Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting
Hospital Boardroom
Chair: Prof. Sir Christopher Edwards
Date: 23 May 2013 Time: 4.00pm

Agenda

		Lead	Time
1	**GENERAL BUSINESS**	**CE**	
1.1	Welcome & Apologies	CE	4.00
1.2	Declaration of Interests	CE	
1.3	Minutes of Previous Meeting held on 14 February 2013 (attached)	CE	
1.3.1	Agree style and format of minutes		
1.4	Matters Arising (attached)	CE	
1.5	Chairman's Report (oral)	CE	
1.6	Chief Executive's Report (oral)	APB	
1.7	Feedback from the April Board (oral)	CE/ML	4.25
2	**ITEMS FOR DISCUSSION/DECISION/APPROVAL**		
2.1	Re-appointment of the Chairman and NED (attached)	JB	4.30
	QUALITY		
2.2	Francis Inquiry Report (attached)	TD	4.45
2.3	*Quality Account Update (attached)	CM	
2.3.1	Approval of the Commentary (attached)	MJ	
2.4	*Quality Sub-Committee report (draft minutes of 19 March 2012 meeting attached)	CM	
	STRATEGY		
2.5	Chelsea & Westminster Hospital 2013/14 Annual Plan – update (attached)	APB	5.00
	COUNCIL OF GOVERNORS		
2.6	Governors' Questions		5.15
2.6.1	Update on progress on arranging the official opening of the Ron Johnson ward, perpetuating the name Thomas Macaulay ward and commemorating Jim Smith (CBir) (oral)		
2.6.2	Move to GUM commissioning by Local Authorities and the possible opt out of tariffs and the future development plans for our GUM services (SV) (attached)		
2.6.3	Preparations made for the oncoming competition to Chelwest services (ACad) (attached)		
2.6.4	Whistleblowing (SMax) (attached)		
2.6.5	Nursing Care (AH-P) (attached)		
2.6.6	Health tourists charges (ML) (attached)		
2.6.7	With 10% CIP - reassurance that the front line services are protected and quality maintained. If applies to management services how this is being met? (BG) (attached)		
2.6.8	Provision of background material to aid understanding of the way the Trust manages various functions. (ACle) (attached)		
2.6.9	Trust's practice in relation to disclosure of patient data during end of life care (ACle) (attached)		
2.6.10	Commissioning, performance management and regulation outline – provision of information (ACle) (attached)		
2.6.11	NHS Litigation Authority (ACle) (attached)		
2.7	Council of Governors Performance Evaluation Report – response to questionnaire (attached)	CE	5.35

2.8	Report on Senior Nurse/Governor Rounds (attached)	TP	5.50
2.9	Open Day 11 May 2013 – feedback (oral)	KD-D	5.55
2.10	Council of Governors Funding Report (attached)	VD	6.05
2.11	FTGA National Development Day on 14 March 2013 (ACle/SM/CBir/ML) (attached)	ACle/SM	6.10
2.12	Healthwatch Kensington & Chelsea report (attached)	PG	6.15
2.13	C&W Election to the Council of Governors (attached)	CBir	6.25
2.13.1	Election to the Council of Governors – communication plan (attached)	VD/LH	6.25
	MEMBER8SHIP		
2.14	*Membership Sub-Committee report (draft minutes of 21 March 2013 meeting attached)	ML	
2.15	* Membership Engagement and communication – update (attached)	KD-D	
2.16	*Membership Report (attached)	SN	
3	**ITEMS FOR INFORMATION**		
	A copy of the Finance and Performance Reports are available via Board papers which are available on the website at the following link: http://www.chelwest.nhs.uk/about-us/organisation/trust-meetings and a hard copy of the board pack in the governors' room		
4	**ANY OTHER BUSINESS**		
5	**DATE OF THE NEXT MEETING – 18 July 2013**		

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

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 23 May 2013

AGENDA ITEM NO.	1.3/May/13
PAPER	Draft Minutes of Council of Governors Meeting – 14 February 2013
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
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Council of Governors Meeting Minutes, 14 February 2013
Draft

Prof. Sir Christopher	Edwards	Chairman		CE
Julie	Armstrong	Staff	Contracted	JA
Walter	Balmford	Patient		WB
Chris	Birch	Patient		CBir
Christine	Blewett	Public	Hammersmith and Fulham 2	CBle
Nicky	Browne	Appointed	The Royal Marsden NHS Foundation Trust	NB
Anthony	Cadman	Patient		ACa
Tom	Church	Patient		TC
Alan	Cleary	Patient		ACle
Samantha	Culhane	Public	Hammersmith and Fulham 1	SC
James	Dennis	Staff	Allied Health Professionals, Scientific and Technical	JD
Jenny	Higham	Appointed	Imperial College	JH
Martin	Lewis	Public	Westminster 1	ML
Kathryn	Mangold	Staff	Nursing and Midwifery	KM
William	Marrash	Patient		WM
Susan	Maxwell	Patient		SM
Wendie	McWatters	Patient		WMW
Harry	Morgan	Public	Wandsworth 1	HM
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	Kings College	AW
Steve	Worrall	Public	Wandsworth 2	SW
Tera	Younger	Patient		TY

