategy.

In response to a question re governors holding the NEDs to account it was noted that there is no guidance on how this is to be achieved.

A governor suggested that governors are rotated around the tables during the breakout sessions. **VD to arrange**. **VD**

2.5 Shaping a Healthier Future - Update **CE**

Governors noted the positive results of the survey for the Chelsea and Westminster Hospital - 83% agreed with the recommendation that Option A is the best way of organising future hospital which means that the Chelsea and Westminster Hospital would be designated as a 'major hospital' with a full A&E service.

The Council of Governors noted that the JCPCTs in North West London will make the recommendation and a final decision will be made by the Secretary of State for Health.

2.6 Report on appraisal of the Chairman **JB**

The Council of Governors noted the process which involved a self appraisal, the feedback from governors, Executive and Non-executive Directors.

It was agreed that that there is a lot of enthusiasm for the Chairman and his commitment and he was approachable and pleasant. Some points for development were highlighted which included interaction between the governors and the Board members, both NEDs and EDs and having a very clear vision. It is important that the Board and Council of Governors work together and the Chairman has to ensure that this happens.

JB said that CE responded positively to comments and wholeheartedly embraced all points.

A governor asked for clarification re a point on the unitary Board and the NEDs and EDs. Another governor agreed that it is important that the Board acts as a unitary Board.

2.7 Lead Governor **CE**

CE outlined the paper and highlighted that the aim is to select one governor to become a Lead Governor.

It is proposed that 'Deputy Chair' of the Council of Governors will be replaced by 'Lead Governor' to avoid confusion with the Vice Chair of the Board of Directors. **This was agreed.**

Interested governors were invited to send expression of interest to VD by 28 December 2012. **All**

It was noted that the successful lead governor may not have 3 years term.

A governor suggested that if more than one governor interested in the role each candidate should produce a statement. **This was agreed.**

2.8 Trust Media Policy **MAk**

The updated Media Policy was outlined and governors noted the Trust process for providing the press cuttings and the process on advising the Board and the Council of Governors in advance of media release. The meaning of VIP was defined.

One governor suggested that the same update for the Board is sent to the Council of Governors. **This was agreed.**

One governor queried if a replacement for the Head of Communications has been identified. TB responded that the active recruitment process is in place and should the need arise to have an interim arrangements this will be organised.

CE expressed his appreciation to Matt Akid for all his hard work and wished him well. He has been a very effective head of Communications.

In relation to a question on governors media training it was noted that it is not appropriate for governors to receive media training and to talk to the press.

It was agreed that this should be made widely available and include ‘dos and don’t’ for staff. It was asked whether governors are in a position to be involved in the decisions about documentaries. It was pointed out that governors were involved in the decision regarding junior doctors programme although one governor felt this was at a very late stage.

2.9 *Council of Governors Membership Sub-Committee Terms of Reference **CBir**

This item was taken as read.

2.10 Governors questions

Governors noted the corrected paper relating to q.2 re the number of medical staff which were incorrect in the original version.

Governors also noted responses provided in the paper in relation to other questions.

2.11 Council of Governors Funding Report **CM**

The Council of Governors noted the budget report.

The Council of Governors approved the funding request of £250 for a pop up banner for Information Zone as outlined in part A of the report.

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

This item was taken as read.

2.13 *Membership Sub-Committee Report **SN**

This item was taken as read.

2.14 Membership Engagement and Communication - update **MAk**

MAk highlighted the success of the event on dementia and noted that the subject of the January Medicine for Members seminar will be end of life care.

Governors were invited to suggest topics of interest for the future Medicine for Members seminars in 2013. One suggestion included a pharmacy project to stop elderly people taking so many drugs called ‘stop it!’.

2.14.1 Christmas at Chelsea and Westminster event **KD-D**

KD-D introduced the paper and highlighted the event as a way to link with the community.

Governors noted that Chelsea Pensioners will turn the tree lights on and there will be two performances and stalls.

The event will be publicised in the Kensington and Chelsea Chronicle and there will be a leaflet drop to primary schools.

Governors were invited to take away some posters and advertise the event in their community and between friends.

PG from LINk suggested that they advertise the event on their website.

2.14.2 Open Day 2013 **KD-D**

The Council of Governors noted the paper.

CE commented that the paper did not include the success of young people being attracted to the NHS at the Open Day 2012 and suggested this is included.

KD-D said that an operational group will be set up to help with planning of the Open Day.

2.15 *Membership Report **SN**

This item was taken as read.

3 ITEMS FOR INFORMATION

3.1 Finance Report – November 2012 **LB**

This item was taken as read.

3.2 Performance Report – November 2012 **DR**

This item was taken as read.

4 ANY OTHER BUSINESS **CE**

A governor asked about provisions re the Mental Health Act re a specialist mental health assessment at night. **CM**
Look at the provisions of the Mental Health Act.

The issue of food at the night for patients and staff was raised.
CM to find out. **CM**

5 DATE OF THE NEXT MEETING

The next meeting of the Council of Governors will be held on 14 February 2013.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 14 February 2013

AGENDA ITEM NO.	1.4/Feb/13
PAPER	Matters Arising from the meeting of the Council of Governors meetings held on 6 December 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: 6 December 2012
Time: 4:00 – 6:30 pm

Ref	Description	Lead	Subsequent Actions or Outcomes
1.2/Dec/12	**Announcement of election results**		
	A governor suggested that the number of votes for each governor should be published. **VD to publish.**	**VD**	Completed
2.4/Dec/13	**Health and Social Care Act 2012 implications**		
	A governor suggested that governors are rotated around the tables during the breakout sessions. **VD to arrange**.	**VD**	Completed
2.7/Dec/12	**Lead Governor**		
	Interested governors were invited to send expression of interest to VD by 28 December 2012.	**All**	Completed
4/Dec/12	**Any other business**		
	A governor asked about provisions re the Mental Health Act re a specialist mental health assessment at night. **Look at the provisions of the Mental Health Act.**	**CM**	
	The issue of food at the night for patients and staff was raised. **CM to find out.**	**CM**	

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 14 February 2013

AGENDA ITEM NO.	2.2/Feb/13
PAPER	High Quality Planning 2013/14
AUTHOR	Mark Harris, Business Development Lead
LEAD	Lorraine Bewes, Director of Finance David Radbourne, Chief Operating Officer Axel Heitmueller, Director of Strategy
EXECUTIVE SUMMARY	This paper sets out the background, actions to date and forthcoming actions as part of the High Quality Planning process.
DECISION/ ACTION	The Council of Governors is asked to note this paper.

High Quality Planning – Update to the Council of Governors

Background and introduction

Our business planning process, *High Quality Planning*, is an opportunity to support our clinical divisions and corporate departments to identify and prioritise the actions needed to deliver excellent and safe service with kindness and respect. This planning process is linked to the annual contracting round with commissioners and provides a basis for subsequent quarterly performance review meetings, held throughout the year, between the clinical divisions and the Executive team.

The purpose of this paper is to update the Council of Governors on our High Quality Planning process to date and to set out subsequent actions between now and May.

The main actions to date

- **We have engaged widely to develop a strong understanding of the strategic context and objectives across the local and national health system**
  - At the Away Day in December the Chief Executive involved the Council of Governors in a discussion about the strategic challenges facing the Trust, and then set out plans to develop a clinical strategy over the coming six months. Subsequently the Trust held its first Clinical Summit which brought together a range of clinical and managerial leaders to: discuss the challenges within health care; identify examples of excellent practice from around the world; identify our strengths and weakness as a provider of clinical services; and to set out threats and opportunities for future development.
  - Building on the strategy session with the Council of Governors and our Clinical Summit we have been engaging strongly with other stakeholders – such as the local and specialist clinical commissioners the local Health and Wellbeing Boards – to determine the main service delivery themes for discussion as part of the contracting round. These include the continued emphasis on developing Out of Hospital and community services, avoiding non-elective admissions and re-admissions where possible, improving discharge planning and post-acute care, and developing excellent specialist services (including a new maternity pathway).
- **We have engaged with staff throughout the trust to ensure that everyone is able to make a contribution to improve the quality and efficiency of our services**
  - Each division developed its own clinical engagement plan, and ideas were also championed by the Directors' Den initiative which provides investment funding for service and technology innovations
- **We have carried out detailed analysis in order to:**
  - assess quality in each clinical division to identify areas of success and to prioritise areas for improvement;
  - estimate the demand for our services and our capacity to deliver so that we can plan activity in order to meet patients' needs for diagnosis and treatment in a way that is timely, excellent and safe;
  - identify (by looking at our own services and trends in the wider health economy) which of our range of services should become priorities for growth; and
  - identify areas where we can improve efficiency by reducing avoidable waste – the resources that we use but which do not add value to the experience or outcomes of our patients. This analysis is helping us to identify the savings needed to meet our Cost Improvement Programme (CIP) target, which is of the order of 4% of income (and 7-8% of controllable spend).
- **We have held a series of Joint Review Meetings between the Executive and the clinical and corporate teams** – so that divisional plans can be discussed in a

collaborative way and decisions made about plans for activity, investment and productivity.

Further actions for the coming quarter

- In February and March we will support our clinical leaders to engage with clinical commissioners to ensure that any proposed changes to services are in the interest of patients.
- In February and March we will work with commissioning teams to agree a contract for the forthcoming year, including the specification of performance metrics and quality payments (CQUIN).
- In March we will finalise our CIP plans and the overall financial plan for Board approval.
- In April we will agree final operational and investment plans with the clinical divisions and corporate departments.
- In April and May we will set out our overall plan in a document to Monitor for the Board's review and will submit this to Monitor in May.
- By the summer we will finalise work on our clinical strategy, setting out a high level vision for the development of the Trust over the coming five-to-ten years.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 14 February 2013

AGENDA ITEM NO.	2.3/Feb/13
PAPER	Health and Social Care Act 2012 - Notes from 13 December Away Day and next steps
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman/Cathy Mooney, Director of Governance and Corporate Affairs
EXECUTIVE SUMMARY	This paper outlines a record of proceedings of a joint Board/Council of Governors Away Day held on 13 December 2012.
DECISION/ ACTION	There are two areas for agreement: the actions from the joint Away Day and the proposals for addressing the other main issues that have arisen from the changes to the Health and Social Care Act 2012. The Council is asked to note the report, proposed actions and agree the next steps.

Health and Social Care Act 2012 – next steps

1.0 Introduction

This paper describes the key issues identified to date with respect to the implications of the Health and Social Care Act 2012 and updates following the workshops at the Away Day. The notes on the strategy session are also included for completeness.

2.0 Background

A workshop was held with governors facilitated by Ray Tarling, Governance Adviser, DAC Beachcroft on 17th October, who also presented to the Board on 25th October 2012.

Following these two sessions some key issues were identified and it was agreed that two areas would be discussed at the joint Away Day. The notes from the Away Day are attached.

The areas discussed, the intended outcomes and proposed actions are as follows:

2.1 Non-executive director accountability and director/governor interactions.

We wanted to discuss the governors' statutory role on holding the Non-executive Directors to account for the performance of the Board, what that meant in practice and whether there would need to be any changes to governance arrangements. We wanted to achieve an agreement on an approach for the governors to hold NEDs to account.

2.1.1 Summary

There is currently a good working relationship and open Board meetings will improve the ability of the governors to hold the NEDs to account. Getting to know the NEDs through informal mechanisms would be valued. Governors need to understand more the context in which they are holding the NEDs to account and would welcome more opportunities to be out and about in the Trust. Important to be assured that there are robust systems and processes in place.

2.1.2 Proposed actions:

As open Board meetings are such a key factor in allowing governors to access the business of the Trust and the NEDs, it is proposed that this issue is revisited later in the year, once the governors have had the opportunity to see how this contributes to their role in holding NEDs to account. This will also help with an understanding of systems and processes in place through the papers that are presented to the Board.

Regarding context (and developing relationships) there is a paper on the agenda for joint visits.

2.2 Duty of governors to represent the interests of the members of the corporation as a whole and the interest of the public

We noted that engagement of the elected governors with the members they represent has been a challenge and wanted to discuss how we can facilitate this further and explore the current methods of engagement, frequency and appropriateness in the light of new statutory duties. We wanted to look at ways of doing this.

2.2.1 Summary

There was a wide range of ideas about how the governors' interactions with the Trust and membership could be improved.

2.2.3 Proposed actions:
It is proposed that these ideas are evaluated by the Council of Governors Membership Sub-Committee with a report back to the Council of Governors.

3. Action from the Council of Governors

To agree on actions following the Away Day to further address the issues identified.

4. Other issues

4. 1 Significant transactions

The governors have confirmed that they wish significant transactions to be defined in the constitution. This applies to financial and other transactions. A starting point could be Monitor's guidance on material and significant transactions. Looking back, and applying this, what would that mean that the governors would be involved in? And what other activities in the last two-three years would be in hindsight deem significant and therefore include in the definition? What governance arrangements will be required to enact this? We want to achieve a definition of significant transactions to be included in future versions of the Constitution, approved by Council and Board and agree a governance mechanism for dealing with approval of significant transactions by the Council of Governors from the effective date.

4.1.1 Next steps

A facilitated workshop involving governors and Board members will be set up to take this forward.

4.2 Composition of the Council

The revision of the constitution is an opportunity to revise the membership of the Council. Issues to address include that the HSCA 2012 requires that the governors are representative of the population we serve, changes in NHS means that some governor posts are no longer appropriate and the size. We want to agree the future size and composition of the Council of Governors.

4.2.1 Next steps

A facilitated workshop involving governors and Board members will be set up to take this forward.

4.3 Constitution

The constitution needs to be revised to meet the requirements of the Act 2012 but we will also use this as an opportunity to simplify it. Work has stated on a comparison with the Monitor model core constitution. Some issues have arisen e.g. composition of the staff constituency. We want to achieve a revised and simplified constitution supported by the Trust Board of Directors Standing Orders and the Council of Governors' Standing Orders.

4.3.1 Next steps

The majority of this work will be undertaken by the existing group of governors with recommendations being brought to the Board and Council of Governors as appropriate (recognising that some issues will be addressed in the work described above)

5.0 Further action required

To note and agree the above processes.

Notes of Joint Board of Directors and Council of Governors Away Day
13 December 2012 – draft

1. Introduction by Chairman

The Chairman outlined the day and how important it was that the Board and Governors worked well together.

Ray Tarling, Governance Adviser, Beachcroft, gave a brief reminder about the changes as a result of the Health and Social Care Act 2012. .

2. SESSION 1

Relationship Board/Governors Feedback from groups

Governors agreed that they feel able to ask question and feel they are listened to.

It is important that Governors are helped to understand the winder picture. Governors do not have enough context to hold the NEDs to account and the meaning of holding to account is not clear. Governors have not seen a Trust organisational chart. Also an overview of the commissioning structure would be helpful to understand the wider context.

The Agenda Sub-Committee is very important and the Governors have the opportunity to send in questions.

There was a mixed response about whether the Board was open and transparent in planning. The decision about naming the Children's Hospital was an example of where the Board might with clarity have involved the Governors. However, the Governors have always been invited to strategy meetings in the Trust.

Felt the Board was good at using the Governors to provide insight.

Some Governors felt that meetings of the Governors should be more frequent. Two and a half hours may not always be enough for all the work that has to be done. However, extending the time may include a lot of people. Have to be careful as not all Governors have the same time to attend meetings. Although some Governors felt excluded others disagreed and felt their time is limited and appreciated all the time that others put in. Stressed that emails are sent to all the Governors for communication and invitations to get involved. More guidance about getting involved might be helpful.

Being at the Board and having the same information as the Board will help with holding the NEDs to account. The Governors do not know the Board very well and once the Board meetings are open and they can be seen in practice the Governors will get to know them.

We are all in this together and want to succeed. Need a sensible approach as to how Governors can help. More informal interaction with the Board is required. Useful to share NEDs area of interest. Helpful if Governors visit local areas in the Trust and get intimately involved. Calling to account is about being visible in the hospital and being integrated. We should avoid more bureaucracy. The best approach is for Governors to be active in hospital and tell us if it is working on the ground rather than attending more meetings. This is the 'value added' of the Governors. The approach to be organic not bureaucratic.

