Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting
Hospital Boardroom
Chair: Prof. Sir Christopher Edwards
Date: 3 May 2012 Time: 4.00pm

Agenda

		Lead	Time
1	**GENERAL BUSINESS**	**CE**	4.00
1.1	Welcome & Apologies	CE	
1.2	Declaration of Interests	CE	
1.3	Minutes of Previous Meeting held on 9 February 2012 (attached)	CE	
1.4	Matters Arising (attached)	CE	
1.5	Chairman's Report (oral)	CE	4.10
2	**ITEMS FOR DISCUSSION/DECISION/APPROVAL**		
2.1	Appointment of Chief Executive (attached)		4.15
2.2	Re-appointment of Non-executive Directors (attached)	CE	4.30
	STRATEGY		
2.3	Business Planning 2012/13 – update (attached)	HL	4.40
2.4	Shaping a healthier future (oral)	MA	4.50
2.5	It's who we are – our values (attached)	TD/MG	5.00
	COUNCIL OF GOVERNORS		
2.6	Governors' Questions (attached) - Trust's plans re lifting the Private Patient Cap (BG) - Hospital plans for expansion (MJ)	HL	5.10
2.7	Report on Senior Nurse/Governor Rounds (attached)	TP	5.20
2.8	Open Day 12 May 2012 – update (attached)	RMB	5.25
2.9	Council of Governors Funding Report (attached)	VD	5.35
2.10	The tenth FTGA National Development Day - 14 March 2012 & FTGA Mental Health Network Event – 24 April 2012 – feedback (attached)	MT/AC	5.40
	QUALITY		
2.11	Chelsea and Westminster Star Awards 2012 (attached)	MG	5.45
2.12	Quality Account Update (attached)	CM	5.50
2.13	Quality Sub-Committee report (draft minutes of 27 March 2012 meeting attached)	MA	5.55
2.14	Staff Survey – Summary (attached)	MG	6.00
2.15	Introduction to the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) – presentation	GS/PS	6.05
	MEMBERSHIP		
2.16	Membership Sub-Committee report (draft minutes of 29 March 2012 meeting attached)	ML	6.15
2.17	Membership Engagement and communication – update (attached)	MAk	6.20
2.18	Membership Report* (attached)	TP	
3	**ITEMS FOR INFORMATION**		
3.1	Finance Report – March 2012 (attached)	LB	
3.2	Performance Report – March 2012 (attached)	DR	
4	**ANY OTHER BUSINESS**		6.25
5	**DATE OF THE NEXT MEETING – 12 July 2012**		

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

Ganesh Sathyamoorthy, CLAHRC - for item 2.15
Dr Paul Sullivan, CLAHRC - for item 2.15

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 3 May 2012

AGENDA ITEM NO.	1.3/May/12
PAPER	Draft Minutes of Council of Governors Meeting – 9 February 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, 9 February 2012
Draft

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

IN ATTENDANCE:

Sir John Baker	Non-executive Director	JB
Jeremy Loyd	Non-executive Director	JL
Sir Geoffrey Mulcahy	Non-executive Director	GM
Richard Kitney	Non-executive Director	RK

Heather Lawrence	Chief Executive	HL
Mark Gammage	Director of HR	MG
Catherine Mooney	Director of Governance and Corporate Affairs	CM
Axel Heitmueller	Director of Strategy and Business Development	AHe
Matt Akid	Head of Communications	MAk
Melanie van Limborgh	Head of Quality and Assurance	MvL
Bill Gordon (in part)	Acting Director of IT	BGor
Vida Djelic	Foundation Trust Secretary	VD

1 GENERAL BUSINESS

1.1 Welcome & Apologies — CE

CE welcomed Dr Yannis, a member of the public to the Council meeting.

Apologies were received from Rosie Glazebrook and Jacinto Jesus.

CE noted the retirement of Heather Lawrence, Chief Executive and that Amanda Pritchard, Deputy Chief Executive was leaving to be Chief Operating Officer at Guy's and St Thomas' Hospital.

On behalf of the Council of Governors and the community ML thanked HL for her remarkable achievements over the last ten years.

ML also thanked Amanda Pritchard who he said brought other expertise to the Trust which has served the Trust extremely well. He said that groups/committees chaired by Amanda were run well and staff regarded her highly and always appreciated her support and guidance. The Council of Governors wished her well.

1.2 Declaration of Interests — CE

None.

1.3 Minutes of Previous Meeting held on 1 December 2011 — CE

Minutes of the previous meeting were accepted as a true and accurate record of the meeting with the following changes:
- p. 1 add Dr Cadman to the list of attendees
- p. 9 item 2.11 second bullet point should read ''CBir presented a paper on the Information Zone saying that it has not been managed well and is not fit for the purpose'

AC referred to the previous minutes and commented with ref to the Chairman's report second para second sentence re 'education about the use' should be removed. CE responded that it should read 're-education'.

Action: VD to amend minutes in line with comments received. **VD**

1.4 Matters Arising **CE**

1.4/Sep/11 Room request from governors

It was noted that governors meeting room is nearly ready. SM said that there are some items which need to be moved and she noted that entry to the room will be controlled with a key pad.

2.5/Sep/11 Governors' generic email account proposal

BGor provided an update on the governors' email account. Governors noted that there are some security issues to be resolved before inviting them to test the solution. BGor confirmed that the current users will not be affected during the time of the switching to a new format email address.

It was agreed that BGor will produce a simple guide for governors' use.

CE provided an update on the St Stephen's Centre incident.

All other actions were noted as being completed.

ACle said he was very impressed with the enthusiasm of the participants in the programme about Junior Doctors 'Your life in their hands' but was concerned about the breach of confidentiality filmed. CE replied that this emphasises the importance of information governance and that it was part of the learning for junior doctors. The programme also emphasised the importance of medical students learning to take blood samples which was also good for learning how to develop a relationship with patients.

1.5 Chief Executive replacement **CE**

CE outlined the process for the appointment of the Chief Executive which was agreed by the Board on 26 January 2012.

The Chief Executive will be appointed by the Non-executive Directors and the appointment will be approved by the Council of Governors.

CE presented two different options for the approval of the Chief Executive by the Council of Governors. One is to have a special meeting to approve the appointment, or alternatively a sub-group of governors to approve the appointment on behalf of the Council.

In response to CN's query if the Council has any power of veto CE said that they do and if this occurred it would be unusual practice. ML said that the Council would not rubber stamp the appointment.

CE presented options for governors involvement in the process.

The Nominations Committee at its meeting on 26 January suggested a meeting with medical staff and non-medical staff to invite their views. He suggested that governors could be invited to that meeting.

Governors could also be involved by expressing their views on the job description and person specification.

Another alternative is to invite governors to meet with the short-listed candidates over lunch – part of an assessment centre approach. There was some discussion about the benefits or otherwise of an assessment centre.

Governors welcomed the opportunity to be involved at an early stage, especially as this was not required by the constitution.

CBir suggested that the draft job specification was circulated. He also suggested BG could represent the Council under the provision for an additional member as described in the Nominations Committee Terms of Reference.

CE noted that an additional member on the Appointments Committee has been agreed by the Nominations Committee, which will be the new Chief Executive of St George's Healthcare NHS Trust, Miles Scott who will act as an independent adviser.

CBle queried how useful it is for governors to be involved in commenting about the job description as the role of governors is to scrutinise the process.

CE responded that he would like the process to be transparent and therefore felt that governors should be involved. They may not want to contribute but have been asked.

Other governors welcomed the opportunity to be involved and also to participate in an informal lunch with the potential candidates. **This was agreed**.

CE informed governors that the Nominations Committee met on 26 January and considered three recruitment agencies. They decided to appoint Saxton Bampfylde. Instructions were given by the Board as to what qualities the potential candidate should have and Saxton Bampfylde will initiate discussions with potential candidates.

CBle queried who was on the Appointments Committee. CE responded that it is the Chairman, Non-executive Directors and the external adviser.

CE said that the timetable will be circulated to the governors.

The job description/person specification and supporting information to be circulated for comments. **VD**

The Council of Governors agreed that a special meeting be called if necessary and that the whole Council of Governors should be involved in the appointment of the new CEO.

2 ITEMS FOR DISCUSSION/DECISION/APPROVAL

2.1 Feedback from 24 November 2011 Away Day — CE

The minutes of a joint Board/Council of Governors Away Day held on 24 November were accepted as a true and accurate record of proceedings.

2.2 Who do you think WE are? – developing Trust's values — HL/MG

CE outlined the paper and said that the themes were developed by the governors at a joint Board/Council of Governors Away Day held on 24 November 2011.

CE informed the governors that the Trust's values will be agreed by the Board at its meeting on 29 March 2012.

CE invited the governors to give their feedback by attending various sessions organised by Carol Dale. Trust values comment cards were circulated for completion.

2.3 Business Planning 2012/13 — AP

AP highlighted the key points from the paper, including the importance of the values work.

This paper set out progress on the strategic priorities and objectives. Our four corporate objectives will remain the same. She noted that we have a £16m Cost Improvement Programme (which was £19m last year).

AP invited governors to attend business planning meetings and dates will be circulated.

CE encouraged governors to fulfill their statutory duty by providing their views on business planning by attending the meetings.

To circulate dates of business planning 2012/13 meetings. — **VD**

ML asked how we can ensure we maximise private patient income and whether we can set our own fees. AHe said that the original Government proposal was to increase the private patient cap to 49%, but that the opposition has proposed to only increase it to 5%. The Trust is developing a private patient strategy, but it should be noted the market is quite flat and it is unlikely to raise significant income. HL said it was important that we fully utilise our current capacity once the cap has been raised

ACle asked if there was a room to explore expenditure on prevention vs. cure? CE replied that there is a risk that funding for prevention will be put on hold by the Government.

The issue of new relationships with Clinical Commissioning Groups (CCGs) was raised and whether that was an issue. HL said that the CCGs are very busy in

their new roles but that the Integrated Care Pilot had been helpful in getting to know people. AP said the relationship with GPs is continuous and important.

2.4 Governors' Questions- Care of the Dying **SC**

Dr Sarah Cox made a presentation on care when dying in hospital.

In response to a question she confirmed that there was guidance from the General Medical council (GMC) on the duties of a doctor which was to do the best for the patient but also to withhold treatment if no benefit.

There was a discussion on the Liverpool Care Pathway and how patients are helped with their fears which is often about the process.

There was also a discussion about training for junior doctors and medical students. Training includes last offices and the involvement of relatives.

ACle thanked Dr. Cox for the presentation and confirmed that it was very helpful and had answered the questions he had raised very well.

The presentation will be circulated to governors.

2.5 Council of Governors Performance Evaluation Report – response to questionnaire **CE**

CE introduced the paper and pointed out that the Trust's overall response rate was slightly better than Monitor's. He thanked those governors who had responded.

The key issues had been abstracted and actions were agreed as follows:

To circulate minutes as soon as practicable after every governors meeting for comments on accuracy. **VD**

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.** **TD**

Regarding contact with Non-executive Directors and Executive Directors it was noted that it was very likely that there will be open Board meetings and possibly a joint meeting in the future. There could also be different roles for governors. This will be discussed again in due course.

To improve on governors' induction and training. CM said that this had been looked at previously by a small group and this could be reviewed again. WMW commented that a mentor would be very useful for new governors.

To address induction and training. **CM**

To consider how to improve on understanding of governors roles and responsibilities. **CM**

To consider how to improve on understanding of the Quality Account. **CM**

In response to a query from EC, VD confirmed that unfortunately she had not

received his response.

The Chairman clarified that the % responses were based on those who had responded.

SS-G commented on the response rate by governors and felt that those who did not respond should let CE know the reason. Some governors felt that the questionnaire was too long, but others disagreed.

2.6 Report on Senior Nurse/Governor Rounds **CE**

CBir raised the issue of having a greater opportunity to talk to patients during Senior Nurse/Governor Rounds. He had outlined his views in the paper.

MJ said that the clinical half days are extremely rewarding for governors, in particular the session at the end when everyone meets together.

KM highlighted that governors input is very valuable to nurses but explained that the main purpose of the clinical half day is to inspect clinical standards and there needs to be a balance between that and helping governors talk to patients.

CE said that this had been very valuable for both sides but that clinical rounds may not give the opportunity to governors to interface with patients in the way they would want and we should look at this. **To review governors involvement in wards and opportunities to speak to patients.** **TP**

2.7 Open Day 12 May 2012 – update **RMcB**

The Council of Governors noted that at the last meeting they agreed to fund the Open Day which will be held in May 2012.

RMB invited governors to join the Open Day Steering Group chaired by HL and also the Open Day Operational Group.

Interested governors were invited to let RMB know if willing to be involved.

Topics suggested:

- Chelsea Health Charity
- careers in NHS
- AHe to help answering questions on the new Health and Social Care Act

2.8 Council of Governors Funding Report **CE**

The Council of Governors agreed to the following proposals for funding:

- The request for funding of £144 for the Council of Governors Handbook
- The request for the consultant database £2,000
- the request for funding of the equipment required for producing podcasts £1,200
- The request for funding of £1,500 for small membership branded gifts for the Open Day 2012 (2012/13 allocation)

- The request for funding of £2,340 for the Members Recruitment Campaign (2012/13 allocation)

There was some discussion about the request for funding for development of the Quality Account and whether it should be funded by the Council or from elsewhere. It was agreed to discuss funding outside of the meeting.

2.9 Quality Awards **CM**

MvL outlined the award and noted that we had learnt from the initiatives.

Each award winner was introduced by the governor who had visited the team. and they received a certificate presented by the Chairman.

MJ outlined the key changes that Lorraine Kilburn had introduced to improve phlebotomy waiting time, including leadership, team working and ownership.

WMW outlined the key areas of the physiotherapy services and commented on how she felt safe in their hands.

CD described the work the plastic surgery team had undertaken to improve use of the VTE risk assessment tool, including its inclusion in hand over and that this initiative had been taken forward by junior doctors.

All award winners were congratulated by the Chairman.

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

MG outlined the paper and said that the Chelsea and Westminster Health Charity will provide funding for a new annual staff awards scheme. ML thought it was an excellent idea but expressed concern about the impact on the Quality Awards and potential confusion.

A Patient Choice Award and a Council of Governors Special Award are proposed as two of the award categories.

MG pointed out that different categories for awards need to be decided. Governors were invited to inform VD about ideas for categories.

MG invited three interested governors to join the judging panel.

Governors to volunteer to join the judging panel and to give ideas for categories. **All**

2.11 Quality Account Update **CM**

CM provided a brief update on the Quality Account outlining the feedback and engagement that had taken place and what was planned. A more detailed update will be provided at the May meeting.

2.12 Quality Sub-Committee report* **MA**

This item was starred and therefore taken as read.

2.13 Membership Sub-Committee report **ML**

ML provided a brief update following on the Membership Sub-Committee meeting held on 3 February 2012.

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

This item was starred and therefore taken as read.

2.15 Membership Report* **TP**

This item was starred and therefore taken as read.

3 ITEMS FOR INFORMATION

3.1 Finance Report – December 2011 **LB**

This item was taken as read.

3.2 Performance Report – December 2011 **AP**

This item was taken as read.

4 ANY OTHER BUSINESS **CE**

EC mentioned the matter of cost savings required by the Coalition Government and asked CE if it was 2%. CE replied that it was a reasonable question and that the required saving was 4%. EC mentioned that he had previously notified VD in writing that he wished to raise two or three brief points but in view of the lateness of the hour he withdrew the remaining points he had intended to make. CE invited EC to email these over to him for consideration by the Agenda Sub-Committee.

VD advised EC that he could submit his Governor Skills Form when he had time and EC confirmed he would so do.

5 DATE OF THE NEXT MEETING

The next meeting of the Council of Governors will be held on 3 May 2012.

Chelsea and Westminster Hospital NHS
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Council of Governors Meeting, 3 May 2012

AGENDA ITEM NO.	1.4/May/12
PAPER	Matters Arising from the meeting of the Council of Governors meetings held on 9 February 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
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MATTERS ARISING
Council of Governors Meeting
Hospital Boardroom
Chair: Prof. Sir Christopher Edwards
Date: 9 February 2012
Time: 4:00 – 6:30 pm

Ref	Description	Lead	Subsequent Actions or Outcomes
1.3/Feb/12	**Minutes of Previous Meeting held on 1 December 2011**		
	VD to amend minutes in line with comments received.	**VD**	Completed
1.5/Feb/12	**Chief Executive replacement**		
	The job description/person specification and supporting information to be circulated for comments.	**VD**	Completed
2.3/Feb/12	**Business Planning 2012/13**		
	To circulate dates of business planning 2012/13 meetings.	**VD**	Completed
2.5/Feb/12	**Council of Governors Performance Evaluation Report – response to questionnaire**		
	To circulate minutes as soon as practicable after every governors meeting for comments on accuracy.	**VD**	Completed
	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.**	**TD**	On the Membership Sub-Committee agenda 1 June meeting
	To address induction and training.	**CM**	The plan is to undertake a Training Needs Analysis (TNA) for the governors to include roles and responsibilities as mandatory and the Quality

			Account as optional. We will then provide training gas in the TNA and regular reports.
	To consider how to improve on understanding of governors roles and responsibilities.	**CM**	As above.
	To consider how to improve on understanding of the Quality Account.	**CM**	As above.
2.6/Feb/12	**Report on Senior Nurse/Governor Rounds**		
	To review governors involvement in wards and opportunities to speak to patients.	**TP**	
2.10/Feb/12	**Chelsea and Westminster Star Awards 2012**		
	Governors to volunteer to join the judging panel and to give ideas for categories.	**All**	Martin Lewis, Melvyn Jeremiah and Susan Maxwell sit on the judging panel for Council of Governors Special Award. Cass J Cass-Horne sits on the judging panel for Patient Choice Award.

Chelsea and Westminster Hospital NHS
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Council of Governors Meeting, 3 May 2012

AGENDA ITEM NO.	2.1/May/12
PAPER	Appointment of Chief Executive
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper provides an update on the process of the appointment of the Chief Executive
DECISION/ ACTION	The Council of Governors is asked to note that the Chief Executive interviews will take place on 2 May and we anticipate being able to make the recommendation for the approval of the appointment of the Chief Executive at the Council meeting on 3 May 2012.

Appointment of Chief Executive

1.0 Introduction

The Nominations Committee is a Standing Committee of the Board of Directors which makes recommendations to the Appointments Committee for the Chief Executive post (subject to approval of the Council of Governors), other Executive Directors (board members) and the Secretary.

2.0 Background

At the February Council of Governors meeting a paper outlining the process for the appointment of the new Chief Executive was presented.

The legislation states that the appointment of a Chief Executive must be undertaken by the Non-executive Directors and be approved by the Council of Governors.

Further detail is as follows (extract from the Monitor Code of Governance):

C.1.10 *It is a requirement of the 2006 Act that the chairman, the other Non-executive Directors and – except in the case of the appointment of a chief executive –the chief executive, are responsible for deciding the appointment of executive directors. The nominations committee with responsibility for executive director nominations should identify suitable candidates to fill executive director vacancies as they arise and make recommendations to the chairman, the other Non-executives Directors and, except in the case of the appointment of a chief executive, the chief executive.*

C.1.11 *It is for the Non-executive Directors to appoint and remove the chief executive. The appointment of a chief executive requires the approval of the Council of Governors.*

C.2.1 *Approval by the Council of Governors of the appointment of a chief executive should be a subject of the first general meeting after the appointment by a committee of the chairman and Non-executive Directors. All other executive directors should be appointed by a committee of the chief executive, the chairman and Non-executive Directors.*

3.0 Process

The Nominations Committee agreed that the recruitment process was conducted by Saxton Bampfylde, Recruitment Agency. They were provided with the job description, person specification and the Trust profile.

The Council of Governors and executive team were consulted on the draft job description, person specification and the Trust profile.

The Chairman held an open forum for non-medical staff and governors on 6 March 2012 to inform them about the process for recruitment and also to listen to their views/questions. The Chairman also held an open forum for medical staff on 7 March 2012.

The job advert was published in the Sunday Times and Health Services Journal with a deadline of 19 March. The Nominations Committee longlisting meeting took place 23 March 2012 and the Nominations Committee shortlisting meeting took place on 16 April 2012 at which four candidates were shortlisted.

Following the shortlisted meeting, all of four candidates were invited to take part in three separate focused discussions. Prof Brian Gazzard was a member of one of the groups representing the governors with Executive, Divisional Directors of Operations and Divisional Medical Directors. The groups were asked to focus on one area each - patient experience, strategy and leadership. The candidates also had an individual meeting with the Chairman.

The Appointments Committee consisting of the Non-executive Directors, Mr Miles Scott, Chief Executive of St George's Healthcare NHS Trust and our Director of HR will undertake a formal interview with the candidates on 3 May with a view to identifying a candidate with sufficient experience, skills and behavioural attributes to fulfil all essential aspects of the job description.

4.0 Action/Decision

The Council of Governors is asked to note that the Chief Executive interviews will take place on 2 May and we anticipate being able to make the recommendation for the approval of the appointment of the Chief Executive at the Council meeting on 3 May 2012.

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Council of Governors Meeting, 3 May 2012

AGENDA ITEM NO.	2.2/May/12
PAPER	Re-appointment of Non-Executive Directors
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper reports on the outcome of the appraisals conducted on Non-executive Directors seeking re-appointment following the expiry of their term of office on 31 October 2012.
DECISION/ ACTION	The Council is asked to note the reports and to approve the re-appointments as recommended.

1.0 Introduction

This paper proposes an extension of one year to the contracts of Professor Richard Kitney and Karin Norman.

2.0 Background

The Constitution of the Trust provides that any re-appointment of a Non-Executive Director by the Council of Governors shall be subject to a satisfactory appraisal carried out in accordance with the procedures which the Board of Directors has approved. The process was first used in 2009 and was reapproved at the Board meetings in 2010 and 2011. The appraisal process was presented to the Council of Governors in July 2011.

In compliance with the Constitution and Monitor's Code of Governance which stipulates that the Board of Directors undertakes a formal and rigorous annual evaluation of its individual directors, the Chairman has conducted this evaluation.

NEDs were asked to complete an appraisal form and the Chairman asked for views from other Board members on each NED.

The Chairman met with individual NEDs to discuss their performance taking into account their views and those of other Board members.

3.0 Monitor Code of Governance

Monitor Code of Governance states the following:

'Any term beyond six years (e.g. two three year terms) for a non-executive director should be subject to particularly rigorous review, and should take into account the need for progressive refreshing of the board. Non-executive directors may in exceptional circumstances serve longer than six years (e.g. two three-year terms following authorisation of the NHS foundation trust), but subject to annual re-appointment. Serving more than six years could be relevant to the determination of a non-executive director's independence (as set out in provision A.3.1).'

This was changed in 2010 from nine years.

4.0 Re-appointment of Non-Executive Directors

There are particular reasons that the Council of Governors has been asked to agree to a further year for both Non-executive Directors.

There are three new NEDs and the Trust is in a position of great challenges and change with the NWL Strategy and the appointment of a new Chief Executive. It is recommended that Richard Kitney and Karin Norman remain on the Board to maintain stability.

Professor Richard Kitney is playing a crucial role in advising the Trust on the IT Strategy and we are about to implement the Electronic Document Management (EDM).

In addition, Karin Norman has taken on role of Chair of the Assurance Committee from October 2011 to replace Charlie Wilson and her experience is crucial for this important committee. The other NEDs on this committee are Jeremy Loyd and Richard Kitney.

5.0 Action/Decision

The Council is asked to note the reports and to approve the re-appointments as recommended.

Report on Non-Executive Director Appraisal

Name	**Prof. Richard Kitney**
Date of First Appointment	**1st May 2006**
End Date of Current Term	**31st October 2012**
Date of Appraisal	**9th December 2011**

Introduction

The Constitution of the Trust provides that any re-appointment of a Non-Executive Director by the Council of Governors shall be subject to a satisfactory appraisal carried out in accordance with the procedures which the Board of Directors has approved.

In compliance with the Constitution and Monitor's Code of Governance which stipulates that the board of directors undertakes a formal and rigorous annual evaluation of its individual directors, the Chairman has conducted this evaluation which involves a face-to-face meeting to discuss the director's statement setting out her views of his past performance and the extent to which she has achieved the stated criteria for delivering results.

Results of Evaluation

The result of this evaluation is that Prof. Richard Kitney continues to contribute effectively and to demonstrate commitment to the role which includes commitment of time for the Board.

Prof. Richard Kitney is found to have remained independent. He has become a member of the Assurance and Audit Committees.

The Chairman has asked Prof. Richard Kitney to take particular responsibility for Information Technology and academic development (especially with regards to the maintenance and development of our links with Imperial College).

Recommendation

In accordance with section 2.3.1 of Standing Orders: 'For the Chairman and Non-Executive Directors, the term of office, in accordance with the terms and conditions of office, including remuneration and allowances, is decided by the Council of Governors in a General Meeting'.

The Council of Governors is asked to approve the re-appointment of Prof. Richard Kitney as non-executive director for a term of one year ending on 30 October 2013.

Report on Non-Executive Director Appraisal

Name	**Karin Norman**
Date of First Appointment	**1st July 2005**
End Date of Current Term	**31st October 2012**
Date of Appraisal	**27th October 2011**

Introduction

The Constitution of the Trust provides that any re-appointment of a Non-Executive Director by the Council of Governors shall be subject to a satisfactory appraisal carried out in accordance with the procedures which the Board of Directors has approved.

In compliance with the Constitution and Monitor's Code of Governance which stipulates that the board of directors undertakes a formal and rigorous annual evaluation of its individual directors, the Chairman has conducted this evaluation which involves a face-to-face meeting to discuss the director's statement setting out her views of his past performance and the extent to which she has achieved the stated criteria for delivering results.

Results of Evaluation

The result of this evaluation is that Karin Norman continues to contribute effectively and to demonstrate commitment to the role which includes commitment of time for Board, including chairmanship of the Assurance Committee, and membership of the Finance & Investment Committee.

Karin is found to have remained independent and possesses expertise in the area of Finance and should continue to play a very important role as the Board faces the challenges of achieving its growth and development objectives against the background of an economic downturn over the next three years.

Recommendation

The Council of Governors is asked to approve the re-appointment of Karin Norman as non-executive director for a term of one year ending on 30 October 2013.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 3 May 2012

AGENDA ITEM NO.	2.3/May/12
PAPER	Business Planning 2012/13 Update
AUTHOR	David Radbourne, Chief Operating Officer Axel Heitmueller, Director of Strategy and Business Development
LEAD	Heather Lawrence, Chief Executive
EXECUTIVE SUMMARY	This paper reminds the Council of Governors of our vision, key strategic priorities and corporate objectives and 2012-13. It also provides in that context a progress on the development of our business plan for 2012-13. The Trust is required to submit its final plan to Monitor in May.
DECISION/ ACTION	The Council of Governors is asked to note this report and proposed next steps.

Business Planning 2012/13

1.0 Introduction

The purpose of this paper is to update the Council of Governors on our business planning process and to invite discussion on the areas outlined.

2.0 Wider Policy Context

As noted in February, Chelsea and Westminster's business planning needs to be considered in the context of national and regional strategic developments as well as our internal work on the development of our values.

3.0 Vision

3.1 The Trust has maintained a consistent vision over recent years:

' To deliver safe and sustainable care of the highest quality and to be the provider of choice for our local population and those using our specialist services, provided in a modern way by multi-disciplinary teams working in an excellent environment, supported by state-of-the-art technology and world class academic research'

4.0 Strategic Priorities

4.1 The Trust agreed three strategic priorities last year:

- Maintaining clinical specialities
- Exploring growth opportunities
- Ensuring sustainability

4.2 These remain relevant in the changing external context, notably:

- The Health and Social Care Bill, which has now made its passage through the House of Commons
- NHS North West London (NWL) proposed consultation on service reconfiguration

4.3 For 2012/13 we intend to focus particularly on the following strategic priorities:

4.4 **Maintaining and developing our key clinical specialities**

- Maintain our key specialties to secure our future both in terms of financial sustainability and reputation.
- Engage fully in the NWL clinical services consultation and developing the Trusts response to best position C&W
- Support services where there are externally driven opportunities and challenges including HIV, cancer and burns because there within the NWL sector and across London for greater centralisation of specialist services
- Influence the NWL tertiary paediatrics review to secure a positive outcome for patients and Chelsea Children's Hospital

4.5 **Exploring opportunities for growth**

- Work in collaboration with partners in NWL on a number of priority projects through the Academic Health Science Partnership

- Proactively develop business propositions in areas that are likely to grow in the years to come including community activity as part of the NWL reconfiguration work.
- Grow private patient income through short-term and long-term opportunities subject to clarification on the proposed management of the cap nationally
- Responding to tenders from commissioners and initiating service developments which are in line with our strategic priorities with the aim of further growing and strengthening our service portfolio

4.6 **Ensuring Sustainability**

- Develop and embed our values through the 'Who do you think WE are' project to improve patient and staff experience of the Trust.
- Maintain financial and environmental sustainability, through initiatives such as the infrastructure project and a focus on 'back office' opportunities with other partner organisations
- Drive efficiency across the organisation, building on the successful first wave service line reviews in 2011.

5.0 Corporate Objectives

5.1 At the meeting in February the following Corporate Objectives were proposed for 2012-13:

Corporate Objective 1: Improve patient safety and clinical effectiveness

Corporate Objective 2: Improve the Patient Experience

Corporate Objective 3: Deliver excellence in teaching and research

Corporate Objective 4: Ensuring financial and environmental sustainability

6.0 Business Planning Process and Key Issues

6.1 With the above objectives in mind the Trust has progressed a number of bilateral meetings with the divisions to translate our strategic aims into detailed delivery plans that will enable progress during 2012-13.

6.2 Whilst our contract for 2012-13 is in discussion with our commissioners we have been able to take a view on the likely operating income and costs for 2012-13 and the total CIP programme. The financial plan for 2012-13 identifies a CIP of £16.2m (7% of controllable costs), and a planned surplus for the year of £9.1m. This provides for a Monitor financial risk rating of 4.

6.3 To deliver the finance, activity and CIP plans a number of review meetings have been held with the divisions to ensure that the proposed activity levels are translated into operational plans and that the CIP schemes are fully identified. At the time of writing the CIP schemes are 88% identified with further review meetings planned over the next week to close the gap.

6.4 As part of the CIP review we are being careful to ensure schemes are realistic, but also don't compromise our commitment to providing high quality, safe care.

6.5 Our plans for 2012-13 help us translate our strategic goals into action. For 2012-13 we propose to take forward the following schemes:

Improving patient safety and clinical effectiveness

- Have no hospital acquired preventable venous thromboembolism (VTE)
- To achieve further reductions in the levels of healthcare acquired infections (HCAIs)
- To perform well against the quality indicators included within our contracts with commissioners
- Be a pilot for the London wide development of emergency care standards, closing remaining gaps in adherence to ensure we are fully compliant with the new commissioning standards

Improve the patient experience

- Take forward the implementation of the values work
- Further improve our facilities through completing the creation of a diagnostics centre and moving forward with our capital upgrade and investment plans worth £22m
- Continue to focus on providing high levels of accessibility for our services, investing in the continued development of our services and meeting growth in demand e.g. surgical services

Deliver excellence in teaching and research

- Join the NWL Academic Health Science Partnership to improve patient care by benefiting from greater co-ordination of research, training and educations
- Work closely with the new Local Education and Training Board (LETB) to retain our place as a leading provider of education and training
- Foster synergies between the Collaboration for Leadership in Applied health Research and Care (CLAHRC) for NWL, NWL Higher Education and Innovation Cluster (HIEC) and Training for Innovation (TFI)
- Implement the Trusts research strategy

Ensure Financial and environmental sustainability

- Our goal is to achieve a FRR of 4 and a surplus position of £9.1m, delivering a CIP programme of £16.2m
- As part of the CIP programme ensuring a significant focus on improvements in productivity and efficiency arising from the application of new ways of working, operating at top quartile / decile productivity levels and implementing improvements in clinical pathway management e.g. the management of long term conditions
- Improving environmental sustainability by exceeding the NHS national target of 10% carbon reduction by 2015

6.6 During the next few weeks we will be finalising our business plan for 2012-13 with the development of divisional business plans and the creation of the Annual Plan for 2012-13 which will need to be submitted to Monitor in May.

7.0 Action/Decision

The Council of Governors is asked to note this report and proposed next steps.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors meeting, 3 May 2012

AGENDA ITEM NO.	2.5/May/12
PAPER	'It's who we are' – Our Values
AUTHOR	Matt Akid, Head of Communications
LEAD	Therese Davis, Chief Nurse and Director of Patient Experience and Flow Mark Gammage, Director of Human Resources
PURPOSE	This paper summarises the results of the 'Who do you think WE are?' consultation on the Trust's proposed values, confirms the values agreed by the Board of Directors on 29 March, and outlines communications activity to publicise the agreed values.
EXECUTIVE SUMMARY	More than 800 patients, members of the public, staff and other key stakeholders voted for their top 4 values during the 'Who do you think WE are?' consultation in February to develop the Trust's values – 130 people also took part in focus groups to discuss the values in more detail. The results of the consultation were analysed in March and presented to the Board of Directors for agreement of the Trust's 4 values on 29 March – the agreed values are 'Respectful', 'Safe', 'Kind' and 'Excellent'. Following agreement of our values by the Board of Directors, they have been publicised widely and will be launched publicly at the hospital Open Day on 12 May.
DECISION/ ACTION	The Council of Governors is invited to note: 1. Process of consultation 2. Confirmation of the Trust's agreed values 3. Communications activity to publicise the agreed values

1.0 Introduction

1.1 Improving the patient experience is one of the Trust's four corporate objectives. Agreeing our values and associated behaviours will improve the patient experience by defining the expectations that patients and families have of us and enabling staff to understand what behaviours are expected of them.