IN ATTENDANCE:

Prof Richard Kitney	Non-executive Director	RK
Sir Geoffrey Mulcahy	Non-executive Director	GM
Karin Norman	Non-executive Director	KN
Tony Bell	Chief Executive	TB
Catherine Mooney	Director of Governance and Corporate Affairs	CM
Lorraine Bewes	Director of Finance	LB
Mark Gammage	Director of HR	MG
Katie Drummond-Dunn	Communications Manager	KD-D
Anthony Pritchard	Deputy Chief Nurse	TP
Vida Djelic	Foundation Trust Secretary	VD
Patricia Gani	LINk representative	PG
Sian Nelson	PALS Manager	SN

Caroline Thomsett	Interim Head of communications	CT
Mark Harris (in part for item 2.2)	Business Development Lead	MH

1 GENERAL BUSINESS

1.1 Welcome & Apologies — CE

Apologies were received from Fergus Cass, Anna Hodson-Pressinger, Melvyn Jeremiah, Cyril Nemeth and Rosie Glazebrook.

1.2 Declaration of Interests — CE

None.

1.3 Minutes of Previous Meeting held on 6 December 2012 — CE

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

- p.3 section 1.7, last para final paragraph should read:' It was noted that the responsibility of the pavement in front of the hospital'
- p.4 section 2.2 change LPC to LCP
- p.4 section 2.2, 3rd para change educating to educational
- p.5 section 2.2 change advanced to advance

SM commented that there was a mixture of names being recorded and comments being unattributed. It was agreed that there should be consistency.

CE clarified that Dr Mike Anderson, Medical Director was stepping down from the Board of Directors and that he remains with the Trust as a Gastroenterology Consultant.

CE noted, with reference to the A&E estate, that the final decision regarding reconfiguration of healthcare services across North West London is expected in the following week.

1.4 Matters Arising — CE

Ref. 4/Dec/12 Any other business - Provision of a specialist mental health assessment at night, it was reported that feedback had been provided to CBlew about general provision of mental health services and that CBlew has a specific issue and this will be addressed outside the meeting.

Ref. 4/Dec/12 Any other business - Food at night availability, it was noted that staff could use the restaurant which is open till 4.30pm and the Costa Coffee shop which serves hot and cold beverages, sandwiches and panninis is open until 7pm. Outside these hours hot and cold vending is available on the ground floor. The restaurant closure time was introduced a year ago due to low uptake at night and once the refurbishment of the restaurant is completed extended opening hours may be considered. It was noted that staff normally bring their own food at night and that most of staff would not normally want a hot meal. It is common that canteens are not open at night and light snacks are available from vending machines. .

1.4.1 Lead governor announcement (oral) **CE**

It was noted that following on the expression of interest received from three governors voting had taken place and Brian Gazzard, staff governor received the most votes. BG was congratulated on being the Lead Governor.

In response to a query from a governor whether his points were taken into account it was confirmed that these were considered.

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

Discussions have been taking place with the Royal Brompton Hospital re the possibility of paediatric cardiac surgery and respiratory surgery being transferred to the C&W. The Board has signed a Memorandum of Understanding. The Chairman had met with Councillor Christopher Buckmaster earlier in the day to discuss the issues. The risks are low as RBH would be responsible for the capital costs.

In response to a question if any merger would need the approval of Brussels it was confirmed that there was no suggestion of merging the two Trusts; it was proposed RBH would run some services at C&W site. There is a timetable for the development of the model of care; business plan etc. which will be discussed by the respective Boards and this should be agreed in May.

Governors were invited to raise any concerns directly with the Chairman.

In response to a query re the transfer of paediatric cardiac surgery it was noted that this will be discussed in detail at the upcoming strategy meeting.

1.6 Chief Executive's Report (oral) **APB**

This was addressed in the strategy section of the meeting.

2 ITEMS FOR DISCUSSION/DECISION/APPROVAL

2.1 Strategy Update (oral) **APB**

It was noted that the final decision by the Joint Committee of Primary Care Trusts (JCPCT) re 'Shaping a Healthier Future' consultation is expected on 18 February. Eight Accident and Emergency departments will become 5 and a business plan is being prepared on how to address that. The plan needs to look at what we need to do to accommodate the increase in A&E flows. Solutions need to be considered with primary care and the community. A&E is different across the country and C&W is the best performer in NWL.

It was noted that 25,000 people signed against the proposed changes for reconfiguration of the healthcare services in the consultation.