Some Governors believe that sometimes they are seen as a necessary evil.

Some disagreement on value of Board members attending the Council of Governors meetings as a waste of a resource and people's time vs. the value of being part of the meetings (and attendance by the Board is reported in the Annual Report).

Important that the Council of Governors is not turned into another Board of Directors. We have to understand the different bodies and their different roles. The Francis Report will be published in January 2013. This will emphasise the role of the Board and systems they have in place to assure themselves e.g. complaints, audits and serious incident investigations. It is important that the concept of a unitary Board is not lost.

Governors could invite the NEDs to come to the Council of Governors' sub-committee meetings.

Governors need to have more context in which to understand their role in holding the NEDs to account. There are opportunities for the Governors to be out and about to understand the Trust more and these could be developed further. The day has shown how Governors and the Board can work together – some FTs hold meetings in the format of the away day i.e. cabaret style. Time is a problem and it is important that all voices are heard. Holding to account needs to be done in such a way that it is not divisive. There was agreement that the success of the Trust is a joint approach.

Consider that Monitor holds the Board to account and the Governors are taking on that role from Monitor – what then should Governors be doing? Important to focus in on principles and methods (systems and processes) so that Governors can be confident in decisions made and are aware how the Board assures itself. Means of assurance includes complaints/MPALS quarterly report/Audit Report/Annual Report/Performance Report waiting times.

VD to circulate NEDs areas of interest and a Trust organisational chart to understand executive and other directors' remits.

3. SESSION 2

Feedback from groups Relationship Governor/Members

Recognised it is almost impossible for Public Governors to talk to members of the public. It is easier for Patient Governors (via meet a governor sessions).

Opportunities for engagement include the Open Day – ensure that groups who engage with us participate. Chelwest is part of a community – how can we harness that and which groups can help us? Perhaps a community champion's programme? There is an important BME element. Other engagement includes Medicine for Members.

The transparency section on the web should be extended. Having email addresses for all elected Governors should help with communication and engagement. Suggestion that there is regular membership news which has its own 2 pages from the Governors or an engage with members section. Build more links with schools and areas we serve.

Governors are very keen that commissioners are represented on the Council e.g. someone from each Clinical Commissioning Group (CCG).
An idea was to connect a governor to a part of the hospital and get feedback and perhaps link in a governor to the three charities. The charities have the support of the communities but we do not link in to this.

Recognised the need for strong external communication.

NEDs/EDs/Governors would benefit from informal meetings rather than formal; suggestions to invite NEDs and EDs to Governors meeting with BG.

Variety of ways of interacting in and around the Trust:

- SSG trolley
- Meet a governor
- Ward visits – accompanying nurses on the clinical rounds very powerful to have a governor and nurse together
- Strong support for educational evening
- Ask for emails at registration
- Governor's role in Quality Account
- Involvement in Shaping a Healthier Future Consultation and values exercise
- Christmas event
- There ought to be a particular focus on paediatrics and use it as a model

However, must recognise that different Governors have different skills and some have skills in analysing reports and not in being out and about.

Concern that the man on the street does not know what a governor does. Although patients and the public are starting to understand the strength or the Governors and someone asked if they could meet a governor.

TB suggested a map of stakeholders.

Volunteers are huge reps and they could be used. They are by nature pro the hospital.

4. Overall Summary

A lot has been achieved in the morning with lots of suggestions. The quotations can be referred to in the future to measure out progress.

We have agreed about everything of value and have a real commonality of commitment. We have modelled a style of discussion that we might want to recreate going forward. We can now look at the detail.

5. Chairman's summary

We have demonstrated a common purpose – to achieve excellence. We have attracted a wide range of able people and we get on well together. We do need to debate how meetings should work in the future. Board meetings will be open to the public and not public meetings and we need to agree how they will work e.g. question at the end rather than throughout the meeting.

Dates have been circulated and we look forward to having the Governors there. It is important that we have all listened to what is being said today and recognise that we are mutually interdependent.

Governors noted that as of April 2013 the Board meetings will be open to public starting with closed sessions and then followed by the open sessions.

STRATEGY SESSION

Governors noted that the clinical summit meeting will be held the following day at which an appraisal of strategic options will be presented to help inform a clinical services strategy.

Governors noted the key messages and possible options – horizontal and vertical integration. Three opportunities to create more horizontally integrate serves presented included: West Middlesex University Hospital Trust, Charing Cross Hospital and Royal Brompton Hospital. These opportunities have been assessed against the set of strategic ambitions.

Importance of patient experience, integrated and accountable care as well as innovation at scale was noted.

Questions included whether the CCGs have been considered; maternity unit at WMH is very successful and this adds value to C&W, PFI and financial debts etc.

Governors noted the criteria use e.g. suitability to meet ambition, feasibility of delivery and acceptability of change.

All Governors were invited to let VD have any comments on the vision and criteria or any other comments.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 14 February 2013

AGENDA ITEM NO.	2.4.1/Feb/13
PAPER	Terms of Reference of the Nominations Committee of the Council of Governors for appointment of Non-executive Directors
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	In preparation for recruitment of NEDs later this year the terms of reference of the Nominations Committee have been reviewed. At this time they are based on the current constitution wording which is reflected in italics in the attached and recommendation of Monitor Code of Governance (see section 2). There is therefore little flexibility to amend the TOR but it is good practice to ensure they are up to date. One change to be considered is quoracy. The current TOR specify that all governors are present. In practice this was achieved for the last recruitment process but may hinder the process in future. It is suggested that the quoracy is two governors, one appointed and one elected so that the Nominations Committee could meet with only two governors if required, although this would be the least preferred option. The other change is to clarify the review period which is stated now as annually, in line with most other TOR in the Trust (an exception is the Audit Committee which is every two years).
DECISION/ ACTION	The Council of Governors is asked to note the process for the appointment of Non-executive Directors as outlined in the Terms of Reference and to agree the proposed changes.

1.0 Introduction

The Nominations Committee is a Standing Committee of the Council of Governors which facilitates the appointment of Non-executive Directors by the Council of Governors.

2.0 Background

The Terms of Reference of the Nominations Committee of the Council of Governors for appointment of Non-executive Directors were approved by the Council of Governors in June 2009 and are attached in appendix 1.

The role of the Nominations Committee is described in the Terms of Reference of the Nominations Committee of the Council of Governors for appointment of Non-executive Directors (attached in appendix 1).

3.0 Terms of Reference

At this time they are based on the current constitution wording which is reflected in italics in the attached and recommendation of Monitor Code of Governance (see section 2). There is therefore little flexibility to amend the TOR but it is good practice to ensure they are up to date.

One change to be considered is quoracy. The current TOR specify that all governors are present. In practice this was achieved for the last recruitment process but may hinder the process in future. It is suggested that the quoracy is two governors, one appointed and one elected so that the Nominations Committee could meet with only two governors if required, although this would be the least preferred option.

The other change is to clarify the review period which is stated now as annually, in line with most other TOR in the Trust (an exception is the Audit Committee which is every two years).

4.0 Decision/Action required

The Council of Governors is asked to note the process for the appointment of Non-executive Directors as outlined in the Terms of Reference and to agree the proposed changes.

Appendix 1

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

TERMS OF REFERENCE OF
THE NOMINATIONS COMMITTEE
OF THE COUNCIL OF GOVERNORS
FOR THE APPOINTMENT OF NON-EXECUTIVE DIRECTORS

1.0 Authority

1.1 The Nominations Committee is a Standing Committee of the Council of Governors which facilitates the Council of Governors in appointing non-executive directors. Its terms of reference shall be as set out below and shall not be amended, revoked or replaced except by a resolution passed at a meeting of the Council of Governors.

2.0 Roles

The Nominations Committee shall:

2.1 Identify appropriate candidates (not more than five for each vacancy) through a process of open competition which takes account of the policy maintained by the Council of Governors and the skills and experience identified by the Board of Directors.

2.2 Make recommendations for the successful candidate to the Council of Governors.

2.3 Review the policy for the size, structure and composition of the non-executive directors which takes account of relevant Trust strategies from time to time and not less than every three years and make recommendations to the Council of Governors.

3.0 Membership

3.1 *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 is invited to act as an independent assessor to the Nominations Committee.*

4.0 Attendance

4.1 The Director of Human Resources will attend the committee to provide advice and secretarial services to assist the committee.

5.0 Meetings

5.1 The Nominations Committee shall meet on occasions when necessary as determined by the Chairman.

5.2 A quorum shall be two governors, one appointed and one elected and the Chairman (or the Vice Chairman of the Board of Directors when a Chairman is being appointed).

Deleted: three Governors including

5.3 The Nominations Committee will report to the Council of Governors after each meeting.

6.0 Review

6.1 The terms of reference of the committee shall be reviewed by the Council of Governors at least annually.

Deleted: bi-

Revised June 2009
Reviewed February 2013

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 14 February 2013

AGENDA ITEM NO.	2.4.2/Feb/13
PAPER	Nominations Committee for appointment of new Non-executive Directors membership – expression of interest
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	A plan for refreshing the membership of the Nominations Committee in preparation for the appointment of new Non-executive directors in October 2013 is outlined in the paper.
DECISION/ ACTION	The Council of Governors is asked to send expressions of interests for the membership of the Nominations Committee to Vida Djelic by Thursday, 28 February 2013.

1.0 Introduction

The Nominations Committee is a Standing Committee of the Council of Governors which facilitates the appointment of Non-executive Directors by the Council of Governors.

2.0 Background

The Terms of Reference of the Nominations Committee of the Council of Governors for appointment of Non-executive Directors were approved by the Council of Governors in June 2009 and are attached in paper 2.4.1.

The role of the Nominations Committee is described in the Terms of Reference of the Nominations Committee of the Council of Governors for appointment of Non-executive Directors (attached in paper 2.4.1). The exact wording may change as part of the review of the constitution but this will not fundamentally change the role of governor on the Nominations Committee.

3.0 Nominations Committee Memberships

With regards to the Nominations Committee membership the Trust's constitution reads as follows:

> '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 is invited to act as an independent assessor to the Nominations Committee.'

We plan to refresh the membership of the Nominations Committee in preparation for the appointment of new Non-executive directors in October 2013 and therefore invite interested governors to submit expression of interest. If more than two elected governors and one appointed governor are interested the Chairman will interview interested governors.

With regards to the commitment, all members of the Nominations Committee will be expected to attend long-listing meeting (approx 3hrs), shortlisting meeting (approx 3hrs) and Interview Panel (approx. 6hrs) and read accompanying papers

4.0 Decision/Action required

The Council of Governors is asked to send expressions of interests for the membership of the Nominations Committee to Vida Djelic **by Thursday, 28 February 2013.**

Council of Governors Meeting, 14 February 2013

AGENDA ITEM NO.	2.5/Feb/13
PAPER	Governors' Questions
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	<u>The question raised by Tera Younger: West London Clinical Commissioning Group Out of Hospital Strategy (WLCCGOOH)</u> 1.Could the UCC at C&W Hospital become a "hub" in the WLCCGOOH strategy? Is C&W interested in becoming more central to WLCCG's OOH strategy and how could we take this forward? We have been extensively involved with NWL commissioners in the overall SAHF programme to ensure that the overall proposals make sense for the local population and fit well with the key role that Chelsea and Westminster has in the NWL health economy. We have been fully involved in the design of the UCC specification, as well as being involved in the development of other important specifications such as maternity and paediatrics. We have expressed our interest to the CCGs in supporting the development of out of hospital services and intend to further discuss this with Daniel Elkeles, Chief Officer of the local partnership of CCGs at a joint strategic development meeting later in February. Our involvement is envisaged as a key part of developments in our immediate catchment, but also as part of the anticipated redevelopment of the Charing Cross site as it becomes a local hospital. The Chef Executive has written to Tera Younger in more detail. <u>The question raised by Martin Lewis: Hospital Signage</u> 2. What is happening to the new signage as people are still wandering the hospital getting lost? The Wayfinding Strategy is being considered by the Executive Group at its meeting on Monday 11th February. Once approved, we will move to tender the installation of the signage and in parallel, will agree our approach to some of the points raised during consultation with patients and staff, including simplifying names of some departments and wards, moving pieces of artwork which will mask some of the wayfinding pointers and agreeing the new look and content of our patient

	appointment letters. The main hospital notice board will be updated as soon as the Strategy is approved, as we can keep this live and up to date in the new format, rather than wasting funds on the old board that would then be removed. This will be done as soon as possible after 11th and should be in place by early March at the latest. Our receptionists and 'Here to Help' volunteers will continue to support patients visiting the hospital in terms of navigating their way through departments. Following tender/procurement, the whole-hospital signage will be installed during July and August. <u>The question raised by Alan Cleary: Organisation chart</u> 3. When can Governors with a background or interest in general management expect to receive a detailed organisation chart together with the basic management information telling them how the hospital conducts its business and thence enable them in future to hold appropriate people to account? A Copy of the organisation chart is enclosed. It should be noted that governors do not have a role in holding managers to account other than the Board of Directors to become holding the Non-executive Directors to account. <u>The question raised by Alan Cleary:</u> Trust view on the report on the role of local authority in end of life care published by LGiU 4. Will the Trust now express its own view of the recent report on the role of the local authority in end of life care published by the LGiU? (attached) The report referred to examined local authorities in their provision of social care (for example home-help type carers and housing) to people at home. Social care in this context is seen as separate from health care. It reports 135 local council officers' responses to a survey about attitudes to and involvement in End of Life care services in the community. The main findings of this report, and my responses, are: 1. There is a need to raise awareness in local government of End of Life Care. This Trust already supports education and training of social care staff in End of Life Care in the community. 2. There is a need for local government to be more involved in commissioning and delivery of End of Life Care. We would strongly support better integration of social and health care services in the community, both for the well being of patients in our catchment area and because the quality of social care in the community influences our ability to provide (for instance) our ability to discharge patients home at the end of life. 3. There is a need to consider the importance of housing in End of Life Care. Issues with placement are common causes of delayed discharge from hospital and can prevent patients at the end of life getting home at all.

	The question raised by Chris Birch: Ron Johnson 4.1 Is it still planned to name some part of the Ron Johnson ward after Jim Smith? Discussions are being held and an update will be provided at the Council of Governors meeting. 4.2 What is the Board of Directors planning for its official opening? Options are being considered and an update will be provided at the Council of Governors meeting. 4.3 Can we please mention on the plaque that the Ron Johnson ward replaces the old Thomas Macaulay ward? Yes, this can be done if the plague is situated within the ward area, so as not to confuse patients and conflicts with the Wayfinding Strategy.
DECISION/ ACTION	To note.

Chelsea and Westminster Hospital NHS
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Council of Governors Meeting, 14 February 2013

AGENDA ITEM NO.	2.6/Feb/13
PAPER	Council of Governors Performance Evaluation
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	Monitor's *Code of Governance* sets out the provision: 'D.2.2 *Led by the chairman, the Council of Governors should periodically assess their collective performance and they should regularly communicate to members details on how they have discharged their responsibilities, including their impact and effectiveness on:* ■ *advising the board on the forward plans of the NHS foundation trust; and* ■ *communicating with their member constituencies and transmitting their views to the board of directors.* *The Council of Governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice.'* The aim of the questionnaire is to evaluate and improve the performance of the Council of Governors. It was based on Monitor's national survey of NHS Foundation Trusts, which allows us to benchmark ourselves with the Monitor survey results. The questionnaire has essentially remained the same to allow us to compare ourselves with last year but some questions which were less relevant have been removed to make the questionnaire a bit shorter as feedback from last year was that it was too long. The following process is suggested: • Draft Questionnaire to be agreed at the Council of Governors meeting on 14 February 2013 • Questionnaires to be distributed to Governors by e-mail on

	15 February 2013 • Questionnaires to be completed and returned to the Trust Secretary by 1 March 2013 Summary report, including any recommended developmental actions, to be prepared and presented by the Chair to the Council of Governors meeting on 23 May 2013.
DECISION/ ACTION	The Council of Governors is asked to agree the questions and process.