1.2 While the Trust has possessed a strong sense of the importance that staff behaviour and attitude has on the patient experience and has sought to improve upon this through various initiatives over the years, the organisation has not previously agreed an explicit and consistent set of core values.

1.3 The process of developing the Trust's values began at the joint Council of Governors and Trust Board away day on 24 November 2011. An initial 'longlist' of 30 values was reduced to a shortlist of 12 values for consultation, agreed by the Chief Executive, Director of HR, and Chief Nurse and Director of Patient Experience and Flow.

1.4 In February the Trust consulted with staff, patients and the public through online and hard copy voting forms, 10 focus groups for internal and external stakeholders, and 5 drop-in sessions in the hospital.

1.5 People were invited to vote for their top 4 values from the shortlist of 12. They were also invited to participate in the focus groups and drop-in sessions to discuss the behaviours associated with these values.

1.6 The campaign, which was branded as 'Who do you think WE are?', was publicised as widely as possible to staff, patients, the public, Foundation Trust members, and anyone else with an interest in Chelsea and Westminster Hospital.

1.7 It utilised a broad range of communication channels including the Trust website, Twitter feed, local media, the Chief Executive's Blog, *Trust News* magazine, *Members' News* e-newsletter for Foundation Trust members, posters and flyers in the hospital.

1.8 Emphasis was placed on the values that the organisation should aspire to, whether they were evident now or not.

2.0 Consultation - Focus Groups

2.1 The Trust ran 10 focus groups - 6 for a representative sample of staff who were individually invited to attend, 1 for student nurses and midwives, and 3 for patients, members of the public, Foundation Trust Governors, Foundation Trust members, key local stakeholder groups such as Kensington & Chelsea Local Involvement Network (LINk), charities and volunteers associated with the Trust. A total of 130 people attended focus groups. Table 1 shows attendance by stakeholder group.

Stakeholder group	**Number of attendees**
Staff	72
Patient and Public representatives	41
Student Nurses and Midwives	17
Total	**130**

Table 1. Attendance by Group

2.2 Focus group members were asked to vote individually for their top 4 values and these were aggregated to find the top 4 values for each focus group. The groups then discussed behaviours that would support, or not support, these values.

3.0 Consultation - Voting Response and Results

3.1 The total number of people who voted during the consultation campaign was 805 (although 3 voting forms were incomplete and therefore disregarded – therefore the total number of valid voters was 802).

3.2 Approximately two thirds of voters were staff with the remaining one third consisting of patients, members of the public and others (eg volunteers). Table 2 below shows a detailed breakdown of the voting response rate to the consultation.

Stakeholder group	**% of total voters**	**Number of voters**
Staff	64.2%	514
Patients	14.2%	114
Members of the public	10.3%	83
Others (eg volunteers)	11.3%	91
Total	**100%**	**802**

Table 2: Response rate by group

3.3 The results of the voting showed a wide range of responses with all 12 values gaining some support. Table 3 below provides a detailed breakdown of the voting results by number and percentage.

Value	**% of total votes**	**Number of votes**
Patient-focused	64.3%	516
Safe	49.0%	393
Excellent	46.9%	376
Expert	39.3%	315
Respectful	33.8%	271
Compassionate	32.0%	257
Innovative	31.4%	252
Positive	28.8%	231
Kind	19.5%	156
Proud	17.5%	140
Inclusive	11.2%	90
Transparent	10.2%	82
Other values (voters were invited to suggest values that were not on the shortlist of 12)	5.2%	42
Total	**389.1%**	**3,121**

Table 3: Results

4.0 Consultation - Analysis of Voting Results

4.1 Overall the 4 most popular values were:

- Patient–focused
- Safe
- Excellent
- Expert

4.2 **Patient-focused** was the most popular value with staff and it was considered that this was central to all of the other values.

4.3 Within the focus group discussions it was identified that **expert** and **excellent** were closely related and the behaviours aligned to both were similar. **Excellent** was the most popular value with patients and members of the public.

4.4 Each focus group discussed the similarity and inter-relationships between the 3 values **kind**, **respectful** and **compassionate** and felt that they were all ways of describing a 'caring' approach. Indeed, all 3 values were popular with those who took part in the consultation.

5.0 Agreeing the Trust's Values – Board of Directors meeting 29 March

5.1 Non-Executive Director Jeremy Loyd and Executive Directors Therese Davis and Mark Gammage recommended to the Board that the Trust should ensure a balance between 'hard' and 'soft' values while retaining **patient-focused** as central to everything that we do as an organisation and as individual members of staff.

5.2 The 4 values agreed by the Trust Board at the meeting on 29 March were **safe** and **excellent** ('hard' values) and **kind** and **respectful** ('soft' values).

6.0 Communicating the Trust's Values

6.1 Communicating our Values – Action Plan

6.1.1 Following their agreement by the Board of Directors on 29 March, the Trust's values have been publicised as widely as possible through a wide range of communications activity culminating in the public launch of our values at the Open Day on 12 May.

6.1.2 This has included the monthly **Team Briefing** for all Trust staff on 13 April, Heather Lawrence's **Chief Executive's Blog** on 18 April, publicity on the **Trust website** and **Twitter feed**, **posters** in the hospital, and the following main items:

- ***Trust News*** - Wraparound cover for the April/May issue which has been sent to all patient and public Foundation Trust members
- ***Members' News*** – Item in the 4 May issue of our e-newsletter which is sent to c.3,500 Foundation Trust members who have provided us with their email addresses
- **Open Day** – Public launch of the values at the Open Day on 12 May including a values 'graffiti wall' as well as values-themed T-shirts, balloons and mugs
- **Star Awards presentation evening** – Values to be a key theme of the Star Awards evening at Chelsea Football Club on 14 May

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Council of Governors Meeting, 3 May 2012

AGENDA ITEM NO.	2.6/May/12
PAPER	Governors' Questions
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	Two questions were received: 1.Trust plans re lifting the Private Patient Cap – Professor Brian Gazzard 2. Hospital plans for expansion – Melvyn Jeremiah
DECISION/ ACTION	The Council of Governors is asked to note that Heather Lawrence will provide response to the above questions.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 3 May 2012

AGENDA ITEM NO.	2.7/May/12
PAPER	Report on Senior Nurse/Governor Rounds
AUTHORS	Tony Pritchard. Deputy Chief Nurse
LEAD	Therese Davis, Chief Nurse and Director of Patient Experience and Flow
EXECUTIVE SUMMARY	This report provides a summary Governor rounds and visits that were conducted during February, March and April 2012. The paper provides details of forthcoming senior Nursing and Midwifery clinical rounds in which we assess the Care Quality Commission essential standards of quality and safety.
DECISION / ACTION	For information.

Report on Senior Nurse / Governor Rounds

1.0 Introduction

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

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

2. Individual Governor Visits

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

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

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

3. Future Individual Governor Visits

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

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

4. Clinical Rounds

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

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

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

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

5. Future Clinical Rounds

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

6. Summary

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

Tony Pritchard
Deputy Chief Nurse
April 2012

Appendix 1

CQC Standards

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

Assessing our standards

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

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

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

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

Evaluation

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

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

Appendix 2

Senior Nursing & Midwifery Clinical Rounds – Assessment of CQC Standards

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

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Council of Governors Meeting, 3 May 2012

AGENDA ITEM NO.	2.8/May/12
PAPER	Open Day 2012 – Update
AUTHOR	Renae McBride, Communications Manager
LEAD	Renae McBride, Communications Manager
EXECUTIVE SUMMARY	This paper provides an update on planning for the Trust Open Day 2012.
DECISION/ ACTION	Governors are invited to provide feedback.

Open Day 2012 – Update

1. Introduction

1.1 Planning is well underway for Open Day 2012 which is being held from 11am—3pm on Saturday 12 May.

1.2 This paper is intended to provide an update for the Council of Governors on preparations.

2. Confirmed participants

2.1 More than 50 individual departments and services have confirmed their involvement in this year's Open Day.

2.2 Some of the main attractions will include:

- Paediatrics – including the Teddy Bear Hospital, tours of the new Chelsea Children's Hospital facilities on the 1st Floor of the hospital and other activities for children.
- Health and Wellbeing Zone – located in Lower Ground Floor Outpatient Department, this will include stands offering free health checks (weight, blood pressure, cholesterol testing) and advice. More staff will be available this year to help ensure that everyone who wants to have a health check is accommodated.
- Careers event – Libby Wingfield (Volunteer Services and Work Experience Manager) has been leading on this with members of the Human Resources team. The event will include short sessions on some of the careers available in the NHS (eg medicine, nursing, therapies) and more than 200 people have registered to attend. There will also be staff available to run CV 'clinics' and show attendees how to navigate the NHS Jobs website to search for opportunities.
- Official launch of the Trust's values – there will be a graffiti artist working on a piece throughout the day and visitors will have the opportunity to contribute. The artwork will be centred around the four values (Respectful, Safe, Kind, Excellent) and the Trust will be able to display the finished piece in the hospital.
- Partnership organisations will be represented including Hospital Discharge Support (British Red Cross), Trust charities including the Chelsea and Westminster Health Charity and the Friends, Trust contractors including ISS, Norland and HATS (patient transport) and the Kensington and Chelsea and Hammersmith and Fulham LINks.
- The Council of Governors – located in the Information Zone on the Ground Floor, Governors will be recruiting new members and have organised giveaways and prizes. Susan Maxwell is leading on arrangements.

3. Advertising and publicity

3.1 Distribution of flyers and posters is ongoing. Thank you to those Governors who have volunteered to help distribute materials in their local area.

3.2 The event will be advertised in the Kensington & Chelsea, Westminster and Hammersmith & Fulham Chronicles.

3.3 A letterbox drop will be carried out to 25,000 residences located within a mile radius of the hospital.

3.4 Targeted mailings to GP surgeries, schools, colleges and nurseries is being carried out.

3.5 An Open Day banner has been added to the Trust's website and the Communications Department is promoting the event through our Twitter feed.

4.0 Action/Decision

Governors are invited to provide feedback.

Renae McBride
Communications Manager
April 2012

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 3 May 2012

AGENDA ITEM NO.	2.9/May/12
PAPER	Council of Governors Funding Report
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Cathy Mooney, Director of Governance and Corporate Affairs
EXECUTIVE SUMMARY	The report provides an overview of the use of the Council of Governors budget to Month 11 of FY 2011/12 and also outlines the requests for funding in part A and B.
DECISION/ ACTION	The Council of Governors is asked to note the report and agree the requests for funding.

Council of Governors Funding Report

1.0 Background

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

The recurring budget was adjusted in the following financial year (2009/10) for the effect of inflation which was estimated at £500 bringing the total budget available in 2009/10 to £100,500.

The history of expenditure is as follows (spent is according to finance):

2009/10 Budget: £100.500
TOTAL AGREED: £85,645
TOTAL SPENT: £60,000.

2010/11 Budget: £100.500
TOTAL AGREED: £92,006.10
TOTAL SPENT: £73,630
The main reason for the difference is as the Directory of Services funds were not used.

2011/12 Budget: £95,000
TOTAL AGREED: £70,513.52
TOTAL SPENT: £30,800 (we have accrued for the remainder)

2.0 Update

It was agreed at the Trust budget setting meetings in January 2011 that the Council of Governors fund should be reduced in line with the Trust's overall cost improvement programme to £95,000.

It was agreed at the Trust budget setting meeting in January 2012 that the recurring budget should be reduced to £80,000. This is in line with the Trust's approach to the cost improvement programme which has been as follows: 10/11 – 10%, 11/12 – 15% (for back room functions) and 12/13 – 8% which totals 32% compared to the Council budget which has been reduced by the CIP as follows: 10/11 – 0%, 11/12 by 5.5% and 12/13 by 15.8% which totals 21.3%.

The recurring budget of £80,000 has been made available for the financial year 2012/13.

3.0 Funding Overview for 2011/12

Of the £95,000 circa £70k was accrued for the activities listed in the table below which were approved by the Council of Governors and this figure was reported at the last meeting. However, unless an order has been placed funds which have not been used cannot be carried over. This affects the allocation for the Discharge Booklets which was agreed in 2008 and for the communications campaign have not been used. This cannot be carried over for a further year and therefore a resubmission will be required if funding still required.

4.0 Use of funds FY 11/12

TABLE 1

Activity 2011/12	Agreed	Estimate Actual*
Trust Open Day 2011	£15,000	£15,000
Web Optimisation	£7,000	£7,000
Discharge Booklet (1)	£8,200	
Face to Face Recruitment Campaign	£2,000	£2,000
Recruitment Campaign for the Annual Members' Meeting	£2,000	£2,000
Learning Disability Membership Leaflet	£1,304	£1,304
Quality Awards	£2,400	£1,350
Communications campaign to publicise the Trust's 4 priorities for quality improvement – from 10/11 (1)	£4,000	
Maternity and Children's Services Events	£5,000	£5,000
Members Recruitment Campaign 2011 extra funding	£2,340	£2,340
Table and chairs in the Information Zone	£580.80	£580.80
Badges for governors	£104.40	£104.40
Capita Membership Recruitment (Mobile Health Clinic)	£3,300	£3,025
Blog system	£2,520	£2,520
Engagement activities - 1 extra membership mailing (Jan 2012) £10,000 - 2 monthly emails (Feb & March 2012) £420 - 1 'Medicine for Members' event (Feb 2012) £1,000	£11,420	£250
Council of Governors Handbook Printing	£144.00	£144.00
Equipment for producing podcasts	£1,200	
Consultant Database	£2,000	£2,000
TOTAL	**£70,513.52**	**£44,618.20**

(1) Not to be carried forward
* Estimate Actual – Actual is to be confirmed with finance (month 12 invoices not considered yet).

The revised total expenditure for 2011/12 including accruals is £70,513.52. This resulted in an unallocated expenditure of circa £25k. Funding of the Quality Account was not approved at the February Council of Governors meeting. However, there was a clear support for the initiatives described in the paper and it was agreed that the allocation which would be otherwise not used, was used for the Quality Account. The total expenditure will be reported for information in due course.

Allocation for 2012/13 already agreed	Estimate
Trust Open Day 2012	£15,000
Small Membership Branded Gifts for Open Day 2012	£1,500
Engagement activities 2012/13 - Membership mailing (Jan 2013) £10,000 - 12 Members' News monthly emails (April 2012-March 2013) £2,520 - Annual Members' Meeting + 2 associated events (Sept 2012) £5,000 - 5 'Medicine for Members' events £5,000 - Christmas event (Dec 2012) £5,000	£27,520
Members Recruitment Campaign 2012 (May & September) (2)	£2,340
Quality Awards (3)	£2,000
TOTAL	**£48,360**

(2) This is less than was spent last year (£9,640) and further funding may be requested.

(3) Quality Awards

Ongoing work is planned for the Council of Governors Quality Awards led by the Council of Governors Quality Sub Committee to continue through 2012/2013 and approval for recurring funding is requested from the Council of Governors to continue to facilitate this work.

The award open to all Chelsea and Westminster Trust employees to recognise and reward contributions to quality initiatives in the Trust from an individual or team who have made a contribution to quality and patient's experience. The award can be received for a project, an initiative or a change in the work of Trust staff that as a result provides benefit to quality care under the categories of Patient Safety, Patient Experience and Clinical Effectiveness.

Applications for awards were received quarterly during 2011/2012 with a variety of departments seeing their applicants being successful in obtaining an award.

Funding of £2,000 is requested. Please note that this about may not be spent as it is dependent on who gets the award.

Part A

Giggle Doctors

1.0 Introduction

The Giggle Doctors, usually trained artists, are provided by the Theodora Children's Trust Charity. They receive intensive training by health professionals, attend regular workshops on medical awareness, including sessions with a clinical psychologist. It takes 2 years to fully train a Giggle Doctor, so you can appreciate how highly skilled they are. They visit over 18 foundation trust hospitals throughout England & Wales.

2.0 Aim

Staying in hospital can be a daunting time for a child away from home & the people they love. Imagine a child's delight when a Giggle Doctor transforms the hospital ward into a magical world! They bring happiness, laughter, fun, joy & delight to these sick children, entertaining them with music, magic & wonder. They visit every child.

Medical professionals have become increasingly aware of the healing benefits of humour. A study by Prof. Alan Gasper at the University of Southampton highlights the unanimous support of doctors, nurses & of course the children, for the Giggle Doctor programme.

The Giggle Doctor project in paediatrics at Chelwest started in March this year & already has proved a great success.

At present, the Giggle Doctors visit Chelwest once a month, which meets the funds I have available for one year. This is kindly sponsored by the Chelsea & Westminster Health Charity. The paediatric matrons & staff are now so enthusiastic, they are anxious to increase the visits to 2 per month, as they have proved so successful. This has also been endorsed by Simon Eccles.

The annual cost is £4,600.

3.0 Action

The Council of Governors is asked to support funding for the Giggle Doctors for £4,600.

Wendie McWatters
Patient Governor
April 2012

Part B

Funding Request – Open Day 2012

1.0 Introduction

1.1 The Council of Governors agreed to fund £15,000 for Open Day 2012 at their meeting on 1 December 2011.

1.2 At the Council of Governors Membership Sub-Committee meeting on 29 March 2012, it was agreed that additional funding should be made available to buy additional advertising in local newspapers and to carry out a letterbox drop.

2.0 Additional funds required

2.1 The Communications Department has received costs for the following activities:

Letterbox drop
The cost for carrying out a letterbox drop to all residences within a mile radius of the hospital (almost 25,000 addresses) including the cost of printing the leaflets is £1,793 including VAT.

Advertising
The cost of an advertising campaign in the three local papers is £3,000 including VAT. This includes:

- A double page spread in Kensington & Chelsea Chronicle and Westminster Chronicle (distribution of 14,392)
- 1/2 page advertisement in the Hammersmith and Fulham Chronicle (distribution of 59,641)
- 1/8 page advertisement on the front page of Kensington & Chelsea Chronicle, Westminster Chronicle and Hammersmith and Fulham Chronicle
- Banner advertisement on the Fulham Chronicle website (67,232)

3.0 Action/Decision

The Council of Governors is asked to agree a total funding request of £4,793.

Renae McBride
Communications Manager
April 2012

THEODORA
Children's Trust
Special clowns for children in hospital

"What's so funny about being in hospital?"

Theodora Clown Doctors

For most children, a stay in hospital is a daunting and anxious experience. Imagine their delight when a Clown Doctor transforms the bedside into a magical play space!

Theodora Children's Trust brings music, magic, fun and laughter to sick children in hospital through weekly visits from Clown Doctors; professional artists trained to work in the hospital environment. In 1994, Andre and Jan Poulie, along with Arpad Busson set up Theodora Children's Trust in the UK.

"The story of Theodora Children's Trust is closely tied to that of Jan and Theodora Poulie, our parents. When we were small and surrounded by their love, my brother Jan and I could have never imagined that one day, in their memory, our lives would be dedicated to bringing moments of joy to children in hospital. Who could have foreseen that one day in September 1975 a very serious accident would change my life forever?

Painful narcoses, operations and the struggle to regain my mobility; such was my daily life. Neither my brother, nor my friends could visit me. There were no other distractions. Fortunately, my mother, Théodora came each day to visit me for 4 hours, the maximum time allowed. How this time used to fly…Théodora had an amazing sense of humour. Her overwhelming cheerfulness gave me so much strength."

Andre Poulie

Founder

"I first met Jack about a year ago; to say he touched my heart is a complete understatement. Just 5 years old and on a bone marrow ward - if you met him, you'd think he was the happiest little boy in the world. Jack loved the Clown Doctors - he'd known Dr Loo Loo, Dr Rodeo and myself for some time. He loved to be shown magic tricks - he'd want to see them again and again. As each week went by, we'd look forward to spending time with Jack and he'd look forward to Wednesday as that was when we would visit him. The thing I treasure most is being privileged to be some part of helping Jack to be Jack - a happy little boy who loved to laugh, joke and play. He even called himself Dr Jack! Sadly, Jack passed away this year - he will remain in my heart because he was and always will be a true inspiration for any sick boy or girl."
Dr Hunny

The full training of a Theodora Clown Doctor takes up to a year and is run in conjunction with health specialists. Clown Doctors attend a series of workshops on medical awareness and artistic development. All Clown Doctors participate in two workshops a year on both medical and artistic topics. Each Clown Doctor also attends four group sessions per year with a clinical psychologist.

THEODORA CHILDREN'S TRUST
"HEALTH CHECK"

- ☑ 17 hospitals and charitable homes throughout the UK
- ☑ 50,000 children visited each year
- ☑ 150,000 parents, siblings and relatives touched by the presence of a Clown Doctor
- ☑ ...millions of smiles

"Whenever the clowns were on the ward it made my son so happy that the reason why he was there seemed to melt away. The smile on my son's face brought tears to my eyes. Making children laugh and smile under such tragic circumstances deserves to be highly rewarded."

Parent of a child with cancer at
Royal Manchester Children's Hospital

Doing the rounds

Clown Doctors wait to be invited by the child before proceeding, ensuring that the child is not confined to the role of spectator but can participate in the magic and the activities. Their clowning skills are tailored to each individual's needs. Feedback from clinical staff confirms that the young patients are much more relaxed when undergoing procedures after the Clown Doctor visits. Future visits are eagerly anticipated to add stimulation to what can be an anxious environment.

Vital statistics

Medical professionals have become increasingly aware of the healing benefits of humour. A study by Professor Alan Glasper at the University of Southampton of our Clown Doctor programme highlights the unanimous support of doctors, nurses and of course, the children. We work closely with hospital staff to monitor and evaluate the quality of our work.

BEFORE CLOWN DOCTOR VISIT
Direct quote written by child.
"Sam is sad because she wants to go to school and play with her friends and do PE. She is going to miss her friends"

AFTER CLOWN DOCTOR VISIT
Direct quote written by child.
"Sam is happy because she saw a Clown Doctor and the clown gave her a ball and done some magic and gave her a picture and a balloon"

Happy Hospitals

WHERE WE VISIT

- → ADDENBROOKE'S HOSPITAL, CAMBRIDGE
- ↓ ROYAL UNITED HOSPITAL, BATH
- ← BIRMINGHAM CHILDREN'S HOSPITAL
- ← BRADFORD ROYAL INFIRMARY
- ↓ ROYAL ALEXANDRA HOSPITAL, BRIGHTON
- → THE ROYAL MARSDEN HOSPITAL
- ↑ EVELINA CHILDREN'S HOSPITAL, LONDON
- ← GREAT ORMOND STREET HOSPITAL, LONDON
- ↑ NORTH MANCHESTER GENERAL HOSPITAL
- → ROYAL MANCHESTER CHILDREN'S HOSPITAL
- → NATIONAL CENTRE FOR YOUNG PEOPLE WITH EPILEPSY
- ← NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST
- ↑ GLAN CLWYD HOSPITAL, RHYL
- → SHEFFIELD CHILDREN'S HOSPITAL
- ← SOUTHAMPTON GENERAL HOSPITAL
- → THE CHILDREN'S TRUST, TADWORTH
- ↑ ROYAL BERKSHIRE HOSPITAL, READING

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or by calling: 020 7713 0044
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Under the Data Protection Act your details will only be used only for administrative purposes and will not be sent to third parties

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(Please make cheques payable to Theodora Children's Trust or enter your card details below)

☐ I am a UK taxpayer and wish to increase this and all other donations by 28%. *giftaid it*

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Special clowns for children in hospital

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Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 3 May 2012

AGENDA ITEM NO.	2.10/May/12
PAPER	FTGA/FTN Development Day for Foundation Trust Staff Governors 14 March 2012 – feedback FTGA Mental Health Network Event – 24 April 2012
AUTHOR	Maddy Than – Staff Governor Dr Anthony Cadman – Patient Governor
LEAD	Maddy Than – Staff Governor Dr Anthony Cadman – Patient Governor
EXECUTIVE SUMMARY	This paper provides feedback from the FTGA/FTN Development Day for Foundation Trust Staff Governors 14 March 2012 and FTGA Mental Health Network Event held on 24 April 2012.
DECISION/ ACTION	The Council is asked to note the paper.

Development Day for Foundation Trust Staff Governors 14 March 2012

The Development Day was organised jointly by the Foundation Trust Governors' Association (FTGA) and the Foundation Trust Network (FTN) and was attended by Maddy Than, Staff Governor at Chelsea and Westminster Hospital Foundation Trust.

The following subjects were covered in the morning and after lunch in the form of interactive presentations:

A Clash of Expectations – Sir Bruce Keogh, NHS Medical Director
Panel Debate on the changing role of the Governor
Mike Farrar CBE, Chief Executive of the NHS Confederation

The first speech was delivered by Sir Bruce Keogh, NHS Medical Director, an excellent speaker.
He talked about Bevan and how the NHS has become one to the largest integrated employers in the world.
He spoke about the 1940's blitz and how the Army extended it's free medical service to other civilians and in 1947 the food rationing, fuel shortage and medical rationing, but that great things can be born out of great hardship.

His main focus was on:

- What people really care about and quality for patient services.
- Diversity of Governors' and good people can bring good ambition into the organisation.
- NHS Outcome Framework – the five domains
  - Safety
  - Quality
  - Clinical Effectiveness
  - Patient Experience
  - Good in Safety
- Information technology – looking to the future – patients may own their own records!
- Economic Philosophy and the profound effect for us (NHS) over the foreseeable future
- Venous Thrombosis Embolism
  - Needs to be a fall in mortality rates
  - More focus on consumer based services
  - A move towards a 7 day service

Debate Panel consisted of:
Baroness Blackstone, Great Ormond Street NHS Trust Chair
Dr. David Bennett, Monitor CEO
Sue Slipman, FTN CEO
Matthew Kershaw, Department of Health Director of Provider Delivery
Dianah Pritchett-Farrell, FTGA Chair

Key Element of the Governor Role
There is not any clear and consistent definition of what a staff governor's role is within the Trust. Various definitions were discussed at the FTGA event and it would be useful for us as a governor group to work with the Chairman to clarify what are role is precisely:

- Staff Governors are a 'representative' staff member and their role is to give a generic staff perspective on Trust activities
- Staff Governors are representative of their constituencies
    - They must engage with their constituencies and 'take the temperature' of the Trust and feed this information back to the board
    - They scrutinise the activity of the board on behalf of staff
    - They must feedback to staff about Trust activities in relation to the effect that these activities may have on staff

In the light of these definitions, the following questions arise:

- How do we engage with our constituents?
  For example: Articles in Trust news, drop in 'surgeries', questionnaires, email address etc
- How do ensure that topics that come up in Board papers that effect staff are raised at meetings? For example: Board pre-meet to discuss any issues that come out of board papers so that they can be raised in a concise, coherent and systematic way at the meeting.
- How do we communicate issues that come from our constituents to the Board?
  For example; quarterly meetings / regular communication with the Chairman
- How do we feedback to our constituents on actions that have been taken on their behalf or actions that will have an impact on them?
- Getting the right skill base. An important element of training, what the role really incubuses, time commitment and energy involved in being a Governor.

There was considerable discussion about communication and what sort of information was communicated in order for staff and staff governors to make informed decisions.

- If Staff Governors are informed about what strategic decisions have been made, what the other options were and why they were not chosen then.
- How can we make a difference and be seen to make a difference to our constituents?
- Does the Trust invest in its Staff Governors by providing them with the time to read papers / attend meetings etc?

The second speaker was Mike Farrar CBE, Chief Executive of the NHS Confederation, another excellent and passionate delivery of speech was given by Mike.

Mike highlighted the best outcome for patients and all partnerships need to work together, including uniting GP's. He went on to say:

- Thinking as much as doing
- Work with the public and engage on how we use our resources and cost
- Power is infinite – empower someone else and give them the opportunity to use power in a responsible way.
- The 'Care Footprint' going green.
- Educate public and Trust staff on membership and what we do.

The Breakout Session I attended in the afternoon was the Care Quality Commission.

FTGA Mental Health Conference 24 April 2012

The Mental Health Conference was organised by the Foundation Trust Governors' Association (FTGA) and was attended by Dr Anthony Cadman, Patient Governor at Chelsea and Westminster Hospital Foundation Trust.

The conference was extremely successful. 28 Governors attended from various trusts. All educated and well informed as opposed to the delegates for the so called FTGA governors training case with the awful speakers. From Monitor and QC this exercise was expertly done.

Firstly, the explanation of the Department of Health £20 million 4 year campaign to reduce discrimination against mental health sufferers especially dementia and Alzheimer's.

Secondly a practical demonstration from Leeds to show how they get it over to the public and combine it with recruiting "Friends of Leeds Hospital".

Thirdly a tour de force on Dementia Alzheimer's etc clarifying the clinical position and how it affects hospitals.

The learning curve was swift and beneficial for me as it is a field in which I was untutored.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 3 May 2012

AGENDA ITEM NO.	2.11/May/12
PAPER	Chelsea and Westminster Star Awards 2012
AUTHOR	Matt Akid, Head of Communications
LEAD	Mark Gammage, Director of HR
EXECUTIVE SUMMARY	Almost 800 nominations were received for the first Chelsea and Westminster Star Awards – more than 650 from staff and 120 from patients. Judging panels shortlisted 3 individual members of staff or teams in each of the 17 Staff Choice categories (staff nominated by staff) and also the Patient Choice Award (staff nominated by patients). In addition, a judging panel of Governors agreed a shortlist of 3 staff and teams for the Council of Governors Special Award and Heather Lawrence will select the recipient of her Chief Executive's Special Award. All 20 awards will be presented during an awards evening at Chelsea Football Club on 14 May – all shortlisted staff and representatives of shortlisted teams have been invited to attend. The Star Awards have been made possible by a grant from Chelsea and Westminster Health Charity.
DECISION / ACTION	The Council of Governors is invited to note this update.

CHELSEA AND WESTMINSTER STAR AWARDS 2012

1.0 Introduction

1.1 A grant of £17,160 from Chelsea and Westminster Health Charity has funded a new annual staff awards scheme, the Chelsea and Westminster Star Awards.

1.2 There are 20 awards including 17 Staff Choice categories (staff nominated by staff), the Patient Choice Award (staff nominated by patients), the Council of Governors Special Award (staff nominated by Governors) and a Chief Executive's Special Award.

2.0 Aim

2.1 The Trust is committed to keeping staff fully informed about everything that has an impact on their working lives at Chelsea and Westminster by providing them with information, engaging with them on key decisions and issues, listening to their concerns, and celebrating success.

2.2 As part of our corporate objective to improve the patient experience, the Trust aims to be in the top 20% of acute trusts nationally for staff engagement. This was achieved for the third consecutive year in the 2011 NHS Staff Survey published in March. In addition, the Trust was rated as the best acute trust nationally for good communication between senior management and staff.

2.3 Evidence from the NHS and elsewhere shows that organisations with better staff engagement perform better – in simplistic terms, happier staff mean happier patients.

2.4 Celebrating success is an important part of staff engagement and communication. The Chelsea and Westminster Star Awards aim to reward and recognise the efforts of both clinical and non-clinical staff, culminating in an awards evening at Chelsea Football Club on 14 May to which all shortlisted staff are invited.

3.0 Organisation

3.1 A small organising committee has been chaired by Mark Gammage (Director of HR) with representatives from HR, Communications, Staffside, and the consultant body.

3.2 This committee chose the name and branding of the Star Awards, approved the details of the awards evening, agreed the 20 award categories, and secured sponsorship of prizes from local businesses and Trust contractors.

4.0 Nominations

4.1 The call for nominations was launched on Friday 2 March with a deadline for nominations of Friday 23 March – the response was as follows:

- **Staff Choice** – 656 nominations received in 17 award categories
- **Patient Choice** – 122 nominations received in 1 award category
- **Council of Governors Special Award** – 7 nominations received from Governors

4.2 Considering this is the first year of the Star Awards and the period for nominations was only 3 weeks, the level of response was excellent.

5.0 Shortlisted staff

5.1 Judging panels led by Directors shortlisted 3 individual members of staff or teams of staff for each of the 17 Staff Choice categories and also the Patient Choice Award.

5.2 A judging panel of 3 Governors shortlisted 3 individual members of staff and teams for the Council of Governors Special Award.

5.3 Governors were invited to nominate staff for the Council of Governors Special Award and to be judges for the Patient Choice Award (1 representative) and the Council of Governors Special Award (3 representatives).