The future of Charing Cross Hospital has been a particular issue and it now looks like there is a solution although it is not clear what this will be. The JCPCT and SHA need to find a solution for local residents, and it is likely that the solution will try and address the aging population. A combined health and social care response is likely.

Another key area of discussion is West Middlesex Hospital.

2.2 High Quality Planning 2013/14 – update **AH**

Mark Harris, Business Development Lead set out the background of the High Quality Planning. Actions to date were outlined and actions for the coming months were highlighted.

It was confirmed that the paper outlined the process rather than the outcomes but that these would be shared. Governors had had the opportunity to contribute at the away day in December. Governors emphasised the need for early involvement and the value of governors on rounds was emphasised so that they can be better informed about the Trust. It was suggested that governors who have interest in particular area of the hospital should be linked to that area.

It was noted that the Trust is developing a clinical strategy for the next 5-10 years

A paper describing the outputs of the planning process will be brought back to the next meeting for discussion with the governors.

2.3 Notes from 13 December 2012 Away Day and next steps **CM/CE**

The areas discussed at the away day were outlined. The paper later on the agenda titled 'A framework for senior team members, NEDs and governors to undertake visits to clinical areas' will assist with director/governor interaction.

It was agreed that the Membership Sub-Committee will take forward discussions on how to meet the requirement of the duty of governors to represent interests of the members of corporation as a whole and the interest of the public, and report to the Council of Governors.

A facilitated workshop which will involve governors and Board members will be set up to take forward significant transactions and the composition of the Council of Governors.

Governors' informal visits to wards will be very helpful in light of the Francis Report and this should be seen as opportunity for governors to contribute. We may need to be more structured to ensure all areas are covered. The idea is to have individual governors and NEDs to relate to certain areas of the hospital which should make it easier to act as a proper accountable interface. This should help with governors being better informed. The Chairman confirmed the policy of the Trust is to be as open as possible.

The role of PALS is being considered with a view to more immediate complaints being dealt with by the areas concerned rather than directing patients to PALS. A governor commented that he has recently visited Guys and St Thomas' Hospital and Charing Cross Hospital and noted that both hospitals have an open style of PALS office which he felt was more welcoming and friendly. It was highlighted that some patients like the anonymity of a survey. It was confirmed that comments picked up by governors could be passed to PALS.

In response to a question regarding whether the Trust has set a timetable to look at the Francis Inquiry Report it was noted that this was discussed by the Board earlier in the day. The Department of Health need to respond first and the report will subsequently be discussed by the Board and the Council of Governors.

Governors agreed that it would be very useful for them to be more involved and should feel encouraged to join various committees, participate in meet a governor session and visits to wards in order to learn how the hospital functions.

2.4.1 Terms of Reference of the Nominations Committee of the Council of Governors for the Appointment of NEDs **CE**

The paper was noted.

Governors agreed that that quoracy should be 2 governors present, one appointed and one elected, instead of three as previously stated and that the terms of reference are reviewed annually. The period of being a member of the Nominations Committee was agreed to be normally 2 years and max of 4 years.

The point 3.1 re 'Another person nominated by the Nominations Committee is invited to act as an independent assessor to the Nominations Committee' was queried. It was noted that it is extremely important to get an external expert view during the selection process and this has worked well in practice.

2.4.2 Nominations Committee of the Council of Governors for the Appointment of NEDs – expression of interest **CE**

The plan outlined in the paper was noted.

Governors should send expressions of interests for the membership of the Nominations Committee to Vida Djelic by Thursday, 28 February 2013. It was noted that should more than two elected governors and one appointed governor express interest the Chairman will interview interested governors.

Governors to send expressions of interest to VD by Thursday, 28 February 2013. **All**

2.5 Governors' Questions

Governors noted questions and responses provided in the paper.

Governors discussed possible invitees for the official opening of the Ron Jonson ward.

2.6 Council of Governors Performance Evaluation **CM**

Governors discussed the draft questionnaire and it was agreed that Q2 should read 'How long have you been a governor?'. VD to amend the questionnaire and circulate to governors to complete by 1 March 2013.

2.7 Open Day 2013 **KD-D**

The proposal for the Trust Open Day 2013 to be held on 11 May was noted.

The idea of a careers event for young people aged 14-17 was extremely well received last year and it is an excellent opportunity for young people interested in healthcare profession.

In relation to a query re point 6.1 of the paper regarding a VIP to open the event it was suggested that a 'star guest' be invited. A list of potential guests would be sent to APB.

This was agreed.

2.8 Council of Governors Funding Report **VD**

Governors noted the funding report as provided in the paper.

Governors supported funding of the free-standing banner to display upcoming dates and times of Meet a Governor sessions in the Information Zone for £250 and that extra funding of £28 is required.

Governors supported funding of the free-standing banner to promote membership for £250.

The funding request of £3,455.74 for gifts for the governors' stand for the Open Day was approved.