The key actions agreed from the last the Council of Governors Performance Evaluation and the progress is outlined below:

Action	**Outcome**
To circulate minutes as soon as practicable after every governors meeting for comments on accuracy.	This is now occurring.
Governors to communicate on what the Trust is doing for the local community, for patients' services and trust membership. **This work will be undertaken by the Membership Sub-Committee.**	This was addressed by the Membership Sub-Committee at its meeting on 1 June 2012. The sub-committee confirmed that this will be done via various engagement activities listed in the membership engagement and communication calendar of events 2012. With regards to Monitor Code requirement ref D.1.5 and D.2.2 the sub-committee confirmed that evidence for these include: consultation on Trust values, the upcoming consultation on 'Shaping a Healthier Future' and Annual Members' Meeting.
To address induction and training.	Induction and Training Task Force met on 9 September 2012 to discuss how to improve governors' induction programme and training. It was agreed that in light of the Act 2012 governors statutory responsibilities expanded this will be considered further once the new constitution has been agreed.

To consider how to improve on understanding of governors roles and responsibilities.	Examples include: Council of Governors Workshop on the Constitution Review held on 17 October 2012, Away Day – 13 December 2012 and 'Being an Elected Governor' leaflet produced prior the November 2012 election.
To consider how to improve on understanding of the Quality Account.	The Quality Account Planning Group (a sub-group of the Quality Sub-Committee) whose main task is to consider the readability and presentation of the Quality Account was set up last year and will be repeated this year. All governors are invited to join. Interested governors to let Vida Djelic know.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors
Performance Evaluation

1. Please read the questions and tick the most appropriate box by inserting √

2. Please answer all questions using knowledge gained as a governor

3. Please add any appropriate comments

4. Please return the questionnaire to Vida Djelic, Foundation Trust Secretary (vida.djelic@chelwest.nhs.uk) by 1 March 2013.

Governor Survey 2012

About you

1. What type of governor are you?

☐ Public/Constituency Governor (elected by the Trust Membership)

☐ Patient/Carer Governor (elected by Trust membership)

☐ Staff Governor (elected by staff)

☐ Stakeholder Governor (appointed to represent local authority, PCT, LHB, university or voluntary service etc.)

2. How long have you been a governor?

☐ Less than 3 months

☐ Between 3 months and 6 months

☐ Between 6 months and 1 year

☐ Between 1 year and 2 years

☐ Longer than 2 years

☐ Since the Trust was first authorized (please also tick this if relevant, in addition to one of the above)

3. How many of the Council of Governors meetings do you attend?

☐ Every or almost every meeting

☐ At least one in two meetings

☐ At least one in three meetings

☐ At least one in four meetings

☐ Less than one in four meetings, but do attend some meetings

☐ Never attended any meetings

☐ Don't know

4. Please indicate the frequency of each of the following. Please tick one box for each statement.

		Always	Most of the time	Sometimes	Never	No opinion/Do not know	Not applicable
4.1	Agenda and supporting documents are circulated in good time for each meeting	☐	☐	☐	☐	☐	☐
4.2	Minutes are circulated after every governors meeting	☐	☐	☐	☐	☐	☐
4.3	Minutes of the meeting are circulated in good time for the next meeting	☐	☐	☐	☐	☐	☐
4.4	Action points are followed up by the governors responsible	☐	☐	☐	☐	☐	☐
4.5	The Chair follows up the action points for which he or she is responsible	☐	☐	☐	☐	☐	☐
4.6	The attending executive board members follow up the action points for which they are responsible	☐	☐	☐	☐	☐	☐
4.7	Governor meetings are productive	☐	☐	☐	☐	☐	☐

Comments:

About your role as a governor

5. For each of the following statements, please tick to indicate the extent of which you agree or disagree:

		Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	No opinion	Not applicable
5.1	Overall, I am clear about my roles and responsibilities as a governor	☐	☐	☐	☐	☐	☐	☐
5.2	I am clear about what the local healthcare priorities are for my Trust	☐	☐	☐	☐	☐	☐	☐
5.3	I am clear about what the priorities are for my Trust's patients/service users	☐	☐	☐	☐	☐	☐	☐
5.4	The governors at my Trust are good at communicating what the Trust is doing for the local community	☐	☐	☐	☐	☐	☐	☐
5.5	The governors at my Trust are good at communicating what the Trust is doing for patients services	☐	☐	☐	☐	☐	☐	☐
5.6	The governors at my Trust are good at communicating what the Trust is doing for the Trust membership	☐	☐	☐	☐	☐	☐	☐

5.7	I understand what it means to hold my Trust's Board to account (to be replaced with NEDs in 2013)	☐	☐	☐	☐	☐	☐	☐
5.8	I feel I have the power as a governor to hold my Trust's Board to account (to be replaced with NEDs in 2013)	☐	☐	☐	☐	☐	☐	☐

Comments:

About how you work with your Trust

6. Thinking about the information you need to perform your role as a foundation trust governor, how well informed do you think the Trust keeps you about its activities?

☐ Very well informed

☐ Fairly well informed

☐ Not very informed

☐ Not at all informed

☐ Don't know

Comments:

7. Thinking about your Trust's strategy or forward planning, how confident would you feel in explaining this to a new governor?

☐ Very confident

☐ Fairly confident

☐ Not very confident

☐ Not at all confident

☐ Don't know

Comments:

8. In your role as a governor, how satisfied or dissatisfied are you with the amount of contact you have with members of the Board of Directors?

	Executive Director	Non-executive Directors
Very satisfied	☐	☐
Fairly satisfied	☐	☐
Neither Satisfied nor dissatisfied	☐	☐
Fairly Dissatisfied	☐	☐
Very Dissatisfied	☐	☐
Don't know	☐	☐

Comments:

9. Please indicate the extent to which you agree or disagree with each of the following statements:

		Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	No opinion/Don't know
9.1	The Chair of my Trust keeps me as a member of the governing body, informed about the activities of the executive board of my Trust	☐	☐	☐	☐	☐	☐
9.2	I wouldn't hesitate to approach the Chair with a query or issue	☐	☐	☐	☐	☐	☐
9.3	I wouldn't hesitate to approach any Board member with a query or issue	☐	☐	☐	☐	☐	☐
9.4	Overall, my Chair is doing a good job	☐	☐	☐	☐	☐	☐
9.5	My Board is supportive of the Council of Governors and view it as an asset	☐	☐	☐	☐	☐	☐

Comments:

Training and briefings

10. Thinking back to when you first became a foundation trust governor, were you given any training or briefings to enable you to do the role

- ☐ Yes
- ☐ No
- ☐ Don't know/Can't remember

11. Since any initial training or briefing you may have had, have you been invited to any further training or briefings to help you develop in your role as governor?

- ☐ Yes
- ☐ No
- ☐ Don't know/Can't remember

12. Thinking about all the training and/or briefings the Trust has provided, in general how satisfied are you with the quality?

- ☐ Very satisfied
- ☐ Fairly satisfied
- ☐ Neither satisfied nor dissatisfied
- ☐ Fairly dissatisfied
- ☐ Very dissatisfied
- ☐ Don't know

Please add any comments you have on this training.

13. If you felt you did need training to help you in your role as a governor, do you think you would be able to secure it from your Trust?

☐ Yes

☐ No

☐ Don't know

Comments:

Final Question

14. Final question - is there anything else you would like to add?

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 14 February 2013

AGENDA ITEM NO.	2.7/Feb/13
PAPER	Open Day 2013
AUTHOR	Katie Drummond-Dunn, Communications Manager
LEAD	Tony Bell, Chief Executive
EXECUTIVE SUMMARY	This paper outlines a proposal for the Trust Open Day 2013 (Saturday 11 May, 11am–3pm).
DECISION/ ACTION	The Council of Governors is asked to discuss the proposal including aims and objectives. Governors are asked to attend the Open Day.

Open Day 2013 – Update

1. Introduction

1.1 The annual Chelsea and Westminster Hospital Open Day has grown in popularity in recent years. It is now the flagship event in the Trust's public and patient engagement programme. It is known within the healthcare sector as one of the most successful hospital open days.

1.2 The event is an opportunity for the Trust to place itself at the heart of its community by opening its doors to local people and giving them a chance to become more involved in their local hospital.

1.3 Last year's Open Day on Saturday 12 May 2012 attracted a record 2,100 visitors and was opened by journalist and television personality Anne Robinson.

1.4 Visitors to last year's Open Day were invited to give their feedback by using the Patient Experience Tracker. More than 100 responses were gathered on the day:

- 100% rated the Open Day as 'Excellent' or 'Good' (up from 98% in 2011)
- 96% would definitely recommend the Open Day to friends and family (up from 92% in 2011)
- 95% said staff at the Open Day were friendly and approachable (up from 94% in 2011)

1.5 Governors recruited 64 new Foundation Trust members on the day.

1.6 The careers event was attended by 331 people.

2. Aims

2.1 Open Day 2013 will take place from 11am-3pm on Saturday 11 May.

2.2 The aims of Open Day 2013 are to:

- Market the Trust to current and potential Foundation Trust members, patients and local residents
- Celebrate the Trust's 20th anniversary
- Promote the achievements of the hospital
- Develop communication between Council of Governor's representatives and Foundation Trust members
- Encourage Open Day visitors to become Foundation Trust members
- Promote health, fitness and wellbeing
- Showcase developments such as the new diagnostic centre
- Foster partnership working
- Improve staff morale
- Utilise the day as a fundraising opportunity for the Chelsea and Westminster Health Charity and other associated charities

3. Implementation

3.1 As in previous years it is recommended that a Steering Group and Operational Group be established to implement the project:

- Steering Group – to provide high-level oversight of the Open Day. Membership to include as a minimum the Chief Executive, a Non-Executive Director and a Council of Governors representative. Tony Bell has asked Fleur Hansen to co-ordinate this group.

- Operational Group – to manage planning and implementation of the Open Day. Membership to include a Council of Governors representative, as well as representatives of Trust charities, directorates and departments in the Trust, and contractors including ISS Mediclean. Karen Robertson has been approached to chair this group and meetings will commence in March.

- The Communications Manager will be responsible for project managing the Open Day including publicity, logistics, liaison with Trust staff and partner organisations.

4. Funding

The Council of Governors has agreed to fund £20,000 for the Open Day.

5. Programme

5.1 Early discussions are taking place in order to plan the major attractions and events which will take place during the Open Day. A number of ideas have been proposed including:

- An area celebrating the Trust's 20th anniversary
- Use of the lower ground floor outpatients to provide health checks (for example diabetes, blood pressure, BMI) for members of the public
- Teddy Bear Hospital in Paediatrics outpatients
- Live music organised by Hospital Arts to run all day
- Focus on key services offered by the hospital including paediatrics, elderly care, diabetes, stroke and HIV/Sexual Health
- Careers in the NHS zone aimed at 14-17 age group
- Tours – various areas but this could include the new Diagnostic Centre, Paediatric Theatres, Antenatal, Simulation Centre and the Assisted Conception Unit
- The Department of Health to provide a Friends and Family Test stand

6. VIP attendance

6.1 Early discussions have taken place with the Chief Executives regarding a VIP to open the event.

Katie Drummond-Dunn
Communications Manager
January 2013

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 14 February 2013

AGENDA ITEM NO.	2.8/Feb/13
PAPER	Council of Governors Funding Report
AUTHOR	Vida Djelic, Foundation Trust Secretary Sian Nelson, Membership Manager, Part A, B & C
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 9 of FY 2012/13. Funding requests are enclosed in part A, B & C.
DECISION/ ACTION	The Council of Governors is asked to note the report and approve requests for funding.

Council of Governors Funding Report

1.0 Background

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

2.0 Update

At the last meeting the Council of Governors it was agreed to support funding of the free-standing banner to display upcoming dates and times of Meet a Governor sessions in the Information Zone for £250.

2.0 Funding Overview for 2012/13

Of the £80k circa £55k has been committed to the activities listed in the table below which were approved by the Council of Governors. It leaves circa £25k available for the remainder of the 2012/13 FY.

3.0 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	£1,080
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	£1,873.55
February 2012	Members Recruitment Campaign for Open Day May 2012	£2,340	Agreed 2012/13 FY	£2,500
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	
December 2012	Free-standing banner	£250	Agreed 2012/13FY	
	TOTAL	**£54,663**		**£23,733.77**

6.0 Progress report re projects for FY 2012/13

6.1 An update on projects re membership engagement approved by the Council of Governors for FY 2012/13 was presented in paper 2.14 in December 2012. A request for funding the membership engagement projects for 2013/14 is outlined in the paper 2.15.

6.2 For an update on projects re the Members Recruitment Campaign see part C of this report.

6.3 Quality Awards – this was presented to the Council of Governors in December 2012.

Part A

Open Day 2013 - Gifts for the Governors Stand

1. Introduction

For the past two years the Membership Sub-Committee has provided gifts to give away at the Governors stall during Open Day. These have proved to be very popular and encourage passers-by to attend the stall and sign up to membership. This year we would like to add mugs to our gift range. We would also like to add colour to the mugs and bags. The message on the gifts will promote membership, and proudly celebrate the Trust's 20 years of keeping patients 'safe in our hands.'

2. Aims

As a gift to people who join membership, to offer free souvenirs – either a mug or bag, plus pen which advertise membership and celebrate the trust's 20th year of service.

3. Funding

Item	**Cost**
1000 pens @ 28 pence each (one colour)	£328.00
500 mugs @ £1.80 each (full colour)	£1,132.00
1000 cotton bags (4-colours)	£1,915.74
Marks and Spencer Vouchers	£50.00
Oat bars/confectionary	£30.00
Total	**3,455.74 exc. VAT**

4. Actions for the Council of Governors

The Council of Governors is kindly asked to approve the funding request of £3,455.74 exc. VAT.

Part B

Funding Request for a new pop-up banner to promote membership

1.0 Introduction

A pop up banner to advertise membership is in need of updating as the current banner is broken and has outdated pictures.

2.0 Aims

A pop up banner saying ‘become a member’ will signpost potential members to the membership application forms and briefly outline the benefits of membership.

3.0 Funding

We would like to ask the Council to agree the funding of £160.00 for one pop up banner.

4.0 Actions for the Council of Governors

The Council are asked to approve the request for funding of £160.00 the project.

Part C

Funding request for the Membership Recruitment for 2013

1.0 Introduction

It is essential to ensure on-going recruitment of new members. Capita Recruitment is commissioned to recruit 600 new members this year, which ensures we keep membership active whilst counterbalancing those members that leave.

2.0 Funding

Capita recruitment will recruit new members on the proposed dates in the table below. The dates coincide with trust activities so that the recruiters can also promote the events to members.

Date/Month	Event/Activity	Existing or new activity?	Lead	Funding required/Funding source	Number recruited
April 2013	Members Recruitment Campaign for Open Day May 2013 and elections	New	Sian Nelson	£2,340	To recruit 300 new members
September 2013	Members Recruitment Campaign and promotion of the Annual Members Meeting (within the hospital)	New	Sian Nelson	£1,170	To recruit 150 new members
October 2013	Members Recruitment Campaign and promotion of Governor Elections (Inc. within the community)	New	Sian Nelson	£1,170	To recruit 150 new members
				TOTAL £4,680	600 members

3.0 Actions for the Council of Governors

The Council of Governors is asked to note the above and agree the funding for membership recruitment.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 14 February 2013

AGENDA ITEM NO.	2.10/Feb/13
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 December 2012 and January 2013. 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 December 2012 and January 2013 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. On Wednesday January 23rd, Mr Martin Lewis joined the Senior Nursing and Midwifery team for their clinical rounds. The team assessed standards relating to 2 CQC essential standards of quality and safety. These were outcome 5; nutrition, and outcome 6, transfer of patients between care providers.

2.2. Mr Lewis joined Tony Pritchard, the Deputy Chief Nurse, to assess these standards on Chelsea Wing, the private patient ward. During the visit, Mr Lewis discussed patients experience with them, and met with staff to discuss the approach within the ward to meeting these standards.

2.3. In relation to outcome 8; meeting peoples nutritional needs, Mr Lewis met with staff to review the use of the electronic nutritional screening tool in the Lastword system, and how this was used to assess the changing nutritional status of a particularly complex patient in the ward. During the visit, Mr Lewis was introduced to the ward hostess who discussed the red and blue meal tray system which is used to identiy patients who need support and assistance at mealtimes. The provision of nutritional supplements and out of hours meals was also discussed.