5.4 Cass J Cass-Horne was the Governor representative on the Patient Choice Award judging panel and Susan Maxwell, Melyvn Jeremiah and Martin Lewis judged the Council of Governors Special Award.

5.5 The shortlist for all 19 award categories was published and publicised through the Trust's usual channels from Friday 13 April – Governors are invited to view the shortlist in full at www.chelwest.nhs.uk/star-awards.

6.0 Presentation of awards

6.1 Winners of all award categories will be announced during an awards evening at Chelsea Football Club on 14 May, together with the winner of the Chief Executive's Special Award chosen by Heather Lawrence.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 3 May 2012

AGENDA ITEM NO.	2.12/May/12
PAPER	Quality Account Update
AUTHOR	Cathy Mooney, Director of Governance and Corporate Affairs
LEAD	Cathy Mooney, Director of Governance and Corporate Affairs
EXECUTIVE SUMMARY	This paper briefly outlines the process for the development of the Quality Account, the progress on priorities for 2011/12, priorities for 12/13 and next steps.
DECISION/ ACTION	The Council of Governors is asked to approve the priorities for 2012/13.

Quality Account Update

1.0 Introduction

This paper briefly outlines the process for the development of the Quality Account, the progress on priorities for 2011/12, priorities 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. Although there are sections prescribed by the Department of Health by Monitor, it should be developed in conjunction with key stakeholders.

3.0 Development of the Quality Account

This is described in more detail in the Quality Account, but a key group informing the development is the Council of Governors Quality Sub-Committee (which includes LINk and PCT representation).

This group has been used to test out priorities and indicators, as well as reading and commenting on the first draft. This year we have used a professional copywriter and the response from the readers has been very positive. A first draft was also sent to the PCT and LINks

4.0 Priorities

The progress on last year's and priorities for 2012/13 have received most comments and have undergone the most change since the original draft. They are attached in Appendix 1 for approval. The statement from the CEO is also included for context and completion. There are some areas requiring confirmation and these are highlighted.

5.0 Next steps

The Council of Governors Quality Sub-Committee agreed a further group – the Quality Account Planning Group. They have contributed ideas for content, the design of the Quality Account and ideas for photographs.

The final layout and design will be led by that group and overseen by the Head of Quality and Assurance.

6.0 Action/Decision

The Council of Governors is asked to approve the priorities for 2012/13.

The full final draft of the Quality Account is available on request from the Director of Governance and Corporate Affairs.

APPENDIX 1

PART ONE
Statement on Quality from the Chief Executive

This Quality Account sets out the approach we are taking to improve quality at Chelsea and Westminster Hospital and how we are translating this into improvements in patient care and clinical outcomes.

In a large and complex organisation such as ours, we aspire to have robust policies and procedures in place, to promote a safe environment for patients and staff.

At its heart, Chelsea and Westminster Hospital is a people organisation and it is human to err. We therefore seek to keep a balance between getting it right for our patients, but at the same time getting it right for our staff. We invest in their development and support them when things go wrong. In short we aim to be a learning organisation.

We are also working at a time of financial constraints in the NHS and it has never been more important to focus on our patients' experience of their care and evidence of clinical effectiveness to continually improve quality.

We must ensure that the quality of our clinical services is not compromised by the need to work more efficiently, and it is fitting that our commitment to this endeavour underpins our corporate objectives:

- Improve patient safety and clinical effectiveness
- Improve the patient experience
- Deliver excellence in teaching and research
- Ensure financial and environmental sustainability

This year we were privileged to have our commitment to quality recognised with a number of achievements:

- We were the only hospital in England with low mortality rates across all four mortality indicators in the Dr Foster Hospital Guide—an annual independent healthcare survey published in November 2011
- We received an 'Excellent' rating for the three categories of Environment, Food and Privacy and Dignity in the annual Patient Environment Action Team (PEAT) assessment
- We achieved our challenging targets to further reduce the number of cases of both MRSA bacteraemia and *Clostridium difficile* in 2011/12
- National surveys of inpatient, outpatient, maternity and paediatric care showed that levels of patient satisfaction with the quality of our services remained consistently high

However, perhaps more telling of our commitment to quality were the results of the national Staff Survey published by the Department of Health in March 2012. This showed that 80% of our staff (compared to a national average of 63% of NHS staff) would recommend the hospital to their family and friends as a place to be treated.

I have said many times that the care we provide for our patients should be the same as we would expect for our loved ones and this endorsement of our services by the very people who provide it speaks volumes.

The efforts of all of our staff have contributed to our achievements, and my hope is that they feel proud of our collective success.

Of course there is always room for improvement and the pursuit of quality is a constant journey, but I hope you will agree that it is important to celebrate our successes.

To the best of my knowledge, the information in this Quality Account is accurate.

Heather Lawrence OBE
Chief Executive

2011/12 priorities for improvement

Our quality priorities and goals for 2011/12
G denotes explained in glossary

Patient Safety

Priority 1:
To have no hospital associated preventable thromboembolism (VTE)

Venous thromboembolism, or VTE for short, is an umbrella term for potentially serious blood clots called deep vein thrombosis (DVT) and pulmonary embolism (PE). A DVT usually develops in the leg or pelvis. Sometimes part of the blood clot breaks off and ends up in the lung (PE) where it can block blood supply. This can be fatal.

The risk of developing VTE is heightened after surgery and/or periods of immobility, and in certain conditions such as pregnancy or advanced cancer. Around half of all cases arise in patients who have recently been in hospital. Around one in three patients will develop VTE despite the best care, but in two thirds a VTE can be avoided with preventive treatment, including the use of compression stockings and appropriate drugs.

What we said we would do in 2011/12

- Set up a system for finding out who developed a VTE associated with their admission but who had not been given appropriate preventive treatment, and analyse the reasons (root cause analysis)

- Produce guidance for doctors and nurses on the correct fitting of compression stockings, to ensure that patients who wear them are adequately monitored

What we actually did

- In July 2011 we started checking all x-ray reports to pick up new blood clots. For any patient with a VTE associated with a hospital admission, classified as during admission or within the preceding 90 days, we carefully reviewed all the steps we took to find out if the appropriate preventive actions had been taken (root cause analysis).

- We produced new good practice guidelines for frontline staff on caring for patients wearing compression stockings, and provided extensive nurse training. We formally checked whether stockings were being fitted correctly and patients were being properly monitored.

- We introduced monthly audits on each of the adult wards to find out how many patients receive appropriate preventive treatment

- We introduced monthly VTE ward rounds on the maternity wards to check that women had been screened and offered appropriate preventive treatment

- We updated the online procedure for assessing VTE risk so that pregnant women could be screened during outpatient clinics

How did we do in 2011/12?
So far, we have measured the number of VTEs between July 2011 and January 2012 and we have identified 12 VTEs that we may have been able to prevent. On analysis

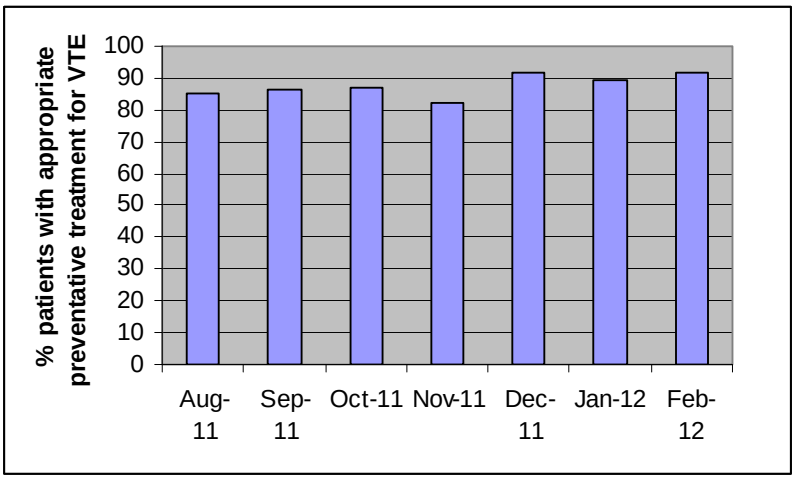
(RCA) most of these patients missed just one or 2 days of their medication to prevent VTE.

We also learnt from an RCA of the case of a pregnant woman who developed a deep vein thrombosis, to start screening pregnant women at their outpatient clinics.

We monitor the number of patients who are screened for their risk of VTE, and since October 2010 we have achieved the national target of more than 90%.

Since August 2011 we have performed monthly audits of medication on each ward to find out how many patients received appropriate preventive treatment and most did. See chart

Monthly medication audit on VTE prevention



We did an audit to find out if patients were having their compression stockings fitted and checked properly. Of 15 patients wearing compression stockings on a orthopaedic surgery ward on one day in April 2012, 60% of patients had a completed stockings monitoring form. Of these patients 100% had their leg measurements recorded and over half had their legs checked daily and the rest had them checked at on average every other day.

And patients are being told about the risks of VTE. An audit carried out between mid June and the end of August 2011 to find out how many patients had been given an information leaflet on VTE at their preoperative assessment showed that all 20 patients had been.

Although we have made improvements we have not achieved our target and we have kept this priority for 2012/13 – see page 13

Patient Experience

Priority 2:
Focus on three key areas: communication, discharge planning, and care of older people

Analysis of responses to the annual national inpatient survey, and complaints and concerns raised by patients about aspects of their care, prompted us to focus on communication, discharge planning, and the care of older people. These themes run through each of the divisional action plans for improving the patient experience.

What we said we would do in 2011/12

Communication

- Set up “campaign groups” to monitor progress
- Make sure that patients are given clear and accurate information about their diagnosis and treatment

Discharge planning

- Look at setting up consultations with a senior member of staff immediately before discharge, and following up the next day by phone
- Look at how to reduce readmission rates

Care of older people

- Set up “wellbeing” ward rounds for the over 75s
- Make sure that we pick up dementia in patients when they are admitted so that their specific needs are met appropriately

What we actually did

Communication

- We established ‘campaign groups’ within each division to monitor progress
- We produced an additional 40 clearly and simply written patient leaflets on a range of conditions and treatments, as well as approx 20 easy read versions for patients with learning disabilities
- We used “patient diaries” G in a general medical ward and in intensive care to record key information and events as a reference for patients
- We produced information booklets for x wards, explaining who everyone is and what routinely happens on a ward
- We introduced a “patient passport” for patients with a learning disability to make sure their needs are communicated effectively between different groups of staff; the concept has since been extended to other groups of patients at the Trust e.g. confused patients.

Discharge planning

- Pre-discharge consultations are taking take place for some patients. Also nurses are following up by phone with patients after they have been discharged. Further information to follow
- We have introduced weekly meetings, attended by clinical staff, the hospital discharge team, and representatives from the community team to plan the discharge of those with more complex needs

Care of older people

- We have tried out “wellbeing” rounds in the maternity wards and a medical ward to ensure that the needs of patients are met in a timely way.

- About 200 staff including therapists, nurses and doctors have received training on recognising the signs of dementia and meeting the particular needs of patients with this condition

- We are now screening all patients over 75 who attend A and E and also all those admitted, for signs of dementia. Patients are then referred to the memory assessment service in consultation with their GP or the older person's psychiatric liaison team. The care plan then makes sure that the inpatient stay is as safe and as least distressing as possible.

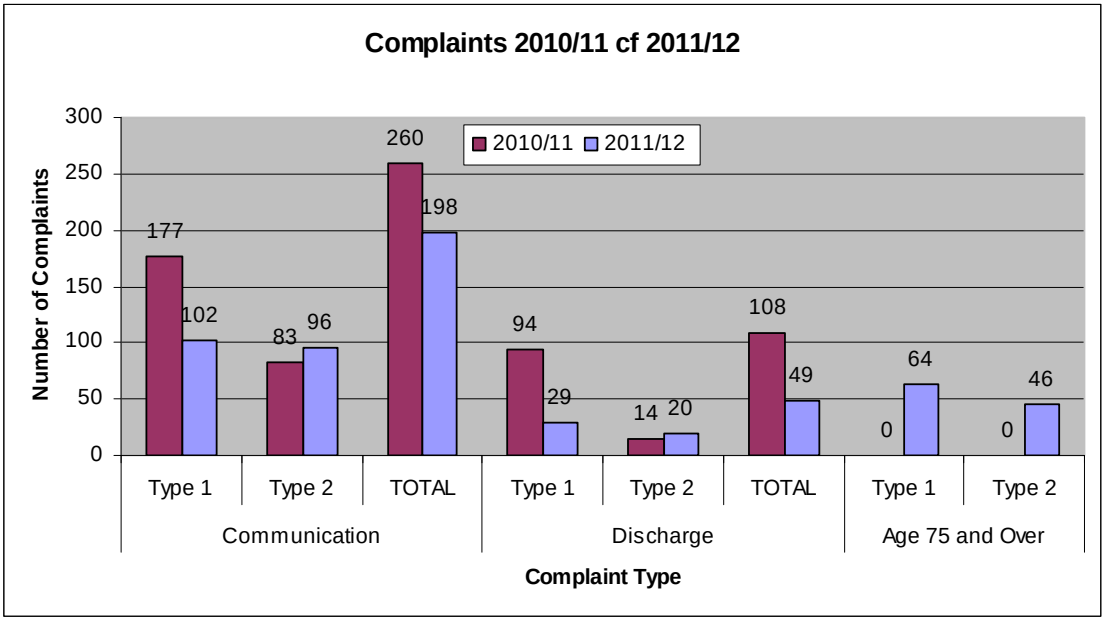
Box

What defines a patient experience as good or bad?
The evidence shows that successful organisations in the healthcare sector devote considerable effort into understanding what defines a patient's experience as either good or bad. So we asked small teams of staff, patients and other interested parties to follow patients with common conditions throughout their journey of care looking for a range of clues that might signal a good or bad experience.

The findings have been fed back to each of the three divisions and linked to their action plans for improving the patient experience. Some of these clues relate to issues across the whole Trust, and will feed into projects such as the Wayfinding project (see PP).

In February 2012, staff, patients and their relatives were also asked to help us come up with a set of four key values and associated behaviours to inform everything we do at the Trust, with a view to improving the consistency of our approach.

How did we perform in 2011/12?
We measured our progress by looking at the number of complaints we received about communication, discharge planning, and the relating to the care of older patients. Type 1 complaints are also known as concerns G and are raised informally through the Membership and Patient Advice and Liaison Service (M-PALS) while type 2 complaints G are managed through the Trust's formal complaints process.



This shows that complaints for communication have decreased by 31% and for discharge by 55%. The category for age 75 and over is new this year.

We also looked at responses to the National Inpatient Survey 2011, which showed that most (89%) of respondents rated their overall care as "good" or "excellent." The table below shows the areas in which we have significantly improved since the 2010 survey, and it compares our performance with the average from 73 other trusts who conduct these particular surveys.

National Inpatient Survey - Areas of significantly improvement since 2010 (Lower scores are better)				
Reference	**Question**	**2010**	**2011**	**Average**
A4	A&E: not given enough privacy during examination or treatment	30%	23%	22%
A12	Planned admission: not given printed information about condition or treatment	26%	17%	20%
B2+	Hospital: mixed sex sleeping area	25%	9%	8%
B7+	Hospital: mixed sex bathing facilities	28%	17%	13%
B9	Hospital: bothered by noise at night from other patients	46%	40%	38%
B15	Hospital: no posters or leaflets asking patients to wash their hands or use disinfectant gels	8%	3%	5%
J9+	Religious beliefs: not always able to practice in hospital	27%	16%	17%

For discharge, the % of patients who said that they were not given completely clear written/printed information about medicines has reduced by 12% and is significantly better than average for all Trusts.

Also, the % of patients who would recommend this hospital to family and friends is significantly better than average.

The areas where we did not do so well remain as communication and discharge and hence our continued focus in these areas.

"How can I help you?"

The M-PALS (Membership – Patient Advice and Liaison Service) team offers: Confidential advice and support to patients, families and their carers

- Information on NHS services and health related queries
- Confidential assistance to resolve concerns
- A place to hear and record concerns, suggestions, queries and compliments
- Explanations about the complaints procedure
- Information or patient leaflets in an alternative format or language

M-PALS acts independently to negotiate immediate and prompt solutions. And it can also refer patients and families to specific local or national support agencies.

Patient Experience

Priority 3:
To remain in the top 20% of acute trusts nationally for staff engagement G and to be in the top 20% for staff appraisals as measured by the national staff survey.

A growing body of evidence shows that there is a direct link between a satisfied and engaged workforce and the quality of care they provide to patients.

Box

Why do appraisals matter?
An appraisal provides the opportunity to reflect on how well individuals have met agreed targets and objectives over the past year and identify any training needs and areas for personal development, in a structured and supportive way.

What we said we would do in 2011/12

- Continue to provide opportunities for staff to meet with the Chief Executive and senior management in face to face briefings and staff forums
- Introduce a competition to encourage staff to come up with innovative ideas to improve patient care
- Introduce a new standardised approach to improve the quantity and quality of appraisals and personal development plans

What we actually did

- We have continued to provide regular opportunities for staff to meet with the Executive Team, members of whom visit specific areas of the Trust each month; the Chief Executive holds monthly team briefings for all staff.
- We launched the Directors' Den initiative in October 2011 to encourage frontline staff to come up with ideas to improve quality and efficiency. The teams with the best ideas will be funded to put them into practice.
- We redesigned the appraisal form to make it easier to use and to be clearer about personal development planning.

How did we perform in 2011/12?
The 2011 NHS Staff Survey results, published in March 2012, show that the Trust improved its score for staff engagement. We achieved 3.81 out of a maximum 5 points, meaning that we remain in the top 20% of acute trusts nationally. The Trust not only improved its score for good communication between senior managers and staff, but also came top out of all acute trusts nationally.

We wanted to increase the appraisal rate from 75% to 84% of staff, the proportion that are structured from 39% to 41% and the % appraised with a personal development from 68% to 72%

- The proportion of staff appraised rose to 80%.
- The proportion of staff who reported having a well structured appraisal rose to 46% which is the highest figure achieved by any London acute trust and keeps us in the top 20% nationally.

- The proportion of staff appraised with a personal development plan rose from 68% to 72%.

Clinical Effectiveness

Priority 4:
To reduce the wait for emergency surgery by 10% and the time spent "nil by mouth," and to give patients and relatives better information

In 2010/11 we reclassified our emergency surgery targets, to reduce the time patients wait for their operation:

- **Immediate**—within 60 minutes of booking (e.g. life-threatening bleeding, obstruction of airway)
- **Urgent**— within 24 hours of booking (e.g. stable non-complex appendicitis, simple abscess)
- **Expedited**—within 4 working days of booking (e.g. small lacerations, fractures where swelling needs to settle before surgery)

In 2011/12 we wanted to reduce waiting times further and to improve other aspects of the patient experience in emergency surgery.

What we said we would do in 2011/12

- Create extra capacity at the weekend with an extra emergency surgery list on Saturday afternoons
- Reduce the wait for adult emergency surgery by moving children's emergency surgery during normal working hours to the new Netherton Grove children's operating theatre suite
- Tell patients what to expect and let them and their relatives know when there are delays
- Cut the length of time patients have to spend without eating or drinking before their surgery ("nil by mouth")
- Make sure that a consultant approves the scheduling of emergency surgery for every patient who needs it to improve quality and safety

What we actually did

- We introduced a second emergency surgery list on Saturday afternoon.

- The opening of the new children's operating theatre suite reduced the wait for adult emergency surgery and enabled us to operate on children more quickly; four further emergency surgery lists will be added in the children's suite from April 2012.

- We designed a leaflet about emergency surgery and anaesthesia for patients and their relatives. Patients tested it in December 2011 and it is now being used.

- We redesigned our admin systems to include nil by mouth prompts so that we review patients regularly and make sure they don't have to go without food or drink before surgery for any longer than is necessary. We need to measure whether this has been effective in cutting the length of time patients are nil by mouth

- Since June 2011 the responsible consultant surgeon/ consultant anaesthetist must approve the decision to operate/agree the anaesthesia to be used

before the patient is booked for surgery/ anaesthetised, An audit showed that this was happening in around half of cases. We are re-enforcing the importance of this practice and will re-audit in September 2012.

- We did better on how we collected and analysed our data to make it easier to spot any delays.

How did we perform in 2011/12?
The following table shows the proportions of patients operated on within the time frames required for cases categorised as immediate (within 60 minutes); urgent (within 24 hours); and expedited (within 4 days).

	Q1 Apr-Jun 2011	Q2 Jul-Sep 2011	Q1 Oct-Nov 2011	Q4 Jan-Mar 2012
IMMEDIATE (within 60 minutes)				
cases within our standard	2	3	8	4
Total Immediate cases	3	3	9	4
% within our standard	**66%**	**100%**	**89%**	**100%**
URGENT (within 24 hours)				
cases within our standard	672	664	698	756
Total Urgent cases	692	710	754	721
% within our standard	**97%**	**94%**	**93%**	**95%**
EXPEDITED (within 4 days)				
cases within our standard	437	523	568	539
Total Expedited Cases	441	533	572	535
% within our standard	**99%**	**98%**	**99%**	**99%**

This shows that we achieved our target which fell within the range that we had set (see section on local indicators, page x)

We started improving the quality of care for emergency surgery patients in 2009. Our first audit in 2010 showed that we had already achieved our standards for more than 90% of patients.

Since then, we have continued to perform at this level or better, so in 2010/11 we planned a 10% reduction in the average waiting time instead. The drawback is that patients do not queue in a 24 hour system: only the most critical, life saving surgery is carried out between midnight and 0800 hours. Although appropriate, this skews the average waiting time figure, which is not affected by shortening the wait at other times of the day. We therefore did not find this measure useful.

Given the significant progress made already, our stakeholders have agreed this will no longer be a priority for 2012/13, but we will continue to monitor our progress on surgery waiting time, information to patients and 'nil by mouth' waiting times and report to the Trust Executive Quality Committee and Assurance Committee.

PART TWO

Our priorities for quality improvement 2012/13

Patient Safety

Priority 1:
To have no hospital acquired preventable venous thromboembolism (VTE)

Why is this important?
Around half of all cases of venous thromboembolism (VTE) occur in patients who have recently been admitted to hospital. VTE is one of the most common preventable causes of hospital deaths, accounting for more than 25,000 deaths in England every year.

We can help prevent VTE occurring by providing preventive treatment, including the use of compression stockings and appropriate drugs.

We have kept this priority from last year because although we have made good progress we have not yet achieved our target.

What will we do in 2012/13?
We will continue to check which patients with preventable VTE associated with their hospital stay or occurring within three months of admission did not receive appropriate preventive treatment.

We will continue to undertake root cause analysis, (RCA)—in-depth analysis to get to the bottom of what happened—in these cases and pinpoint what action we need to take to make sure that patients do get appropriate preventive treatment in future.

We will continue to monitor how many patients on each ward receive appropriate preventive treatment and ensure that we focus on those areas that are falling short.

We will create an online training module on VTE prevention and treatment for all doctors working at the Trust to complement the training modules we already have for nurses. This will ensure that all frontline staff are aware of the preventive treatments we use in this hospital and help us standardise training

How will we track progress?

We will track progress through continuing to review the number of adults who are assessed for their risk of VTE when they are admitted to hospital, those who acquire a VTE that could have been prevented and check every month how many were given appropriate preventive treatment See below – I have rewritten – what do you think?

Our target is to reduce the number of preventable VTEs to zero and we will monitor the numbers every month. We will achieve this target through education and training, ensuring risk assessments are undertaken and that every patient identified to be at risk of VTE is offered appropriate preventative treatment (compression stockings and/or medicines). We will also monitor the uptake of training, the use of leaflets, risk assessments being undertaken and the correct preventative treatment being used.

How will progress be reported?
Progress will be reported at the multidisciplinary Thrombosis and Thromboprophylaxis Committee, and at the Trust Executive Quality Committee and the Assurance Committee.

Patient experience

Priority 2:
Continue to focus on communication, discharge planning, and the care of older people

Why is this important?
We have made improvements in all three areas over the past year, but these need to be continued, and our National Inpatient Survey results show that there is still room for improvement in these areas.

What will we do in 2012/13?

Communication

- Communicate the agreed Trust values and related behaviours to staff, patients and their families as well as our other stakeholders
- Improve the content, presentation and timeliness of appointment letters
- Produce information on ward routines for all adult inpatients which will be laminated and attached to each bedside locker

Discharge planning

We are setting up a discharge project and will agree with stakeholders how to measure success. We will however:

- Aim to improve the coordination of discharge with primary and community care teams, and so reduce the length of stay and readmissions for those with complex needs
- Continue to look at setting up consultations with a senior member of staff immediately before discharge, and following up the next day by phone

Care of the older person

- The evidence suggest that the 'wellbeing' rounds are linked to a fall in complaints and a decrease in the number of falls and so we will roll out 'wellbeing' ward rounds to all adult inpatient areas
- We will continue to monitor our performance against the essential standards of quality and safety relating to privacy and dignity through the senior nursing and midwifery clinical rounds
- We will continue monthly audits of nutritional screening and look at other measures to ensure our patients are well fed e.g. volunteer meal time support
- Objective re dementia to be added linked to CQUIN

How will we track progress?
We will continue to monitor complaints within each division against these three themes as part of our patient experience strategy. We will initiate quarterly patient experience surveys based on a number of key questions.

For each of the objectives above we have agreed how we will measure progress and how often.

How will progress be reported?
Progress will be reported through the Trust Executive Quality Committee and Assurance Committee

Patient Experience

Priority 3:

To stay in the top 20% of acute trusts nationally for staff engagement and for appraisals and to be in the top 20% for all aspects of appraisal and to ensure our agreed Trust values inform everything that we do

Why is this important?

Research shows that there is a clear link between satisfied staff and the quality of patient care they deliver. Motivated and engaged staff feel more able to come up with innovative ideas to improve quality and efficiency at work. And they are more likely to want to stay working for us and to provide high quality care.

We have developed a set of four core values—respectful, kind, safe and excellent—which have been agreed with staff and patients, to underpin everything we do at the Trust. We are in the process of coming up with behaviours that reflect these values in every day practice, but first, we would like all staff to sign up to these values, so that our approach is consistent across the Trust and patients know what to expect.

What will we do?

- Launch annual awards in May 2012 to recognise staff achievements
- Increase appraisal rates to at least 87% and % staff appraised with a PDP to 75%.
- Increase the % staff reporting a well structured appraisal to at least 50%. Achieving these targets will put us in the top 20% of acute trusts nationally.
- Every member of staff will receive written confirmation of our Trust values by the end of June 2012
- We will review all aspects of staffing policy, including recruitment, appraisal, and training in light of these values and take action to amend practice.

How will we track progress?

We will measure the staff engagement score in the annual staff survey, including whether staff would recommend the Trust as a place to work and be treated, and the areas relating to communication. We will look for improvements in the 16 questions in the national patient survey where we scored below the national average, in light of our four key values.

We will monitor appraisal rates every month and undertake regular checks on the quality of appraisal documentation.

How will progress be reported?

Appraisal rates and their quality will reported at the operational managers meeting, while the staff survey action plan and progress on progress on the translating the Trust's values into every day behaviours will be reported through the Trust Executive Quality Committee and the Assurance Committee.

Clinical Effectiveness

Priority 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 or within 14 hours of their arrival at the hospital

Why is this important?

The evidence from several professional bodies shows that patients admitted as an emergency and seen by consultants fare better, usually because they are diagnosed and treated more quickly.

We were the only hospital in England with low mortality rates across all four mortality indicators in the Dr Foster Hospital Guide. But we know there is more we can do to improve care and this is why we are committed to ensuring that emergency patients are seen by a consultant within 12 hours of admission, whatever day of the week they are admitted.

Feedback and analysis of complaints data show that involving consultants earlier on in a patient's care can improve their satisfaction with, and confidence in, the care they receive. And our own figures show that we tend to discharge fewer patients at weekends – which means we are not making the most efficient use of our staff and bed space.

What will we do?
For our emergency medical and general surgical patients we will ensure that there are consultant led ward rounds occurring twice a day, in the morning and in the evening, seven days a week.

This will allow us to ensure that all emergency medical and general surgical patients are seen within 12 hours of their admission throughout the week and also at weekends.

How will we track progress?
Our Electronic Patient Record (EPR) system, known as LastWord, has the potential to capture when a patient is reviewed, and by whom. And we will use this system to monitor how well we meet our target from the summer of 2012 onwards.

We think this will help improve patients' care and experience whilst also shortening hospital stays.

How will this be reported?
Progress will be reported to the Trust Executive Quality Committee and the Assurance Committee.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 3 May 2012

AGENDA ITEM NO.	2.13/May/12
PAPER	Draft Minutes of the Council of Governors Quality Sub-Committee meeting held on 27 March 2012
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Mike Anderson, Chairman of the Quality Sub-Committee
EXECUTIVE SUMMARY	Draft minutes are enclosed.
ACTION	To note.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Quality Sub-Committee meeting, 27 March 2012

Draft Minutes

Attendees	Carol Dale		Staff Governor – Management	
	Rosie Glazebrook	RG	Appointed Governor- PCT NHS Hammersmith & Fulham	Apologies
	Melvyn Jeremiah	MJ	Public Governor – Westminster 2	
	Jacinto Jesus	JJ	Staff Governor – Contracted	Apologies
	Martin Lewis	ML	Public Governor – Westminster 21	
	Susan Maxwell	SM	Patient Governor	
	Wendie McWatters	WMW	Patient Governor	
	Cyril Nemeth	CN	Appointed Governor - Westminster City Council	Apologies
	Sandra Smith-Gordon	SS-G	Public Governor – Kensington & Chelsea 2	
	Maddy Than	MT	Staff Governor – Support, Admin & Clerical	
	Mike Anderson	MA	Medical Director, Chairman	Apologies
	Cathy Mooney		Director of Governance and Corporate Affairs	
	Therese Davis	TD	Chief Nurse	
	Tony Pritchard	TP	Deputy Chief Nurse	Apologies
	Christopher Collister	CC	PALS Manager	Apologies
	Patricia Gani	PG	LINk representative	
	Dr Oyejumoke Okubadejo	OOk	NHS North West London representative	Apologies
	Melanie van Limborgh	MvL	Head of Quality and Assurance	
	Vida Djelic	VD	Foundation Trust Secretary	

1 Welcome and Apologies **CM**

Apologies were received as noted above.

2 Minutes of previous meeting 24 January 2012 **CM**

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

3 Matters arising **MA**

TD said that the Signage Group will consider the look of reception and any issues that need addressing will be dealt with by this group.

The sub-committee noted that some actions have been completed and that those that have not been will be dealt with in due course.

4 Update on outpatients **MD**

MD gave an update on cancellation of appointments and explained that verification of each cancellation has to be done manually.

There is a procedure in place and each appointment cancelled has to be reviewed by the clinicians. Information to patients will be available on screens in waiting areas.

5 Quality Account

5.1 Report from the Quality Account Planning Group

The sub-committee noted that a small group of governors and others has been set up with a view to consider the presentation and design of the Quality Account.

MvL highlighted the main points discussed and agreed by the Quality Account Planning Group:

- A survey of the last year's Quality Account was conducted by Capita at the beginning of March asking patients what they thought of the current Quality Account in order to ensure that this year's Quality Account is readable and relevant to patients.
- Photographs will be included illustrating themes.
- We engaged a designer who attended the meeting earlier today and explained the front cover and the colour pallet to be used; the group discussed the possible designs and the photo for the cover page.
- We have approached divisions re some ideas for case studies.
- We will chose the final photographs for inclusion in the Quality Account at the beginning of May.
- We have engaged a professional writer and we have already sent some pieces of the text to the writer.
- We have looked at the Central London Community Healthcare Trust with a view to find out what processes they have in place re design of the Quality Account. They have significantly more resources than are available to us even with the extra this year. There is a project manager who is responsible for creation of the Quality Account.
- It was suggested that stakeholder logos will be included in the Quality Account.
- A Council of Governors commentary may be included in the account if there are one or more prepared to co-ordinate this.

5.2 Content of the Quality Account

CM introduced the content of the Quality Account and highlighted two important areas. These are the quality priorities and the local performance indicators. The Sub-Committee was invited to comment and agree on priorities and indicators. There has been a wide range of engagement and a description of this will be included in the Quality Account.

CM highlighted the main quality priorities. These are:

<u>Objective 1: Patient safety</u>
We now have a baseline for no hospital acquired preventable venous thromboembolism (VTE) and will consult with Helen Yarranton on a target for next year as we work towards an eventual target of zero.

This was agreed.

Objective 2: Clinical effectiveness
We have continued to meet the standards around waiting time for surgery but have been unable to demonstrate a 10% reduction as on reflection this was difficult to measure. However, a reduction from 4 to 3 days was noted for expedited cases. The sub-committee noted that the overall reduction is good and that the data collection is very complex and technical. SS-G queried the arrangement proposed last year to have a computer which would record data. CM responded that this is in place and has made it much easier but the data still needs to be validated by a clinician. More information is required on nil by mouth times and information for patients. In view of the progress and the proposal that we have another priority the group was asked if they agreed that this priority was no longer considered as a priority. This was agreed providing work continued with a view to being reported in the next Quality Account.