2.9 Chelsea and Westminster Star Awards 2013 **MG**

The star awards process was described. The ceremony will be held on 18 April at the Chelsea Football Club.

Different nominations for awards need to be decided. Governors were invited to inform VD about nominations.

Interested governors were invited to join the judging panel.

Governors to volunteer to join the judging panel.

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

This paper was noted.

2.11 Draft Minutes of the Council of Governors Quality Sub-Committee meeting held on 29 January 2013 **CM**

This paper was noted.

2.12 Quality Account 2012/13 **CM**

This paper was noted.

2.13 A Framework for Senior Team Members, Non-Executives and Governors to **TD**

undertake visits to clinical areas

The paper was outlined and it was noted that the paper provides a formal structure for governors and NEDs to undertake visits to clinical areas. This should enable them to have a comprehensive understanding of clinical areas.

TP will liaise with governors re areas to visit and dates. The visits are not an inspection but an opportunity for a critical friend to help and support. Visitors should be aware that they are entering a working are with a lot going on and some 'ground rules' need to be agreed, including an explanation for patients. The primary concern is privacy and dignity of patients.

There was a discussion about whether governors should go to wards unannounced and it was emphasised that governors do have the opportunity to speak to patients alone even on the senior nurse rounds which take place every two weeks to which governors are also invited.

The proposal was agreed.

2.14 Francis Inquiry Report **APB**

The publication of the Francis Inquiry Report and the importance of considering all recommendations were noted. However, this will be done once the Department of Health has published their response.

Robert Francis will talk at the FTGA event on 14 March and it was suggested that governors attend and if there is more than two governors interested to attend this should be allowed. This was agreed.

2.15 Membership Sub-Committee report **ML**

This paper was noted.

2.16 Membership Engagement and communication – update **KD-D**

An update on the current engagement activities of 2012/13 and the proposal for membership engagement for 2013/14 was provided.

The Council of Governors agreed to fund the proposed engagement and communication activity 2013/14 for £30,600.

2.17 Membership Report **SN**

This paper was noted.

It was suggested that members should be asked about sex and disability on joining and this should be provided in the report. **SN to discuss this with Priti Bhatt, Equality and Diversity Manager.** **SN**

3 ITEMS FOR INFORMATION

3.1 Finance Report – December 2012 **LB**

This item was taken as read.

3.2 Performance Report – December 2012 **DR**

This item was taken as read.

4 ANY OTHER BUSINESS **CE**

KD-D provided a summary of the Francis Inquiry Report recommendations and invited all governors to take a copy.

5 DATE OF THE NEXT MEETING

The next meeting of the Council of Governors will be held on 23 May 2013.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 23 May 2013

AGENDA ITEM NO.	1.4/May/13
PAPER	Matters Arising from the meeting of the Council of Governors meetings held on 14 February 2013
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper lists matters arising from previous meeting and the action taken or subsequent outcomes.
DECISION/ ACTION	The Council of Governors is asked to note the matters arising and the updates.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

MATTERS ARISING
Council of Governors Meeting
Hospital Boardroom
Chair: Prof. Sir Christopher Edwards
Date: 14 February 2013
Time: 4:00 – 6:30 pm

Ref	Description	Lead	Subsequent Actions or Outcomes
2.4.2	**Nominations Committee of the Council of Governors for the Appointment of NEDs – expression of interest**		
	Governors to send expressions of interest to VD by Thursday, 28 February 2013.	**All**	Completed.
2.17	**Membership Report**		
	It was suggested that members should be asked about sex and disability on joining and this should be provided in the report. **SN to discuss this with Priti Bhatt, Equality and Diversity Manager.**	**SN**	There is a section on the membership application form that requests disability status. Sexuality was requested to be included on the membership application form. The Human Resources advised not to include it due to the sensitivity of the issue, including data protection.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 23 May 2013

AGENDA ITEM NO.	2.1/May/13
PAPER	Recruitment of Non-Executive Directors and Chairman Designate, and re-appointment of the Chairman, Prof. Sir Christopher Edwards and Non-executive Director, Karin Norman
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Sir John Baker, Vice Chair of the Board of Directors
EXECUTIVE SUMMARY	This paper proposes a plan for the recruitment of new Non-Executive Directors and a Chairman Designate and, in that context, an extension of one year to the term of office of the Chairman, Professor Sir Christopher Edwards and Non-executive Director, Karin Norman
DECISION/ ACTION	The Council of Governors is asked to agree the proposed plan and an extension of Prof. Sir Christopher Edwards' and Karin Norman's offices for a term of one year ending on 31 October 2014

1.0 Introduction

The current appointment of Professor Sir Christopher Edwards as Chairman of the Chelsea & Westminster Hospital Foundation Trust expires on 31 October 2013, as does that of Karin Norman and Dick Kitney as Non-Executive Directors (NEDs). They have served for six and eight years respectively.