2.4. In relation to outcome 6; discharge and transfer o patients, Mr Lewis discussed the impeding discharge of one patient with them. It was identified that further steps to provide information and preparation for discharge would be useful. Mr Lewis also reviewed records of patients who had been transferred between wards, and we discussed the continuing need to focus on compliance with this handover and communication process.

2.5. Mr Lewis attended the feedback and action planning meeting which follows the Wednesday rounds, and provided feedback on his observations during the afternoons visit.

3. Future Clinical Rounds

3.1. 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.

3.2. This assessment is aligned to the 16 Care Quality Commission (CQC) essential standards for quality and safety relating to clinical care. A local toolkit has been developed to

enable of assessment of these standards across our wards and departments. In September 2011, a proposal was presented to the Council of Governors for them to join us during these clinical half days, so that they could work alongside our staff in assessing these standards. A timetable of future rounds is shown in appendix 1.

4. Future Governor Visits

Governor Wendie McWatters is organising a visit to the hospital school in February.

5. Summary

This report has provided a summary of Governor visits conducted during December 2012 and January 2013. The Details of future Senior Nursing and Midwifery Clinical Rounds have been provided.

Tony Pritchard
Deputy Chief Nurse
January 2013

Appendix 1

Senior Nursing & Midwifery Clinical Rounds – Assessment of CQC Standards

Feb 20th 13	**March 6th 13**	**April 3rd 13**	**April 17th 13**	**May 1st 13**
10. Safety & suitability of premises 11. Safety, availability & suitability of equipment	16. Assessing, monitoring and improving the quality of service provision 17. Complaints	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
May 15th 13	**Jun 5th 13**	**Jun 19th 13**	**July 3rd 13**	**Jul 17th 13**
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

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 14 February 2013

AGENDA ITEM NO.	2.11/Feb/13
PAPER	*Draft Minutes of the Council of Governors Quality Sub-Committee meeting held on 29 January 2013
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Cathy Mooney, Acting Chair
EXECUTIVE SUMMARY	Draft minutes are enclosed.
ACTION	To note.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Quality Sub-Committee meeting, 29 January 2013

Draft Minutes

Attendees	Martin Lewis	ML	Public Governor, Westminster 1
	Wendie McWatters	WMW	Patient Governor
	Susan Maxwell	SM	Patient Governor
	Sandra Smith-Gordon	SS-G	Public Governor – Kensington & Chelsea 2
	Cathy Mooney	CM	Director of Governance and Corporate Affairs
	Tony Pritchard	TP	Deputy Chief Nurse
	Melanie van Limborgh	MvL	Head of Quality and Assurance
	Sharon Connell		Chaplaincy Representative
	Patricia Gani	PG	LINk representative
	Vida Djelic	VD	Foundation Trust Secretary
	Karen Baker (in part for item 6)	KB	EDM Project Lead
	Holly Ashforth	HA	Medicine and Surgery Lead Divisional Nurse
	Mitchell Haines	MH	Medicine and Surgery
	Stephen Lord	SL	
	Sophie Western	SW	

1 Welcome and Apologies **CM**

Apologies were received from Mike Anderson, Melvyn Jeremiah and Maddy Than.

2 Minutes of previous meeting held on 13 November 2012 **CM**

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

- note that CM chaired
- add MT to attendees
- p2 , clarify that the response was in relation to white coats
  p.3, section 7, change 2013/14 to 2012/13
- p.4 section 8, change first bullet to 'are you at'
- p.4 under staff appraisal add to the second sentence at the end 'for staff'

Also to add that WMW reported on a very positive experience which was that a nurse accompanied her to the Royal Brompton Hospital and stayed with her all day.

CM noted that governor allocation to Divisions was not discussed at the last meeting as a draft paper had to be discussed with the Executive Team and noted that a related proposed plan for visits will be discussed later in the meeting by TP.

The availability of wheelchairs at the front entrance was also noted to be a success and thanks was noted to TP for organising.

3 Matters arising **CM**

The sub-committee noted that progress on actions was as indicated in the paper.

Re. Feedback from governors on patient experience
TP invited SM to provide some more detail about two patients who were admitted to hospital via A&E and sent back home without being made aware who provides care. One relates to arrangements for wound care.
SM to provide more detail to TP.

Junior doctors wearing white coats
The sub-committee noted that there has been an extensive discussion on this subject at the Executive Team meeting and CM was asked to determine the strength of feeling from the governors. There is a focus on not wearing scrubs out of the hospital at the moment.

The sub-committee agreed that professional appearance is very important and the reassurance patients get from a white coat. It is also important that patients can differentiate between doctors and other staff by the uniform they wear. The possibility of ordering a thinner fabric uniform was suggested if the problem was that people were too hot. Badges are worn but are often hidden.

The sub-committee asked for evidence from the Infection Control Team.
TP to raise it at the next Infection Control Committee.

A wider issue of appropriate dress in clinical environment was also discussed.

It was suggested that a survey of patients was conducted to gauge how important this was to them.
CM to report back to the Executive Team.
It was noted that it is more important to enforce some rules i.e theatre staff going out without scrubs.

4 Quality Account overview and timescales **MvL**

MvL outlined the themes and timescales for production and publication of the Quality Account 2012/13 and the sub-committee were invited to submit feedback.

The sub-committee were also invited to consider areas of innovation and high quality work from the 2011/12 Quality Account and consider additional areas i.e. themes, stories, innovations etc.

MvL highlighted that feedback on the 2011/12 Quality Account has improved compared with the previous version. However, there was still a significant view that large parts of the report were 'boring' and written for managers and not patients. It was suggested that possibly two versions should be produced, one for submission to the Parliament/Department of Health and a considerably shorter version for patients and public.

Suggestions for a shorter version included: more patient and staff stories, human interest stories and use of vibrant colour. Another suggestion was that more information was put in the back section e.g. the local indicators and Monitor indicators, leaving the front section for more patient focus

stories. The number of indicators reported on could be reduced.

Positive feedback from other hospitals and Deloitte was noted.

CM said she will sound out the auditors and the commissioners about alternative approaches.

Quality priorities

The sub-committee discussed quality priorities. These are as follows:

1. To have no hospital associated preventable venous thromboembolism (VTE). It was agreed this should continue.
2. Continue to focus on communication, discharge planning, and care of older people. TP said we might slightly re-word this and take into account out of hospital care.
3. To be in the top 20% of acute trusts nationally for staff engagement and staff appraisals as measured by the NHS staff survey and to ensure our agreed Trust values inform everything that we do. To follow up with HR regarding suggestions for change e.g. we might want to focus on the values.
4. At least 75% of emergency general medical and surgical patients to be seen by a consultant within 12 hours of the decision to admit to hospital or within 14 hours of their arrival at the hospital. To ask the executive to comment.

TP suggested that we change appraisal to communication.

It was noted that feedback on discharge was improving but we recognise the need for further improvements.

Medication and waiting for discharge was suggested as a focus.

The sub-committee was invited to submit any further views on priorities and key themes.

CM to follow up with the appropriate staff on the above suggestions and report to the executive. **CM**

5 Quality Account Survey **MvL**

This item was discussed earlier in the meeting.

PG said she was attending a K&C LINk Management meeting the following evening at which she will find out about Healthwatch.

PG to send to VD information to circulate to the sub-committee. **PG/VD**

6 Electronic Document Management Project demo **KB**

Karen Baker, the EDM Project Lead provided a demonstration of the EDM system and how it works in practice.

It was noted that the EDM is a system to digitalise medical paper records and create electronic records. All records contain a bar code to ensure that they are filed in the right place. Deployment of EDM improves access to hospital medical records. This will improve internal communication but will not address different consultants at different hospitals for different ailments. We are exploring the possibilities of putting records on encrypted

CDs and also the Royal Brompton Hospital having access to medical records via a password. It is important to develop use of the system internally and then develop it externally.

There is an audit trail on everything that is done e.g. on all steps of the access to files and amendments made to the records.

The system overall should improve quality of services we provide.

KB was thanked for the helpful demonstration.

7 Patient Survey and Action Plan **TP**

TP provided an overview of the paper and explained that Carol Dale has been appointed for a short term as a patient experience facilitator to assist with embedding the Trust values which should in the end help with improving patient experience.

TP noted the themes of the surveys and highlighted the recent introduction of Friends and Family Test.

Key themes from patient feedback have been collated and an action plan has been developed including the next steps.

TP highlighted priorities for 2013/14 and next steps. Some of these include:

- Real time surveys
- Continue with family and friends test
- You Said – We Did communications
- More work on patient engagement and focus groups and how we develop our services
- Embedding Trust values
- Developing customer care skills
- Inpatient comfort rounds and roll out widely
- Post discharge phone survey has been piloted.

7.1 Comfort Rounds update **HA**

Holly Ashforth, Medicine and Surgery Lead Divisional Nurse introduced her team and explained patient comfort rounds and how they were developed.

Comfort rounds are done every two hours, and there is a documentation that should be completed.

Comfort rounds have been rolled out to Edgar Horne Ward, Chelsea Wing and Rainsford Mowlem Ward. It was noted that the AAU does not have comfort rounds and we are considering how we take it forward.

Regarding implementation of comfort rounds, it was noted that wards are given freedom how this is done and documented.

This method gives both patient and staff the opportunity to ask questions without interrupting and in a more relaxed way.

HA circulated a copy of comfort rounding patient information and how it is done.

ML suggested that information about comfort rounds is included in the hospital guide.

HA highlighted that work on developing an audit tool will be done to measure the impact and success of comfort rounds.
HA invited interested governors to advise her if they would be interested in doing an audit of comfort rounds. **All governors to let HA know if interested.** **All**

7.2 A Framework for Senior Team Members, Non Executives and Governors to Undertake Visits to Clinical Areas **TP**

TP said it is proposed to introduce a framework and process for regular ward rounds by senior team members, Non Executives and Governors. The purpose of these rounds would be to enable a 'board to ward' approach through linking senior nurses and managers with patients and families, whilst also providing a visible presence for staff within clinical areas.

It was noted that the idea is supported by the Trust Executive and the plan is to take it the proposal to the Board and the Council of Governors.

8 Complaints – summary and themes Q2 **TP**

This paper was noted.

9 Council of Governors funding report **VD**

This paper was noted.

10 Feedback from governors on patient experience

SM raised the delay with appointments in the hand therapy department. She wondered if they needed more therapists. **TP to take it forward**. **TP**

WMW said she passed on to CM feedback she had received from a patient re paediatrics which is an administrative process issue. The clinical staff were good but were being let down by the administrative staff.

WMW reported on a patient who came to the hospital to have a knee surgery and had previously had all tests done. However, on the day of operation he found out that he could not be treated due to the fact that he was not fit. This brings up an issue of the results of the pre-assessment and how these are coordinated.

WMW said she also had received feedback re failed attempts to take blood in a baby and she had passed it to Vanessa Sloane, Directorate Nurse, Neonatal Services, Childrens' & Young People's Services. She suggested there should be specialists in taking blood in young children.

ML queried the hospital signage and if directing patients to outpatients area can be improved by having a volunteer on the lower ground floor. TP said that we do that when there are enough volunteers.

11 Any other business

None.

12 Date of next meeting – 19 March at 4pm

Council of Governors Meeting, 14 February 2013

AGENDA ITEM NO.	2.12/Feb/13
PAPER	*Quality Account 2012/13
AUTHOR	Cathy Mooney, Director of Governance and Corporate Affairs
LEAD	Cathy Mooney, Director of Governance and Corporate Affairs
EXECUTIVE SUMMARY	The process for the development of the Quality Account is described
ACTION	For information

Quality Account 2012/13

1.0 Introduction

This paper briefly outlines the process for the development of the Quality Account for 2012/13 and next steps.

2.0 Background

The Quality Account is an annual report for the public about the quality of services delivered. Parts of the content is prescribed by the Department of Health and by Monitor, but there is flexibility for local development

3.0 Development of the Quality Account

The involvement of stakeholders in the development of the quality account is a key part of the process and one important group informing the development is the Council of Governors Quality Sub-Committee (which includes LINk and commissioners representation). Another important group is Trust staff and this is managed through the Trust Executive Quality Committee.

4.0 Process

Both the Council of Governors Quality Sub-Committee and Trust Executive Quality Committee have been briefed on the timetable for the Quality Account and discussions on priorities has commenced. Please see the Council of Governors Quality Sub-Committee draft minutes for further information. The Council of Governors Quality Sub-Committee reviewed the results of a survey amongst patients of the current Quality Account and this feedback will be taken into account. It showed that despite significant improvement many patients would still find the document difficult to read, due to the density of information and uncertainty about the purpose. However, the benefits of a medical copywriter were clear and this will be retained

5.0 Next steps

More detailed planning will now occur with the help of a Quality Account Planning Group (which was a sub group of the Council of Governors Quality Sub-Committee) in due course.

6.0 Action/Decision

For information

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 14 February 2013

AGENDA ITEM NO.	2.13/Feb/13
PAPER	A Framework for Senior Team Members, Non-Executives and Governors to undertake visits to clinical areas
AUTHORS	Tony Pritchard. Deputy Chief Nurse
LEAD	Therese Davis, Chief Nurse and Director of Patient Experience and Flow
EXECUTIVE SUMMARY	This paper presents a proposed framework for senior team members, Non Executives and Governors to undertake planned visits to clinical areas. In August 2012, the senior nursing and managerial team linked to nominated wards and initiated regular rounds to discuss the patients experience and to promote the annual national patient survey. These rounds were positively evaluated by both patients and staff. This paper presents a proposal for the future continuation of this approach and the inclusion of wider representation. The purpose of these rounds would be to enable a 'board to ward' approach through directly linking senior nurses, managers and Governors with patients and families, whilst also providing a visible presence for staff within clinical areas. These rounds would be used to focus on our priorities around safety, effectiveness and patient experience. The proposal has been presented and discussed in a number of forums and is seen as a valuable way of providing a focus on patient experience through direct contact with those clinical areas.
DECISION / ACTION	To agree the process.

A Framework for Senior Team Members, Non Executives and Governors to Undertake Visits to Clinical Areas

1. Introduction

1.1. This paper presents a proposal to introduce senior team rounds within the trust. The senior nursing and managerial team initiated rounds during August 2012 to promote the national patient survey. This paper presents a proposal for the future continuation of these.

2. Background

2.1. During August, the senior clinical and managerial team initiated regular ward rounds within adult inpatient wards. The initial driver for these rounds was to promote the National patient survey with staff, patients and families and to gain direct feedback from patients on their experience of being in hospital.

2.2. From feedback to the Senior Nursing and Midwifery Committee and anecdotal feedback from patients, these daily ward rounds were seen to be a positive development. They provided staff and patients with a senior presence whilst patients valued the opportunity to be asked about their experience by members of the senior team. The initiative also enabled the provision of objective, real-time feedback to staff on any issues that were raised by patients and their families.

3. Proposal

3.1. It is proposed that we now introduce a framework and process for regular ward rounds by senior team members, Non Executives and Governors.

3.2. The purpose of these rounds would be to enable a ‘board to ward’ approach through linking senior nurses and managers with patients and families, whilst also providing a visible presence for staff within clinical areas.

3.3. These rounds would be used to focus on our priorities around safety, effectiveness and patient experience, for example;

- Discussing patients experience with them and providing direct feedback to staff on any issues or concerns raised by patients and families in the ward
- Promoting patient feedback surveys such as the Hospedia bed-side surveys and Friends and Family Test.
- Completing a number of post discharge phone surveys from each clinical area on a weekly basis
- Discussing staff experience with members of the clinical team and focus on the embedding of the Trust values and behaviours
- Supporting and monitoring the implementation of initiatives such as intentional rounding by ward staff and the provision of information on ward routines.
- Promoting the Quality Theme of the Week with staff

4. Structure and Process

4.1. It is proposed that a member of the senior nursing team will be linked to each ward area and will link with nominated members of the senior management team

such as Service and General Managers, members of the Trust Executive team, Non Executives and Governors

4.2. Nominated individuals will plan dates and time to conduct a senior team round at least once per week for around 1.5 hours.