CM invited views from the sub-committee on an objective proposed by the executive team regarding improving the quality of emergency services. This is to aim for 75% of medical and general surgery patients admitted as an emergency to be seen by a consultant within 12 hour of decision to admit or 14 hrs from arrival in hospital.

The sub-committee discussed various reasons impacting on the length of hospital stay and noted the importance of a patient being seen within 12 hours of being admitted which helps with treatment plans.

The new priority was agreed.

Objective 3: Patient Experience
TD said this is a key objective which was discussed with the divisions and is directly linked to the values. The sub-committee noted that the Trust values paper is to be agreed by the Board on 29 March and these values will need to be embedded and consolidated and we would develop behaviours and some specific measures. From these outcomes we would be expecting patient's satisfaction to increase and this will be used in our survey.

ML suggested that all staff and patients have a pledge card so that they know what to expect.

CM draw attention of the sub-committee to the table in section 3.2 which presented local performance indicators being broken into three top headings: communication, discharge and care of the older people.

The sub-committee noted the importance of the Trust's values being embedded in the recruitment process and that these will be applied to when recruiting the new Chief Executive.

TD noted that the Trust's values will be launched at the Hospital Open Day on 12 May 2012.

In response to SM's query re vulnerable patients' discharge TD said that the discharge should be planned from the day of admission and we are trying to improve.

The sub-committee noted that the integrated care initiatives between acute, primary and community care will be kept in and the opportunity to

implement nurse led discharge has been identified.

TD said that comfort rounds will be rolled out to all adult inpatient area. On David Erskine ward the nurses check basic needs of all of patients on a routine basis and there has not been a complaint in over a year on this ward.

CM pointed out that we need to do some more work on ensuring the quality of the data in the local indicators and this is ongoing. CM said the idea is that this will be published on the web as part of transparency process once the correct data is available.

TD explained the NHS safety thermometer. It is a national requirement and will record falls, urinary catheter infections, pressure ulcers and VTEs. This will require a lot of data collection. CM said some other areas for inclusion included focus on learning.

ML suggested quality awards were included.

6 Quality Awards **MvL**

The sub-committee noted an email from MvL suggesting that due to the launch of Star Awards in May the Quality Awards is postponed till late Spring.

The sub-committee discussed the timing of Quality Awards and Star Awards. It was agreed that some consideration needs to be given to allow enough time between the two awards so that each awards get the necessary attention.

MvL proposed 3 quality awards a year. SM felt that as the Quality Awards are funded by the Council of Governors they should have their Quality Awards in May and the Star Award can be moved to later in spring.

7 Report from the Commission on Improving Dignity in Care **SSG**

SS-G said felt that this applies to all patients, not only elderly.

TD welcomed the input from governors and suggested this could be discussed again. Any comments arriving after the consultation deadline will also be taken in consideration.

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

SS-G commented that the floors in some areas of the hospital need reviewing.

SS-G brought up an issue of nurses hierarchy on the wards.

SS-G said her sister was in a day surgery and pointed out that most of staff were very kind and helpful but she could not find where in the hospital her sister was treated.

ML conveyed positive comments re ‘how can we help you’ banner at the main entrance door.

PG pointed out that screens and hand sanitizer need to be placed near the entrance door.

WMW brought up a question of MLPALS not being known by patients and visitors of hospital. She suggested an MPALS leaflet being placed on each ward outlining if there are any comments/complaints these will be resolved efficiently and quickly. TD said there is a plan to reorganize the MPALS office and it will be called ‘How can I help you?’ The office will assist a patient to talk to the right person and get any issues resolved immediately.

9 Any other business

None

10 Date of next meeting – 15 June 2012

Council of Governors Meeting, 3 May 2012

AGENDA ITEM NO.	2.14/May/12
PAPER	NHS Staff Survey 2011 - Summary of Results
AUTHOR	Mark Gammage, Director of Human Resources
LEAD	Mark Gammage, Director of Human Resources
EXECUTIVE SUMMARY	The annual staff survey is sent to every member of staff and the results are forwarded directly to an external agency who process the results. The same survey is used throughout the NHS and conducted during Autumn each year. 61% of all staff completed the questionnaire (a response rate which places the Trust in the top 20% of acute trusts nationally). The Trust's performance has improved significantly with scores for 26 out of 38 key indices improving since last year, 11 remaining broadly the same and only 1 deteriorating. The Trust continues to compare very favourably with other acute trusts with 24 indices better than average, 5 scoring average and 9 worse than average. Analysis from the Association of UK University Hospitals identified the Trust as showing the greatest year on year improvement, even though our comparative scores were above average last year. On the key questions of whether staff would recommend this Trust as a place to be treated and as a place to work, the trust scored in the top 20% of acute Trusts nationally. The Trust scored the highest of all acute Trusts in 4 indices including staff reporting good communication between senior management and staff. However there are areas for improvement including the percentage of staff undertaking health and safety training and staff reporting hand washing materials available at all times and the Trust will be taking action to ensure these issues are addressed.
DECISION/ ACTION	For information.

NHS Staff Survey 2011

Chelsea and Westminster Hospital NHS Foundation Trust

1. Executive Summary

1.1 The Care Quality Commission (CQC) Staff Survey 2011 results were published nationally on 20 March 2012.

1.2 All NHS organisations use the same staff survey using one of three approved contractors. This Trust uses Capita, in common with approximately 30% of NHS Trusts.

1.3 Department of Health research carried out by Aston University using NHS staff survey results shows that high levels of staff engagement have a positive impact on financial management, health and well-being, quality of service provision, patient satisfaction and absenteeism.

1.4 1,713 staff from Chelsea and Westminster completed the questionnaire in Autumn 2011. This is a response rate of 61% which places the Trust in the top 20% of acute NHS trusts in England in terms of response rates with the second highest response rate of acute trusts in London.

1.5 The CQC bases its report on a 10% sample of staff and it is this sample that is used to make national comparisons. Although NHS organisations are only required to survey a sample, we opt each year to survey all our employees. A response rate of 61% demonstrates our commitment to engaging with as many staff as possible.

1.6 The survey report is structured around the 4 national pledges to staff given in the NHS Constitution and 2 additional themes of staff satisfaction and equality & diversity. These pledges and themes are reported under 38 key findings (KFs).

1.7 The Trust's performance has improved significantly since the 2010 survey based on a year-on-year comparison of scores for the 38 KFs: 26 improved, 11 remained broadly the same, and only 1 deteriorated.

1.8 When compared with other acute trusts the Trust scored better than average on 24 KFs, average on 5 KFs and worse than average on 9 KFs.

1.9 The Trust achieved the best score of any acute trust nationally for 4 of the KFs[1].

1.10 The CQC has provided an overall 'Staff Engagement Score' for the last three years. This includes staff's perceived ability to contribute to improvements at work, their willingness to recommend the Trust as a place to work/receive treatment, and the extent to which staff feel motivated and engaged with their work. The Trust's engagement score was 3.81 (on a Likert scale of 5, where 5 is best) placing us in the top 20% of acute trusts nationally for the third year running.

[1] In some cases these scores were shared by other acute trusts but no acute trust scored better than us on these 4 KFs.

1.11 The Trust has undertaken a detailed analysis of this data at Trust level and also at directorate and department level, and will disseminate findings to staff. An action plan is being completed which will outline the key priorities for the Trust as well as more detailed plans for each division and directorate.

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

1.13 Results are communicated to all staff and managers take action to address issues of importance.

2. High Level Indicators

2.1 The Trust achieved the highest score nationally for acute trusts for 4 of the KFs. Trust commitment to work-life balance (KF:7), % of staff feeling there are good opportunities to develop their potential at work (KF:10), % of staff experiencing physical violence from patients/relatives or the public in the last 12 months (lowest = best) (KF:23), and % of staff reporting good communication between senior management and staff (KF:30).

2.2 The Trust scored in the top 20% of acute trusts in a further 13 KFs, and above average in another 7. (For further details see Appendix 1- Key Findings Staff Survey Analysis Mar 2012)

2.3 Areas of concern for the Trust are focused around five key findings, some of which, while they have shown some improvement on last year, continue to be below the national average. These are % of staff working extra hours, % of staff receiving health and safety training in the last year, % of staff saying handwashing materials are always available, impact of health and wellbeing on ability to perform work or daily activities and % of staff experiencing discrimination at work in the last 12 months. Further work will be undertaken to understand these scores and action taken to ensure these concerns are addressed.

2.4 The Trust achieved a 5% increase in KF12: % of staff having an appraisal within the last 12 months, remaining average for all acute trusts in this area, however KF13: % of staff having a well structured appraisal scored in the top 20% of trusts reflecting the work that has been undertaken on appraisals this year. Further activity is planned for this year to ensure that the Trust is in the top 20% for appraisals in 2012.

2.5 The percentage of staff always saying that handwashing materials are always available (KF:19) showed an improvement on last year but the Trust remains in the bottom 20% of trusts for this. Analysis indicates that while the vast majority of staff agreed that such materials were either always or mostly available (94%), the % saying ‘always’ was lower than other acute trusts.

2.6 Improvements were also reported in staff satisfaction with the quality of work/patient care they deliver, work pressure felt by staff, Trust commitment to work-life balance, % of staff feeling valued by work colleagues, % of staff using flexible working options, % of staff having well structured appraisals, support from immediate managers, % of staff experiencing harassment/bullying/abuse from patients/relatives/staff, perceptions of effective action from Trust towards violence and harassment, staff able to

contribute to improvements at work, staff job satisfaction and staff intention to leave jobs.

2.7 The CQC calculated a 'Staff Engagement Score' for the third consecutive year. It measures against staff's perceived ability to contribute to improvements at work (KF:31), their willingness to recommend the Trust as a place to work/receive treatment (KF:34) and the extent to which staff feel motivated and engaged with their work (KF:35). The Trust's engagement score was 3.81 which put us in the top 20% of acute Trusts in the country.

2.8 A summary of 2011 compared with our own 2010 results and the national results is shown in Appendix 1.

2.9 Analysis of the results of other London trusts can be seen in Appendix 2. This shows that the Trust ranked well in the majority of Key Findings, with 16 in the top 5 (of 24 trusts), of which 4, Trust commitment to work-life balance, % of staff receiving relevant training or development in last 12 months, % of staff having a well structured appraisals, staff reporting good communication between senior management and staff, ranked in first place.

2.10 Analysis provided by the Association of UK University Hospitals of member Trusts results identified Chelsea and Westminster as ranked number 1 for year on year improvement, with 24 of the 38 KFs in the top quartile and 4 of which Chelsea and Westminster achieved the top ranking (Trust commitment to work-life balance, % of staff believing there are good opportunities to develop their potential, % of staff receiving job relevant training and % of staff agreeing there is good communication between senior management and staff).

3. Responses from different professional groups

3.1 89% of medical staff had an appraisal within the last 12 months, a significant improvement on the 71% agreeing in 2010. However only 75% of A&C staff said the same.

3.2 Staff recommending the Trust as a place to receive treatment or a place to work was above 4 (on a scale of 1 to 5) in 4 of the 8 staffgroups (AHPs, senior managers[2], scientific staff and nursing support). All staffgroups increased in this KF on the previous year.

3.3 Overall the Trust achieved the highest % nationally of staff reporting good communications between senior management and staff, with 50% of medical staff agreeing while 32% of A&C staff said the same. A majority of staff in all staffgroups felt that they were able to contribute towards improvements at work.

3.4 Within the areas of concern highlighted above (see 2.3), 91% of medical staff and 94% of senior managers said they worked extra hours. Only 46% of A&C (Bands 2-6 staff) had received health and safety training and 41% of AHP staff and 48% of A&C staff said handwashing materials were always available. Staff perception of the impact of their health and wellbeing on their work was highest for A&C staff at 1.80 (on a scale of 1 to 5.) 24% of nursing staff said they had experienced discrimination in the last 12 months, 19% of A&C staff said the same.

[2] defined as AfC Bands 7 and above so including middle managers

4. Link with the Quality Account

4.1. A growing body of evidence has shown a clear correlation between a satisfied workforce and high quality patient care. The staff engagement score in the national staff survey includes the following:

- staff feeling able to contribute towards improvements at work;
- the extent to which staff feel motivated and engaged with their work, and
- willingness of staff to recommend the Trust as a place to work and/ or receive treatment.

- The Trust committed to maintaining it's position within the top 20% of acute trusts for overall Staff Engagement. This was maintained and improved in the 2011 Survey, scoring 3.81 (on a scale of 1 to 5, 5 being the most engaged).
- While our appraisal rate improved to 80%, we did not achieve the 84% target (we aim to improve this to 87% this year and have included this in our Action Plan).
- The percentage of staff who stated they had a well structured appraisal exceeded our target of 41%, achieving 46% (we aim to continue to improve this percentage in the 2012 survey)
- The percentage of staff appraised with personal development plans met our target of 72% (and we aim to increase this from to >75%)

5. Reporting, action planning and implementation

5.1 The CQC report has been uploaded for all staff to view on the Trust Intranet. This and further Trust analyses will be shared with the Executives, Divisional Medical Directors and Divisional Directors of Operations for dissemination throughout the organisation.

5.2 Communication will include:

5.2.1. External: A press release has been sent to local, regional and trade media and details of our survey results has been published on the Trust website.

5.2.2 Internal: The staff survey results will be shared with Staffside colleagues including the JMTUC and LNC, the Trust Executive, the Equality & Diversity steering group, managers and clinicians, Heads of Departments and other relevant groups. The key results will appear in Team Briefing, Trust News, at the Council of Governors and performance meetings and at the annual Open Day in May.

5.3 Action planning: A draft Trust Action plan is included as Appendix 3. This will be revised following submissions of Directorate action plans by the 4th May 2012.

5.4 Departments and Directorates will be able to analyse data for their areas and form their own action plans.

April 2012

Key findings 2011

Notes: Based on Sample of 475 staff
This data is gathered from the full CQC report. Responses have been weighted to match the profile of an average Acute Trust and therefore may vary from initial unweighted analysis. A higher score is better except on Key Findings marked with an asterisk and shown in italics.

CQC interpretation	↑ Improvement/better than average	↓ Deterioration/worse than average	= Same/no significant change	n/a Comparison not possible

Overall Staff Engagement (KF31, KF34 and KF35)	2011	2010	Nat Avg	C&W 2011 vs C&W 2010	C&W 2011 vs National Acute Trusts
Overall Staff Engagement Indicator	3.81	3.74	3.62	↑	Highest (best) 20%

Staff Pledge 1 : Provide staff with clear roles, resp. & rewarding jobs	2011	2010	Nat Avg	C&W 2011 vs C&W 2010	C&W 2011 vs National Acute Trusts
KF1: % of staff feeling satisfied with quality of work & patient care they are able to deliver**	82%	76%	74%	↑	Highest (best) 20%
KF2: % of staff agreeing that their role makes a difference to patients	91%	91%	90%	=	Above (better than) average
KF3: % of staff feeling valued by their work colleagues	77%	73%	76%	↑	Above (better than) average
KF4: Quality of job design (clear job content, feedback and staff involvement)	3.50	3.43	3.41	↑	Highest (best) 20%
* ***KF5:*** *Work pressure felt by staff*	2.93	3.03	3.12	↑	Lowest (best) 20%
KF6: Effective team working	3.75	3.69	3.75	↑	Above (better than) average
KF7: Trust commitment to work-life balance**	3.64	3.50	3.36	↑	Highest nationally
* ***KF8:*** *% working extra hours*	70%	70%	65%	=	Highest (worst) 20%
KF9: % of staff using flexible working options	62%	56%	61%	↑	Above (better than) average

** Highlighted by CQC as area of significant improvement (yr on yr).

Staff Pledge 2 : Provide all staff with personal dev, training and line mgt support	2011	2010	Nat Avg	C&W 2011 vs C&W 2010	C&W 2011 vs National Acute Trusts
KF10: % of staff feeling there are good opportunities to develop their potential at work	51%	51%	40%	=	Highest nationally
KF11: % of staff receiving job-relevant training, learning or development in last 12 mths	83%	80%	78%	↑	Highest (best) 20%
KF12: % of staff appraised in last 12 months	80%	75%	81%	↑	Average
KF13: % of staff having well structured appraisals in last 12 months	46%	40%	34%	↑	Highest (best) 20%
KF14: % of staff appraised with personal development plans in last 12 mths	72%	69%	68%	↑	Above (better than) average
KF15: Support from immediate managers**	3.79	3.66	3.61	↑	Highest (best) 20%

** Highlighted by CQC as area of significant improvement (yr on yr).

Staff Pledge 3 : Provide support & opportunities for staff health, well-being & safety	2011	2010	Nat Avg	C&W 2011 vs C&W 2010	C&W 2011 vs National Acute Trusts
KF16: Percentage of staff receiving health and safety training in last 12 mths	64%	59%	81%	↑	Lowest (worst) 20%
* ***KF17:*** *Percentage of staff suffering work-related injury in last 12 months*	14%	15%	16%	↑	Below (better than) average
* ***KF18:*** *Percentage of staff suffering work-related stress in last 12 months*	29%	30%	29%	=	Average
KF19: % of staff saying hand washing materials are always available	58%	54%	66%	↑	Lowest (worst) 20%
* ***KF20:*** *% of staff witnessing potentially harmful errors, near misses or incidents in last mth*	37%	36%	34%	=	Above (worse than) average
KF21: % of staff reporting errors, near misses or incidents witnessed in the last mth	96%	96%	96%	=	Average
KF22: Fairness and effectiveness of procedures for reporting errors, near misses or incidents	3.56	3.56	3.46	=	Highest (best) 20%
* ***KF23:*** *% of staff experiencing physical violence from patients/relatives or public in last 12 mths***	4%	7%	8%	↑	Lowest (best) nationally
* ***KF24:*** *% of staff experiencing physical violence from staff in last 12 mths*	1%	1%	1%	=	Below (better than) average
* ***KF25:*** *% of staff exp harassment, bullying or abuse from patients/relatives or public in last 12 mths*	15%	19%	15%	↑	Average
* ***KF26:*** *% of staff exp harassment, bullying or abuse from staff in last 12 months*	13%	16%	16%	↑	Lowest (best) 20%
KF27: Perceptions of effective action from employer towards violence & harassment	3.64	3.57	3.58	↑	Highest (best) 20%
* ***KF28 :*** *Impact of health and well-being on ability to perform work or daily activities*	1.66	1.61	1.56	↓	Highest (worst) 20%
* ***KF29:*** *% of staff feeling pressure in last 3 mths to attend work when feeling unwell*	22%	24%	26%	↑	Lowest (best) 20%

** Highlighted by CQC as area of significant improvement (yr on yr).

Staff Pledge 4 : Engage staff in decisions to deliver better and safer services	2011	2010	Nat Avg	C&W 2011 vs C&W 2010	C&W 2011 vs National Acute Trusts
KF30: % of staff reporting good communication between senior management and staff	42%	37%	26%	↑	Highest nationally
KF31: % of staff able to contribute towards improvements at work	69%	68%	61%	=	Highest (best) 20%

Additional Theme: Staff satisfaction	2011	2010	Nat Avg	C&W 2011 vs C&W 2010	C&W 2011 vs National Acute Trusts
KF32: Staff job satisfaction**	3.58	3.48	3.47	↑	Highest (best) 20%
* ***KF33:*** *Staff intention to leave jobs*	2.62	2.75	2.59	↑	Above (worse than) average
KF34: Staff recommendation of the trust as a place to work or receive treatment**	3.89	3.77	3.50	↑	Highest (best) 20%
KF35: % Staff motivation at work	3.83	3.81	3.82	↑	Average

** Highlighted by CQC as area of significant improvement (yr on yr).

Additional Theme - Equality and Diversity	2011	2010	Nat Avg	C&W 2011 vs C&W 2010	C&W 2011 vs National Acute Trusts
KF36: % of staff having equality and diversity training in last 12 mths	42%	42%	48%	=	Below (worse than) average
KF37: % of staff believing trust provides equal opps for career progression or promotion	86%	85%	90%	=	Below (worse than) average
* ***KF38:*** *% of staff experiencing discrimination at work in last 12 mths*	16%	19%	13%	↑	Highest (worst) 20%

	2010 C&W	National
↑/Better than average	26	25
= / Average	11	4
↓ / Worse than average	1	10

2011 NHS Staff Survey
Overall Staff Engagement

Trust	Overall Staff Engagement	KF31: % of staff able to contribute towards improvements at work	KF34: Staff recommendation of the trust as a place to work or receive treatment	KF35: Staff motivation at work	Q21a "I would recommend my trust as a place to work" (Agree/Strongly agree %)	Q21b "If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust" (Agree/Strongly agree %)
Barking, Havering and Redbridge Hospitals NHS Trust	3.39	51%	3.08	3.72	28%	39%
Barnet and Chase Farm Hospitals NHS Trust	3.66	66%	3.52	3.86	54%	63%
Barts and The London NHS Trust	3.63	64%	3.50	3.83	50%	60%
Chelsea and Westminster Hospital NHS Foundation Trust	3.81	69%	3.89	3.83	73%	80%
Croydon Health Services NHS Trust (formerly Mayday)	3.57	68%	3.18	3.92	36%	33%
Ealing Hospital NHS Trust	3.65	66%	3.43	3.93	47%	50%
Epsom & St Helier University Hospitals NHS Trust	3.62	64%	3.47	3.84	47%	60%
Guy's and St Thomas' NHS Foundation Trust	3.90	68%	4.05	3.96	77%	85%
Homerton University Hospital NHS Foundation Trust	3.83	77%	3.80	3.95	71%	72%
Imperial College Healthcare NHS Trust	3.72	67%	3.66	3.86	56%	70%
King's College Hospital NHS Foundation Trust	3.75	65%	3.83	3.85	68%	75%
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	3.63	66%	3.54	3.78	56%	61%
Newham University Hospital NHS Trust	3.61	61%	3.43	3.86	50%	49%
North Middlesex University Hospital NHS Trust	3.53	61%	3.32	3.79	45%	50%
North West London Hospitals NHS Trust	3.67	59%	3.54	3.94	52%	57%
Royal Brompton and Harefield NHS Trust	3.91	72%	4.09	3.92	76%	92%
Royal Free Hampstead NHS Trust	3.72	68%	3.66	3.88	59%	71%
St George's Healthcare NHS Trust	3.60	63%	3.57	3.73	55%	64%
The Hillingdon Hospital NHS Trust	3.67	61%	3.53	3.91	56%	56%
The Royal Marsden NHS Foundation Trust	3.86	70%	4.00	3.89	70%	85%
The Whittington Hospital NHS Trust	3.74	64%	3.70	3.91	61%	70%
University College London Hospitals NHS Foundation Trust	3.86	67%	3.99	3.91	68%	85%
West Middlesex University Hospital NHS Trust	3.39	57%	3.10	3.69	35%	46%
Whipps Cross University Hospital NHS Trust	3.68	62%	3.56	3.90	53%	66%
C&W ranking in this selection of Trusts	**6/24**	**4/24**	**5/24**	**18/24**	**3/24**	**5/24**
All Acute Trusts	**3.62**	**61%**	**3.50**	**3.82**	**52%**	**62%**
Average London Acute & Fulham Rd	**3.67**	**65%**	**3.60**	**3.86**	**54%**	**60%**

Trust	Response rate
Barts and The London NHS Trust	64%
Ealing Hospital NHS Trust	64%
Chelsea and Westminster Hospital NHS Foundation Trust	61%
Barnet and Chase Farm Hospitals NHS Trust	59%
The Royal Marsden NHS Foundation Trust	57%
University College London Hospitals NHS Foundation Trust	55%
Guy's and St Thomas' NHS Foundation Trust	51%
North Middlesex University Hospital NHS Trust	51%
Whipps Cross University Hospital NHS Trust	50%
King's College Hospital NHS Foundation Trust	50%
Epsom & St Helier University Hospitals NHS Trust	48%
Croydon Health Services NHS Trust (formerly Mayday)	46%
Barking, Havering and Redbridge Hospitals NHS Trust	46%
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	44%
St George's Healthcare NHS Trust	44%
Royal Free Hampstead NHS Trust	44%
North West London Hospitals NHS Trust	43%
The Hillingdon Hospital NHS Trust	43%
Homerton University Hospital NHS Foundation Trust	42%
Royal Brompton and Harefield NHS Trust	42%
Imperial College Healthcare NHS Trust	42%
The Whittington Hospital NHS Trust	39%
West Middlesex University Hospital NHS Trust	35%
Newham University Hospital NHS Trust	32%
All Acute Trusts	*53%*
Average London Acute	*48%*

Key

Rating Indicator:
H = Higher rating better.
L =Lower rating better.

Rating:
% = % of respondents who agreed with the Key Finding questions.
Ratings without a % are measured on a scale of 1 to 5, the higher (or lower for L rated questions) the better the response.

Ranking: (of 24)
C&W ranking of those trusts measured. 1will always be top, regardless of whether positive or negative score is better.
Green indicates ranking within top 5
Red indicates ranking within bottom 5

Key Finding	Rating indicator	Chelsea and Westminster rating	Ranking (of 24)
KF7: Trust commitment to work-life balance	H	3.64	1
KF11: % of staff receiving job-relevant training, learning or development in last 12 mths	H	83%	1
KF13: % of staff having well structured appraisals in last 12 months	H	46%	1
KF30: % of staff reporting good communication between senior management and staff	H	42%	1
KF24: % of staff experiencing physical violence from staff in last 12 mths	*L*	*1%*	1
KF10: % of staff feeling there are good opportunities to develop their potential at work	H	51%	2
KF15: Support from immediate managers	H	3.79	2
KF26: % of staff exp harassment, bullying or abuse from staff in last 12 months	*L*	*13%*	*2*
KF5: Work pressure felt by staff	*L*	*2.93*	*3*
KF37: % of staff believing trust provides equal opps for career progression or promotion	H	86%	3
KF23: % of staff experiencing physical violence from patients/relatives or public in last 12 mths	*L*	*4%*	*3*
KF29: % of staff feeling pressure in last 3 mths to attend work when feeling unwell	*L*	*22%*	*4*
KF31: % of staff able to contribute towards improvements at work	H	69%	4
KF38: % of staff experiencing discrimination at work in last 12 mths	*L*	*16%*	*4*
KF27: Perceptions of effective action from employer towards violence & harassment	H	3.64	5
KF34: Staff recommendation of the trust as a place to work or receive treatment	H	3.89	5
KF22: Fairness and effectiveness of procedures for reporting errors, near misses or incidents	H	3.56	6
KF1: % of staff feeling satisfied with quality of work & patient care they are able to deliver	H	82%	6
KF9: % of staff using flexible working options	H	62%	6
KF32: Staff job satisfaction	H	3.58	6
KF33: Staff intention to leave jobs	*L*	*2.62*	6
KF6: Effective team working	H	3.75	7
KF17: Percentage of staff suffering work-related injury in last 12 months	*L*	*14%*	*7*
KF4: Quality of job design (clear job content, feedback and staff involvement)	H	3.5	7
KF14: % of staff appraised with personal development plans in last 12 mths	H	72%	7
KF18: Percentage of staff suffering work-related stress in last 12 months	*L*	*29%*	*7*
KF3: % of staff feeling valued by their work colleagues	H	77%	8
KF25: % of staff exp harassment, bullying or abuse from patients/relatives or public in last 12 mths	*L*	*15%*	*8*
KF21: % of staff reporting errors, near misses or incidents witnessed in the last mth	H	96%	9
KF2: % of staff agreeing that their role makes a difference to patients	H	91%	10
KF19: % of staff saying hand washing materials are always available	H	58%	10
KF36: % of staff having equality and diversity training in last 12 mths	H	42%	12
KF20: % of staff witnessing potentially harmful errors, near misses or incidents in last mth	*L*	*37%*	13
KF12: % of staff appraised in last 12 months	H	80%	14
KF8: % working extra hours	*L*	*70%*	15
KF35: Staff motivation at work	H	3.83	18
KF28: Impact of health and well-being on ability to perform work or daily activities	*L*	*1.66*	*19*
KF16: Percentage of staff receiving health and safety training in last 12 mths	H	64%	20

Choose a Key Finding from this drop down box

KF35: Staff motivation at work

Trust	Rating
Guy's and St Thomas' NHS Foundation Trust	3.96
Homerton University Hospital NHS Foundation Trust	3.95
North West London Hospitals NHS Trust	3.94
Ealing Hospital NHS Trust	3.93
Croydon Health Services NHS Trust (formerly Mayday)	3.92
Royal Brompton and Harefield NHS Trust	3.92
University College London Hospitals NHS Foundation Trust	3.91
The Hillingdon Hospital NHS Trust	3.91
The Whittington Hospital NHS Trust	3.91
Whipps Cross University Hospital NHS Trust	3.90
The Royal Marsden NHS Foundation Trust	3.89
Royal Free Hampstead NHS Trust	3.88
Barnet and Chase Farm Hospitals NHS Trust	3.86
Imperial College Healthcare NHS Trust	3.86
Newham University Hospital NHS Trust	3.86
King's College Hospital NHS Foundation Trust	3.85
Epsom & St Helier University Hospitals NHS Trust	3.84
Chelsea and Westminster Hospital NHS Foundation Trust	3.83
Barts and The London NHS Trust	3.83
North Middlesex University Hospital NHS Trust	3.79
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	3.78
St George's Healthcare NHS Trust	3.73
Barking, Havering and Redbridge Hospitals NHS Trust	3.72
West Middlesex University Hospital NHS Trust	3.69
C&W ranking in this selection of Trusts	**18/24**
Average	**3.86**
Highest value in column	**3.96**
Lowest value in column	**3.69**

About this report

- The trusts included in this report include London Acute and the Fulham Road trusts, however CQC reporting includes the Royal Marsden and Royal Brompton & Harefield in another category in their reporting. Rankings may therefore vary from CQC analysis.

Rating:
% = % of respondents who agreed with the Key Finding questions.
Ratings without a % are measured on a scale of 1 to 5, the higher (or lower for L rated questions) the better the response.