The NEDs, together with the Chairman and the Chief Executive, have reviewed the needs of the Trust in the light of, first, its on-going operational needs to sustain clinical excellence and to put patients first, and, second, the fast-changing and complex strategic issues that face the Trust. These argue for refreshing the leadership of the Trust by organising succession to Professor Sir Christopher Edwards as Chairman and progressively recruiting new NEDs, whilst also ensuring stability at a time when both the Chief Executive and the Chief Operating Officer are relatively new in post, and a new Medical Director is just taking up her positions and a new Director of Nursing joining at some stage.

It is therefore proposed that

- as regards the Chair of the Trust, Professor Sir Christopher Edwards should be re-appointed for one year from 1 November 2013 but that a successor should be appointed this Autumn as a NED and chair designate, to take over the chair during the ensuing twelve months (probably the Spring of 2014) subject to confirmation of the appointment.

- in addition, another one or possibly two NEDs should be appointed this Autumn, with Karin Norman's appointment also being extended for a further year to 31 October 2014, when she in turn would be replaced. (Note: the terms of appointment of Sir John Baker, Sir Geoff Mulcahy, and Mr Jeremy Loyd would then expire a year later than that, giving an orderly refreshment to the make-up of the NEDs).

All these appointments are in the gift of the Council of Governors, and the proposed recruitment would be carried out by the Nominations Committee, where the responsibility lies ultimately with the Governors for running the recruitment process and making recommendations for appointments to the Council of Governors.

In accordance with normal practice, it is proposed to employ a search agency to identify suitable candidates for interview by the Nominations Committee. In addition, however, it is also proposed that

- in order to ensure that any recommendations made by the Nominations Committee both as to a prospective chair person and new NEDs are people that (i) the Chief Executive can work with, and also (ii) are agreeable in principle to the NEDs who, as a body, are now held statutorily under the Health & Social Care Act 2012 to be accountable to the Council of Governors for the performance of the Board, all short-listed candidates should be interviewed by the Chief Executive and by the NEDs, prior to being interviewed by the Nominations Committee, so that their views can be made known to the Nominations Committee, and

- in addition to the voting members of the Nominations Committee (in this case, the Trust Vice-Chairman who will chair the Nominations Committee, the three appointed Governors and the external appointee) a NED should also be invited to sit in on the final interviews as a non-voting attendee able to offer advice to the Committee.

2.0 Background

The Constitution of the Trust provides that any appointment or re-appointment of a NED is to be made by the Council of Governors and, in the case of a re-appointment, shall be

subject to a satisfactory appraisal carried out in accordance with the procedures which the Board of Directors has approved.

On the basis of the proposed plan of recruitment set out in Section 1 above, it is proposed that Professor Sir Christopher Edwards be re-appointed as Chairman for a further term of one year from 1 November 2013, and that Karin Norman be re-appointed as a NED for one further year from 1 November 2013.

In December 2012 the appraisal of the Chairman was reported to the Council of Governors. In summary the results and evaluation were as follows:

'The Chairman's written statement demonstrated the significant progress made by the Trust in the period under review and that it was sustaining high standards of operational achievement. All parties commended the Chairman's high level of commitment to the work of the Trust, the energy he puts in to developing and maintaining good relations with the key external parties with whom the Trust interacts and his enthusiastic and sensitive support for governors, colleagues and staff. His Chairmanship style encourages participation in proceedings, whilst his own sharp eye for detail enables him to bring pertinent experience to bear on the work of the Trust. The business gets done.'

The Chairman's term of office of 6 years ends on 31 October 2013.

In May 2012 the appraisal of Karin Norman was reported to the Council of Governors. In summary the results and evaluation were as follows:

'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.'

Karin Norman's term of office was extended for a further year and ends on 31 October 2013.

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).'

4.0 Commentary

The NEDs have carefully considered whether in the case of either
Professor Sir Christopher Edwards or Karin Norman their extensive existing periods of office have in any way led to behaviour that could no longer be considered truly independent, i.e. have they been "captured" by the institution that is the Trust. In both cases, the NEDs are clear that, whilst both are supportive of the Executive team and

powerful advocates for the work of the Trust, they provide sharp and appropriate challenge and are diligent in probing the performance of the Trust and its leadership. They therefore conclude that there is no risk that either has lost his/her independence.

The NEDs and the Chief Executive have also reviewed the balance to be struck between the need to refresh the Board but also to provide continuity and stability when there are a lot of moving parts both in relation to the future of the Trust and within the Executive team. They believe this argues for

- one year extensions to the terms of office for Professor Sir Christopher Edwards and for Karin Norman

- initiating now the search for two or three new NEDs to be appointed this Autumn, one of whom also to be appointed as chair person designate.