4.3. To enable and guide the process, a template of prompts will be developed for those conducting the rounds

4.4. Following the rounds, it is proposed that the ward team should be provided with both positive feedback and identification of any issues.

4.5. Feedback and any themes from senior team rounds will be presented at the Senior Nursing and Midwifery Committee, the Patient and Staff Experience Committee, the Quality and Assurance Committees and relevant divisional forums

5. Consultation

5.1. This proposal has been discussed within the Senior Nursing and Midwifery committee. Divisional Senior Nurses are committed to supporting the process

5.2. The proposal has been presented and discussed in the Trust Senior Operational Group with Trust Executives and it was seen as a valuable way of providing a focus on patient experience through direct contact in clinical areas.

6. Next steps

Present the proposal to Non Executives and Governors
Plan to commencement of visits from February 2013

Tony Pritchard
Deputy Chief Nurse
January 2013

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 14 February 2013

AGENDA ITEM NO.	2.15/Feb/13
PAPER	*Minutes of the Council of Governors Membership Sub-Committee meeting held on 24 January 2012 – draft
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Martin Lewis, Chairman of the Membership Sub-Committee
EXECUTIVE SUMMARY	Draft minutes are enclosed.
DECISION/ ACTION	For information.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Membership Sub-Committee, 24 January 2013
Draft

Attendees	Martin Lewis	ML	Chairman
	Chris Birch	CB	Patient Governor
	James Dennis	JD	Staff Governor
	Susan Maxwell	SM	Patient Governor
	Wendie McWatters	WMW	Patient Governor
In attendance	Katie Drummond-Dunn	KD-D	Communications Manager
	Tony Pritchard	TP	Deputy Chief Nurse
	Sian Nelson	SN	Membership Manager
	Vanessa Sloane	VS	Directorate Nurse Neonatal Services, Childrens' & Young People's Services
	Vida Djelic	VD	Foundation Trust Secretary

1. Welcome & Apologies **ML**

ML welcomed JD to his first meeting of the Membership Sub-Committee.

Apologies were received from Samantha Culhane, Melvyn Jeremiah and Maddy Than and Priti Bhatt.

2. Minutes of previous meeting held on 27 September 2012 **ML**

Minutes were accepted as a true and accurate record of the meeting.

3. Matters arising **ML**

SN said that the contract with Capita is due for renewal later in the year and there will be the opportunity to consider the terms of the contract against the Trust needs. A possibility of keeping it in house was raised.

The sub-committee discussed the issue of membership application forms.

CB queried present and the future arrangements re the membership application forms and the return address that feature on the current forms and also if any old forms are retained by members and returned back to the old address. SN confirmed that redirecting of post has worked so far and that to her knowledge old forms are not retained in the hospital.

It was confirmed that any questionnaires/surveys could be circulate with the mail shot to members at no extra cost.

The sub-committee noted that the current membership form will be revised before the new print of forms is scheduled in.

4 Membership Application Form – wording

It was noted that the Membership application form required updating. CB tabled a copy of suggested wording re the role of the Council of Governors.

The sub-committee discussed a suggested wording and agreed the following wording for inclusion in the Membership Application Form:

‘The Council of Governors is required to represent the interests of the Trust's members and the public and to hold the Board of Directors to account. A driving force behind NHS Foundation Trusts is the active participation of the members who can be elected to the Council of Governors, which includes representatives of patients, the public and staff.'

VD to provide the agreed wording to KD-D. **VD**

5 Council of Governors handbook – wording **CB**

CB tabled a copy of suggested text to go in the handbook which was originally drafted by drafted by MJ and modified by himself and others. It was further amended by the sub-committee.

CB proposed that the Introduction section gets removed and is substituted with the proposed text which should be headed ‘Council of Governors’:

'The Council of Governors is a key part of all Foundation Trusts, holding the Board of Directors to account and helping to shape policy. The Council is governing body of the Trust ensuring that it fulfils its purposes as set out in the Trust's authorisation, while the Board of Directors is responsible for the operational management of the hospital. The Council is required to represent the interests of the Trust's members and the public.

It has certain other statutory powers and duties. These include the appointment and removal of the Chairman and other Non-executive Directors and deciding their remuneration, allowances and other conditions and terms of office. The Council of Governors can require any of the Non-executive Directors to attend a Council of Governors meeting and explain particular decisions of the Board. It appoints and removes the Trust's Auditors, who report to the Council. The consent of the Council is required for any Trust decision of substance and for the appointment of the Chief Executive after initial approval by the Board. It plays a key part in the strategic planning and annual reporting processes.

Individual governors take part in the work of a number of important Trust committees to contribute an independent view. They also participate in three sub-committees of the Council itself.'

The 'Council sub-committees meeting dates and membership' would follow exactly as in the present handbook, and the 'Key roles of the Council of Governors' would be scrapped, and it should all fit on pages 3, 4 and 5 as at present.

Some governors felt that the Board is not aware of the role of governors and also

that staff are unaware who governors are.
VD to provide the agreed wording to KD-D. **VD**

WMW suggested that if governors wish to update their biographies should inform George Vasilopoulos of any changes/additions.

6 Information Zone

Banner design

SM said she has a wording for the banner and will circulate the wording for inclusion in the banner to the sub-committee for comments and suggested that governors' pictures are not included.

Welcome to Chelsea and Westminster banner – become a member

ML suggested a welcome to Chelsea and Westminster banner which would invite patients and public to become a member. TP suggested it contains a few bullets to describe what it means to be a member.

SN and ML to look at welcome to Chelsea and Westminster Hospital banner wording and to put a request for funding to the Council of Governors on 14 February. **SN**

TP noted that the table in the Information Zone is unscrewed and that it should be fixed to the floor.

7 Membership Engagement and communication calendar of events **KD-D**

KD-D outlined the calendar of events which presented an overview of events for 2011/12 and schedule of events for January, February and March 2013.

She highlighted the launch of the Star Awards in January and noted the deadline for nominations. She also highlighted Medicine for Members event on 19 and 27 February. ML offered to chair the event on 19 February and SM offered to chair the event on 27 February.

CB repeated his plea that future updates should concentrate on the present and future and not on the past.

WMW suggested a link to be established with the Sickle Cell which might help with recruiting diverse membership. TP said that the Trust has a link with the Sickle Cell Support Group. JD offered help with passing the contact details of the Chairman of Sickle Cell to the Trust to establish channel of communication.

SN commented that contrary to what the perception might be the Trust is balanced re ethnicity compared against the eligible population. However, we recognise that representing the local black community could be improved.

JD raised the question of the information provided to patients and whether the patient information leaflets are appropriate for patients with disability, minority and

how to better provide information to patients. TP responded that a lot of work has been done on easy read leaflets and disability.

WMW suggested use of the mobile health clinic bus in Portobello in summer where there is diverse population. ML suggested this is discussed further at the next meeting. **VD to put on the March Membership Sub-Committee agenda.**

It was agreed that a topic for one of future Medicine for Members events is on 'who governors are and what they do?' This was agreed. **KD-D to schedule in.**

As a way of promoting the work of governors TP suggested a governor presentation at the corporate induction.

8 Chelsea and Westminster Star Awards 2013 **KD-D**

The sub-committee noted the format of the event and the deadline for nominations.

KD-D clarified the purpose of the event and the difference between the Quality Awards, Christmas Cheer and Star Awards.

It was noted that the Star Awards dinner will be held on 18 April at the Royal Surrey.

9 Governors stand for Open Day 2013 – suggestions **KD-D**

The sub-committee discussed the event and suggestions the Council of Governors stall included fruit, pens, mugs, bags and vouchers, bubbles for kids.
SM to put a funding request to the Council of Governors for 14 February meeting. **SM**

It was proposed that one volunteer should be nominated to help recruiting new members on the day.

TP noted that Maddy Than will lead a volunteers stall and the theme will be on customer care skills training.

10 Membership Recruitment – update **SN**

SN highlighted that the latest membership number which currently totals 15,448.

It was noted that the total numbers of leavers and joiners were 1,199 and 1,789 respectively.

She highlighted a list of recruitment events planned for 2013/14 and the funding required.

The sub-committee discussed the recruitment evens planned and it was agreed that 2 sessions will be held at the Trust, 1 session at Dean Street, 1 at the West London Sexual Clinic and 1 in White City (Somali women). SN clarified that an event means 5 active recruitment days.

ML recognised the need for governors involvement in helping with recruiting

members and suggested that they join Capita recruiters.

It was noted that the membership should represent those eligible to be members.

VD queried the BME event which was planned for January 2013. SN responded that the uptake by staff invited to present was not great due to lack of time. TP commented that we will explore how to get most of the engagements events we already have planned for.

JD suggested to have an overall theme for recruitment sessions i.e have a voice-become a member

TP noted that carers needed better representation and we have set up a forum called Carers Forum which would address issue as to how to inform and support carers who are often referred to as 'hidden carers'

11 Young Persons Membership **VS**

She highlighted that the idea which has been put forward to Directors Den for a funding for a young worker role, on Saturdays during the school term and the working week during the school holiday. She outlined the variety of ways for their engagement i.e in the recruitment process, to sit on a group of governors, participate in meetings, etc. The role is aimed at young patients and siblings who would provide their view on the hospital and its environment.

This was perceived as a way of engaging with the community and local schools. SN said that Cathy Mooney, Director of Governance and Corporate Affairs felt this was an excellent idea and could potentially be funded from the Council of Governors budget, if agreed.

CB noted that if we were to proceed with the young persons' membership the adequate changes would need to be made to the Trust's Constitution. He said he understand that a young person's champion would attend the governors meetings and would participate in discussions, however, he/she would not have any voting rights.

On a question of safeguarding VS said that this is in line with the Trust's Safeguarding Children Policy.

The sub-committee felt that funding the project would be worth to be considered. It was agreed that a request would be put to the Council of Governors for funding should it be declined by Directors Den.

12 Council of Governors Funding Report for the Membership Sub-Committee **VD**

KD-D outlined a list of events planned for 2012/13.
The Membership Sub-Committee agreed to support the funding of membership engagement events for value of £30,600.

It was noted that as the funding request for the 2013 Open Day was made earlier in 2012 the total amount to be spent on the engagement events will be circa £50k.

13 Any other business

WMW expressed a positive view on rejoining a meet a governor session in the Information Zone.

14 Date of next meeting – 21 March 2013

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 14 February 2013

AGENDA ITEM NO.	2.16/Feb/13
PAPER	Membership Engagement and Communication - update
AUTHOR	Katie Drummond-Dunn, Communications Manager
LEAD	Therese Davis, Chief Nurse and Director of Patient Experience and Flow
EXECUTIVE SUMMARY	This paper provides an update the current engagement activities of 2012/13 and the proposal for membership engagement for 2013/14, which has been supported by the Membership Sub-Committee.
DECISION/ ACTION	Governors are asked to discuss the proposals and consider the request for funding.

MEMBERSHIP ENGAGEMENT 2012/13

Date	Event/Activity	New or existing activity?	Lead	Cost/Funding source
February 2013				
Fri 1 Feb	Members' News Issue 13	New activity	Communications Manager	£210 (Council of Governors)—funding approved at Council of Governors meeting 1 Dec 2011
Mon 18 Feb	Closing date for Star Awards nominations – Patient Choice category and Council of Governors Special Award	New activity	Communications Manager	Not from Council of Governors budget (funded by Chelsea and Westminster Health Charity)
Tue 19 Feb	Medicine for Members 7th event—End of Life Care seminar	New activity	Communications Manager	£1,000 (Council of Governors)—funding approved at Council of Governors meeting 1 Dec 2011
Wed 27 Feb	Medicine for Members 8th event—Managing Your Medicines seminar	New activity	Communications Manager	£1,000 (Council of Governors)—funding approved at Council of Governors meeting 1 Dec 2011
March 2013				
Fri 1 Mar	Members' News Issue 14	New activity	Head of Communications	£210 (Council of Governors)—funding approved at Council of Governors meeting 1 Dec 2011

PROPOSALS FOR MEMBERSHIP ENGAGEMENT AND COMMUNICATION 2013/14

1. Introduction

The Trust's membership as of 31 March 2012 was14,858.

Date	Total	Patients	Public	Staff
31 March 2007	13,287	5,898	6,982	407
31 March 2008	13,140	6,095	6,580	465
31 March 2009	15,438	6,136	6,372	2,930
31 March 2010	15,186	6,010	6,130	3,046
31 March 2011	14,501	5,591	5,737	3,173
31 March 2012	14,858	5,685	5,942	3,231

Overall membership numbers declined between 2009 and 2011 but has shown recovery in the last 12 months, after the communication and engagement strategy was enhanced in 2012/13. Membership currently stands at 15,448 (December 2012).

We need to continue to actively engage with our Foundation Trust members to ensure we maintain a steady level of membership and fulfil our role as a locally accountable organisation.

2. Engagement and communication

Membership numbers alone are meaningless unless we engage and communicate with our members.

Limited engagement and communication with members may be a contributory reason for membership numbers decreasing in previous years.

There are also sound 'political' reasons for engaging and communicating with members in a more systematic and committed way:

- Government policy on the NHS has a strong emphasis on patient involvement and empowerment – 'No decision about me without me' – and FT membership is seen as an example of the 'Big Society' in action
- Last year's Shaping a Healthier Future public consultation into the reconfiguration of NHS services in North West London demonstrated the power of an engaged, supportive community – 11,263 people completed postcards supporting option A to save A&E at Chelsea and Westminster

2.1 Current engagement and communication activity

- **3 membership mailings per year** – where possible sent via email to members in order to reduce postage costs, the mailings are timed to publicise the Open Day and Annual Members' Meeting
- **Open Day** – successful annual event which attracts more than 2,000 people
- **Annual Members' Meeting** – good attendance by members
- **'Meet a Governor' sessions**
- **Members e-News** – monthly e-bulletin which is sent to the members via e-mail
- **Website** – 'Get Involved' section about membership
- **'Christmas at Chelsea and Westminster'** – this event ran for the first time in December 2012 and was well supported with very positive feedback. Last year we had a budget of £5,000 but for 2013 it would improve the event to invest in decorations for the grotto.

- **'Medicine for members' seminars** – by the end of 2012/13 there will have been seven 'Medicine for Members' events (The dementia seminar ran twice due to its popularity). These have been popular seminars attracting approximately 30 people at each and receiving very positive feedback. Funding is required for refreshments and printing flyers.

2.2 Proposed engagement and communication activity 2013/14

The Communications team is currently appointing a new Head of Communications and Markeitng so it is proposed that the existing engagement activities are continued for the next 12 months, with just an increase in funding for 'Christmas at Chelsea and Westminster'.

- **3 membership mailings per year (including Trust News)** –) 1 funded through the Council of Governors budget £10,000 (2 funded through existing Trust budget)
- **Open Day 2013** – funding of £20,000 from the Council of Governors agreed (12 July 2012)
- **Annual Members' Meeting** – bid for funding of £5,000 from the Council of Governors
- **'Meet a Governor' sessions** – no funding required but sessions to be communicated better to members in advance
- **6 'Medicine for Members' seminars** - bid for funding for £5,000 from the Council of Governors
- **'Christmas at Chelsea and Westminster'** - bid for £8000 funding from the Council of Governors
- **12 monthly Members e-News** – bid for £2,600 funding form the Council of Governors

3. Request for funding by Council of Governors

Project	**Funding**
3 membership mailings per year	£10,000
Annual Members' Meeting	£5,000
Medicine for Members seminars	£5,000
Christmas at Chelsea and Westminster	£8,000
Members' e-News	£2,600
Total	£30,600

For action: Governors to consider this request for funding

Katie Drummond-Dunn
Communications Manager

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 14 February 2013

AGENDA ITEM NO.	2.17/Feb/13
PAPER	*Council of Governors Membership Report
AUTHOR	Sian Nelson, Membership and Engagement Manager
LEAD	Anthony Pritchard, Deputy Chief Nurse
EXECUTIVE SUMMARY	The paper outlines a current membership figures and plans for recruitment during 2013/14.
DECISION/ ACTION	The Council of Governors is asked to review.