Ranking: (of 24)
C&W ranking of those trusts measured. 1 will always be best regardless of whether a lower or higher score is better.
Green indicates ranking within top 5
Red indicates ranking within bottom 5

Question
KF1: % of staff feeling satisfied with quality of work & patient care they are able to delive
KF2: % of staff agreeing that their role makes a difference to patients
KF3: % of staff feeling valued by their work colleagues
KF4: Quality of job design (clear job content, feedback and staff involvement)
KF5: Work pressure felt by staff
KF6: Effective team working
KF7: Trust commitment to work-life balance
KF8: % working extra hours
KF9: % of staff using flexible working options
KF10: % of staff feeling there are good opportunities to develop their potential at work
KF11: % of staff receiving job-relevant training, learning or development in last 12 mths
KF12: % of staff appraised in last 12 months
KF13: % of staff having well structured appraisals in last 12 months
KF14: % of staff appraised with personal development plans in last 12 mths
KF15: Support from immediate managers
KF16: Percentage of staff receiving health and safety training in last 12 mths
KF17: Percentage of staff suffering work-related injury in last 12 months
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KF29: % of staff feeling pressure in last 3 mths to attend work when feeling unwell
KF30: % of staff reporting good communication between senior management and staff
KF31: % of staff able to contribute towards improvements at work
KF32: Staff job satisfaction
KF33: Staff intention to leave jobs
KF34: Staff recommendation of the trust as a place to work or receive treatment
KF35: Staff motivation at work
KF36: % of staff having equality and diversity training in last 12 mths
KF37: % of staff believing trust provides equal opps for career progression or promotion
KF38: % of staff experiencing discrimination at work in last 12 mths
KF1: % of staff feeling satisfied with quality of work & patient care they are able to delive
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KF6: Effective team working
KF7: Trust commitment to work-life balance
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KF7: Trust commitment to work-life balance
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KF9: % of staff using flexible working options
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Trust	Score	Rank
Barnet and Chase Farm Hospitals NHS Trust	78%	
Barnet and Chase Farm Hospitals NHS Trust	93%	
Barnet and Chase Farm Hospitals NHS Trust	74%	
Barnet and Chase Farm Hospitals NHS Trust	3.49	
Barnet and Chase Farm Hospitals NHS Trust	3.08	
Barnet and Chase Farm Hospitals NHS Trust	3.74	
Barnet and Chase Farm Hospitals NHS Trust	3.41	
Barnet and Chase Farm Hospitals NHS Trust	69%	
Barnet and Chase Farm Hospitals NHS Trust	52%	
Barnet and Chase Farm Hospitals NHS Trust	45%	
Barnet and Chase Farm Hospitals NHS Trust	78%	
Barnet and Chase Farm Hospitals NHS Trust	78%	
Barnet and Chase Farm Hospitals NHS Trust	42%	
Barnet and Chase Farm Hospitals NHS Trust	68%	
Barnet and Chase Farm Hospitals NHS Trust	3.68	
Barnet and Chase Farm Hospitals NHS Trust	85%	
Barnet and Chase Farm Hospitals NHS Trust	21%	
Barnet and Chase Farm Hospitals NHS Trust	31%	
Barnet and Chase Farm Hospitals NHS Trust	62%	
Barnet and Chase Farm Hospitals NHS Trust	42%	
Barnet and Chase Farm Hospitals NHS Trust	95%	
Barnet and Chase Farm Hospitals NHS Trust	3.48	
Barnet and Chase Farm Hospitals NHS Trust	10%	
Barnet and Chase Farm Hospitals NHS Trust	2%	
Barnet and Chase Farm Hospitals NHS Trust	18%	
Barnet and Chase Farm Hospitals NHS Trust	19%	
Barnet and Chase Farm Hospitals NHS Trust	3.54	
Barnet and Chase Farm Hospitals NHS Trust	1.62	
Barnet and Chase Farm Hospitals NHS Trust	28%	
Barnet and Chase Farm Hospitals NHS Trust	27%	
Barnet and Chase Farm Hospitals NHS Trust	66%	
Barnet and Chase Farm Hospitals NHS Trust	3.47	
Barnet and Chase Farm Hospitals NHS Trust	2.61	
Barnet and Chase Farm Hospitals NHS Trust	3.52	
Barnet and Chase Farm Hospitals NHS Trust	3.86	
Barnet and Chase Farm Hospitals NHS Trust	66%	
Barnet and Chase Farm Hospitals NHS Trust	85%	
Barnet and Chase Farm Hospitals NHS Trust	20%	
Chelsea and Westminster Hospital NHS Foundation Trust	82%	
Chelsea and Westminster Hospital NHS Foundation Trust	91%	
Chelsea and Westminster Hospital NHS Foundation Trust	77%	
Chelsea and Westminster Hospital NHS Foundation Trust	3.50	
Chelsea and Westminster Hospital NHS Foundation Trust	2.93	
Chelsea and Westminster Hospital NHS Foundation Trust	3.75	
Chelsea and Westminster Hospital NHS Foundation Trust	3.64	
Chelsea and Westminster Hospital NHS Foundation Trust	70%	
Chelsea and Westminster Hospital NHS Foundation Trust	62%	
Chelsea and Westminster Hospital NHS Foundation Trust	51%	
Chelsea and Westminster Hospital NHS Foundation Trust	83%	
Chelsea and Westminster Hospital NHS Foundation Trust	80%	
Chelsea and Westminster Hospital NHS Foundation Trust	46%	
Chelsea and Westminster Hospital NHS Foundation Trust	72%	
Chelsea and Westminster Hospital NHS Foundation Trust	3.79	
Chelsea and Westminster Hospital NHS Foundation Trust	64%	
Chelsea and Westminster Hospital NHS Foundation Trust	14%	

Chelsea and Westminster Hospital NHS Foundation Trust	29%
Chelsea and Westminster Hospital NHS Foundation Trust	58%
Chelsea and Westminster Hospital NHS Foundation Trust	37%
Chelsea and Westminster Hospital NHS Foundation Trust	96%
Chelsea and Westminster Hospital NHS Foundation Trust	3.56
Chelsea and Westminster Hospital NHS Foundation Trust	4%
Chelsea and Westminster Hospital NHS Foundation Trust	1%
Chelsea and Westminster Hospital NHS Foundation Trust	15%
Chelsea and Westminster Hospital NHS Foundation Trust	13%
Chelsea and Westminster Hospital NHS Foundation Trust	3.64
Chelsea and Westminster Hospital NHS Foundation Trust	1.66
Chelsea and Westminster Hospital NHS Foundation Trust	22%
Chelsea and Westminster Hospital NHS Foundation Trust	42%
Chelsea and Westminster Hospital NHS Foundation Trust	69%
Chelsea and Westminster Hospital NHS Foundation Trust	3.58
Chelsea and Westminster Hospital NHS Foundation Trust	2.62
Chelsea and Westminster Hospital NHS Foundation Trust	3.89
Chelsea and Westminster Hospital NHS Foundation Trust	3.83
Chelsea and Westminster Hospital NHS Foundation Trust	42%
Chelsea and Westminster Hospital NHS Foundation Trust	86%
Chelsea and Westminster Hospital NHS Foundation Trust	16%
Barts and The London NHS Trust	76%
Barts and The London NHS Trust	92%
Barts and The London NHS Trust	73%
Barts and The London NHS Trust	3.46
Barts and The London NHS Trust	3.13
Barts and The London NHS Trust	3.72
Barts and The London NHS Trust	3.40
Barts and The London NHS Trust	66%
Barts and The London NHS Trust	61%
Barts and The London NHS Trust	40%
Barts and The London NHS Trust	77%
Barts and The London NHS Trust	86%
Barts and The London NHS Trust	44%
Barts and The London NHS Trust	77%
Barts and The London NHS Trust	3.66
Barts and The London NHS Trust	76%
Barts and The London NHS Trust	19%
Barts and The London NHS Trust	31%
Barts and The London NHS Trust	51%
Barts and The London NHS Trust	35%
Barts and The London NHS Trust	95%
Barts and The London NHS Trust	3.51
Barts and The London NHS Trust	6%
Barts and The London NHS Trust	3%
Barts and The London NHS Trust	17%
Barts and The London NHS Trust	17%
Barts and The London NHS Trust	3.50
Barts and The London NHS Trust	1.62
Barts and The London NHS Trust	25%
Barts and The London NHS Trust	32%
Barts and The London NHS Trust	64%
Barts and The London NHS Trust	3.46
Barts and The London NHS Trust	2.85
Barts and The London NHS Trust	3.50
Barts and The London NHS Trust	3.83

Barts and The London NHS Trust	38%
Barts and The London NHS Trust	85%
Barts and The London NHS Trust	19%
Ealing Hospital NHS Trust	74%
Ealing Hospital NHS Trust	93%
Ealing Hospital NHS Trust	77%
Ealing Hospital NHS Trust	3.43
Ealing Hospital NHS Trust	3.19
Ealing Hospital NHS Trust	3.77
Ealing Hospital NHS Trust	3.42
Ealing Hospital NHS Trust	67%
Ealing Hospital NHS Trust	62%
Ealing Hospital NHS Trust	40%
Ealing Hospital NHS Trust	83%
Ealing Hospital NHS Trust	69%
Ealing Hospital NHS Trust	36%
Ealing Hospital NHS Trust	63%
Ealing Hospital NHS Trust	3.65
Ealing Hospital NHS Trust	70%
Ealing Hospital NHS Trust	13%
Ealing Hospital NHS Trust	32%
Ealing Hospital NHS Trust	45%
Ealing Hospital NHS Trust	30%
Ealing Hospital NHS Trust	96%
Ealing Hospital NHS Trust	3.47
Ealing Hospital NHS Trust	4%
Ealing Hospital NHS Trust	1%
Ealing Hospital NHS Trust	12%
Ealing Hospital NHS Trust	15%
Ealing Hospital NHS Trust	3.61
Ealing Hospital NHS Trust	1.58
Ealing Hospital NHS Trust	21%
Ealing Hospital NHS Trust	33%
Ealing Hospital NHS Trust	66%
Ealing Hospital NHS Trust	3.51
Ealing Hospital NHS Trust	2.74
Ealing Hospital NHS Trust	3.43
Ealing Hospital NHS Trust	3.93
Ealing Hospital NHS Trust	46%
Ealing Hospital NHS Trust	85%
Ealing Hospital NHS Trust	16%
University College London Hospitals NHS Foundation Trust	84%
University College London Hospitals NHS Foundation Trust	92%
University College London Hospitals NHS Foundation Trust	78%
University College London Hospitals NHS Foundation Trust	3.58
University College London Hospitals NHS Foundation Trust	2.98
University College London Hospitals NHS Foundation Trust	3.73
University College London Hospitals NHS Foundation Trust	3.45
University College London Hospitals NHS Foundation Trust	72%
University College London Hospitals NHS Foundation Trust	59%
University College London Hospitals NHS Foundation Trust	46%
University College London Hospitals NHS Foundation Trust	78%
University College London Hospitals NHS Foundation Trust	82%
University College London Hospitals NHS Foundation Trust	46%
University College London Hospitals NHS Foundation Trust	75%
University College London Hospitals NHS Foundation Trust	3.74

University College London Hospitals NHS Foundation Trust	76%
University College London Hospitals NHS Foundation Trust	15%
University College London Hospitals NHS Foundation Trust	30%
University College London Hospitals NHS Foundation Trust	61%
University College London Hospitals NHS Foundation Trust	39%
University College London Hospitals NHS Foundation Trust	98%
University College London Hospitals NHS Foundation Trust	3.58
University College London Hospitals NHS Foundation Trust	7%
University College London Hospitals NHS Foundation Trust	2%
University College London Hospitals NHS Foundation Trust	16%
University College London Hospitals NHS Foundation Trust	17%
University College London Hospitals NHS Foundation Trust	3.66
University College London Hospitals NHS Foundation Trust	1.60
University College London Hospitals NHS Foundation Trust	24%
University College London Hospitals NHS Foundation Trust	33%
University College London Hospitals NHS Foundation Trust	67%
University College London Hospitals NHS Foundation Trust	3.60
University College London Hospitals NHS Foundation Trust	2.50
University College London Hospitals NHS Foundation Trust	3.99
University College London Hospitals NHS Foundation Trust	3.91
University College London Hospitals NHS Foundation Trust	49%
University College London Hospitals NHS Foundation Trust	83%
University College London Hospitals NHS Foundation Trust	18%
North West London Hospitals NHS Trust	84%
North West London Hospitals NHS Trust	91%
North West London Hospitals NHS Trust	78%
North West London Hospitals NHS Trust	3.51
North West London Hospitals NHS Trust	3.09
North West London Hospitals NHS Trust	3.75
North West London Hospitals NHS Trust	3.46
North West London Hospitals NHS Trust	63%
North West London Hospitals NHS Trust	63%
North West London Hospitals NHS Trust	42%
North West London Hospitals NHS Trust	79%
North West London Hospitals NHS Trust	66%
North West London Hospitals NHS Trust	36%
North West London Hospitals NHS Trust	59%
North West London Hospitals NHS Trust	3.61
North West London Hospitals NHS Trust	70%
North West London Hospitals NHS Trust	15%
North West London Hospitals NHS Trust	29%
North West London Hospitals NHS Trust	63%
North West London Hospitals NHS Trust	32%
North West London Hospitals NHS Trust	98%
North West London Hospitals NHS Trust	3.44
North West London Hospitals NHS Trust	9%
North West London Hospitals NHS Trust	1%
North West London Hospitals NHS Trust	19%
North West London Hospitals NHS Trust	17%
North West London Hospitals NHS Trust	3.54
North West London Hospitals NHS Trust	1.62
North West London Hospitals NHS Trust	27%
North West London Hospitals NHS Trust	34%
North West London Hospitals NHS Trust	59%
North West London Hospitals NHS Trust	3.47
North West London Hospitals NHS Trust	2.65

North West London Hospitals NHS Trust	3.54
North West London Hospitals NHS Trust	3.94
North West London Hospitals NHS Trust	37%
North West London Hospitals NHS Trust	81%
North West London Hospitals NHS Trust	19%
Homerton University Hospital NHS Foundation Trust	85%
Homerton University Hospital NHS Foundation Trust	92%
Homerton University Hospital NHS Foundation Trust	79%
Homerton University Hospital NHS Foundation Trust	3.59
Homerton University Hospital NHS Foundation Trust	2.95
Homerton University Hospital NHS Foundation Trust	3.79
Homerton University Hospital NHS Foundation Trust	3.58
Homerton University Hospital NHS Foundation Trust	69%
Homerton University Hospital NHS Foundation Trust	69%
Homerton University Hospital NHS Foundation Trust	47%
Homerton University Hospital NHS Foundation Trust	80%
Homerton University Hospital NHS Foundation Trust	74%
Homerton University Hospital NHS Foundation Trust	43%
Homerton University Hospital NHS Foundation Trust	62%
Homerton University Hospital NHS Foundation Trust	3.79
Homerton University Hospital NHS Foundation Trust	72%
Homerton University Hospital NHS Foundation Trust	17%
Homerton University Hospital NHS Foundation Trust	34%
Homerton University Hospital NHS Foundation Trust	53%
Homerton University Hospital NHS Foundation Trust	37%
Homerton University Hospital NHS Foundation Trust	98%
Homerton University Hospital NHS Foundation Trust	3.58
Homerton University Hospital NHS Foundation Trust	6%
Homerton University Hospital NHS Foundation Trust	1%
Homerton University Hospital NHS Foundation Trust	20%
Homerton University Hospital NHS Foundation Trust	18%
Homerton University Hospital NHS Foundation Trust	3.62
Homerton University Hospital NHS Foundation Trust	1.62
Homerton University Hospital NHS Foundation Trust	27%
Homerton University Hospital NHS Foundation Trust	38%
Homerton University Hospital NHS Foundation Trust	77%
Homerton University Hospital NHS Foundation Trust	3.61
Homerton University Hospital NHS Foundation Trust	2.62
Homerton University Hospital NHS Foundation Trust	3.80
Homerton University Hospital NHS Foundation Trust	3.95
Homerton University Hospital NHS Foundation Trust	29%
Homerton University Hospital NHS Foundation Trust	84%
Homerton University Hospital NHS Foundation Trust	19%
Imperial College Healthcare NHS Trust	80%
Imperial College Healthcare NHS Trust	91%
Imperial College Healthcare NHS Trust	78%
Imperial College Healthcare NHS Trust	3.45
Imperial College Healthcare NHS Trust	3.06
Imperial College Healthcare NHS Trust	3.75
Imperial College Healthcare NHS Trust	3.42
Imperial College Healthcare NHS Trust	64%
Imperial College Healthcare NHS Trust	52%
Imperial College Healthcare NHS Trust	44%
Imperial College Healthcare NHS Trust	79%
Imperial College Healthcare NHS Trust	81%
Imperial College Healthcare NHS Trust	37%

Imperial College Healthcare NHS Trust	71%
Imperial College Healthcare NHS Trust	3.52
Imperial College Healthcare NHS Trust	45%
Imperial College Healthcare NHS Trust	18%
Imperial College Healthcare NHS Trust	26%
Imperial College Healthcare NHS Trust	64%
Imperial College Healthcare NHS Trust	33%
Imperial College Healthcare NHS Trust	96%
Imperial College Healthcare NHS Trust	3.47
Imperial College Healthcare NHS Trust	7%
Imperial College Healthcare NHS Trust	1%
Imperial College Healthcare NHS Trust	12%
Imperial College Healthcare NHS Trust	13%
Imperial College Healthcare NHS Trust	3.58
Imperial College Healthcare NHS Trust	1.50
Imperial College Healthcare NHS Trust	27%
Imperial College Healthcare NHS Trust	31%
Imperial College Healthcare NHS Trust	67%
Imperial College Healthcare NHS Trust	3.47
Imperial College Healthcare NHS Trust	2.71
Imperial College Healthcare NHS Trust	3.66
Imperial College Healthcare NHS Trust	3.86
Imperial College Healthcare NHS Trust	29%
Imperial College Healthcare NHS Trust	85%
Imperial College Healthcare NHS Trust	18%
Croydon Health Services NHS Trust (formerly Mayday)	72%
Croydon Health Services NHS Trust (formerly Mayday)	90%
Croydon Health Services NHS Trust (formerly Mayday)	75%
Croydon Health Services NHS Trust (formerly Mayday)	3.39
Croydon Health Services NHS Trust (formerly Mayday)	3.31
Croydon Health Services NHS Trust (formerly Mayday)	3.73
Croydon Health Services NHS Trust (formerly Mayday)	3.29
Croydon Health Services NHS Trust (formerly Mayday)	76%
Croydon Health Services NHS Trust (formerly Mayday)	63%
Croydon Health Services NHS Trust (formerly Mayday)	34%
Croydon Health Services NHS Trust (formerly Mayday)	80%
Croydon Health Services NHS Trust (formerly Mayday)	86%
Croydon Health Services NHS Trust (formerly Mayday)	36%
Croydon Health Services NHS Trust (formerly Mayday)	74%
Croydon Health Services NHS Trust (formerly Mayday)	3.62
Croydon Health Services NHS Trust (formerly Mayday)	77%
Croydon Health Services NHS Trust (formerly Mayday)	16%
Croydon Health Services NHS Trust (formerly Mayday)	33%
Croydon Health Services NHS Trust (formerly Mayday)	44%
Croydon Health Services NHS Trust (formerly Mayday)	39%
Croydon Health Services NHS Trust (formerly Mayday)	98%
Croydon Health Services NHS Trust (formerly Mayday)	3.37
Croydon Health Services NHS Trust (formerly Mayday)	9%
Croydon Health Services NHS Trust (formerly Mayday)	3%
Croydon Health Services NHS Trust (formerly Mayday)	20%
Croydon Health Services NHS Trust (formerly Mayday)	22%
Croydon Health Services NHS Trust (formerly Mayday)	3.45
Croydon Health Services NHS Trust (formerly Mayday)	1.56
Croydon Health Services NHS Trust (formerly Mayday)	23%
Croydon Health Services NHS Trust (formerly Mayday)	23%
Croydon Health Services NHS Trust (formerly Mayday)	68%

Croydon Health Services NHS Trust (formerly Mayday)	3.41
Croydon Health Services NHS Trust (formerly Mayday)	2.88
Croydon Health Services NHS Trust (formerly Mayday)	3.18
Croydon Health Services NHS Trust (formerly Mayday)	3.92
Croydon Health Services NHS Trust (formerly Mayday)	34%
Croydon Health Services NHS Trust (formerly Mayday)	78%
Croydon Health Services NHS Trust (formerly Mayday)	20%
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	75%
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	91%
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	73%
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	3.43
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	3.16
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	3.69
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	3.37
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	71%
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	61%
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	48%
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	75%
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	77%
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	37%
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	66%
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	3.65
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	72%
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	15%
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	28%
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	49%
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	35%
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	97%
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	3.42
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	7%
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	1%
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	16%
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	18%
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	3.57
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	1.69
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	24%
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	31%
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	66%
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	3.50
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	2.71
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	3.54
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	3.78
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	53%
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	83%
Lewisham Healthcare Trust (formerly The Lewisham Hospital)	21%
Whipps Cross University Hospital NHS Trust	78%
Whipps Cross University Hospital NHS Trust	93%
Whipps Cross University Hospital NHS Trust	75%
Whipps Cross University Hospital NHS Trust	3.50
Whipps Cross University Hospital NHS Trust	3.17
Whipps Cross University Hospital NHS Trust	3.80
Whipps Cross University Hospital NHS Trust	3.35
Whipps Cross University Hospital NHS Trust	67%
Whipps Cross University Hospital NHS Trust	59%
Whipps Cross University Hospital NHS Trust	38%
Whipps Cross University Hospital NHS Trust	76%

Whipps Cross University Hospital NHS Trust	83%
Whipps Cross University Hospital NHS Trust	40%
Whipps Cross University Hospital NHS Trust	70%
Whipps Cross University Hospital NHS Trust	3.61
Whipps Cross University Hospital NHS Trust	58%
Whipps Cross University Hospital NHS Trust	18%
Whipps Cross University Hospital NHS Trust	32%
Whipps Cross University Hospital NHS Trust	54%
Whipps Cross University Hospital NHS Trust	40%
Whipps Cross University Hospital NHS Trust	96%
Whipps Cross University Hospital NHS Trust	3.43
Whipps Cross University Hospital NHS Trust	7%
Whipps Cross University Hospital NHS Trust	1%
Whipps Cross University Hospital NHS Trust	18%
Whipps Cross University Hospital NHS Trust	20%
Whipps Cross University Hospital NHS Trust	3.51
Whipps Cross University Hospital NHS Trust	1.57
Whipps Cross University Hospital NHS Trust	27%
Whipps Cross University Hospital NHS Trust	29%
Whipps Cross University Hospital NHS Trust	62%
Whipps Cross University Hospital NHS Trust	3.47
Whipps Cross University Hospital NHS Trust	2.69
Whipps Cross University Hospital NHS Trust	3.56
Whipps Cross University Hospital NHS Trust	3.90
Whipps Cross University Hospital NHS Trust	45%
Whipps Cross University Hospital NHS Trust	80%
Whipps Cross University Hospital NHS Trust	23%
Guy's and St Thomas' NHS Foundation Trust	85%
Guy's and St Thomas' NHS Foundation Trust	94%
Guy's and St Thomas' NHS Foundation Trust	80%
Guy's and St Thomas' NHS Foundation Trust	3.57
Guy's and St Thomas' NHS Foundation Trust	2.78
Guy's and St Thomas' NHS Foundation Trust	3.75
Guy's and St Thomas' NHS Foundation Trust	3.62
Guy's and St Thomas' NHS Foundation Trust	70%
Guy's and St Thomas' NHS Foundation Trust	56%
Guy's and St Thomas' NHS Foundation Trust	51%
Guy's and St Thomas' NHS Foundation Trust	83%
Guy's and St Thomas' NHS Foundation Trust	79%
Guy's and St Thomas' NHS Foundation Trust	46%
Guy's and St Thomas' NHS Foundation Trust	66%
Guy's and St Thomas' NHS Foundation Trust	3.71
Guy's and St Thomas' NHS Foundation Trust	86%
Guy's and St Thomas' NHS Foundation Trust	16%
Guy's and St Thomas' NHS Foundation Trust	26%
Guy's and St Thomas' NHS Foundation Trust	63%
Guy's and St Thomas' NHS Foundation Trust	39%
Guy's and St Thomas' NHS Foundation Trust	97%
Guy's and St Thomas' NHS Foundation Trust	3.65
Guy's and St Thomas' NHS Foundation Trust	6%
Guy's and St Thomas' NHS Foundation Trust	2%
Guy's and St Thomas' NHS Foundation Trust	12%
Guy's and St Thomas' NHS Foundation Trust	14%
Guy's and St Thomas' NHS Foundation Trust	3.75
Guy's and St Thomas' NHS Foundation Trust	1.55
Guy's and St Thomas' NHS Foundation Trust	20%

Guy's and St Thomas' NHS Foundation Trust	41%
Guy's and St Thomas' NHS Foundation Trust	68%
Guy's and St Thomas' NHS Foundation Trust	3.61
Guy's and St Thomas' NHS Foundation Trust	2.46
Guy's and St Thomas' NHS Foundation Trust	4.05
Guy's and St Thomas' NHS Foundation Trust	3.96
Guy's and St Thomas' NHS Foundation Trust	32%
Guy's and St Thomas' NHS Foundation Trust	85%
Guy's and St Thomas' NHS Foundation Trust	17%
King's College Hospital NHS Foundation Trust	82%
King's College Hospital NHS Foundation Trust	90%
King's College Hospital NHS Foundation Trust	72%
King's College Hospital NHS Foundation Trust	3.44
King's College Hospital NHS Foundation Trust	3.00
King's College Hospital NHS Foundation Trust	3.72
King's College Hospital NHS Foundation Trust	3.40
King's College Hospital NHS Foundation Trust	63%
King's College Hospital NHS Foundation Trust	60%
King's College Hospital NHS Foundation Trust	46%
King's College Hospital NHS Foundation Trust	80%
King's College Hospital NHS Foundation Trust	83%
King's College Hospital NHS Foundation Trust	41%
King's College Hospital NHS Foundation Trust	69%
King's College Hospital NHS Foundation Trust	3.58
King's College Hospital NHS Foundation Trust	65%
King's College Hospital NHS Foundation Trust	19%
King's College Hospital NHS Foundation Trust	29%
King's College Hospital NHS Foundation Trust	53%
King's College Hospital NHS Foundation Trust	36%
King's College Hospital NHS Foundation Trust	96%
King's College Hospital NHS Foundation Trust	3.52
King's College Hospital NHS Foundation Trust	8%
King's College Hospital NHS Foundation Trust	1%
King's College Hospital NHS Foundation Trust	15%
King's College Hospital NHS Foundation Trust	18%
King's College Hospital NHS Foundation Trust	3.61
King's College Hospital NHS Foundation Trust	1.52
King's College Hospital NHS Foundation Trust	25%
King's College Hospital NHS Foundation Trust	34%
King's College Hospital NHS Foundation Trust	65%
King's College Hospital NHS Foundation Trust	3.45
King's College Hospital NHS Foundation Trust	2.63
King's College Hospital NHS Foundation Trust	3.83
King's College Hospital NHS Foundation Trust	3.85
King's College Hospital NHS Foundation Trust	44%
King's College Hospital NHS Foundation Trust	80%
King's College Hospital NHS Foundation Trust	20%
Barking, Havering and Redbridge Hospitals NHS Trust	73%
Barking, Havering and Redbridge Hospitals NHS Trust	90%
Barking, Havering and Redbridge Hospitals NHS Trust	66%
Barking, Havering and Redbridge Hospitals NHS Trust	3.27
Barking, Havering and Redbridge Hospitals NHS Trust	3.36
Barking, Havering and Redbridge Hospitals NHS Trust	3.60
Barking, Havering and Redbridge Hospitals NHS Trust	3.08
Barking, Havering and Redbridge Hospitals NHS Trust	74%
Barking, Havering and Redbridge Hospitals NHS Trust	47%

Barking, Havering and Redbridge Hospitals NHS Trust	33%
Barking, Havering and Redbridge Hospitals NHS Trust	72%
Barking, Havering and Redbridge Hospitals NHS Trust	86%
Barking, Havering and Redbridge Hospitals NHS Trust	37%
Barking, Havering and Redbridge Hospitals NHS Trust	77%
Barking, Havering and Redbridge Hospitals NHS Trust	3.38
Barking, Havering and Redbridge Hospitals NHS Trust	70%
Barking, Havering and Redbridge Hospitals NHS Trust	19%
Barking, Havering and Redbridge Hospitals NHS Trust	40%
Barking, Havering and Redbridge Hospitals NHS Trust	56%
Barking, Havering and Redbridge Hospitals NHS Trust	35%
Barking, Havering and Redbridge Hospitals NHS Trust	94%
Barking, Havering and Redbridge Hospitals NHS Trust	3.31
Barking, Havering and Redbridge Hospitals NHS Trust	9%
Barking, Havering and Redbridge Hospitals NHS Trust	2%
Barking, Havering and Redbridge Hospitals NHS Trust	20%
Barking, Havering and Redbridge Hospitals NHS Trust	22%
Barking, Havering and Redbridge Hospitals NHS Trust	3.42
Barking, Havering and Redbridge Hospitals NHS Trust	1.68
Barking, Havering and Redbridge Hospitals NHS Trust	31%
Barking, Havering and Redbridge Hospitals NHS Trust	19%
Barking, Havering and Redbridge Hospitals NHS Trust	51%
Barking, Havering and Redbridge Hospitals NHS Trust	3.26
Barking, Havering and Redbridge Hospitals NHS Trust	2.93
Barking, Havering and Redbridge Hospitals NHS Trust	3.08
Barking, Havering and Redbridge Hospitals NHS Trust	3.72
Barking, Havering and Redbridge Hospitals NHS Trust	38%
Barking, Havering and Redbridge Hospitals NHS Trust	75%
Barking, Havering and Redbridge Hospitals NHS Trust	23%
The Hillingdon Hospital NHS Trust	78%
The Hillingdon Hospital NHS Trust	90%
The Hillingdon Hospital NHS Trust	75%
The Hillingdon Hospital NHS Trust	3.45
The Hillingdon Hospital NHS Trust	3.01
The Hillingdon Hospital NHS Trust	3.64
The Hillingdon Hospital NHS Trust	3.37
The Hillingdon Hospital NHS Trust	60%
The Hillingdon Hospital NHS Trust	48%
The Hillingdon Hospital NHS Trust	43%
The Hillingdon Hospital NHS Trust	76%
The Hillingdon Hospital NHS Trust	90%
The Hillingdon Hospital NHS Trust	46%
The Hillingdon Hospital NHS Trust	83%
The Hillingdon Hospital NHS Trust	3.59
The Hillingdon Hospital NHS Trust	81%
The Hillingdon Hospital NHS Trust	15%
The Hillingdon Hospital NHS Trust	26%
The Hillingdon Hospital NHS Trust	59%
The Hillingdon Hospital NHS Trust	34%
The Hillingdon Hospital NHS Trust	96%
The Hillingdon Hospital NHS Trust	3.38
The Hillingdon Hospital NHS Trust	9%
The Hillingdon Hospital NHS Trust	1%
The Hillingdon Hospital NHS Trust	15%
The Hillingdon Hospital NHS Trust	14%
The Hillingdon Hospital NHS Trust	3.57

The Hillingdon Hospital NHS Trust	1.56
The Hillingdon Hospital NHS Trust	29%
The Hillingdon Hospital NHS Trust	29%
The Hillingdon Hospital NHS Trust	61%
The Hillingdon Hospital NHS Trust	3.48
The Hillingdon Hospital NHS Trust	2.68
The Hillingdon Hospital NHS Trust	3.53
The Hillingdon Hospital NHS Trust	3.91
The Hillingdon Hospital NHS Trust	57%
The Hillingdon Hospital NHS Trust	85%
The Hillingdon Hospital NHS Trust	16%
Royal Free Hampstead NHS Trust	81%
Royal Free Hampstead NHS Trust	95%
Royal Free Hampstead NHS Trust	72%
Royal Free Hampstead NHS Trust	3.49
Royal Free Hampstead NHS Trust	3.00
Royal Free Hampstead NHS Trust	3.77
Royal Free Hampstead NHS Trust	3.42
Royal Free Hampstead NHS Trust	69%
Royal Free Hampstead NHS Trust	67%
Royal Free Hampstead NHS Trust	47%
Royal Free Hampstead NHS Trust	78%
Royal Free Hampstead NHS Trust	76%
Royal Free Hampstead NHS Trust	41%
Royal Free Hampstead NHS Trust	70%
Royal Free Hampstead NHS Trust	3.65
Royal Free Hampstead NHS Trust	69%
Royal Free Hampstead NHS Trust	17%
Royal Free Hampstead NHS Trust	34%
Royal Free Hampstead NHS Trust	52%
Royal Free Hampstead NHS Trust	47%
Royal Free Hampstead NHS Trust	98%
Royal Free Hampstead NHS Trust	3.46
Royal Free Hampstead NHS Trust	8%
Royal Free Hampstead NHS Trust	2%
Royal Free Hampstead NHS Trust	19%
Royal Free Hampstead NHS Trust	24%
Royal Free Hampstead NHS Trust	3.63
Royal Free Hampstead NHS Trust	1.66
Royal Free Hampstead NHS Trust	25%
Royal Free Hampstead NHS Trust	30%
Royal Free Hampstead NHS Trust	68%
Royal Free Hampstead NHS Trust	3.48
Royal Free Hampstead NHS Trust	2.65
Royal Free Hampstead NHS Trust	3.66
Royal Free Hampstead NHS Trust	3.88
Royal Free Hampstead NHS Trust	54%
Royal Free Hampstead NHS Trust	82%
Royal Free Hampstead NHS Trust	19%
St George's Healthcare NHS Trust	76%
St George's Healthcare NHS Trust	91%
St George's Healthcare NHS Trust	71%
St George's Healthcare NHS Trust	3.39
St George's Healthcare NHS Trust	3.16
St George's Healthcare NHS Trust	3.63
St George's Healthcare NHS Trust	3.35

St George's Healthcare NHS Trust	74%
St George's Healthcare NHS Trust	63%
St George's Healthcare NHS Trust	41%
St George's Healthcare NHS Trust	74%
St George's Healthcare NHS Trust	86%
St George's Healthcare NHS Trust	38%
St George's Healthcare NHS Trust	71%
St George's Healthcare NHS Trust	3.50
St George's Healthcare NHS Trust	70%
St George's Healthcare NHS Trust	15%
St George's Healthcare NHS Trust	33%
St George's Healthcare NHS Trust	50%
St George's Healthcare NHS Trust	35%
St George's Healthcare NHS Trust	96%
St George's Healthcare NHS Trust	3.43
St George's Healthcare NHS Trust	5%
St George's Healthcare NHS Trust	1%
St George's Healthcare NHS Trust	12%
St George's Healthcare NHS Trust	21%
St George's Healthcare NHS Trust	3.54
St George's Healthcare NHS Trust	1.60
St George's Healthcare NHS Trust	26%
St George's Healthcare NHS Trust	28%
St George's Healthcare NHS Trust	63%
St George's Healthcare NHS Trust	3.40
St George's Healthcare NHS Trust	2.81
St George's Healthcare NHS Trust	3.57
St George's Healthcare NHS Trust	3.73
St George's Healthcare NHS Trust	40%
St George's Healthcare NHS Trust	78%
St George's Healthcare NHS Trust	19%
The Whittington Hospital NHS Trust	77%
The Whittington Hospital NHS Trust	88%
The Whittington Hospital NHS Trust	79%
The Whittington Hospital NHS Trust	3.49
The Whittington Hospital NHS Trust	3.06
The Whittington Hospital NHS Trust	3.82
The Whittington Hospital NHS Trust	3.59
The Whittington Hospital NHS Trust	69%
The Whittington Hospital NHS Trust	60%
The Whittington Hospital NHS Trust	44%
The Whittington Hospital NHS Trust	83%
The Whittington Hospital NHS Trust	80%
The Whittington Hospital NHS Trust	42%
The Whittington Hospital NHS Trust	68%
The Whittington Hospital NHS Trust	3.71
The Whittington Hospital NHS Trust	70%
The Whittington Hospital NHS Trust	13%
The Whittington Hospital NHS Trust	31%
The Whittington Hospital NHS Trust	53%
The Whittington Hospital NHS Trust	34%
The Whittington Hospital NHS Trust	96%
The Whittington Hospital NHS Trust	3.48
The Whittington Hospital NHS Trust	7%
The Whittington Hospital NHS Trust	3%
The Whittington Hospital NHS Trust	13%