5.0 Action/Decision

The Council of Governors is invited

- to agree to an extension of Professor Sir Christopher Edwards' office for a term of one year ending on 31 October 2014

- to agree to an extension of Karin Norman's office for a term of one year ending on 31 October 2014

- to agree to initiation of a recruitment process as outlined in Section 1 above for the appointment of two or three new NEDs, one to be chair person designate, the process to make provision to ensure that the views of the Chief Executive and of the NEDs collectively on candidates considered for these appointments are made available to the Nominations Committee as part of the process.

Council of Governors Meeting, 23 May 2013

AGENDA ITEM NO.	2.2/May/13
PAPER	Francis Inquiry Report
AUTHOR	Thérèse Davis, Chief Nurse and Director of Patient Experience and Flow
LEAD	Thérèse Davis, Chief Nurse and Director of Patient Experience and Flow
EXECUTIVE SUMMARY	Robert Francis QC, Chairman of the Inquiry, published his final report, following consideration of over 250 witnesses and over one million pages of documentary evidence on 6 February 2013. The Inquiry has made 290 recommendations designed to change this culture and make sure patients come first by creating a common patient centred culture across the NHS. The recommendations are far reaching and all organisations across the NHS will need time to consider these and agree how to respond. Any recommendations we develop will; support the work we are already undertaking to improve quality of care at the Trust. For Chelsea and Westminster NHS Foundation Trust one of the first steps has been to arrange listening events during April to listen to our frontline staff. The listening events were run by the Executive Directors. At the event, the main themes from the Francis Enquiry Report were presented and staff were asked to tell us; • How do we always ensure we put the patients interest first and how can we improve? • How do we support our staff to speak out and how can we improve? • Is there anything else we should be doing? The listening events are continuing during the months of May and June. We would welcome Governors joining any of these. Following the listening events themes will be identified and fed back to the Trust Quality Committee and a plan of action to address these discussed and developed. This plan will be presented to the Trust Board in July 2013.
DECISION/ ACTION	For information

Publication of the Final Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

1.0 Purpose of the Report

The following paper provides a summary of the key findings outlined in the Mid Staffordshire NHS Foundation Trust Public Inquiry and outlines what steps the Trust has taken//will take going forward to address these.

2.0 Background

Robert Francis QC, Chairman of the Inquiry published his final report following consideration of over 250 witnesses and over one million pages of documentary evidence on 6th February 2013.

The Inquiry has been examining the commissioning, supervisory and regulatory bodies in relation to the monitoring of Mid Staffordshire hospital between January 2005 and March 2009. It has been considering why the serious problems at the Trust were not identified and acted on sooner, and identifying important lessons to be learnt for the future of patient care. It builds on Robert Francis's earlier report, published in 2010.

The report examines how the situation happened, the roles of various parts of the NHS and other organisations and 'how the system which ought to have picked up and dealt with a deficiency of this scale failed in its primary duty to protect patients and maintain confidence in the healthcare system'.

3.0 The Findings and Associated Recommendations

3.1 The Key Aims of the Findings

The Inquiry has made 290 recommendations designed to change culture and ensure 'patients not numbers come first' by creating a common patient centred culture across the NHS. Francis says no single one of the recommendations is on its own the solution to the many concerns identified.

The essential aims of what has been suggested are to:

- Foster a common culture shared by all in the service of putting the patient first.
- Develop a set of fundamental standards, easily understood and accepted by patients, the public and healthcare staff.
- Provide professionally endorsed and evidence-based means of compliance with these fundamental standards which can be understood and adopted by the staff that have to provide the service.
- Ensure openness, transparency and candour throughout the system about matters of concern.
- Ensure that the relentless focus of the healthcare regulator is on policing compliance with these standards.
- Make all those who provide care for patients – individuals and organisations – properly accountable for what they do and to ensure that the public is protected from those not fit to provide such a service.
- Provide for a proper degree of accountability for senior managers and leaders to place all with responsibility for protecting the interests of patients on a level playing field.

- Enhance the recruitment, education, training and support of all the key contributors to the provision of healthcare, but in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything they do.
- Develop and share ever improving means of measuring and understanding the performance of individual professionals, teams, units and provider organisations for the patients, the public, and all other stakeholders in the system.

3.2 Overarching Themes from the Recommendations

There has been vast comment and analysis of the report and associated recommendations. The central defining core is that the patient is to be put at the centre of everything the NHS does. All the other points follow from that and include:

- The merger of the regulation of care into one body so there is a single regulator for patient safety, quality, finance and governance.
- A common culture of care, clear standards of service and an increased role for NICE to set standards, working with professional bodies.
- Senior managers to be given a code of conduct and the ability to disqualify them if they are not fit to hold such positions. There is to be a fit and proper test for directors.
- Hiding information about poor care to become a criminal offence as would failing to adhere to basic standards that lead to death or serious harm.
- A statutory obligation on doctors and nurses for a duty of candour so they are open with patients about mistakes.
- An increased focus on compassion in the recruitment, training and education of nurses, including an aptitude test for new recruits and regular checks of competence as is being rolled out for doctors.
- Staffing level guidance for nursing, regulation of health care assistants, and a supervisory role for the ward sister.
- Training only to take place where there is good care, and in medical training greater integration of deanery functions and regulators.
- Leadership development for staff.
- Improvements and openness in handling of complaints.
- Improvements in the professional regulation of fitness to practice.