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 year 2012 to January 2013 by cumulative totals and by membership type.

Table 1. Size and movement of membership

OVERALL MEMBERSHIP OVERVIEW	Last Year 1 Apr 11 – 31 Mar 12	Current Situation 2 January 13
As at start	**14,501**	**14,858**
New Members	1,512	1,789
Members leaving or changing constituency	1,210	1,199
TOTAL	**14,803**	**15,448**
PUBLIC MEMBERSHIP OVERVIEW	**Last Year 1 Apr 11 – 31 Mar 12**	**Current Situation 2 January 13**
As at start	**5,737**	**5,942**
New Members	659	208
Members leaving or changing constituency	454	209
TOTAL	**5,942**	**5,941**
PATIENT MEMBERSHIP	**Last Year 1 Apr 11 – 31 Mar 12**	**Current Situation 2 January 13**
As at start	**5,591**	**5,685**
New Members	487	568
Members leaving or changing constituency	393	170
TOTAL	**5,685**	**6,083**
STAFF MEMBERSHIP	**Last Year 1 Apr 11 – 31 Mar 12**	**Current Situation 2 January 13**
As at start	**3,173**	**3,231**
New Members	508	1,013
Members leaving or changing constituency	450	820
TOTAL	**3,231**	**3,424**

2.0 Membership Joiners and Leavers January to June 2011/12

2.1 Public Membership

Table 2 below shows public membership joiners and leaves between July and December 2012. There were 119 public who joined as members and 88 who left membership during this period

Month	July	August	Sept	Oct	Nov	December
Joiners	6	4	13	90	1	5
Leavers	1	16	63	2	5	1

Table 2. Public Membership joiners and leavers July to December 2012

2.2 Patient Membership

Table 3 below shows patient membership joiners and leavers between July and December 2012. There were 225 public who joined as members whilst 65 left patient membership during this period

Month	July	August	Sep	Oct	Nov	December
Joiners	2	2	6	207	6	2
Leavers	2	6	48	6	3	0

Table 3. Patient membership joiners and leavers July to December 2012

2.3. Staff Membership

Total staff membership at the end of December 2012 was 3,424

3. Public Membership Ethnicity December 2012

Figure 1 shows public membership ethnicity. The highest proportion of ethnicity is within the white category, and the lowest representation remains in the 'mixed' group.

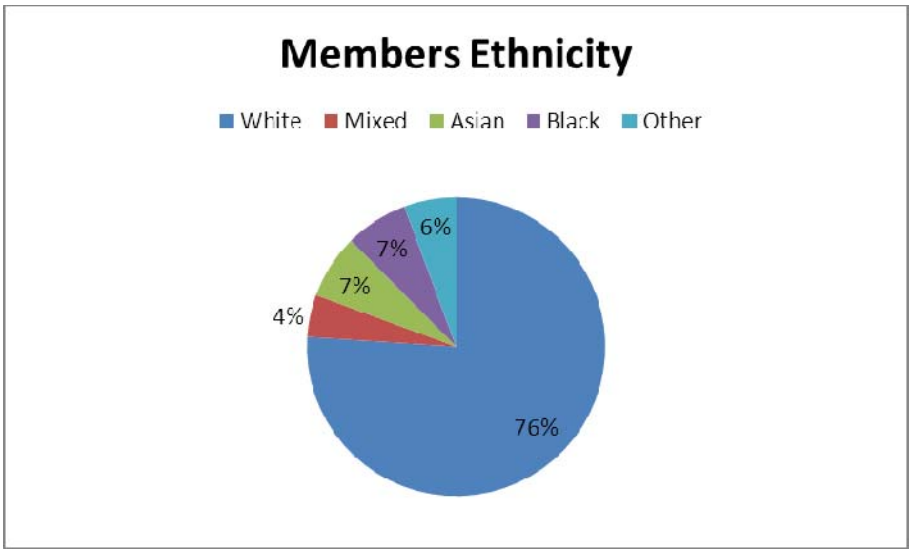
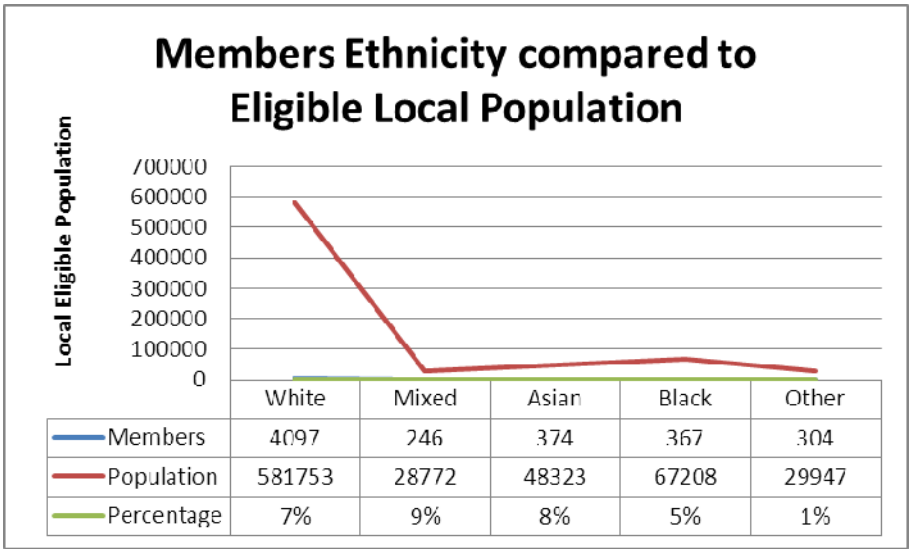


Figure 1. Public Membership Ethnicity December 2012

3.1. Public Membership Ethnicity – comparison against local eligible population

Figure 2 shows the public membership comparison against the local eligible population. Here representation is highest in the Mixed population and lowest in the Black population.



	White	Mixed	Asian	Black	Other
Members	4097	246	374	367	304
Population	581753	28772	48323	67208	29947
Percentage	7%	9%	8%	5%	1%

Figure 2. Public Membership ethnicity comparison against local eligible population

4.0 Public Membership Age

Figure 3 shows a profile of public membership by age. Public membership representation peaks at age group 40-49 years whereas the lowest age group is those within the 16-19 age group.

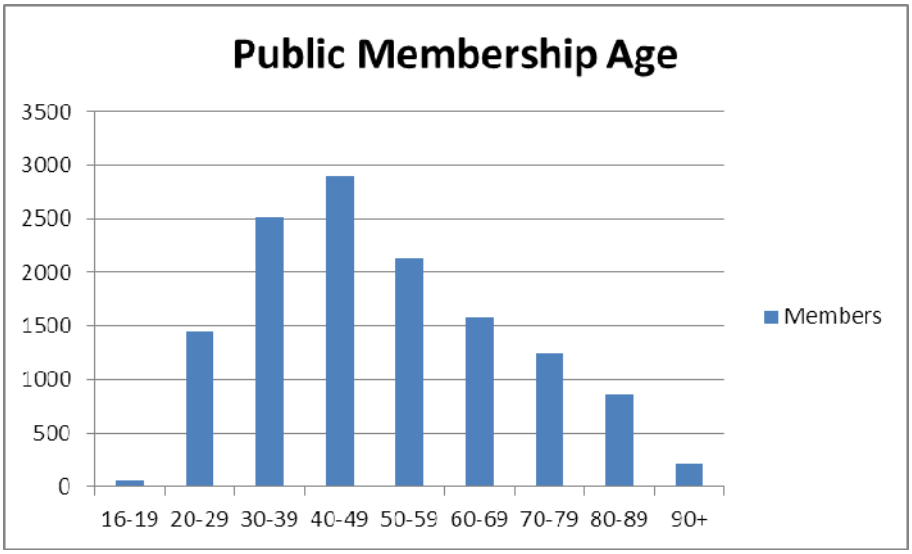
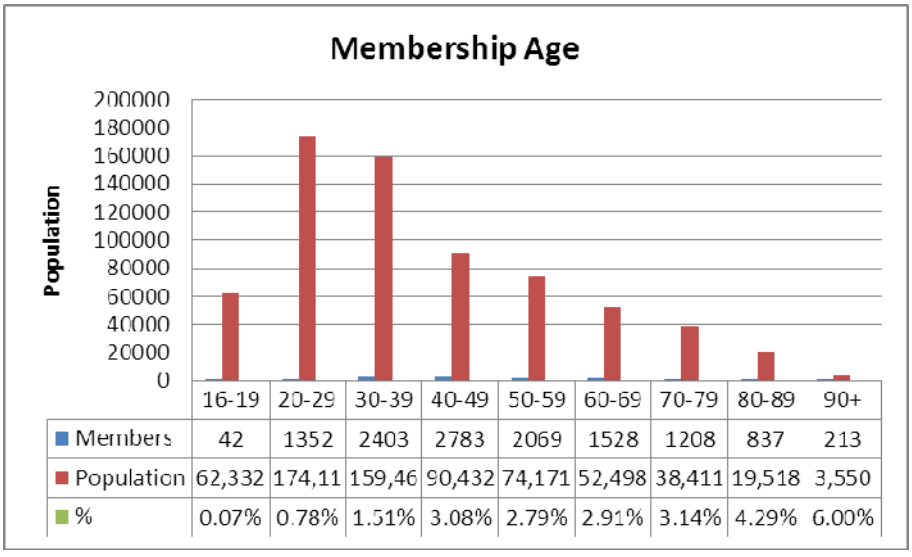


Figure 3. Public Membership Age

4.1 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 40 years and peaks in the 80-89 year group.



	16-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90+
Members	42	1352	2403	2783	2069	1528	1208	837	213
Population	62,332	174,11	159,46	90,432	74,171	52,498	38,411	19,518	3,550
%	0.07%	0.78%	1.51%	3.08%	2.79%	2.91%	3.14%	4.29%	6.00%

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

5.0 Public Membership - Socio-economic grouping

Figure 5 below shows public membership by socio-economic groups. In December 2012 the highest representation remains in the ABC1 category*

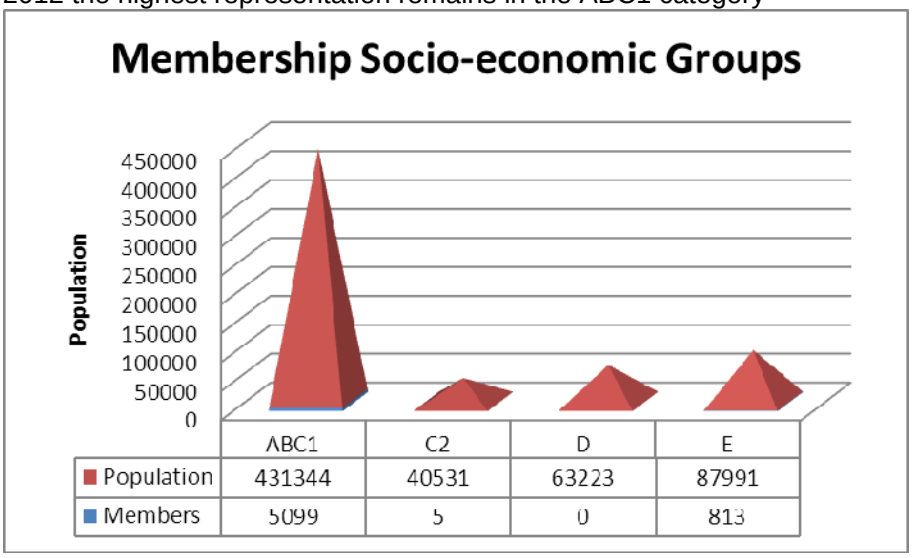


Figure 5 Public Membership - Socio-Economic Groups*

*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).

6.0 Membership Recruitment

6.1 At the start of 2012/13 there were 14,858 members. From January 2012 until end of December 2012, 776 new public and patients joined membership whilst 379 public and patient members left membership, so far resulting in a gain of 397 members during 2012/13.

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

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

6.4. 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.

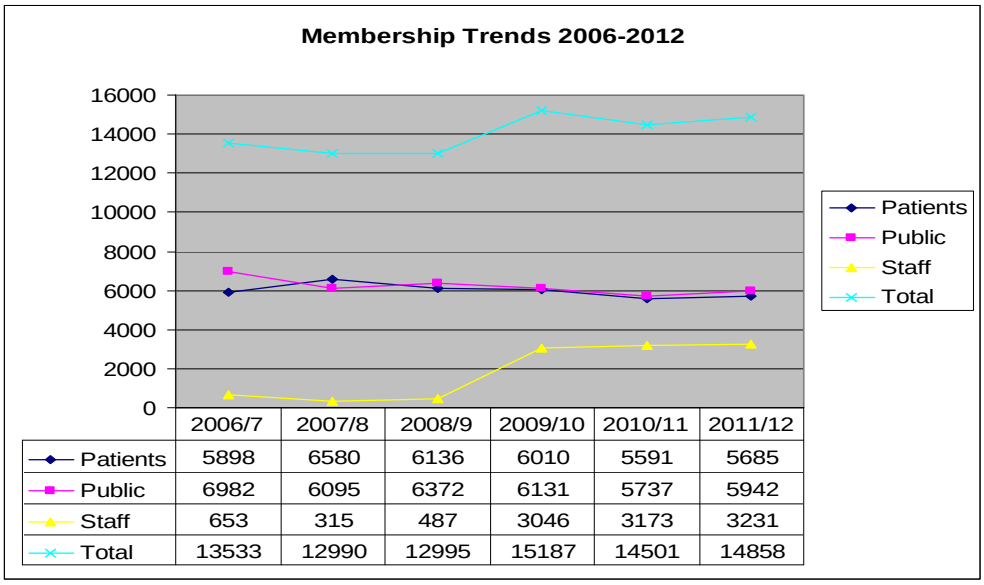
6.5. The Patient Advice and Information Service support membership promotion. Visitors to the PALS office, when appropriate are offered a membership application form. Application forms are sent with patient response letters and the team will continue to actively promote membership.

6.6. 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.

6.7. The Communications team concentrate on Membership engagement. During 2012 members were invited to the popular seminars 'Medicine Matters' which was funded by the Council of Governors.

6.8. Members were invited to attend the trusts Christmas event in December.

6.9. 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

7. Recruitment Campaigns

7.1. In the current year, we have commissioned Capita, our recruitment providers, to run 2 recruitment events in May and September/October.

7.2. The first event took place within the Trust in May and the objective was to recruit 300 new members with Capita whilst also promoting the Trust Open day on Saturday May 12th. Capita recruiters achieved the aim of 300 new members.

7.3. During the Trust open day on May 12th, a further 64 members were recruited by Governors.

7.4. The second recruitment event took place in September and October 2012. This campaign was split between the two months to promote the Trust Annual General Meeting in September and Governor Elections during October. A total of 300 new members were recruited.

7.5. An initial annual budget of £2,340 was agreed for recruitment campaigns via Capita recruitment personnel. The cost for each recruitment event is £3,600 - a request for an additional £1260 of recruitment funding was agreed to support these events

7.6. We are awaiting developments to the Trust letter distribution system so that initial appointment letters can include a membership application form.

7.7. Recruitment can now be tracked to events with database coding. This will help us to measure the success of differing membership recruitment activities.

8.0 Developing a Representative Membership

8.1. Analysis of the membership database by age, gender and ethnicity ensures we work towards representative memberships within the communities we serve.

8.2. 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.

8.3. Table 3.1 highlights that although trust membership figures are higher in the white category; ethnic groups are more balanced when compared to the local eligible population.

8.4. 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.

8.5. We will now explore further options to recruit from local community groups as a part of our strategy to develop a representative membership. All membership engagement activities during 2013 will be promoted to local BME groups.

9.0 Summary

9.1. 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'.

9.2. 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.