The Whittington Hospital NHS Trust	17%
The Whittington Hospital NHS Trust	3.60
The Whittington Hospital NHS Trust	1.63
The Whittington Hospital NHS Trust	22%
The Whittington Hospital NHS Trust	34%
The Whittington Hospital NHS Trust	64%
The Whittington Hospital NHS Trust	3.55
The Whittington Hospital NHS Trust	2.65
The Whittington Hospital NHS Trust	3.70
The Whittington Hospital NHS Trust	3.91
The Whittington Hospital NHS Trust	38%
The Whittington Hospital NHS Trust	85%
The Whittington Hospital NHS Trust	14%
Newham University Hospital NHS Trust	79%
Newham University Hospital NHS Trust	91%
Newham University Hospital NHS Trust	71%
Newham University Hospital NHS Trust	3.42
Newham University Hospital NHS Trust	3.06
Newham University Hospital NHS Trust	3.58
Newham University Hospital NHS Trust	3.32
Newham University Hospital NHS Trust	60%
Newham University Hospital NHS Trust	60%
Newham University Hospital NHS Trust	39%
Newham University Hospital NHS Trust	77%
Newham University Hospital NHS Trust	88%
Newham University Hospital NHS Trust	43%
Newham University Hospital NHS Trust	75%
Newham University Hospital NHS Trust	3.53
Newham University Hospital NHS Trust	63%
Newham University Hospital NHS Trust	13%
Newham University Hospital NHS Trust	32%
Newham University Hospital NHS Trust	43%
Newham University Hospital NHS Trust	39%
Newham University Hospital NHS Trust	93%
Newham University Hospital NHS Trust	3.44
Newham University Hospital NHS Trust	7%
Newham University Hospital NHS Trust	4%
Newham University Hospital NHS Trust	18%
Newham University Hospital NHS Trust	23%
Newham University Hospital NHS Trust	3.57
Newham University Hospital NHS Trust	1.57
Newham University Hospital NHS Trust	26%
Newham University Hospital NHS Trust	25%
Newham University Hospital NHS Trust	61%
Newham University Hospital NHS Trust	3.40
Newham University Hospital NHS Trust	2.85
Newham University Hospital NHS Trust	3.43
Newham University Hospital NHS Trust	3.86
Newham University Hospital NHS Trust	32%
Newham University Hospital NHS Trust	72%
Newham University Hospital NHS Trust	30%
The Royal Marsden NHS Foundation Trust	77%
The Royal Marsden NHS Foundation Trust	90%
The Royal Marsden NHS Foundation Trust	83%
The Royal Marsden NHS Foundation Trust	3.52
The Royal Marsden NHS Foundation Trust	2.93

The Royal Marsden NHS Foundation Trust	3.86
The Royal Marsden NHS Foundation Trust	3.62
The Royal Marsden NHS Foundation Trust	72%
The Royal Marsden NHS Foundation Trust	58%
The Royal Marsden NHS Foundation Trust	55%
The Royal Marsden NHS Foundation Trust	83%
The Royal Marsden NHS Foundation Trust	81%
The Royal Marsden NHS Foundation Trust	44%
The Royal Marsden NHS Foundation Trust	72%
The Royal Marsden NHS Foundation Trust	3.84
The Royal Marsden NHS Foundation Trust	83%
The Royal Marsden NHS Foundation Trust	10%
The Royal Marsden NHS Foundation Trust	27%
The Royal Marsden NHS Foundation Trust	63%
The Royal Marsden NHS Foundation Trust	34%
The Royal Marsden NHS Foundation Trust	98%
The Royal Marsden NHS Foundation Trust	3.70
The Royal Marsden NHS Foundation Trust	3%
The Royal Marsden NHS Foundation Trust	1%
The Royal Marsden NHS Foundation Trust	7%
The Royal Marsden NHS Foundation Trust	11%
The Royal Marsden NHS Foundation Trust	3.68
The Royal Marsden NHS Foundation Trust	1.52
The Royal Marsden NHS Foundation Trust	24%
The Royal Marsden NHS Foundation Trust	40%
The Royal Marsden NHS Foundation Trust	70%
The Royal Marsden NHS Foundation Trust	3.64
The Royal Marsden NHS Foundation Trust	2.42
The Royal Marsden NHS Foundation Trust	4.00
The Royal Marsden NHS Foundation Trust	3.89
The Royal Marsden NHS Foundation Trust	46%
The Royal Marsden NHS Foundation Trust	93%
The Royal Marsden NHS Foundation Trust	8%
Royal Brompton and Harefield NHS Trust	85%
Royal Brompton and Harefield NHS Trust	91%
Royal Brompton and Harefield NHS Trust	76%
Royal Brompton and Harefield NHS Trust	3.54
Royal Brompton and Harefield NHS Trust	2.85
Royal Brompton and Harefield NHS Trust	3.68
Royal Brompton and Harefield NHS Trust	3.54
Royal Brompton and Harefield NHS Trust	70%
Royal Brompton and Harefield NHS Trust	58%
Royal Brompton and Harefield NHS Trust	49%
Royal Brompton and Harefield NHS Trust	79%
Royal Brompton and Harefield NHS Trust	65%
Royal Brompton and Harefield NHS Trust	33%
Royal Brompton and Harefield NHS Trust	57%
Royal Brompton and Harefield NHS Trust	3.70
Royal Brompton and Harefield NHS Trust	68%
Royal Brompton and Harefield NHS Trust	12%
Royal Brompton and Harefield NHS Trust	23%
Royal Brompton and Harefield NHS Trust	65%
Royal Brompton and Harefield NHS Trust	36%
Royal Brompton and Harefield NHS Trust	96%
Royal Brompton and Harefield NHS Trust	3.68
Royal Brompton and Harefield NHS Trust	2%

Royal Brompton and Harefield NHS Trust	2%
Royal Brompton and Harefield NHS Trust	8%
Royal Brompton and Harefield NHS Trust	15%
Royal Brompton and Harefield NHS Trust	3.69
Royal Brompton and Harefield NHS Trust	1.53
Royal Brompton and Harefield NHS Trust	18%
Royal Brompton and Harefield NHS Trust	41%
Royal Brompton and Harefield NHS Trust	72%
Royal Brompton and Harefield NHS Trust	3.60
Royal Brompton and Harefield NHS Trust	2.47
Royal Brompton and Harefield NHS Trust	4.09
Royal Brompton and Harefield NHS Trust	3.92
Royal Brompton and Harefield NHS Trust	54%
Royal Brompton and Harefield NHS Trust	90%
Royal Brompton and Harefield NHS Trust	13%
Epsom & St Helier University Hospitals NHS Trust	80%
Epsom & St Helier University Hospitals NHS Trust	94%
Epsom & St Helier University Hospitals NHS Trust	75%
Epsom & St Helier University Hospitals NHS Trust	3.41
Epsom & St Helier University Hospitals NHS Trust	3.11
Epsom & St Helier University Hospitals NHS Trust	3.67
Epsom & St Helier University Hospitals NHS Trust	3.27
Epsom & St Helier University Hospitals NHS Trust	75%
Epsom & St Helier University Hospitals NHS Trust	61%
Epsom & St Helier University Hospitals NHS Trust	38%
Epsom & St Helier University Hospitals NHS Trust	79%
Epsom & St Helier University Hospitals NHS Trust	75%
Epsom & St Helier University Hospitals NHS Trust	30%
Epsom & St Helier University Hospitals NHS Trust	68%
Epsom & St Helier University Hospitals NHS Trust	3.57
Epsom & St Helier University Hospitals NHS Trust	86%
Epsom & St Helier University Hospitals NHS Trust	11%
Epsom & St Helier University Hospitals NHS Trust	30%
Epsom & St Helier University Hospitals NHS Trust	67%
Epsom & St Helier University Hospitals NHS Trust	41%
Epsom & St Helier University Hospitals NHS Trust	96%
Epsom & St Helier University Hospitals NHS Trust	3.37
Epsom & St Helier University Hospitals NHS Trust	8%
Epsom & St Helier University Hospitals NHS Trust	2%
Epsom & St Helier University Hospitals NHS Trust	18%
Epsom & St Helier University Hospitals NHS Trust	16%
Epsom & St Helier University Hospitals NHS Trust	3.62
Epsom & St Helier University Hospitals NHS Trust	1.63
Epsom & St Helier University Hospitals NHS Trust	26%
Epsom & St Helier University Hospitals NHS Trust	25%
Epsom & St Helier University Hospitals NHS Trust	64%
Epsom & St Helier University Hospitals NHS Trust	3.44
Epsom & St Helier University Hospitals NHS Trust	2.71
Epsom & St Helier University Hospitals NHS Trust	3.47
Epsom & St Helier University Hospitals NHS Trust	3.84
Epsom & St Helier University Hospitals NHS Trust	42%
Epsom & St Helier University Hospitals NHS Trust	85%
Epsom & St Helier University Hospitals NHS Trust	16%
North Middlesex University Hospital NHS Trust	74%
North Middlesex University Hospital NHS Trust	88%
North Middlesex University Hospital NHS Trust	68%

North Middlesex University Hospital NHS Trust	3.42
North Middlesex University Hospital NHS Trust	3.19
North Middlesex University Hospital NHS Trust	3.64
North Middlesex University Hospital NHS Trust	3.35
North Middlesex University Hospital NHS Trust	63%
North Middlesex University Hospital NHS Trust	60%
North Middlesex University Hospital NHS Trust	40%
North Middlesex University Hospital NHS Trust	78%
North Middlesex University Hospital NHS Trust	82%
North Middlesex University Hospital NHS Trust	42%
North Middlesex University Hospital NHS Trust	71%
North Middlesex University Hospital NHS Trust	3.61
North Middlesex University Hospital NHS Trust	63%
North Middlesex University Hospital NHS Trust	21%
North Middlesex University Hospital NHS Trust	33%
North Middlesex University Hospital NHS Trust	56%
North Middlesex University Hospital NHS Trust	37%
North Middlesex University Hospital NHS Trust	94%
North Middlesex University Hospital NHS Trust	3.31
North Middlesex University Hospital NHS Trust	11%
North Middlesex University Hospital NHS Trust	4%
North Middlesex University Hospital NHS Trust	19%
North Middlesex University Hospital NHS Trust	22%
North Middlesex University Hospital NHS Trust	3.39
North Middlesex University Hospital NHS Trust	1.69
North Middlesex University Hospital NHS Trust	29%
North Middlesex University Hospital NHS Trust	22%
North Middlesex University Hospital NHS Trust	61%
North Middlesex University Hospital NHS Trust	3.38
North Middlesex University Hospital NHS Trust	2.88
North Middlesex University Hospital NHS Trust	3.32
North Middlesex University Hospital NHS Trust	3.79
North Middlesex University Hospital NHS Trust	42%
North Middlesex University Hospital NHS Trust	73%
North Middlesex University Hospital NHS Trust	23%
West Middlesex University Hospital NHS Trust	63%
West Middlesex University Hospital NHS Trust	86%
West Middlesex University Hospital NHS Trust	76%
West Middlesex University Hospital NHS Trust	3.31
West Middlesex University Hospital NHS Trust	3.34
West Middlesex University Hospital NHS Trust	3.63
West Middlesex University Hospital NHS Trust	3.22
West Middlesex University Hospital NHS Trust	69%
West Middlesex University Hospital NHS Trust	55%
West Middlesex University Hospital NHS Trust	32%
West Middlesex University Hospital NHS Trust	79%
West Middlesex University Hospital NHS Trust	84%
West Middlesex University Hospital NHS Trust	35%
West Middlesex University Hospital NHS Trust	68%
West Middlesex University Hospital NHS Trust	3.52
West Middlesex University Hospital NHS Trust	82%
West Middlesex University Hospital NHS Trust	16%
West Middlesex University Hospital NHS Trust	40%
West Middlesex University Hospital NHS Trust	54%
West Middlesex University Hospital NHS Trust	43%
West Middlesex University Hospital NHS Trust	95%

West Middlesex University Hospital NHS Trust	3.33
West Middlesex University Hospital NHS Trust	9%
West Middlesex University Hospital NHS Trust	2%
West Middlesex University Hospital NHS Trust	18%
West Middlesex University Hospital NHS Trust	21%
West Middlesex University Hospital NHS Trust	3.35
West Middlesex University Hospital NHS Trust	1.78
West Middlesex University Hospital NHS Trust	37%
West Middlesex University Hospital NHS Trust	17%
West Middlesex University Hospital NHS Trust	57%
West Middlesex University Hospital NHS Trust	3.36
West Middlesex University Hospital NHS Trust	2.98
West Middlesex University Hospital NHS Trust	3.1
West Middlesex University Hospital NHS Trust	3.69
West Middlesex University Hospital NHS Trust	47%
West Middlesex University Hospital NHS Trust	80%
West Middlesex University Hospital NHS Trust	21%

APPENDIX 3 Staff Survey Action Plan

Theme	Key Finding Summary	Specific deliverables	How delivered	Timescale	Lead	Operational Lead
Key Finding 12: % of staff receiving an appraisal within the last 12 months	The Trust improved it's performance on 2010 for this Key Finding up from 75% to 80% of staff receiving an appraisal, however this missed the target of 84% set for this years survey and ranked as average for acute trusts. It is worth noting that Trust performance within Staff Pledge 2 (Trust commitment to development) outside of this Key Finding was very strong, with 4 of the 6 KFs in the top 20% of acute trusts nationally.	The Trust has set a target of 87% of staff agreeing they had an appraisal within the last 12 months for the 2012 Survey.	i) Rollout of Medical appraisal reporting in advance of Revalidation	Jul-12	MA/MG	RA/HRBPs/Mgu
			ii) Quarterly targets for poor performing Directorates to monitor and improve performance.	Apr-12	MG	AH/HRBPs/SOG/MGu
			iii) Implement more active communication from HR to notify managers of upcoming appraisals	Apr-12	MG	HRBPS/MGu
			iv) Appraisals to be reported on monthly to Performance Board to ensure continued focus throughout the year	Apr-12	MG	MGu
			v) Ensure delivery of appraisals is includes in all managers performance objectives and local Staff Survey action plan	May-12	MG	HRBPs/SOG
Theme	**Key Finding Summary**	**Specific deliverables**	**How delivered**	**Timescale**	**Lead**	**Operational Lead**
Key Finding 16: % of staff receiving H&S training within the last 12 months	The Trust improved it's performance on 2010 for this Key Finding up from 59% to 64% of staff receiving training, however the national average is 81%. Medical & Dental (51% and Administrative staff at all levels were the lowest scored respondents	NHSLA Level 3 requires Trusts to achieve 95% compliance of mandatory training or have action plan towards this.	i) Promote the uptake of Health & Safety training through Daily Noticeboard	Jul-12	TD/MG	CD/HE
			ii)Schedule Update days for staffgroups for up to 18 months, and to include H&S training.	Apr-12	MG	CD/HE
			iii) Current 'Directors Den' concept of DVD training resource subject to approval will help facilititate improved training for Admin (and possibly Medical)staff	Aug-12	MG	CD
			iv) Action plans in place from all Subject matter experts to achieve 95% compliance of mandatory training.	May-12	MG/CM/TD	CD/KC/VC
			v) Develop a Trust wide escalation policy for non-attendance and follow up.	May-12	MG	CD/KC

Theme	Key Finding Summary	Specific deliverables	How delivered	Timescale	Lead	Operational Lead
Key Finding 28: Impact of health and wellbeing on ability to perform daily activities	This KF measures on a scale of 1-5, the impact of health and well-being on ability to perform work or activities. The Trust score deteriorated from 1.61 to 1.66 against a national average of 1.56. Administrative staff (Bands 2-6) and Nursing staff scored above the Trust average. 19% said their work within the last 4 weeks was affected to at least some extent by their health, with 16% saying emotional problems affected their ability to work.	Reduce the Key finding for next years survey to National average or below	i) Rollout of Stress Management Training for staff/managers	Ongoing	MG	CD
			ii) Promotion of Wellbeing Agenda, through 'Wellbeing events' ii) Review follow up of Wellbeing Days with Trust commitment to ongoing activities	Ongoing	MG	AS
			iii) Promote Staff counselling services and staff help leaflets/access to services (masseuses / osteopath)	Ongoing	MG	OH Dept
			iv) Promote staff access to Physio for MSK related illnesses.	6 months	MG/AH	AH
			Building Manager capability and strengthening local induction		MG	CD
Theme	**Key Finding Summary**	**Specific deliverables**	**How delivered**	**Timescale**	**Lead**	**Operational Lead**
Key Finding 38: % of staff experiencing discrimination within the last 12 months.	This Key Finding measures the % of staff experiencing discrimination either from other staff or members of the public (including patients) It is worth noting that while the Trust is in the worst 20% nationally, it is one of the best performing London trusts, reflecting the more diverse populations served locally. It is primarily discrimination from members of the public that is an issue, with staff discrimination lower than the national average. Nearly a quarter of nurses and 20% of administrative staff said they had experienced discrimination	Reduce the score for question on discrimination from patients/public and visitors to national average or below	i) Review implementation of the violence and aggression policy to ensure it supports the Trust values	Jun-12	TD	HE
			ii)Develop a branded campaign to highlight/raise awareness of the Trust values to patients/public	Jun-12	TD	HE/PB
			iii) Review the content of the 'Making a Difference' training programme to ensure that the content takes account of the varying needs of departments.	Jun-12	MG	CD/HE/PB
			iv) Identify poorly performing areas and ensure tailored action to minimise and address discrimination within the Directorate Action Plans for patients/public	Jun-12	HE	HE/PB
Theme	**Key Finding Summary**	**Specific deliverables**	**How delivered**	**Timescale**	**Lead**	**Operational Lead**

Key Finding 8: % of Staff Working Extra Hours	Overall Trust performance remained the same at 70% from last year, 62% of staff said they worked additional hours unpaid each week, with 36% stating they worked additional paid hours each week. 91% of medical staff said they worked additional hours each week (paid or unpaid), while 94% of senior managers (A&C Band 7+) said the same.	Review management meeting start and end times Trust wide to minimise long hours	i) Aim to have meetings that start and end punctually with all attendees and do not last longer than 1 hour (where possible and within core hours). All to diary in breaks/ time to get from one meeting to another and follow up on actions within core hours.	Ongoing	Exec Directors	Cascade down from Exec Directors to SOGs to local Directorate meetings check as this was a QIPP initiative who is leading
			ii)All Managers to advocate and role model work-life balance and time management/meeting etiquette	Ongoing		
			iii) Managers to recognise employee commitment to Trust productivity by being flexible about time back for attending essential meetings outside core hours	Ongoing		
		Review continued WTD rota compliance for Medical staff	i) Continue job planning reviews to ensure of most productive planned use of DCC and SPA activity	Ongoing	MA/MG	HRBPs/Medical Directors

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 3 May 2012

AGENDA ITEM NO.	2.16/May/12
PAPER	Draft Minutes of the Council of Governors Membership Sub-Committee meeting held on 29 March 2012.
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Martin Lewis, Chairman
EXECUTIVE SUMMARY	This is a draft of proceedings at the meeting held on 29 March 2012.
DECISION/ ACTION	The meeting is asked to agree the minutes as a correct record of proceedings.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Membership Sub-Committee, 29 March 2012
Draft

Attendees	Martin Lewis	ML	Chairman
	Cass J. Cass-Horne	CC-H	Patient Governor
	Chris Birch	CB	Patient Governor
	Melvyn Jeremiah	MJ	Public Governor, Westminster 2
	Susan Maxwell	SM	Patient Governor
	Maddy Than	MT	Staff Governor – Support, Admin and Clerical
In attendance	Matt Akid	MA	Head of Communications
	Tony Pritchard	TP	Deputy Chief Nurse
	Mel Christodoulou	MC	LINk representative
	Vida Djelic	VD	Foundation Trust Secretary

1. Welcome & Apologies **ML**

The Chairman welcomed Maddy Than, Staff Governor – Support, Admin & Clerical and Mel Christodoulou, LINk representative to the Membership Sub-Committee.

Apologies were received from Priti Bhatt, Christopher Collister, Sam Culhane, Wendie McWatters and Renae McBride.

2. Minutes of previous meeting held on 3 February 2012 **ML**

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

CB commented that the executive summary on the cover page should read minutes of 3 February.

3. Matters arising **ML**

All actions were complete and those that have not featured on the agenda.

CB said it should be noted that the following three items should also appear as matters arising:

- To update Governors' pictures board in the Information Zone
- To install some racks in the Information Zone for Trust News

VD to amend the mattes arising list appropriately and to note the outcome as discussed. **VD**

CB noted that it was agreed at the November 2011 meeting of the Membership Sub-Committee that the Information Zone would be checked on a daily basis by a member of MPALS Office.

He said that the plasma screen in the Information Zone, mentioned at item 3 of the

minutes, still was not working and should be 'Matters arising' so that we do not forget about it. The decision of our November meeting was that we would ask M-PALS to check the Info Zone not daily but twice daily.

SM responded that the MPALS office was short staffed due to sickness and annual leave. TP suggested that Angela Clarke could also be trained to update the information display board.

ML noted that the touch screen in the outpatients department was not working.

There was a discussion whether VD's picture should appear on the governors' picture board. **It was agreed that VD's picture as the Secretary to the Council of Governors should remain on the board.**

CB suggested that the Chairman's picture should also appear on the picture board. **This was agreed. To put Chairman's picture on the picture board.** **MA**

MT asked about future dates of 'meet a governor' sessions. The sub-committee congratulated MT on being proactive in organising meet a governor sessions for staff and agreed that it was a good idea to coordinate these with any existing meet a governor sessions.

4. Membership engagement and communication calendar of events 2012 **MA**

MA updated the sub-committee on the progress with the membership engagement and communication.

MA highlighted events for 2012:

- Members' News issue 1 was circulated in February
- Medicine for Members event on Bowel Cancer held on 22 February was very successful; 50 members were booked and 35 attended;
- Values focus groups meetings organised in February were attended by more than 40 members and reps from LINk and other patient groups;
- Members' News issue 2 was circulated in March
- In April there will be Members' News issue 3 and a membership mailing including April's Trust News – both with the aim of publicising the Open Day in May;
- 2nd Medicine for Members event on Dementia with Dr Richard Morgan has been arranged to take place on 1 May at 5.30pm;
- Talk by Paul Mason (from Newsnight) re. his new book on economics and revolution in the Middle East – date TBC
- Open Day 12 May event;
- There is likely to be an engagement event for members re public consultation on 'Shaping a healthier future' due in June – a proposal for reconfiguration of services in the sector to improve quality and reduce costs.

The sub-committee discussed the timing of Member' News Issue 3 and the membership mailing. It was agreed that the Members' News Issue 3 should be sent out a week earlier. **MA to arrange.** **MA**

CB commented that he has not been receiving Members' News. MA said that this was probably because CB had not registered his email address with Capita when he became a member. **MA to email Governors with details for Capita in order to register email addresses and ensure they received future FT communications electronically.** **MA**

5. Chelsea and Westminster Star Awards 2012 **MA**

MA highlighted the main points from the paper, updated following the closing date for nominations on 23 March.

- More than 650 nominations received in 17 Staff Choice award categories.
- More than 120 nominations received for 1 Patient Choice award category
- 7 nominations received for the Council of Governors Special Award

The judging panel for the Council of Governors Special Award consisted of Martin Lewis, Melvyn Jeremiah and Susan Maxwell.

The judging panel for Patient Choice Award included Cass J Cass-Horne as a Governor representative.

The shortlist will be announced in the week after Easter. Winners will be announced at the awards evening at Chelsea Football Club on 14 May.

The sub-committee noted that the Council of Governors Quality Awards was discussed by the Quality Sub-Committee at its meeting on 27 March and it was agreed that these will have to be restructured to allow time in between the Quality Awards which are held quarterly and Star Awards which are held annually.

6 'Who do you think we are?' values consultation – update **MA**

The sub-committee noted that following the consultation with patients, members of the public, staff and other key stakeholders to develop the Trust's values a paper was put forward to the Board today to agree the Trust's values, the plan to communicate and embed the agreed values.

MA said that these values will be communicated to staff as well as members and how these can be translated in behaviors

The Communication Department proposed to launch the 4 chosen values via Trust News (wraparound cover for the April edition), Open Day (branded T-shirts with 4 values to be worn by staff on the day and a 'graffiti wall').

There was a suggestion to have a small card with values and behaviors to help staff apply these.

7 Open Day 2012 – Update **MA**

The sub-committee noted a written update on the organisation of the Open Day May 2012.

The Open Day Operational Group was set up in order to assist with the arrangements for the Open Day. Susan Maxwell, patent governor represents the Council of Governors on the Operational Group.

This year's events will include:

- Teddy Bear Hospital
- Hospital tours
- Health checks; this will be expanded this year as it was very popular last year (there will be more nurses available and the cost will increase therefore)
- Careers events

MJ said that the placing of some of the stands in the corridors on the Ground Floor meant they did not have enough room to exhibit properly: an example was the stand where visitors could try their hand at delivering a baby (using a doll and plastic lower torso). More care was needed in allocating particular spaces to particular stands. SM explained that this year there has been a deliberate allocation of spaces which was negated by certain units arriving early and taking the best ones whether they had been allocated to them or not. It was agreed that this should not be allowed.

SM said that at the Quality Sub-Committee meeting held on 27 March there was a suggestion to have a quality stand.

MA highlighted that there will also be a focus on launch of the Chelsea Children's Hospital.

SM brought up a question of advertising. MA responded that the Open Day will be advertised extensively. Some proposals included:

- A letterbox drop locally in Kensington & Chelsea and Hammersmith & Fulham; we will have to pay for this service and it was proposed that the cost is covered by the Council of Governors.
- Buying additional advertising in the local papers – to produce 'wrap' to go around the Kensington and Chelsea Chronicle
- Advertise amongst local schools, colleges and nurseries

The sub-committee agreed to support funding of a letter box drop.

Renae McBride to put forward a request for additional funding to the Council of Governors meeting on 3 May in relation to advertising the Open Day 2012 event. **RMB**

The sub-committee discussed funding of the Open Day.

For this upcoming 2012 Open Day, the funding was down to the wire. It was also noted that last year the budget overran. SM requested that the governors agree an added £1,500 to cover the cost of the enhanced advertising listed here in the minutes, but also to take into account a planned Graffiti Wall and also to cover the increase in VAT costs on invoicing. On top of these costings there needs also to be a contingency amount added to cover emergency needs/added costs arising nearer the time or on the day. It was recognised that this could only be dealt with at the 3 May

Council of Governors Meeting and would therefore fall as a charge against the 2012/13 Council of Governors budget. **It was also agreed that for the 2013 Open Day the opening bid to the Council of Governors should be for an extra £5000, ie a total allocation of £20,000 for the 2013 event.**

RMB to put forward a request for additional funding of £5,000 ie a total allocation of £20,000 for the Open Day 2013 event to the Council of Governors. **RMB**

In discussion it was agreed that it was difficult for the Membership Sub-Committee to keep track of what was happening with the Budget. It would be helpful if for each meeting an overall summary could be produced of the size of the budget, the amount already spent and on what, and commitments which had been agreed against the balance. MJ was requested to arrange for such a note to be presented to each meeting. **MJ to arrange for an overall summary of the Council of Governors Budget to be produced for each meeting of the Membership Sub-Committee.** **MJ**

8 Membership recruitment – update **TP**

TP provided an update on the membership which currently totals 14,803.

TP outlined the recruitment activities planned for 2012.

The key recruitment activities are planned for May and September (2 recruitment sessions per each month).

TP said we need to plan when in May and where and also think carefully about briefing. Through each of these events we plan to recruit 300 members. Some recruitment sessions will be hospital based and some will take place out of the hospital.

The Sub-Committee suggested the following locations – Sloane Square near Sainsbury and Vinton Rd – Sainsbury.

MJ commented on the Mobile Health Clinic being used for recruiting members and asked TP to find out from Capita why their recruitment team had not been successful at Shepherds Bush Market. He said that the idea is that the health clinic be used as a flag pole or rallying point for the recruiters and not that they should focus their efforts on people actually using the clinic, which would not be helpful either to the recruiters or the clinic staff.

The sub-committee noted that 140 members were recruited via session in the King's Mall, Hammersmith.

MA felt that the upcoming consultation re 'Shaping a healthier future' is an opportunity to get members support and potentially more members will sign up for the membership.

The sub-committee noted that Jonathan Harris, GP Relationship Manager attempted to organise a recruitment session at the local GP surgeries but this was not very successful as none of GPs responded.

It was noted that the Capita recruiters understand the business and do excellent job.

9 Membership Recruitment Leaflet **MA**

ML updated the sub-committee on work undertaken by a small group of governors from the Membership Sub-Committee to review the current membership leaflet which needed refreshing. A group photo of staff members and a few governors was taken to be included on the leaflet.

MA said that the leaflet had been circulated to the group and all comments received will be taken on board. He invited further comments from the sub-committee.

CB pointed out that when a group photo was taken they were all asked to wear the hospital badge. In retrospective this would not seem very attractive to people from the outside thinking all people on the picture are staff members.

The sub-committee agreed that MA produces a draft leaflet with two photos and circulates for comments. The group will chose one sample to be used in the interim time as the leaflet was due for reprint.
MA to circulate and the sub-committee to choose the most preferred picture for the membership leaflet. **MA**

SM suggested a group photo of members to be taken at the Open Day which can be used for the leaflet.

SM commented on 'why become a member' section and suggested under the fourth bullet where it reads members could also attend events 'other' than *Medicine for Members* events, such as talks by members of the media.

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

There was no feedback.

11. Any other business

Minutes of Membership Sub-Committee meetings
CB requested that draft minutes of sub-committee meetings be circulated as soon as practicable after each meeting for comments in the similar fashion as the Council of Governors minutes. VD responded that this can be arranged. **This was agreed.**

Trust News
ML queried if it would be possible to include the membership leaflet in the Trust News which are placed by the reception. MA responded that he could arrange for an additional rack to be fixed next to the Trust News rack.

Follow-up appointment letters/invitation to join the Trust
CB noted that some time ago it was proposed that a letter from the Chairman inviting a patient to join the Trust would be sent with the initial appointment letter and that care would be taken to ensure that the letter was not sent again and again with any follow-up appointment letters. He commented that this was not followed up yet to his knowledge.
TP suggested that Angela Clarke or Alex Prior would be the appropriate leads to discuss this with. **TP**

Governors' picture board

ML noted that some pictures on the governors' picture board have started going curly.

TP to look into this. **TP**

12. Date of next meeting – 17 May 2012

VD said that she may have a problem with the date of next meeting and asked the sub-committee if they would want to proceed with 17 May or consider rearranging the meeting to the w/c 21 May. The sub-committee agreed that the meeting be rearranged to the w/c 21 May 2012.

VD to rearrange the Membership Sub-Committee meeting on 17 May to the w/c 21 May. **VD**

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 3 May 2012

AGENDA ITEM NO.	2.17/May/12
PAPER	Membership engagement and communication update
AUTHOR	Matt Akid, Head of Communications
LEAD	Therese Davis, Chief Nurse and Director of Patient Experience and Flow
EXECUTIVE SUMMARY	This paper is an update on progress in implementing an enhanced calendar of membership engagement events and improved communication in 2012 – following the approval of funding at the Council of Governors meeting on 1 December 2011. Appendix 1 ('Calendar of events 2012 UPDATED') should be read in conjunction with this paper.
DECISION / ACTION	Governors are invited to note this update and to provide their feedback on the proposed activity and future plans.

MEMBERSHIP ENGAGEMENT AND COMMUNICATION UPDATE

1.0 Introduction

An application for funding of an enhanced calendar of membership engagement and communication in 2012 was approved at the Council of Governors meeting on 1 December 2011. The bid for funding was broken down by financial years. Full details are below – please note that 2011-12 funding amount has been reduced by £210 because the first monthly email to members was sent in February, not January, and 2012-13 funding has been reduced by £5,000 because the budget for Open Day is £15,000 and not £20,000. In addition, it is likely that only a small proportion of funding allocated to 'Medicine for Members' events will be spent because these events are proving cost-effective with the only spend on catering.