4.0 Implications for Chelsea and Westminster NHS Foundation Trust

The recommendations cover a variety of organisations such as DH, Commissioners, CQC, Monitor and Professional regulators. After carrying out a comprehensive internal review of all 290 recommendations, approximately 20% of the recommendations require direct action from the Trust. The key themes and related messages for the Trust at this stage are:

- Putting the patient first
- Governance, compliance and assurance
- Fundamental standard of behaviour
- Responsibility for, and effectiveness of, healthcare standards (e.g. information in our quality accounts and reporting of inquests to the CQC)
- Effective complaints handling
- Medical training and education
- Openness, transparency and candour
- Nursing and workforce
- Caring for the elderly
- Information
- Coroners and inquests

The Chief Nurse will be leading the Trust's review of the Mid Staffordshire NHS Foundation Trust Public Inquiry working with colleagues across the Trust.

4.1 What Have We Done So Far And What Are The Next Steps ?

The Trust has already taken several actions in response to the report which include:

- Formally responding to NHS London regarding what action the Trust is taking (Appendix1)
- Discussing the report at the; Trust Board Seminar March 2013
- Running listening events during April to listen to our frontline staff. The listening events were run by the Executive Directors and at the event, the main themes from the Francis Enquiry Report were presented and staff were asked to tell us;
  - How do we always ensure we put the patients interest first and how can we improve?
  - How do we support our staff to speak out and how can we improve?
  - Is there anything else we should be doing?

The listening events are continuing during the months of May and June. We would welcome Governors joining any of these.

Following the listening events themes will be identified and fed back to the Trust Quality Committee and a plan of action to address them discussed and developed. This plan will be presented to the Trust Board in July 2013.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

APPENDIX 1

Chelsea and Westminster Hospital
369 Fulham Road
London
SW10 9NH

Chairman's Office
Tel: 020 3315 6711

Professor Mike Spyer
Chairman
NHS London
Southside
105 Victoria Street
London SW1E 6QT

28th February 2013

Dear Mike,

Thank you for your letter of the 21st February in relation to the Francis Report and specifically what we are doing at Chelsea and Westminster to 'ensure that staff and patient views are listened to and inform the Trust's views on the quality of its services'.

Last year Chelsea and Westminster was given a Special Award for Best Outcomes by Dr Foster for being the only hospital in England with low mortality rates across all four of the key indicators. Given that the key outcome measure that alerted people to the problems at Mid Staffordshire was excess mortality, this achievement demonstrates the Trust's commitment to quality and safety.

In early 2012 we also undertook a consultation to define our values with more than 900 staff, patients and members of the public responding to our survey as to what our key values should be. The Board and the Council of Governors have held a dedicated Away Day to define what these values mean in practice and we are now setting about making sure that those values are embedded in staff behaviour. One of our non-executive directors is leading this piece of work with support from staff and governors.

In relation to staff the Trust already has a number of measures in place but is also instigating further methods of engagement to ensure all staff have the opportunity to speak openly and honestly but with confidentiality if needed. For the second year in a row the Trust is the highest performing nationally in the CQC Staff Survey for the number of staff reporting good communication between management and staff. Whilst we are not complacent, this reflects the culture and values we will continually work to embed in the organisation whereby all staff feel they can talk openly with not only management but other members of staff.

The Trust is currently undertaking a dedicated exercise to redefine our clinical strategy with teams of staff from across the organisation coming together at a series of 'clinical summits'. These are critically important opportunities for making sure that clinicians from all professions are actively involved in the Trust's strategy development.

In light of the publication of the Francis Report we have convened listening groups to discuss some of the key findings with staff and to hear their views on the report and other issues they would like to discuss. These sessions have been led by the chief executive and the executive directors and the feedback will be discussed at the Board and the Council of Governors and will form a key component of our post-Francis action plan.

We are also strengthening our bond between the non-executive directors, our governors and our staff. We have recently extended our senior clinical and management team ward rounds to include Board members and governors to enable a 'Board to ward' approach with the focus being patient experience, effectiveness and safety.

These visits will provide an additional method for listening to patients, their families and their carers. The Trust already has a number of well-established mechanisms in place for listening to patients which include, but are not limited to: quarterly Picker patient surveys, real time feedback through our patient bedside system, patients governors on our Council of Governors who also sit on a number of Trust committees, direct engagement through clinical divisions, feedback through our website and our Twitter feed, review of complaints, our Patient Advice and Liaison Service, and various listening and patient experience groups across the Trust.