10. Membership Recruitment Achievements 2012/13

The below table summarises key recruitment events undertaken and planned between April and October 2012

Month	Event	Total Recruited
April 2012	No events	
May	Trust Open Day	64
May	Capita Trust Recruitment	355
September and October	2 recruitment events. 1 timed to promote AGM 1 timed to promote Governor elections	300

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 14 February 2013

AGENDA ITEM NO.	3.1/Feb/13
PAPER	Finance Report – December 2012
AUTHOR	Peter Chapman, Acting Chief Management Accountant
LEAD	Lorraine Bewes, Director of Finance
EXECUTIVE SUMMARY	For the financial year to the end of December 2012/13 the Trust has achieved an EBITDA of £24.1m (£0.8m behind plan) and a net surplus of £8.8m (£0.9m behind plan). The Trust financial performance to date has been driven by income under-performance relating to elective inpatients and against planned waiting list & demand growth (exaggerated over the xmas/new year period) and increased costs relating to utilities; which have been partially offset by the release of provisions for bad debt. The Trust has been successful in controlling pay costs in the first 9 months of the year and has continued to monitor the use of temporary staffing through quotas in nursing and medical staff groups. Departments have been managing the use of temporary staff flexibly in line with activity under-performance. Year to date the Trust pay spend is £1.5m within budget, with a small pressure in Medical staffing being only staff area with an adverse budget position. Non pay costs are overspent by £0.7m for the year to date. The most significant element of this over-spend is due to the costs of consultancy (although many parts of this are being used to cover pay vacancies and underspends); as well as increased costs for utilities (energy and water). These costs have been partially offset by the release of provisions made at 2011/12 year end for potential bad debts which are no longer required. The Trust set a CIP target for 2012/13 of £16.2m, which is over identified in 2012/13. The Trust has now achieved 100% of these schemes, although the recurrent value achieved currently stands at 83% of the £16.2m. The Trust is currently forecasting a year end surplus of £11.8m, £0.9m behind the agreed annual plan. A number of potential upside and downside scenarios associated with this forecast are being continually assessed over the remaining weeks of the financial year, in order to improve the forecast plan for the year and to enable continued funding of the agreed capital investment programme.

DECISION / ACTION	The Council is asked to note the financial position for the financial year to date December 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

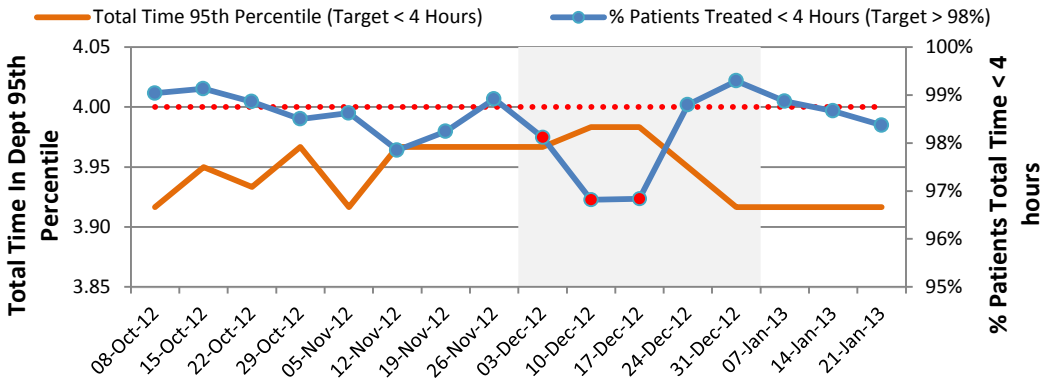
Council of Governors Meeting, 14 February 2013

AGENDA ITEM NO.	3.2/Feb/13
PAPER	Performance Report – December 2012
AUTHOR	Jen Allan, Head of Performance Improvement
LEAD	David Radbourne, Chief Operating Officer
EXECUTIVE SUMMARY	Overall, the Trust has performed well to December 2012, achieving the required performance level in all Monitor indicators with the exception of the A&E 4 hour target, which was 97.9% against the internal 98% target. However, performance for Quarter 3 was well above the target at 98.37% and it should be noted that Chelsea and Westminster was the only Trust in England to achieve over 98% for A&E Q3. The Trust achieved its 18 weeks Referral to Treatment indicators and continues to undertake access improvement initiatives to reduce waits for appointments and surgery in key specialties. The Trust achieved all cancer waiting time indicators and excellent performance against infection control standards. CQUIN targets, including for the turnaround of Discharge summaries, Outpatient letters, and the completion of VTE assessments, were all met in Quarter 3. This reflected improvements in performance through the quarter, following delivery of new technology in Q2 and focus by the Divisions on these standards. Efficiency, Quality and Patient Experience performance remains on track against contractual and internal targets. Of particular note, the number of complaints received in Q1-3 2012/13 decreased across all our key themes of communication, discharge and care of the older person, compared to last year. The commissioning process for 2013/14 has now started and discussions are taking place with both North West London and Specialised commissioners. We anticipate that many of the same performance indicators will be retained. There is a focus on out of hospital care and to support this, the Trust is actively engaged in projects to promote care closer to home and deliver services in the community.
DECISION/ ACTION	The Council of Governors is asked to note this report.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

29th January 2013 | www.chelwest.nhs.uk | No: 17 | Hospital Health: Excellent | Month 9

A & E: Total Time in A&E



The Trust did not achieve the A&E: Total time in A&E standard for December 2012 (97.9% against a 98% internal target). The Trust is achieving this target year to date (98.58%) and for Quarter 3 (98.37%). The Trust is focusing on this area weekly to achieve sustainable improvements but experienced a challenging month in December with 9,586 attendances and peaks in demand, which was reflected across London. It should be noted that Chelsea and Westminster was the only Trust in England to perform over 98% for Q3.
Detailed analysis and review has been undertaken and actions agreed to address this, supported by additional Winter Pressure funding of £260,000 allocated by NHS London to enhance A&E staffing and specialty input, and support earlier discharge. Performance to date in January has been 98.75%.

CQUINs and Contractual KPIs

No.	CQUIN Title	Q3 position
1	**VTE Prevention**	Fully achieved
2	**Patient Experience**	Results not yet confirmed
3	**Diagnosis & Management of Dementia**	Fully achieved
4	**NHS Safety Thermometer**	Fully achieved
5	**GP Real Time Information** for notifications of attendance, admission, discharge summaries and outpatient clinic letters	Fully achieved
6	**Use of NWL Integrated Formulary** for outpatient prescribing	Fully achieved
7	**End of Life Care Planning**	Awaiting final result; 3 of 4 indicators fully achieved
8	**12 Hour Consultant Assessment**	Fully achieved
9	**Neonatal BCG vaccine**	Fully achieved

Readmissions Audit: Status

A random sample of Trust readmissions was audited by GP Commissioners in November 2012. The purpose of the audit was to determine the proportion of readmissions that were avoidable by the Trust, Primary Care or Social Services. The Trust has been working with the commissioners to develop community schemes that will reduce the readmission rate of the hospital. Initial feedback from the audit suggests the proportion of avoidable readmissions was lower than commissioners expected, and with most arising from issues with community and social care packages, but with some data quality issues for the Trust to address.

GP Real Time Information

The Trust has worked hard on delivering patient information to GPs electronically and within shorter timescales. Operational and clinical teams focussed on this during Q3 and achieved 70% of discharge summaries sent within 24hrs, and 80% of letters sent within 5 days, fully meeting CQUIN requirements to make timely communications available on our web portal for GPs.

Improvements and Concerns

Never Events. There was one never event reported on 21st December, where the wrong ligament of a patient's right ankle was operated on in error (lateral instead of medial). A lead investigator has been appointed; an investigation commenced and is scheduled for initial consideration at the Medicine and Surgery Divisional Investigation Standing Panel in January 2013.

Cancer 31 Day Pathway: Subsequent Surgery The Trust reported one breach against this indicator in November 2012 resulting on not achieving the cancer 31 Day pathway subsequent surgery target for Q3. However this breach was reported in error and will shortly be removed from the system. The team have addressed this administrative error to ensure it does not recur.

Hospital Associated Infections the Trust recorded no hospital associated *Clostridium Difficile or MRSA* infections in December, assisting progress on our trajectory to meet these targets over 2012/13.

Choose and Book Slot Issues. The trust has been actively managing slot capacity to ensure that enough slots are available for previously noted areas of concern; most notably Paediatric Ophthalmology and Paediatric Cardiology. Since October our performance has steadily improved from over 5%; December performance is 1.11% against a target of 3%. This improvement will position us better to build market share based on patient and GP choice.

Monitor Compliance: 2012/13

Indicator Name	Target	YTD	Dec 2012
Clostridium difficile cases	<31	11	0
MRSA objective	<3	1	0
All cancers: 31-day wait from diagnosis to treatment	> 96%	100.0%	100.0%
All cancers: 31-day wait for second or subsequent treatment Surgery	> 94%	97.9%	
All cancers: 31-day wait for second or subsequent treatment anti cancer drug treatments	> 98%	100.0%	100.0%
All cancers:62-day wait for first treatment from urgent GP referral to treatment	> 85%	94.1%	86.7%
All cancers:62-day wait for first treatment from consultant screening referral	> 90%	100.0%	
Cancer: Two Week Wait from referral to date first seen comprising all cancers	> 93%	96.4%	97.5%
Referral to treatment waiting times < 18 Weeks - Admitted	> 90%	92.7%	92.2%
Referral to treatment waiting times < 18 Weeks - Non-Admitted	> 95%	99.3%	98.2%
Referral to treatment waiting times < 18 Weeks - Incomplete Pathways	> 92%	92.6%	92.5%
A&E: Total time in A&E < 4hrs	> 98%	98.6%	97.9%
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability		Compliant	Compliant

Internal target; Monitor target=95%

Quality KPIs

Clinical Effectiveness	Dec	Trend	YTD
Catheter Care Bundle Compliance *			N/A
Income lost to first to follow-up ratio			
Maternity Booking Access Target			
Breastfeeding initiation rates			
Caesarean section rate			
Cellulitis Admissions			
Non-Elective avg. Length of stay			
Stroke: Treatment within 24 hours			
Category 3/4 pressure ulcers			
Stroke: Time spent on stroke unit			
Rapid access chest pain clinic wait			
Elective average length of stay			
Daycase rate (Basket 25 procedures)			

*Hand Hygiene / Catheter care bundle data is supplied in an aggregated form and therefore YTD is not available

Process Effectiveness	Dec	Trend	YTD
Delayed transfers of care			
13 week outpatient waits			
Call Centre Hang Up %			
DNA Rate			
DNA Rate Treatment Centre			
26 week inpatient waits			
2 Week HIV Appointment wait			
Fracture Neck of Femur - Time to Theatre			
ACU - Medical Pregnancies per cycle			
Outpatients NHS Number Completion			
Inpatient NHS Number Completion			
A&E NHS Number Completion			
Smoking cessation			
LAS Patient Handover Times - 15 mins			
LAS Patient Handover Times - 30 mins			
LAS arrival to handover more than 60mins			
Pulmonary TB 2 Week wait			

Safety	Dec	Trend	YTD
Hand Hygiene Completion			N/A
Hand Hygiene Compliance			N/A
Incident reporting			
Never events			
Patient Falls per 1000 Inpatient Bed Days			
PEAT audit composite score (1mth behind)			
Hospital Associated VTE			
Ratio of midwives to deliveries			
3/4th degree perineal tears			
1:1 care of women in established labour			
Emergency MRSA screening rate			
Elective MRSA screening rate			
NICU Nurse: Patient ratio vs. BAPM compliance			
MSSA Reduction of Incidences			

Patient Experience	Dec	Trend	YTD
Complaints upheld by the Ombudsman			
Breach of same sex accomodation			
Staff job satisfaction			
Slot issues on Choose and Book			
Access to GUM clinics			
Rebooking cancelled operations			
Six week diagnostic test wait			
Choice of named consultant led team	Awaiting Data		

Key:- = Better than plan = Within 5% of plan = More than 5% worse than plan

= >5% increase in performance : perf. improved same <5% decrease >5% decrease

T Month on month trend in performance YTD Year to date position against target

- **Income Lost to First follow-up ratios:** The income lost in relation to the follow-up to new outpatient metric to the end of December was £937,779. The largest losses were in gynaecology (£169k), paediatric medicine (£126k), paediatric gastroenterology (£104k) and rheumatology (£103k). Gynaecology is reviewing pathways at a subspecialty level with a focus on supporting clinicians to discharge patients appropriately, through increasing use of telephone follow-up and supporting this through developing the role of our CNS. This metric will be a key focus for discussion with divisional and clinical teams, feeding into contract negotiation, to identify both areas for improvement and those where we can clinically justify higher rates of follow up, e.g. specialised services.
- **Breastfeeding initiation rates: t**he stretch target of 95% has not been reached, there are exceptions to the calculations (still births, babies admitted to NICU, mother's on drugs not compatible with breastfeeding) that we have asked the clinical commissioners to support. The breastfeeding team are carrying out an audit alongside improving data quality on recording of initiation rates.
- **Category 3 and 4 pressure ulcers:** There were 3 hospital acquired grade 3 pressure ulcers in December and 1 grade 4. The grade 4 deteriorated from a grade 2 while the patient was admitted to David Erskine ward. The grade 3s developed on Rainsford Mowlem, Nell Gwynne and Lord Wigram wards respectively. Root cause analysis is underway for all 4 cases following which a panel review will be held where recommendations will be made to prevent further hospital acquired pressure ulcers.
- **Elective average length of stay:** Two areas have been identified as outliers for patients staying longer than the national 75th percentile. The areas are Trauma and Orthopaedics and General Surgery. The divisions are undertaking clinical audits on the identified long stay patients to understand any patterns and implement improvements to the patient pathway.
- **Call Centre Hang Up:** During December there was a high level of staff sickness in the appointments team combined with a high volume of calls. Staffing levels have now improved. The team provide email address for patients whilst they are queuing as an alternative means of contacting the appointments office, which has led to an increase in the hang up rate. The team have asked Thamesnet to provide statistics to show the increase in hang up rate vs the data provided via the email service.
- **Outpatient DNA rate:** There are a number of specialties of concern including pain management, dermatology and gynaecology. Work is ongoing to reduce DNAs using reminders, and an Outpatient Transformation project has been launched.
- **Fractured Neck of Femur – Time to Theatre** – performance has declined in December to 88.9% against YTD performance of 91.8%. This reflects peaks in demand during the month, and the surgery team are planning investment in more complex hip orthopaedic resource in future to support potential transfer of work due to the NWL Shaping a Healthier Future reconfiguration.
- **Incident Reporting** – There was a significant drop in incident reporting in December to 6.2 per 100 discharges (target 8.0); this has affected YTD performance. As incident reporting is based on the date forms are received & entered to the system by clinical risk team, this can lead to peaks and troughs. In particular the team was coordinating the CNST assessment in December and together with Christmas this is likely to have led to a delay in entering incidents to the system
- **Elective MRSA Screening:** Performance has been fed back to infection control and senior nursing teams who are taking action with the wards to improve rates of screening.