2.0 Funding

2011-12

1 extra membership mailing (Jan 2012)	£10,000	new activity
2 monthly emails (Feb & March 2012)	£420	new activity
1 'Medicine for Members' seminar (Feb 2012)	£1,000	new activity
TOTAL	**£11,420 (all new activity)**	

2012-13

1 extra membership mailing (Jan 2013)	£10,000	new activity
12 monthly emails (April 2012-March 2013)	£2,520	new activity
Open Day	£15,000	existing activity
Annual Members' Meeting (+ 2 associated events)	£5,000	existing activity
5 'Medicine for Members' seminars	£5,000	new activity
Christmas event	£5,000	new activity
TOTAL	**£42,520 (£22,520 new activity)**	

3.0 Activity to date 2012

- **2 membership mailings** – sent to all patient and public members in January and April
- **3 Members' News e-newsletters** – sent to all patient and public members who have provided us with their email addresses in February, March and April (May e-newsletter due to be sent out on 4 May)
- **2 'Medicine for Members' seminars** – first event held in February (Bowel Cancer Awareness) and second event due to be held 1 May (Dementia – partnership event with Kensington & Chelsea Memory Service and Age UK Kensington & Chelsea)
- **3 Values consultation focus groups** – held in February as part of the 'Who do you think WE are?' consultation on choosing the Trust's values which also included FT members and other patients voting online for their top 4 values
- **Chelsea and Westminster Star Awards nominations** – 130+ FT members and other patients voted for staff in the Patient Choice category of the Star Awards during the call for nominations in March
- **1 Values implementation focus group** – due to take place on 4 May as part of the 'It's who we are' implementation of the Trust's agreed values and associated staff behaviours
- **'Show us the way' consultation** – to be held throughout May to help develop the Trust's new wayfinding strategy for approval by the Trust Board on 28 May
- **Open Day** – due to take place on 12 May

See Appendix 1 ('calendar of events 2012 UPDATED') for full details.

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

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

Date/Month	Event/Activity	Existing or new activity?	Lead	Cost/Funding source
w/c Mon 16 Apr	Membership mailing for all public and patient members (including covering letter from Chairman, Trust News and A5 flyers about future events for members)	Existing activity	Communications Manager	£10,000 (Foundation Trust budget) - funding already budgeted for in Trust budget as part of our membership 'offer' of 2 mailings/year
May				
Tues 1 May	Medicine for Members 2nd event – Dementia seminar	New activity	Communications Dept	£1,000 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
Fri 4 May	'It's who we are' Values implementation focus group	New activity	Learning & Development Manager (Staff Governor Carol Dale)	Not from Council of Governors budget
Fri 4 May	Members' News Issue 4	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
Sat 12 May	Open Day	Existing activity	Communications Manager	£15,000 (Council of Governors) – funding approved at Council of Governors meeting 1 Dec 2011
Throughout May	'Show us the way' consultation to help develop the Trust's new wayfinding strategy	New activity	Head of Communications (with wayfinding consultants Applied)	Not from Council of Governors budget
June				
Fri 1 Jun	Members' News Issue 5	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011

Date/Month	Event/Activity	Existing or new activity?	Lead	Cost/Funding source
Date TBC	Medicine for Members 3rd event (seminar/talk or behind the scenes tour)	New activity	Communications Dept	£1,000 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
July				
Fri 6 Jul	Members' News Issue 6	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
Date TBC	Talk by Paul Mason (Economics Editor, BBC *Newsnight*)	New activity	Head of Communications	TBC
Dates TBC	'Shaping a healthier future' public consultation by NHS North West London on changes to NHS services – membership engagement and communication activity to be agreed with Trust Board, consultation due to start end June	New activity	Head of Communications with Directors	Not from Council of Governors budget
August				
Fri 3 Aug	Members' News Issue 7	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
w/c Mon 13 or 20 Aug	Membership mailing (including covering letter from Chairman, Trust News, Annual Members' Meeting invitation and A5 flyers about future events for members)	Existing activity	Communications Manager	£10,000 (Foundation Trust budget) - funding already budgeted for in Trust budget as part of our membership 'offer' of 2 mailings/year
September				
Fri 7 Sep	Members' News Issue 8	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011

Date/Month	Event/Activity	Existing or new activity?	Lead	Cost/Funding source
Thu 13 Sep	Annual Members' Meeting + 2 other engagement events for groups of members who do not traditionally attend the Meeting (eg Maternity, Paediatrics, HIV/GUM)	Existing activity	Head of Communications	£5,000 to cover costs of Annual Members' Meeting + 2 other events (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
Date TBC	Medicine for Members 4th event (seminar/talk or behind the scenes tour)	New activity	Communications Dept	£1,000 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
October				
Fri 5 Oct	Members' News Issue 9	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
November				
Fri 2 Nov	Members' News Issue 10	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
Date TBC	Medicine for Members 5th event (seminar/talk or behind the scenes tour)	New activity	Communications Dept	£1,000 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
December				
Fri 7 Dec	Members' News Issue 11	New activity	Head of Communications	£210 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011
Date TBC	Christmas event (mini Open Day)	New activity	Communications Dept	£5,000 (Council of Governors) - funding approved at Council of Governors meeting 1 Dec 2011

Other activity not included in calendar

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

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 3 May 2012

AGENDA ITEM NO.	2.18/May/12
PAPER	Council of Governors Membership Report*
AUTHOR	Tony Pritchard, Deputy Chief Nurse
LEAD	Therese Davis, Chief Nurse and Director of Patient Experience and Flow
EXECUTIVE SUMMARY	This paper presents an overview of Foundation Trust membership and provides an analysis of trends for the period February and March 2012. The report shows an overall gain of 18 patient and public members during the 2 month period. There were 117 patient and public members who left whilst 135 new patient and public members joined. During the year of 2011 - 12, there have been a total of 1,654 new members and 1,297 who have left membership. This provides an overall gain of 357 members, which is mainly attributable to 2 recruitment campaigns in June and September 2011.
DECISION/ ACTION	For information.

Membership Report

1.0 Membership size and movements

Table 1 below shows the size and movement of membership for the year 2010-2011, and for the year 2011 - 12.

Table 1. Size and movement of membership

1.0 Membership size and movements

OVERALL MEMBERSHIP OVERVIEW	Last Year 1 Apr 10 – 31 Mar 11	Current Year 1 Apr 11 – 31 Mar 12
As at start	**15,187**	**14,501**
New Members	2,008	1,654
Members leaving or changing constituency	2,694	1,297
TOTAL	**14,501**	**14,858**
PUBLIC MEMBERSHIP OVERVIEW	**Last Year 1 Apr 10 – 31 Mar 11**	**Current Year 1 Apr 11 – 31 Mar 12**
As at start	**6,131**	**5,737**
New Members	257	659
Members leaving or changing constituency	651	454
TOTAL	**5,737**	**5,942**
PATIENT MEMBERSHIP	**Last Year 1 Apr 10 – 31 Mar 11**	**Current Year 1 Apr 11 – 31 Mar 12**
As at start	**6,010**	**5,591**
New Members	396	487
Members leaving or changing constituency	815	393
TOTAL	**5,591**	**5,685**
STAFF MEMBERSHIP	**Last Year 1 Apr 10 – 31 Mar 11**	**Current Year 1 Apr 11 – 31 Mar 12**
As at start	**3,046**	**3,173**
New Members	1,355	508
Members leaving or changing constituency	1,228	450
TOTAL	**3,173**	**3,231**

2.0 Membership Joiners and Leavers April 2011 – March 2012

2.1 Public Membership

Table 2 below shows public membership joiners and leaves during February and March 2012. There were 117 public who joined and 68 who left membership during this period

Month	February	March	Total
Joiners	113	4	117
Leavers	8	60	68

Table 2. Public Membership joiners and leavers February and March 2012

2.2 Patient Membership

Table 3 below shows patient membership joiners and leavers during February and March 2012. There were 18 new joiners and 49 who left membership during this period.

Month	February	March	Total
Joiners	14	4	18
Leavers	11	38	49

Table 3. Patient membership joiners and leavers February and March 2012

3. Membership Demographics

3.1. Public Membership Ethnicity March 2012

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

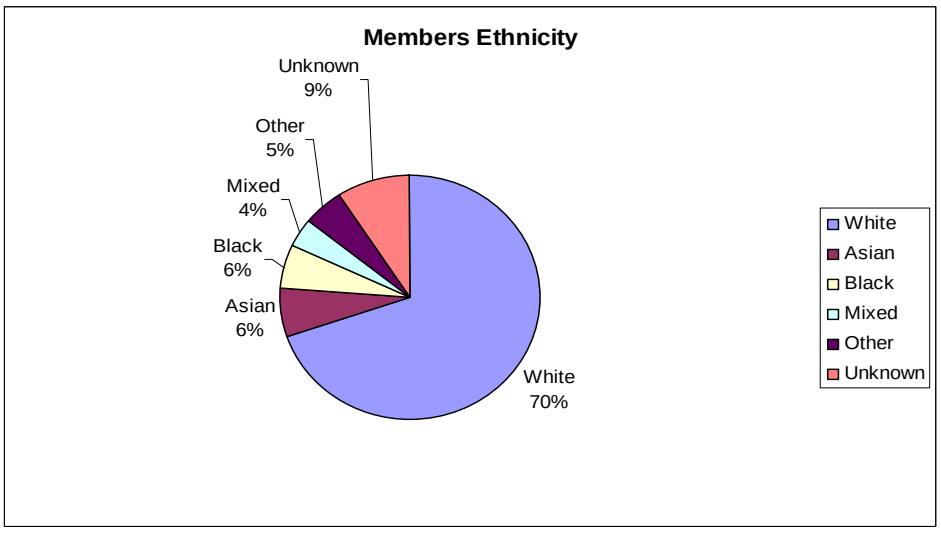
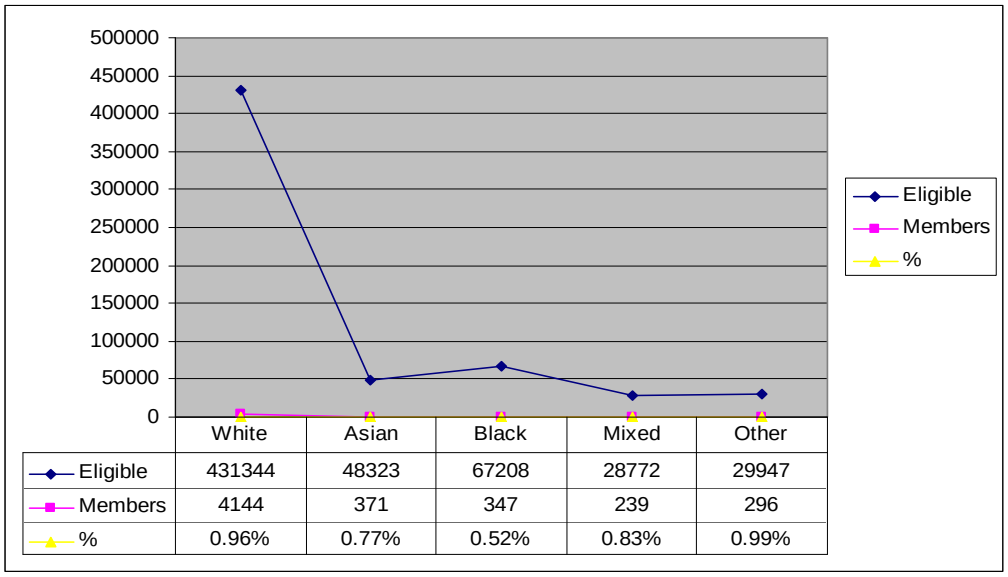


Figure1. Public Membership Ethnicity

3.2. Public Membership Ethnicity – comparison against local eligible population

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



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

Figure 2. Public Membership comparison against local eligible population

3.3. Public Membership Age

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

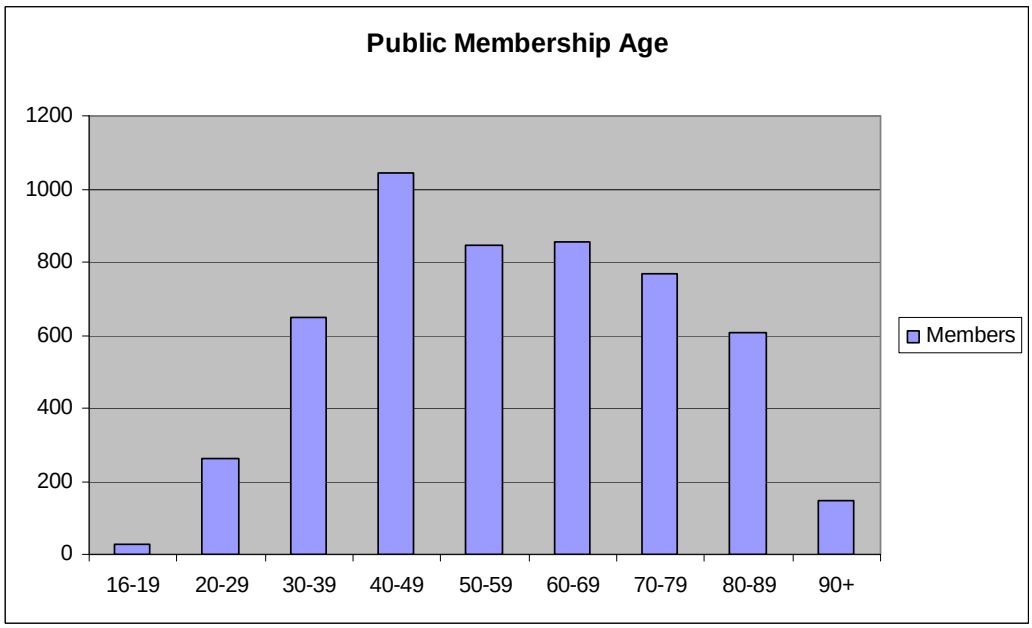
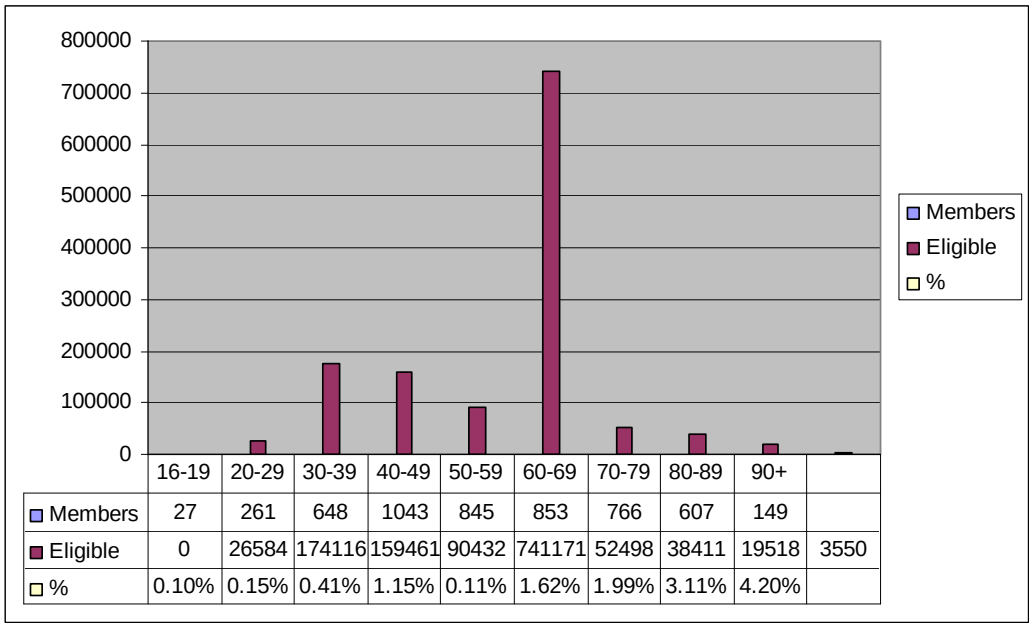


Figure 3. Public Membership Age

3.4. Public Membership Age – Comparison against local eligible population

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

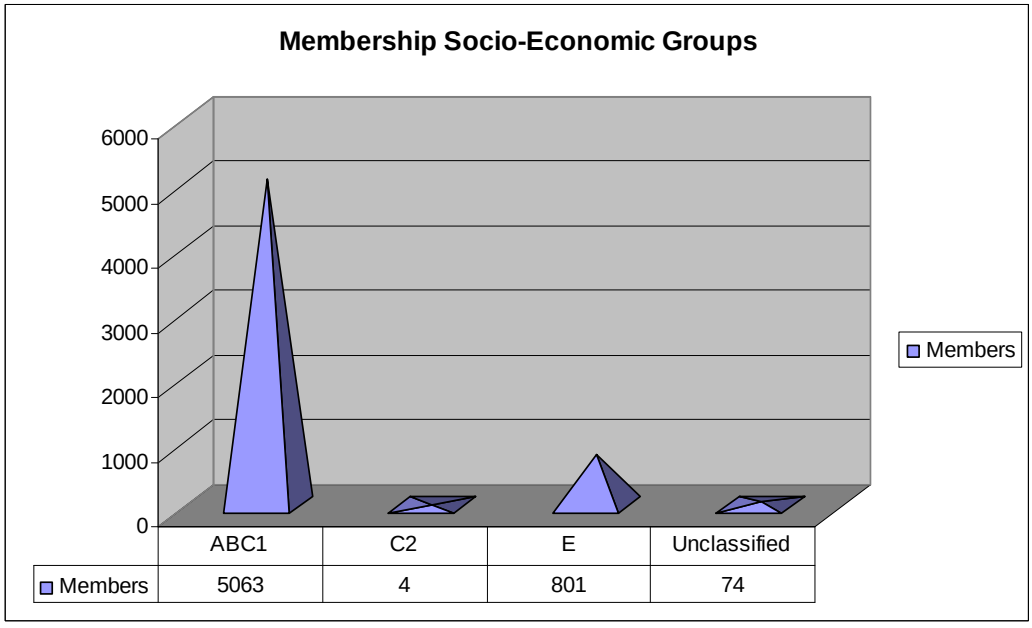


	16-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90+	
Members	27	261	648	1043	845	853	766	607	149	
Eligible	0	26584	174116	159461	90432	741171	52498	38411	19518	3550
%	0.10%	0.15%	0.41%	1.15%	0.11%	1.62%	1.99%	3.11%	4.20%	

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

3.5. Public Membership - Socio-economic grouping

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



	ABC1	C2	E	Unclassified
Members	5063	4	801	74

Figure 5. Public Membership - Socio-Economic Groups*

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

4.0 Membership Recruitment

4.1 During the year 2011 – 12, there have been a total of 1,654 new members and 1,297 who have left membership. This provides an overall gain of 357 members

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

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

4.5. In November 2011, the Council of Governors approved a sum of £3,300 to fund 5 additional membership recruitment events. 2 health bus events were attended by Capita during November and December 2011, but recruitment numbers were low. On March 28th, Capita was commissioned to recruit within a Somali Women's group at West London Centre for Sexual Health and 31 members were recruiterd.

4.6. During February, our M-PALS Manager contacted General Practices within North Wandsworth to seek agreement for the hosting of recruitment activities within these practices. The Trust GP Relationship Manager had identified a number of large practices that also have over 50% of patients having outpatient appointments at Chelsea and Westminster and are also geographically close to the Trust. To date, there has been no positive response to these enquiries.

4.7. We plan to commission Capita, our recruitment providers, to provide 2 recruitment events in May and September of 2012. Through each of these events we aim to recruit 300 members. The May recruitment event will also be used to promote the Trust Open Day whilst the September event will be used to promote both the Governor elections and the Trust Annual General Meeting.

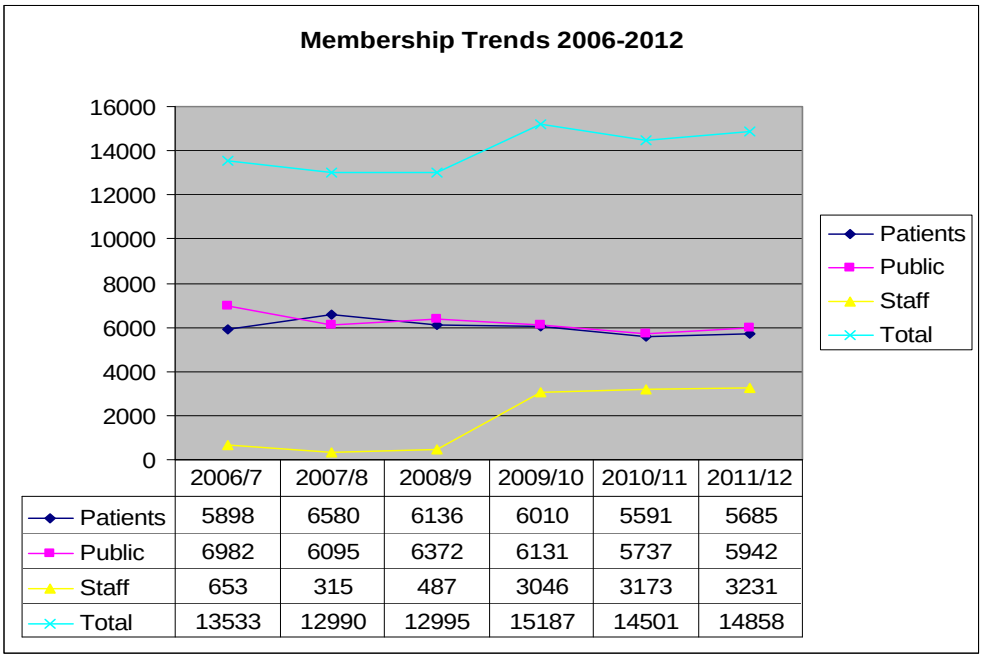
4.8. The Membership – Patient Advice and Liaison Services support membership promotion. Any visitor to the M-PALS office is offered a membership application form when appropriate. The forms are sent with all patient response letters from the M-PALS service and the team will continue to actively promote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

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

4.7 A booklet for patients coming in for elective surgery, funded by the Council of Governors is currently being developed and will be given to patients on admission and includes a membership application form.

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

4.9. Figure 6 below shows the trends in Trust membership from 2006-2012.



	2006/7	2007/8	2008/9	2009/10	2010/11	2011/12
Patients	5898	6580	6136	6010	5591	5685
Public	6982	6095	6372	6131	5737	5942
Staff	653	315	487	3046	3173	3231
Total	13533	12990	12995	15187	14501	14858

Figure 6. Membership trends 2006-2012

5.0 Developing a Representative Membership

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

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

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

5.4 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.

5.5 To create equal representation, It is recognised that membership recruitment should focus on increasing its numbers and engagement with Black, Ethnic and Minority groups. Our recruitment strategy will continue to focus on activities which can encourage wider representation within our membership.

6.0 Summary

6.1. 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'.

6.2. 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.

7. Membership Recruitment Achievements 2011/12

The below table summarises key recruitment events between April and March 2012

Month	Event	Total Recruited
April	No events	
May	Open Day	79
June	• Capita Recruitment Campaign H&F • Mobile clinic at Shepherds Bush Market • Meet a Governor Session	• 300 Public Members
September	• Capita recruitment campaign for patients and public members within the hospital	• 300

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 3 May 2012

AGENDA ITEM NO.	3.1/May/12
PAPER	Finance Report - March 2012
AUTHOR	Mike Fox, Chief Management Accountant
LEAD	Lorraine Bewes, Executive Director of Finance
EXECUTIVE SUMMARY	For the financial year 2011/12 the Trust achieved an EBITDA of £34m (£4m ahead of plan) and a net surplus of £13.6m (£5.2m ahead of plan). The Trust financial performance to date has been driven by contractual over-performance for NHS clinical activity which has been delivered at a lower cost than the income generated. The Trust is continuing to monitor pay costs with a significant focus on the use of temporary staffing in Medical and Nursing groups. Weekly monitoring of these costs has led to better control of this spend so that increased costs are only incurred where required by increased levels of clinical activity. Year to date the Trust pay spend is broadly in line with budget. Non pay costs were overspent by £5.4m for the financial year. The most significant element of this over-spend is due to increase levels of bad debt provision the Trust has made against potential contractual and data disputes by commissioners. Other areas of over-spend relate to the costs of pathology and clinical supplies which have increase in line with higher levels of clinical activity. During 2011/12 the Trust had set a target of identifying and delivering Cost Improvement Programmes (CIP) with £19.7m, in fact the Trust achieved £20.9m worth of CIP during the year with a recurrent value of £19.9m. The Trust is anticipating a CIP target of £16.2m for 2012/13 and has currently identified schemes worth £14.2m (88% of target). The Trust's continuing strong financial performance during 2011/12 has been underpinned by a combination of high levels of clinical activity, strong control of variable costs ensuring these are in line with clinical activity levels and the identification and delivery of the Trust CIP target. For the Trust to continue to achieve its financial targets in future years it will be important it maintains the control of costs and ensures CIP are identified and delivered without impacting on the quality of clinical

	services.
DECISION / ACTION	The Council is asked to note the financial position for the financial year 2011/12.

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.

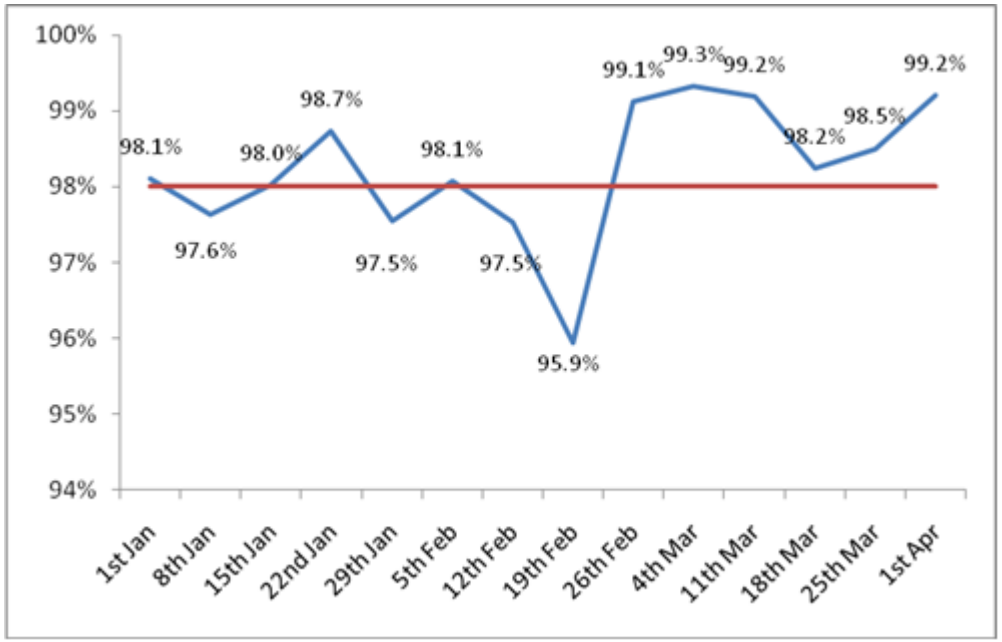
Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 3 May 2012

AGENDA ITEM NO.	3.2/May/12
PAPER	Performance Report – March 2012
AUTHOR	Helen Byrne, Interim Head of Performance Improvement
LEAD	David Radbourne, Chief Operating Officer
EXECUTIVE SUMMARY	Overall, the Trust has performed well throughout the year and in month 12, achieving the required performance level in all Monitor indicators which could be measured. The Trust's performance against the 4 hour waiting time target in A&E at year end position was over 98% at 98.5%. This is a significant achievement for the Trust which remains one of the best performing Trusts in London against this target. The Trust is predicting achievement of 88% of the total value of CQUIN schemes in 2011/12. There are two schemes that account for the majority of the predicted £600k shortfall between the potential and predicted value of the CQUIN schemes – £425k of this £600k can be linked to the Trust's Responsiveness to Personal Needs Inpatient Survey and HIV CQUINS. Financial performance for the Trust's Responsiveness to Personal Needs Inpatient Survey CQUIN, which is conducted over one week with results released later in the financial year, is extremely difficult to predict with any certainty and subsequently it was thought that a prudent view should be taken with regards to financial achievement. Subsequently financial performance for this CQUIN has been predicted at predicted at 25% of the total value of the CQUIN, or £95k of the available £380k, which leaves a potential shortfall of 285k. Due to lengthy negotiations on the total value of the HIV Contract, work on the HIV CQUIN was unable to commence until late into Quarter 3 of this financial year. Subsequently it is an anticipated £400k or 75% of the total value of the total CQUIN, valued at £540k, will be achieved with a shortfall of £140k. At the March Board, a year to date total of six 'Never Events' was reported. One 'Never Event' has subsequently been downgraded, bringing the total to 5 'Never Events' at the year end. The Trust continues to focus on improving outpatient (OP) letter turnaround times and there is now much greater accuracy of monitoring due to the roll out of the Bighand digital dictation system across all specialties, which suggests a deterioration in performance in March. This will be a major area of focus for the Trust in 2012/13.

	Back up data relating to the performance report can be found in Appendix 1.
DECISION/ ACTION	The Council is asked to note this report.

A&E Performance Trend



2011/12 Performance

The Trust has had a good year in performance terms with achievement of all major targets.

A number of areas are highlighted. Throughout the year, the Trust achieved over 98% against the 4 hour wait in the Emergency Department (ED) with the exception of January 2012, when performance dipped to 97.8% because of the very significant pressures in the ED that month. The national target is 95%. The Trust remains one of the best performing hospitals in London against this target.

On cancer targets, the Trust has also performed very well, exceeding all targets throughout the year, which at times has been very challenging because of very low numbers of patients. A breach of one patient can result in failure to meet the target.

The Trust has performed well on all waiting times targets, and throughout the year has exceeded- the 90% target for admitted patients and the 95% target for non admitted patients to be seen and treated within 18 weeks in any one month.

In the PEAT assessment undertaken in February 2012, the Trust scored Excellent in all 3 categories assessed: privacy and dignity; standard of the environment; and food and nutrition. The Trust also had excellent performance on infection control with only 2 cases of MRSA and 17 cases of C Diff. In terms of single sex breaches, the Trust also performed well only 12 breaches that could have been avoided in the year.

Where there have been concerns about performance, corrective action has been taken for example in relation to readmission rates, turnaround of Outpatient letters and discharge summaries and adherence to the mixed sex accommodation policy and procedures within the Trust.

2012/13: Performance Challenges Ahead

The Trust is still in negotiation with NHS North West London (NHSNWL), our commissioners, on the performance targets and quality initiatives to be implemented during 2012/13.

There are over 90 Quality Indicators (or Key Performance Indicators), many of which are the same as for 2011/12. One significant new target is the requirement of the Trust to ensure 92% of patients on incomplete pathways are seen and treated within 18 weeks at any one time. The Trust has undertaken a major validation exercise during March 2012 to ensure preparedness and with a change to the Lastword system is confident that this target will be met. The RTT targets for admitted and non admitted patients remain the same as for 2011/12 except that there is now the requirement to deliver at specialty level rather than at Trust level. This will pose particular problems in a number of paediatric and surgical specialities.

The Trust has yet to agree a number of the Quality Indicators which includes challenging a number of 'metrics' with unacceptable stretch targets applied by the commissioners, in the following areas:

New to Follow up ratios; non GP referrals; day case to outpatient procedures; ambulatory care pathways; orthopaedic excess bed days; readmissions; ante natal admissions; Procedure with a Threshold (PPwT).

The Trust is putting forward counter proposals for all metrics. In addition, the Trust has developed proposals to implement the 9 proposed CQUINs by the commissioners and is awaiting feedback.

There are 4 nationally mandated CQUINs as follows: Patient Experience; VTE; Safety Thermometer; and Dementia. There are 5 local CQUINs: GP real-time information; adoption of the NWL Integrated Formulary; End of life care; BCG vaccination and assessment within 12 hours of admission by a Consultant.

Nightly Discharges: Following a report from the Mirror indicating that 8,000 patients a week are discharged between the hours of 11pm to 6am. The Trust position is that 4.17% of patients were discharged between these hours in11/12. The majority (50.65%) were Women's and Neonates and had a length of stay of less than 10 hours. Further analysis is underway to identify any possible areas of concern.

Monitor Compliance: 2011/12

NHSQuarter	Target	2011/12	Apr-Jun 2011	Jul-Sep 2011	Oct-Dec 2011	Jan- Mar 2012	Score YTD	Expected Score
Clostridium difficile cases	< 31	17	6	3	5	3	0	0
MRSA objective	<3	2	0	1	0	1	0	0
All cancers: 31-day wait from diagnosis to treatment	96.0%	99.9%	100.0%	100.0%	100.0%	99.5%	0	0
All cancers: 31-day wait for second or subsequent treatment Surgery	94.0%	98.2%	100.0%	100.0%	100.0%	94.1%	0	0
All cancers: 31-day wait for second or subsequent treatment anti cancer drug treatments	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0	0
All cancers:62-day wait for first treatment from urgent GP referral to treatment	85.0%	96.5%	95.5%	97.7%	97.5%	93.0%	0	0
All cancers:62-day wait for first treatment from consultant screening referral	90.0%	96.4%	100.0%	93.3%	100.0%	100.0%	0	0
Cancer: Two Week Wait from referral to date first seen comprising all cancers	93.0%	96.7%	95.8%	95.4%	98.2%	97.4%	0	0
Referral to treatment waiting times - Admitted (95th percentile)	<23 Wks	22.9	22.9	22.5	22.4	20.4	0	0
Referral to treatment waiting times - Non-Admitted (95th percentile)	< 18.3 Wks	16.1	11.9	11.5	16.1	12.7	0	0
A&E: Total time in A&E*	=> 95%	98.5%	98.5%	98.9%	98.5%	98.2%	0	0
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability		Compliant	Compliant	Compliant	Compliant	Compliant	0	0

Green Green

Quality KPIs

Know your arrows: - The arrows in the dashboard below relate to the month on month variance in Trust performance. An upwards arrow indicates an improved performance across all KPIs. For example DNA rates have reduced from 10% in Feb to 9.91% in Mar which is an improvement in performance; year to date performance of 10.46% did not meet the target (8.68%).