Patient Experience – Q3

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Our patient experience strategy for 2012-13 aims to reduce concerns on: communication and information; discharge and care of the older person

		Communication								Discharge								Concern Age 75 and Over							
		Type 1				Type 2				Type 1				Type 2				Type 1				Type 2			
Division	**Directorates**	**Q 1**	**Q 2**	**Q 3**	**Q4**	**Q 1**	**Q 2**	**Q 3**	**Q4**	**Q 1**	**Q 2**	**Q 3**	**Q4**	**Q 1**	**Q 2**	**Q 3**	**Q4**	**Q 1**	**Q 2**	**Q 3**	**Q4**	**Q 1**	**Q 2**	**Q 3**	**Q4**
Clinical Support Services		2	2	5		**0**	1	2		0	0	0		0	0	0		2	1	1		0	0	1	
Women, Children, Young People & Neonates, HIV, GUM & Dermatology	HIV GUM Directorate	4	6	0		0	1	0		0	0			0	0	0		0	0	0		0	0	0	
	Women & Children Directorate	0	8	13		2	7	4		1	1	0		0	0	1		0	0	0		0	0	0	
Medicine & Surgery	Medical Directorate	1	1	4		4	3	5		0	0	3		2	0	4		2	5	5		6	0	7	
	Surgical Directorate	1	7	3		4	3	5		1	0	1		0	0	1		1	0	0		6	2	1	
Central Outpatient Services		3	4	9		3	0	0		0	0	0		0	0	0		1	1	3		0	0	0	
Non Clinical Support Services		3	3	0		0	0	1		0	0	0		1	0	0		1	0	2		1	0	0	
Totals for Quarters		**14**	**31**	**34**		**13**	**15**	**17**		**2**	**1**	**4**		**3**	**0**	**6**		**7**	**7**	**11**		**13**	**2**	**9**	
2012/13 YTD		**79**				**45**				**7**				**9**				**25**				**24**			
2011/12 Q1-Q3		**87**				**70**				**27**				**18**				**46**				**34**			

N.B. Type 1 complaints are informal complaints which are dealt with by the M-PALS office. Type 2 complaints are formal complaints of a more serious nature which need to be escalated

	Communication	Discharge	Concern Age 75 and Over
Themes	Concerns rose regarding the accuracy of information held in discharge summaries and clinic letters. In one instance the patient felt that the doctor had misrepresented the discussion had. Concerns rose regarding communication about on-going care; a number of patients were assessed for their treatment but then did not hear anything further and received no correspondence about the next stages. Concerns were raised regarding the delay in receiving test results and the communication between teams which impacts on the length of time patients wait to receive their chemotherapy. Communication issues raised, that information not always passed to the family or to other health care professionals. Concerns rose regarding the communication of between this hospital and an external hospital, which resulted in a lot of time being wasted and parking charges being incurred.	Poor communication with hospital staff and relatives regarding patients discharge. Medication not ready for discharge resulting in long delays on the ward. Poor communication with home care teams or misunderstanding between teams about a patients discharge date or needs. Home care either not in place or further referral required.	Concerns were raised regarding the nursing care elderly patients received on some wards. In particular with regard to dignity and help to meet nutritional needs. Other patients have expressed their concern regarding the delay in answering call bells and coming to elderly patients' aid when they call out. Concerns raised by other patients about the manner in which the elderly are spoken to and the impression given that staff considers caring for the elderly as a burden. Concerns rose regarding the care of dying elderly patients, in particular with regard to the communication with their relatives and their understanding of what is happening.
Actions	Localisation of Trust values and behaviours to individuals and teams. Trust values included in appraisal meetings Development of 'You said / we did' boards for clinical areas Development of prompts to assist staff in challenging colleagues attitude / behaviour. Compassion in Practice vision and strategy disseminated Establishment of ambulatory care project and development of integrated care pilots in medicine	Discharge transformation project Implementation of new discharge planning assessment and discharge checklist in the Lastword system	Roll out of care and comfort rounds to remaining medical and surgical ward Reconfiguration of ward specialties, refurbishment of David Erskine ward to reflect a dementia friendly environment and planned refurbishment of Edgar Horne Development of an end of life care steering group to review and develop practice Development of an end of life care discharge co-ordinator role. Stroke patient forum initiated January 2013

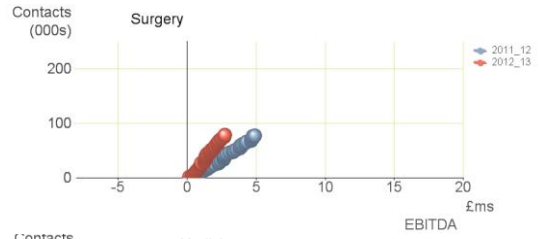
****Maternity Real Time Patient Feedback:** In Q3 86 patients from 1465 discharges (5.87%) gave us feedback on the following questions. Our local target is to achieve an overall satisfaction score of ≥ 90%. Compared to Q2, there has been an improvement in the cleanliness score, but a deterioration in other scores. Patients feeling they were left alone during labour is of particular concern. Our national maternity patient survey showed around 75% of patients were satisfied on this indicator so we are aiming to improve on this score. We know there are patient flow issues between antenatal and labour wards and work is in progress to address this during February. The response rate in Q3 is also poor and the maternity team are actively focussing on improving this to provide a more representative view.

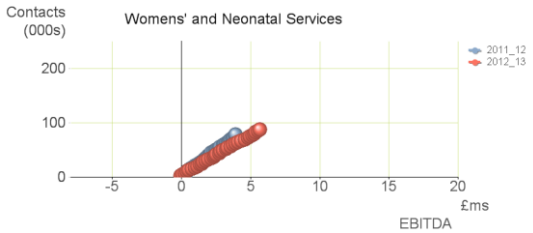
I felt I was not left alone when I did not want to be, when I was in established labour	62.87%
Overall, how would you rate the care received during your pregnancy?	**89.13%**

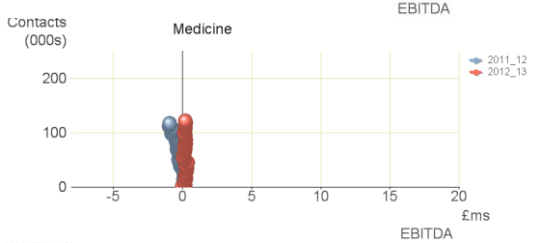
Thinking about the care you have received in hospital after the birth of your baby, have you been treated with kindness and understanding?	87.56%
Would you recommend our services to friends and family if they needed similar treatment?	89.48%

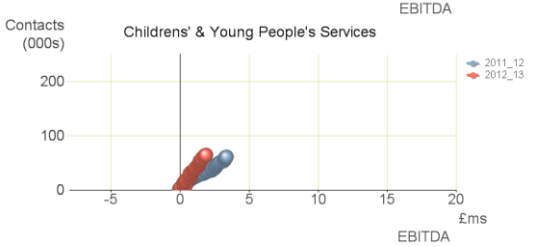
Finance / Efficiency KPIs

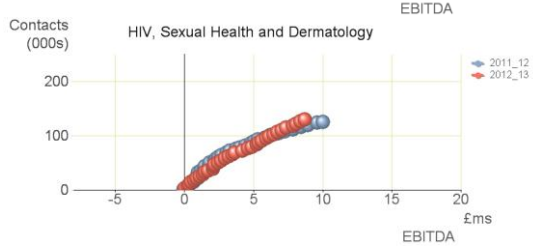
Know Your Chart:
Each blob is a week
Size of blob is average cost
Volume and EBITDA (profit) is cumulative for each week.
More recent weeks are in front of weeks at the beginning of the year.







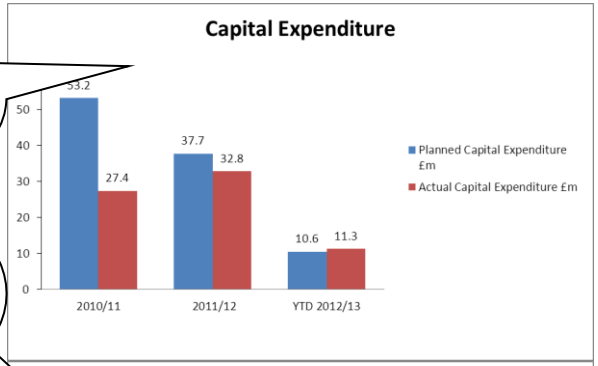


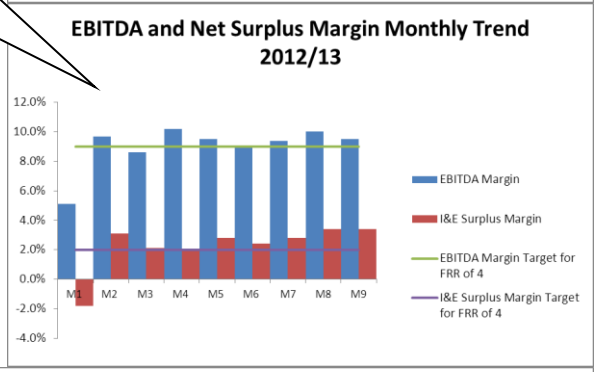


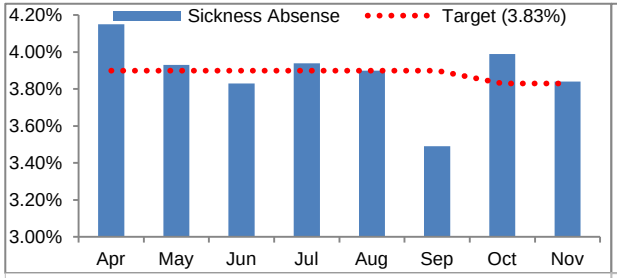
	M1 YTD	M2 YTD	M3 YTD	M4 YTD	M5 YTD	M6 YTD	M7 YTD	M8 YTD	M9 YTD
EBITDA margin	5.1%	9.7%	8.6%	10.2%	9.5%	9.1%	9.4%	10.0%	9.5%
EBITDA , % plan achieved	76.3%	96.8%	97.0%	93.0%	90.0%	95.5%	94.0%	97.0%	97.5%
Net Return after financing	-0.2%	2.9%	1.9%	3.4%	2.7%	2.2%	2.6%	3.3%	2.7%
I&E surplus margin net of dividend	-1.8%	3.1%	2.1%	2.0%	2.8%	2.4%	2.8%	3.4%	3.4%
Liquidity days	32	35	35	36	37	40	41	42	38
Overall Financial Risk Rating	3	4	4	4	4	4	4	4	4

Plan at M9 is based on the revised capital forecast submitted to Monitor in Nov 2012

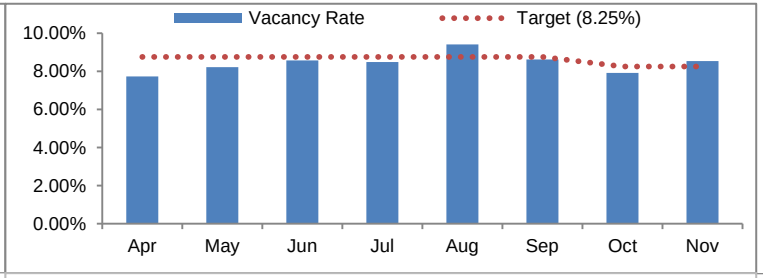
EBITDA margin 9.5% (FRR of 4) and I&E Surplus margin 3.4% (FRR of 5) at M9.



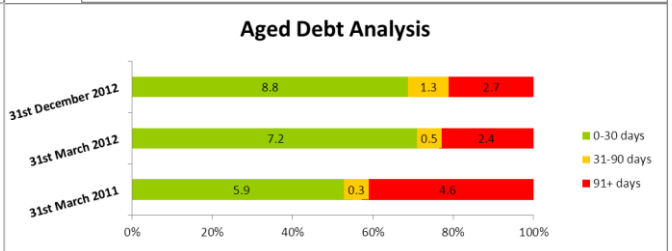




The Trust's sickness absence rate in November was 3.84% which is lower than December 2011 (4.17%). Sickness absence was lower in all Divisions except Medicine and Surgery than the same month last year.
As part of the QIPP project to reduce the cost of sickness and agency usage across the Trust, HR is currently running management training sessions across all Divisions on improving sickness management. Further activity is planned to ensure that the sickness reduction target is achieved.



The Trust's vacancy rates are calculated using the budgeted WTE and the WTE of staff in post at the end of the month. This represents the 'total vacancy' position. The full Trust vacancy rate for December 2012 was 8.53%, a decrease of 0.42% on the previous year. This improvement year to date has resulted from increased recruitment and the removal of posts from the budgeted establishment in order to achieve cost improvements. The Trust has frozen a number of posts in order to achieve cost improvement targets, but some of these will remain in the establishment and therefore feature as vacancies.



Commentary:

1) The Trust achieved a surplus of £1.1m in December, an adverse variance against plan of £0.2m, whilst the YTD position is a surplus of £8.8m, which is an adverse variance of £0.9m against plan.

2) There was considerable under performance on elective and outpatient activity in December, with a corresponding underspend on non-pay.

3) The forecast is for an EBITDA of 9.5% and a deficit of £0.9m against the planned £12.6m surplus. There are some significant risks associated with this forecast, mainly around NHS income, activity and winter cost pressures, and the Executive is working with the Divisions to develop a recovery plan to secure the best case income and non-pay position which will involve stopping non-essential expenditure.

4) CIPs are forecast to be fully achieved by year-end, with 99% achievement year to date.

Key Commissioner Priorities Dec 2012

Key Priorities

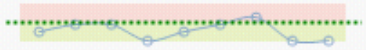
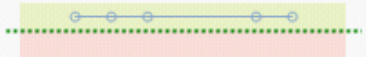
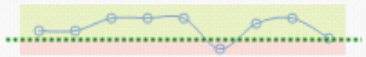
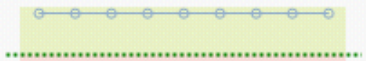
	Performance Indicator	Trend	YTD Value	YTD	Forecast
Priorities	VTE Assessment (Target: > 90%)		92.3%		
	OP Letter Turnaround Times (Target: 80% Sent in 5 Days)		60.5%		
	Discharge Summaries (Target: 70% Sent within 24 Hrs)		66.5%		
	Emergency Re-Admissions following Non-Elective spell (Target: < 2.8%)		2.3%		
	Emergency Re-Admissions following Elective spell (Target: 0%)		1.0%		
	NCE POD Recommendations (Target: 95% within waiting time)		97.4%		
	Mortality - HSMR (Target: < 87.34)		77.1		
	LAS Handover - HAS Data Quality (Target > 90%)		91.6%		
	GP Referrals Recieved		Avg: 6,507 Last Month: 5,955		

- The Trust has made excellent improvements in the delivery of Outpatient letters and Discharge summaries to GPs within challenging timescales. Operational teams focussed on both these priorities and achieved the required standards of 80% of letters sent within 5 days, and 70% of discharge summaries within 24 hours, by the end of Quarter 3, achieving CQUIN targets in full. These measures continue to be closely monitored through Quarter 4 against higher targets and in order to support a high quality patient and GP experience of our services.

- Emergency readmissions are an area of focus as our contract states we will not be paid for avoidable readmissions. A readmissions audit was undertaken by CCGs in Nov 2012 and initial results suggest that the Trust has a lower than anticipated proportion of avoidable readmissions, with those that did occur primarily due to failures in community and social care. We plan to work jointly on this with community colleagues for example by developing a hospital based discharge team and this will be discussed at January CQG.

- Time to treatment in A&E has exceeded the 1 hour target in December, relating as explained above to high levels of and peaks in attendances during the month. Winter pressure funding of £260,000 has been allocated by NHS London to support A&E and acute services at the Trust and plans are in place to ensure robust performance through Q4.
- Unplanned re-attendances A&E – The hospital did not meet the threshold for the last completed month. We are showing a rate of 5.7% for Dec 2012 against a target of less than 5%. We are continuing to work on improving aftercare for patients coming to our A&E as well as those admitted by ensuring they are directed to the most appropriate service to meet their on-going needs.

Monitor Indicators

	Performance Indicator	Trend		YTD	Forecast
Infection Control	MRSA (Less than 31 in 12/13)		1		
	Clostrium Difficile (Less than 31 12/13)		11		
Accident & Emergency	A&E: Initial Assessment (Target < 15mins)		00:13		
	A&E: Total Time (Less than 4 hours)		03:57		
	A&E: Time to Treatment (Less than 1 hr)		01:04		
	A&E: Left without being seen (Less than 5%)		4.3%		
	A&E: Unplanned Re-Attendances (Less than 5%)		5.20%		
Cancer Services (Quarters)	Cancer: 2-WW Ref to Seen (> 93%)		96.4%		
	Cancer: 62 Day Wait (Consultant Screening) (>90%)		100.0%		
	Cancer: 62 Day Wait (Ref to Treat) (>85%)		94.1%		
	Cancer: Diag to Treat (31 day) (>96%)		100.0%		
	Cancer: Subsequent Surg (31 Day) (>94%)		97.9%		
	Cancer: Subsequent Drugs (31 Day) (>98%)		100.0%		
Access	RTT Admitted (90% < 18 weeks)		92.7%		
	RTT Non Admitted (95% < 18 Weeks)		99.3%		
	RTT Incomplete (92% < 18 Weeks)		92.6%		
	Compliance with requirements regarding access to people with a learning disability (100%)		100%		