Clinical Effectiveness	Mar	Trend	YTD
Urinary Catheter Usage			
Income lost to first to follow-up ratio			
Maternity Booking Access Target			
Breastfeeding initiation rates			
Caesarean section rate			
Cellulitis Admissions			
DVT 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)			

Process Effectiveness	Mar	Trend	YTD
Delayed transfers of care			
Referral to Treatment Non-admitted			
Referral to treatment incomplete pathways			
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			

KPIs Under-development

Delay in offering patients ERPC within 12 hours, Paeds turnover, Paeds & Neonatal occupancy %, % of Colorectal Cancer resections performed laparoscopically

Safety	Mar	Trend	YTD
Hand Hygiene Completion			N/A
Hand Hygiene Compliance			N/A
Incident reporting			
Never events			
Patient falls resulting in moderate or major harm			
PEAT audit composite score (1mth behind)			N/A
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			

Clinical Effectiveness	Mar	Trend	YTD
Formal complaints responded in 25 working days			
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			

Pathway Colour Code

- APPLIES TO ALL PATHWAYS
- OUTPATIENT PATHWAYS
- MATERNITY PATHWAYS
- EMERGENCY PATHWAYS
- PAEDIATRIC PATHWAYS
- ELECTIVE PATHWAYS
- LONG TERM PATHWAYS

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

- The % of acute and general patients with a urinary catheter was 15.35% against a target of less than 12.5%. The Deputy Chief Nurse, together with the senior nurses continuing to monitor areas with higher usage of catheters and ensure that the 'saving lives' audit tool is in use. They are also implementing the use of the 'Safety Thermometer' which will collect data on patients with a urethral catheter and the duration of insertion
- YTD £550k of outpatient new to follow up activity has been undertaken without payment as result of breaching first follow-up ratio thresholds. There is deterioration in performance compared to February and is predominantly in Rheumatology and T&O. Colleagues in both medicine and surgery are reviewing the reasons as to why and will agree action plans with their clinicians. In T&O there was an increase in fracture activity resulting in more follow ups. In Rheumatology, the intention is to ensure the virtual clinics work more effectively which should prevent the need for a follow up appointment.
- The % of A&E attendances for cellulitis which end in admission was 60.9% against national best practice of 10-40%. The Directorate is continuing to undertake a review of admissions and has put in place an ambulatory care pathway where patients are identified from the AAU and begin IV antibiotic treatment. Patients are followed up at the Trust on days 4, 7 and 10 of the pathway and for the remaining days will be visited by the community nursing team to administer treatment. This will begin in April and will lead to an improvement in performance.
- % of A&E attendances for DVT which end in admission: a review of data capture and calculation of this indicator is to be undertaken during Q1 which will inform discussions with commissioners in order to set meaningful thresholds.
- Pressure Ulcers: there are root cause analysis underway (using a Trust wide standardised tool) by the nominated lead investigators. A pressure ulcer care bundle has just been piloted on David Erskine ward with a plan to roll this out on Lord Wigram ward next, prior to the document being used Trust wide. . In addition there is a lot of local and ward based training and education on-going as well as a bi-monthly pressure ulcer action group meeting
- Patient Falls: There was 1 reportable fall causing moderate or severe injury in March. The fall occurred on David Erskine and is being investigated by the Divisional Nurse who will take the findings to the divisional standing incident review panel in May for discussion and agreement of recommendations/action plan.
- Elective Average Length of Stay: the focus is on reducing the number of patients who have a long stay in hospital. The average elective length of stay is 3.9 days across the Trust against a national average of 3.7 days. 59 patients stayed longer than the national 75 percentile whereas the Dr Foster model predicts this should be 55 patients; hence the reason the target was not met. The Divisions are continuing to focus on specific pathways to drive improvement in performance.
- Day case rate: there was deterioration in March compared to February of 5% from 86.5% to 81.5%. This is predominantly in Paediatric Orthopaedics and Paediatric ENT. The reasons include: clinical need for the child to stay, inaccurate coding, lack of detail provided as to why a child should stay overnight. Admissions and coding staff are being reminded to ensure cases are to be listed as day cases unless the Consultant advises otherwise and on ensuring accurate recording..
- DNA rates: there was performance of 10.46% 2011/12 against an target of 8.68%, showing an improvement on February 10.02 to Mar - 9.91%. The DNA target is set at national median for each speciality. An area in which there are high DNA rates against the national median is GUM where many patients self-book. There have been improvements in hand therapy and elderly medicine. Top performers include Physiotherapy, Gastro HIV and ECG and paediatric dentistry.
- Hand hygiene audit completion was 97.0% against a target of 100%. Non completion of hand hygiene audits are monitored each month through the Synbiotix. This is reported to the Infection Prevention and Control committee where non completion is followed up with individual leads for the respective areas
- Emergency & Elective MRSA screening rates have improved since ED & AAU processes have been reviewed. A daily screening report is awaiting final development data warehouse. 94% of elective patients were screened for MRSA within 3 months of their surgery. The target was not achieved for 11 patients, 3 patients were screened outside of the 3 month timeframe. The nurse consultant is working with pre-op staff to identify any gaps in the current screening process.
- Breach of same sex accommodation: In March there were2 mixed sex breaches reported from the Children's bay on the Burns Unit. The Single Sex policy was not followed by colleagues on the Burns Unit and the policy to escalate the need to mix sexes was not followed. The lead nurse is taking action to ensure colleagues are aware of the policy and its importance to patients and to the Trust.

Patient Experience

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Our patient experience strategy for 2011-12 aims to reduce complaints and concerns on: communication and information; discharge and care of the older person

Complaints and Concerns for Quarter 4 2011 by Campaign & Division

		Communication								Discharge								Concern Age 75 and Over							
		Type 1				Type 2				Type 1				Type 2				Type 1				Type 2			
Division	**Directorates**	**Q 1**	**Q 2**	**Q 3**	**Q4**	**Q 1**	**Q 2**	**Q 3**	**Q4**	**Q 1**	**Q 2**	**Q 3**	**Q4**	**Q 1**	**Q 2**	**Q 3**	**Q4**	**Q 1**	**Q 2**	**Q 3**	**Q4**	**Q 1**	**Q 2**	**Q 3**	**Q4**
Clinical Support Services		5	0	2	0	0	0	3	2	5	0	0	0	1	1	0	0	1	0	1	1	0	1	0	2
Women, Children, Young People & Neonates, HIV, GUM & Dermatology	HIV GUM Directorate	4	4	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
	Women and Children Directorate	4	4	7	2	6	7	3	6	5	0	0	0	0	0	0	0	1	0	1	0	0	0	0	1
Medicine & Surgery	Medical Directorate	7	4	0	2	5	7	6	7	2	1	2	1	5	5	1	1	3	1	5	8	10	4	7	5
	Surgical Directorate	11	3	9	4	1	4	10	9	11	0	1	1	2	1	1	1	0	14	9	2	0	3	4	3
Central Outpatient Services		0	13	6	5	0	5	10	2	0	0	0	0	0	0	0	0	0	0	4	4	0	2	2	1
Non Clinical Support Services		3	0	1	1	1	0	1	0	0	0	0	0	0	0	0	0	5	0	0	3	0	0	1	0
Totals for Q1, Q2, Q3 and Q4		**34**	**28**	**25**	**15**	**13**	**23**	**34**	**26**	**23**	**1**	**3**	**2**	**8**	**7**	**2**	**2**	**10**	**15**	**21**	**18**	**10**	**10**	**14**	**12**
2011/12 YTD		**102**				**96**				**29**				**19**				**64**				**46**			
2010/11 Total		**177**				**83**				**94**				**14**				**-**				**-**			

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

	Communication	Discharge	Concern Age 75 and Over
Themes	• Next of kin not kept informed regarding future plans • Failure to communicate with family following a fall • Concern withinformation provided re to expect following a procedure. • Patient arrived on time given conflicting advice as to whether operation would go ahead. • Referral to department not received and patients received conflicting information. • Lack of communication between specialities involved in care. • Expressed concern with the care and treatment in fracture clinic, with regard to the late running of clinic and communication with patient • Patients describe leaving numerous messages and no one has called them back	• Concern regarding discharge which relatives felt was inappropriate. Patient re admitted as sustained another fall at home. Thorough assessment of discharge needs was undertaken. Patient had capacity and was aware of risks but wished to go home • Patient discharged from clinic but believes condition not treated	• Lack of information to families regarding the management of care. Difficulties in getting updates and family not informed re changes to care plan • Attitude of staff towards elderly patients requesting help. • Failure to answer call bells refusal to get patient a commode
Actions	• The leaflet for patients having colonoscopy has been amended to provide information on what to expect following a procedure • Pre assessment unit to record notes from their assessments electronically as well as on paper. • All referrals copied to the Medical Admissions staff to ensure they are logged on waiting list. This will ensure there is an accurate record of all patients waiting for the procedure. • The name of the nurse allocated to each clinic [T and O] is now displayed outside each clinic room to ensure that all queries are directed to the appropriate person. • Reception staff are due to take a Customer Service Apprenticeship	• Trust has piloted joint working between hospital and community teams to strengthen discharge planning and to ensure right support is in place following the patients discharge. • Weekly meetings to plan the discharge of those with more complex needs have been introduced. These involve clinical staff, the hospital discharge team and community representatives.	• Taken forward work to ensure that patients with dementia are identified on admission and that a clear plan is in place to enable the communication and coordination of care between different members of the team. • Planning for roll out of care and comfort rounds to 3 further wards

Maternity Real Time Patient Feedback: In Q4 488 patients from 1044 discharges (46.7%) gave us feedback on the following questions. Our local target is to achieve an overall satisfaction score of ≥ 90%

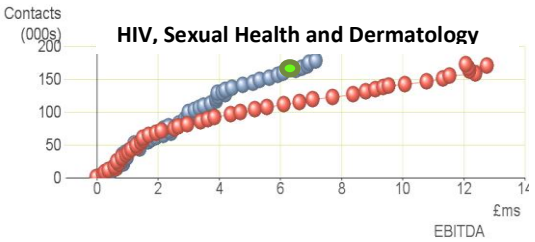
I felt I was not left alone when I didn't want to be, when I was in established labour	96.6%
Overall, how would you rate the care received during your pregnancy?	96.11%

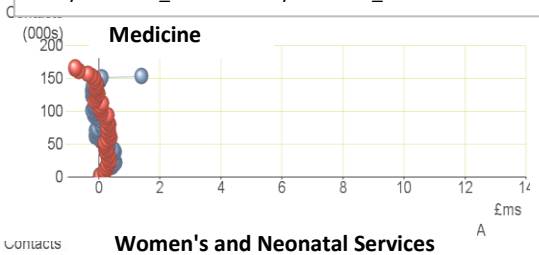
Thinking about the care you have received in hospital after the birth of your baby, have you been treated with kindness and understanding?	93.75%
Do you feel the ward is clean enough?	93.78%

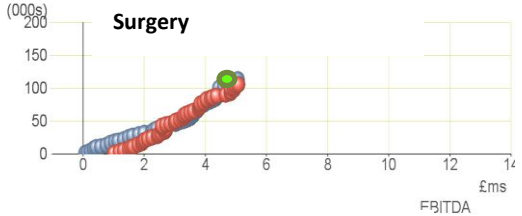
N.B. Due to issues with the patient experience devices it is not possible to report accurately on areas apart from Maternity. All Questions are set nationally and the Trust has scored above 90% on all satisfaction indicators.

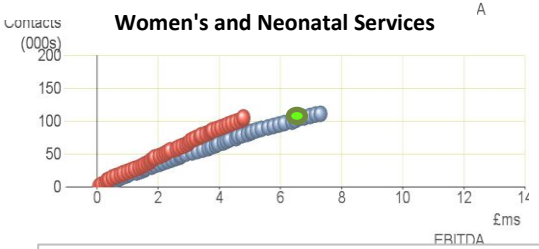
Finance / Efficiency KPIs

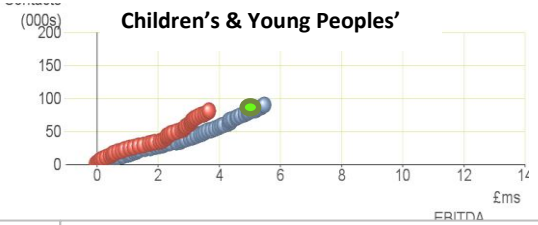
Know Your Chart:
Each blob is a week. The current week last year is highlighted in green.
Size of blob is average cost
Volume and EBITDA (profit) is cumulative for each week.
More recent weeks are in front of weeks at the beginning of the year. 2010_11 is the full year. 2011_12 is to month 10



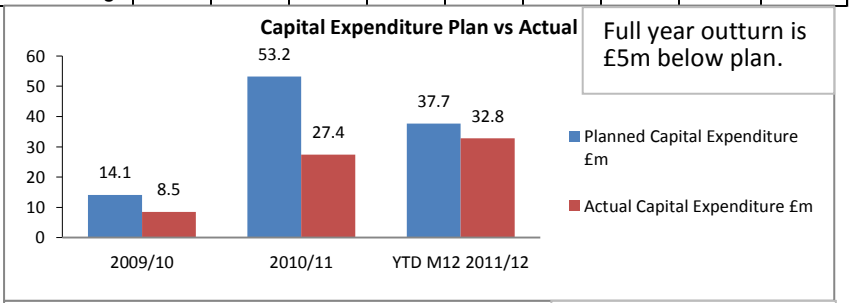




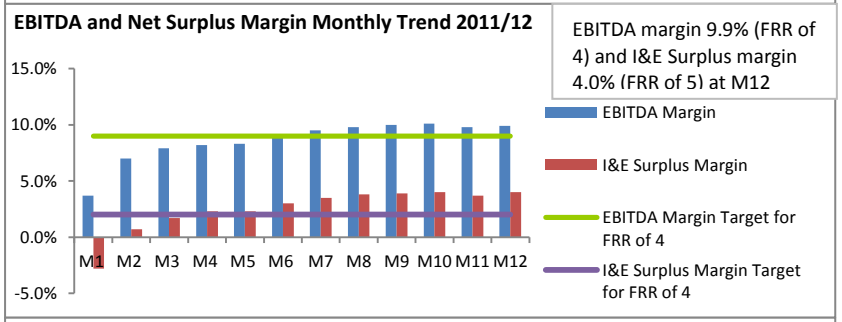




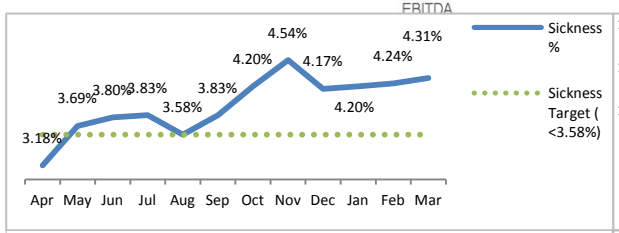
	M1	M2	M3	M4	M5	M6	M7	M12 Monitor Plan	M12 Forecast
EBITDA margin	3.7%	7.0%	7.9%	8.2%	8.3%	8.9%	9.5%	9.1%	8.9%
EBITDA , % plan achieved	75.1%	112.9%	109.6%	108.7%	110.0%	112.3%	106.2%	102.4%	99.9%
Return on assets	0.5%	3.8%	4.8%	5.1%	5.2%	5.8%	6.3%	5.6%	5.7%
I&E surplus margin	-2.8%	0.7%	1.7%	2.3%	2.3%	3.0%	3.5%	2.6%	2.7%
Liquidity days	26.4	26.6	22.0	21.5	19.9	17.0	28.7	16.1	16.5
Overall Financial Risk Rating	2	3	3	4	4	4	5	4	4



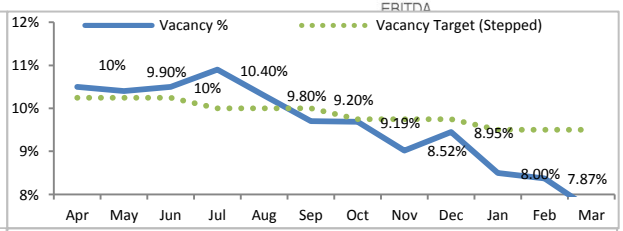
Full year outturn is £5m below plan.



EBITDA margin 9.9% (FRR of 4) and I&E Surplus margin 4.0% (FRR of 5) at M12

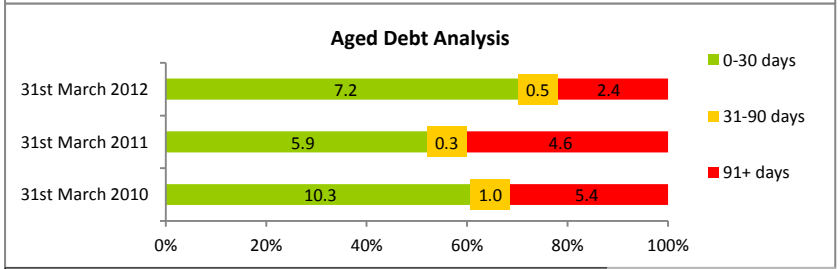


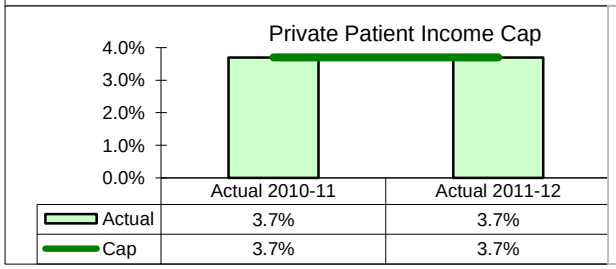
The Trust's sickness absence rate in March was 4.31% which is slightly higher than the previous month (4.24%) and March 2011 (3.90%). The Trust narrowly missed it's year to date target of 3.90% average sickness across the year. This was partly due to improved reporting mechanisms across the Trust which has led to an increase in the number of departments reporting absence. The Trust Senior Operational Group has set up a working group to review Absence management and will introduce recommendations in the new financial Year to improve the management of sickness absence, as part of a QIPP programme to reduce sickness across the Trust as part of a QIPP programme to reduce sickness across the Trust.



The full Trust vacancy rate for March 2012 was 7.14%, a decrease of 2.56% on the previous year. This reduction was principally due to increased recruitment within the Medicine and Surgery and Women's, Children and Sexual Health Divisions.

A truer measure of vacancies is those posts being actively recruited to, based on the WTE of posts being advertised through NHS jobs throughout March 2012. The active vacancy rate is currently 3.01%, and is below target for the year.





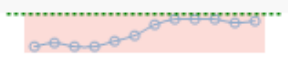
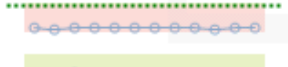
Full year performance against PP cap is 3.7% i.e. at the maximum point of the PPI threshold.

Commentary:

1) The Trust has generated private patient income for the full year of £11.3m which equates to 3.7% of total patient related income, i.e. at the maximum point of but still within the PPI threshold.
2) The provisional Financial Risk Rating is a 5.
3) CIPs: £20.9m achieved for 2011/12 (106% of target), with a recurrent value of £19.9m (101%).
4) Clinical income: Contract income over performed by £1.1m in M12, driven by continued overpeformance in elective and outpatient income. he Trust has provisions of £5.8m relating to commissioner data challenges / other queries. The Trust continues to negotiate on 2012/13 contracts with NWL and the contract gap is reducing - the Trust is confident that it will achieve the NWL income financial envelope.
5) Expenditure: pay costs were overspent by £0.6m against budget in month after accounting for unidentified CIP and pass through costs. Non pay costs overspent by £2m in month, mainly due to £1.6m additional provisions costs relating to commissioner data challenges and contractual disputes. This was partially offset by a backdated correction relating to the value of HIV drugs issues which resulted in a £1m underspend against the drugs budget in month. Non operational costs underspent by £0.6m in month due to the fact that the final PDC dividend calculation was £0.5m lower than the full year estimate.
6) Capital expenditure: Outturn is £32.8m i.e. £5m below plan. Phase 2 of the Netherton Grove extension has been capitalised and the final position is a small underspend against forecast. The Trust has instructed external valuers to undertake a valuation of the Trust's estate and the actual movementafter accounting for 2011/12 capital expenditure is a downward revaluation of £6.5m which has been charged to the revaluation reserve.
7) Total billed debt at M12 has reduced by £9m due to significant cash collection in March - this related to collection of contract overperformance and NCA activity both invoiced and paid within March, plus collection of HIV Out of London debt of @ £5.5m.

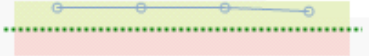
REGULATORY COMPLIANCE & KEY PRIORITIES

Key Priorities

	Performance Indicator	Trend	YTD Value	YTD	Forecast
Priorities	VTE Assessment (Target: > 90%)		91.8%		
	OP Letter Turnaround Times (Target: Less than 5 Days)		N/A		
	Discharge Summaries (Target: 100% Complete within 24 Hrs)		88.1%		
	Emergency Re-Admissions following No Elective spell (Target: < 2.8%)		2.84%		
	Emergency Re-Admissions following Elective spell (Target: 0%)		1.5%		
	NCE POD Recommendations (Target: 95% within waiting time)		95.5%		
	Mortality - HSMR (Target: < 87.34)		71.4		
	LAS Handover - HAS Data Quality (Target > 90%)		<80%		
	GP Referrals Recieved		Avg: 6,392 Last Month: 6,405		

- OP letter turnaround time is a key priority for the Trust in its drive to ensure timely and accurate information to GPs about patients. However, in March, there was a dip in performance for two reasons: 1) Bighand has been introduced to all specialities across the Trust which allows a more accurate reflection of the median turnaround time. However, as with every new system, some anomalies have been identified, which are being rectified.
  2) there was a significant push to clear the backlog of letters moving into 2012/13. There is a determined effort moving into the new year to improve performance and to achieve a 5 day turnaround time, not least because this will be a component of the proposed 'real time information for GPs' CQUIN for 2012/13.
- Over the financial year 2011/12, there was a significant improvement in discharge summaries turnaround from 71.3% in April 2011 to 94.1% in March 2012. There continues to be detailed discussions underway with commissioners as part of the 'real time information' CQUIN proposal about moving to a paperless system and the electronic transfer of discharge summaries by the end of 2012/13.
- Significant improvement has been achieved this year in reducing readmission rates compared with the previous year. Based on benchmarking information, however, there is some room for improvement. Monthly meetings are occurring with the Divisions to ensure progress continues and performance improved, with learning from elsewhere as appropriate.
- LAS handover performance is within standard on a new electronic recording system (HAS) and our performance will be measured via this new system. In March, a significant improvement was seen and the Trust will continue to work very closely with LAS to ensure this improvement is sustained.
- Work to reduce unplanned A&E re-attendances continues in parallel with work to reduce readmissions described above. An action plan is in place which includes internal initiatives such as the implementation of an Acute Review Card system in Paediatric A&E and working with external partners to better manage the care of patients who repeatedly attend A&E.

Monitor Indicators

	Performance Indicator	Trend	YTD Value	YTD	Forecast
Infection Control	MRSA (Less than 3 11/12)		2		
	Clostrium Difficile (Less than 31 11/12)		17		
Accident & Emergency	A&E: Initial Assessment (Target < 15mins)		15		
	A&E: Total Time (Less than 4 hours)		02:12		
	A&E: Time to Treatment (Less than 1 hr)		00:53		
	A&E: Left without being seen (Less than 5%)		3.97%		
	A&E: Unplanned Re-Attendances (Less than 5%)		6.9%		
Cancer Services (Quarters)	Cancer: 2-WW Ref to Seen (> 93%)		96.7%		
	Cancer: 62 Day Wait (Consultant Screening) (>90%)		96%		
	Cancer: 62 Day Wait (Ref to Treat) (>85%)		96.5%		
	Cancer: Diag to Treat (31 day) (>96%)		99.9%		
	Cancer: Subsequent Surg (31 Day) (>94%)		98.2%		
	Cancer: Subsequent Drugs (31 Day) (>98%)		100.0%		
Access	RTT Admitted (95% Percentile) (< 23wks)		22.49		
	RTT Non Admitted (95% Percentile) (<18.3 weeks)		11.95		
	Compliance with requirements regarding access to people with a learning disability (100%)		100%		

Appendix 1 - Quality Report Actuals

Clincial Effectiveness	Target	Feb	Mar	YTD	Trend
% General and acute patients with a urinary catheter	12.5%	15.96%	15.35%	16.78%	3.85%
Income lost due to first to follow-up ratio	£0.0	£-13k	£85k	£550k	-759.8%
Maternity Access 12 weeks + 6 Days	90.0%	92.4%	94.0%	91.3%	1.6%
Breastfeeding initiation rates	91.1%	92.7%	92.2%	92.3%	-0.5%
Caesarean section rate	30.0%	26.6%	24.4%	27.4%	-2.2%
Percentage of A& E attendances for cellulitis that end in admission	40.0%	47.8%	60.9%	47.7%	13.1%
Percentage of A& E attendances for DVT that end in admission	10.0%	-	0.0%	28.9%	-
Non-Elective average length of stay (Last month target: < 642 long stays)	<642	435	435	5140	4.0%
Stroke: % High risk TIA patients assessed and treated within 24 hours	60.0%	85.7%	100.0%	97.1%	14.29%
Incidence of newly-acquired category 3 and 4 pressure ulcers	2	2	6	28	-200.0%
Stroke: Patients who had a stroke who spend at least 90% on a stroke unit	90.0%	90.0%	92.9%	94.0%	2.9%
% Rapid access chest pain clinic patients seen within 2 weeks	98.0%	100.0%	100.0%	100.0%	0
Elective average length of stay (Last month target: < 55 long stays)	<55	57	59	733	13.7%
Daycase rate (Basket 25 procedures YTD Target = 84.2%)	84.2%	86.8%	81.8%	82.6%	-5.0%

Process Effectiveness	Target	Feb	Mar	YTD	Trend
Delayed transfers of care (% Beds effected - snapshot)	3.5%	0.7%	0.9%	0.02%	-0.2%
Referral to treatment: Non Admitted (Outpatient Median Weeks)	6.6	0.78	0.00	0.8	78.0%
Referral to treatment: Incomplete Median (Weeks)	7.2	6.19	0.00	6.1	100.0%
% Outpatients waiting longer than 13 weeks	0.03%	0.031%	0.016%	0.013%	-0.015%
Did Not Attend Rate - Outpatients	< 8.68%	10.02%	9.91%	10.46%	0.10%
Call Centre Hang Up %	9.5%	7.6%	8.0%	11.0%	-0.3%
DNA Rate Treatment Centre	3.0%	1.3%	2.7%	3.2%	-1.4%
Inpatients waiting longer than the 26 week standard	0.0%	0.0%	0.0%	0.0%	0
2 week wait for appointments for newly diagnosed HIV	100.0%	100.0%	100.0%	98.3%	0.0%
Fracture Neck of Time to Theatre for Medically Fit Patients	100.0%	100.0%	100.0%	91.2%	0.0%

Safety	Target	Feb	Mar	YTD	Trend
Hand Hygiene Completion	100%	97.9%	97.0%		-0.9%
Hand Hygiene Compliance	90.0%	92.0%	94.0%		2.0%
Incident reporting rate per 100 discharges	8	8.6	8.6	7.9	-0.3%
Never events	0.0	1	0	5	100.0%
Patient falls resulting in moderate or major harm	2.3	2	1	11	150.0%
PEAT Audit	95.0%	94.88	0	89.7	-94.9%
Hospital Associated VTE	0.0	0	0	16	0.0%
Ratio of midwives to deliveries	TBC	32.36	22.92	33.11	78.70%
3/4th degree perineal tears	3.0%	1.7%	3.0%	2.5%	-2.1%
1:1 care of women in established labour	100.0%	100.0%	100.0%	100.0%	0.0%
Emergency MRSA screening rate	100.0%	93.9%	96.2%	88.7%	2.3%
Elective MRSA screening rate	100.0%	92.7%	94.8%	84.2%	2.0%
NICU Nurse: Patient ratio vs. BAPM compliance	85.0%	95.0%	99.0%	89.8%	4.0%

Clinical Effectiveness	Target	Feb	Mar	YTD	Trend
Formal complaints responded in 25 working days	90.0%	97.1%	-	80.2%	27.9%
Breach of same sex accomodation	0.0%	0	2	12	-200.0%
Staff job satisfaction	60.0%	60.0%	60.0%	45.0%	0.00%
Slot issues on Choose and Book	4.0%	2.7%	3.7%	4.1%	-0.9%
Access to GUM clinics	100.0%	100.0%	100.0%	99.9%	0.0%
Rebooking cancelled operations	0%	0%	0%	0%	0%
Six week diagnostic test wait	0%	0.0%	0.0%	0.01%	0.0%
ACU - Medical Pregnancies per cycle - Q2 & Q3	> 30%	31.5%	30.5%	100.0%	0.0%

B: Indicators marked with a star have case mix adjusted target. In these cases the latest month's target is used.

Key Commissioner Priorities

Key Commissioner Priorities Actuals

MonthYear	YTD	Apr 2011	May 2011	Jun 2011	Jul 2011	Aug 2011	Sep 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012
VTE Assessment	91.8%	93.0%	92.1%	91.8%	91.9%	94.5%	92.4%	91.2%	91.2%	91.3%	91.9%	90.7%	90.4%
OP Letter Turnarounds	7.58	-	-	-	9.10	8.40	6.30	6.10	6.93	7.95	6.79	6.80	9.83
Discharge Summary Completion	88.1%	71.3%	77.5%	77.5%	79.0%	85.8%	91.6%	91.0%	94.8%	95.1%	95.0%	94.1%	94.4%
Emergency Re-admissions Following a Non-elective spell	2.8%	3.3%	2.7%	2.8%	2.6%	2.8%	2.3%	2.8%	2.7%	2.8%	3.1%	3.0%	2.9%
Emergency Re-admissions Following a Elective spell (Target 0)	1.5%	1.5%	1.2%	1.7%	1.7%	1.5%	1.5%	1.6%	1.4%	1.6%	1.2%	1.4%	1.5%
NCE POD Recommendations (One month in arrears)	95.5%	-	96.6%	98.6%	93.7%	97.0%	94.9%	92.9%	95.5%	92.2%	94.6%	97.1%	97.4%
HSMR	71.39	66.04	71.43	61.11	71.66	75.60	85.53	81.97	56.48	68.68	76.19	-	-
LAS Handover - 90% HAS Data Completeness	-	66.0%	70.0%	79.0%	81.0%	82.0%	73.0%	72.0%	71.0%	77.0%	76.0%	86.0%	84.8%
GP Referrals	76707	5916	7102	7261	6416	5923	6189	6609	6827	5284	6573	6405	6202

Monitor Indicators

Monitor Indicators

NHSQuarter	YTD	Apr-Jun 2011	Jul-Sep 2011	Oct-Dec 2011	Jan-Mar 2011	Score YTD	Expected Score
Clostridium difficile cases	17	6	3	5	3	0	1
MRSA objective	2	0	1	0	1	0	0
All cancers: 31-day wait from diagnosis to treatment	99.9%	100.0%	100.0%	100.0%	99.5%	0	0
All cancers: 31-day wait for second or subsequent treatment Surgery	98.2%	100.0%	100.0%	100.0%	94.1%	0	0
All cancers: 31-day wait for second or subsequent treatment anti cancer drug treatments	100.0%	100.0%	100.0%	100.0%	100.0%	0	0
All cancers: 31-day wait for second or subsequent treatment radiotherapy	N/A	N/A	N/A	N/A	N/A	0	0
All cancers:62-day wait for first treatment from urgent GP referral to treatment	96.5%	95.5%	97.7%	97.5%	93.0%	0	0
All cancers:62-day wait for first treatment from consultant screening referral	96.4%	100.0%	93.3%	100.0%	100.0%	0	0
Cancer: Two Week Wait from referral to date first seen comprising all cancers	96.7%	95.8%	95.4%	98.2%	97.4%	0	0
Cancer: Two Week Wait from referral to date first seen comprising symptomatic breast patients (cancer not initially suspected)	N/A	N/A	N/A	N/A	N/A	0	0
Referral to treatment waiting times - Admitted (95th percentile)	22.9	22.9	22.5	22.4	20.4	0	0
Referral to treatment waiting times - Non-Admitted (95th percentile)	16.1	11.9	11.5	16.1	12.7	0	0
A&E: Total time in A&E*	98.5%	98.5%	98.9%	98.5%	98.2%	0	0
Stroke indicator	TBC	TBC	TBC	TBC	TBC	0	0
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability	Compliant	Compliant	Compliant	Compliant	Compliant	0	0
						Green	Green