In 2012 we also introduced 'comfort rounds' every two hours. These rounds are conducted by ward staff who will spend time with every patient ensuring they have sufficient food and water as well as repositioning patients if required and assisting them to the bathroom. These rounds have been very well received by patients and their families as well as the nursing staff who value the importance of having the time to provide more holistic care. One of our ward sisters who has led the development of the comfort rounds says it makes for a calmer ward environment and with notably happier patients which is reflected in the significant reduction in complaints we have seen in relation to dignity and nutrition needs.

The Trust also has a well-established volunteers programme with a specific scheme for patient support. This dedicated team of volunteers visits patients, provides support and company at meal times and escorts patients to their hospital appointments. The team are here to make our patients' stay more enjoyable and we know that offering these services can make a huge difference to the patient experience. In addition to arranging this through our volunteers' office, families, friends or other professionals such as GPs can request a volunteer to visit their relative or friend on the ward through the Trust's website.

Ensuring you have many points and methods for engaging patients is vital and we will continue to listen to our patients, staff and community to ensure these mechanisms are effective, accessible and useful in the future.

Yours sincerely,

Professor Sir Christopher Edwards
Chairman

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 23 May 2013

AGENDA ITEM NO.	2.3/May/13
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 used for the development of the Quality Account, the progress on priorities for 2012/13, priorities for 13/14 and next steps.
DECISION/ ACTION	For information

Quality Account Update

1.0 Introduction

This paper briefly outlines the process used for the development of the Quality Account, the main changes 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 and 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 (now Healthwatch) and commissioner 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 used a professional copywriter again. The final draft was issued to stakeholders on 8th May 2013

4.0 Priorities and new sections

The performance for last year and priorities for 2013/14 are attached in Appendix 1. We have a slightly different focus on patient experience (including compassion) and a new priority around end of life care. New sections include a quality card which gives a sample of what we did well and what needs to improve, a section 'measuring what matters', which explains why we measure what we do, and 'measuring at the front line' which describes what we do to assess quality for patients directly. We also have a section on 'What our stakeholders told us they would like to know' – which includes what we were told from our consultation process and comments from last year that our stakeholders wanted to know.

5.0 Next steps

The final draft has been issued to stakeholders for them to provide a commentary. It will be attached to the Annual Report for laying before Parliament. Subsequently it will be produced as a separate document and the advice of the Council of Governors Quality Sub-Committee will be sought for layout and photographs.

6.0 Action/Decision

For information

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

APPENDIX 1 Extract from Quality Account

Our priorities for quality improvement 2012/13

Priority 1 (Patient Safety): To have no hospital associated preventable venous 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 the 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 third of patients will develop VTE despite the best care, but in the remaining two-thirds of patients a VTE can be avoided with preventive treatment.

We have made improvements, but have not yet achieved our target and so have kept this as a priority for 2013/14.

What we said we would do in and what we actually did in 2012/13

VTE risk assessments
All adult patients should have a VTE risk assessment completed on admission to hospital to identify any risk factors that may be present.

We said we would continue to ensure that we meet our target of 90% adult patients admitted with completed VTE risk assessments. Our weekly and monthly monitoring of completed VTE risk assessments showed that we achieved this target.

Patient information
If patients are informed about the risks of VTE, and its signs and symptoms, they will know when to seek urgent medical attention.

We said we would continue to offer our patient information leaflet '*Are you at risk of blood clots?'* to all patients admitted to the hospital, all pregnant women, and all patients attending A&E who require a lower limb plaster cast.

Our monthly audits confirmed the VTE patient information leaflets were available and visible on all adult wards.

We were unable to measure on a regular basis whether inpatients were offered the VTE patient information leaflet as there was no systematic recording of whether information leaflets were given. Following other successful areas of practice, we have added VTE patient information to the hospital's admission and discharge checklist to ensure patients receive the leaflet.

VTE patient information has been included in the maternity patient-held notes for pregnant women and it is recorded in the booking notes when patients are offered our '*Are you at risk of blood clots in pregnancy?'* information leaflet. An audit throughout the year showed 96% of women on the maternity wards received the VTE patient information leaflet.

An audit in February 2013 showed that all 20 patients undergoing day case procedures in the Treatment Centre were offered the VTE leaflet. A similar audit

between April and June 2012 showed that only 69% of patients with leg plaster casts were given an information leaflet in the Emergency Department and Urgent Care Centre.

As a result, surgeons and emergency care staff were updated on the importance of providing VTE information to patients, and this message was included in the VTE newsletter circulated to all staff. The VTE risk assessment document which helps determine whether preventive treatment is required was updated to highlight VTE patient information more clearly.

Preventive treatment
We said that adult patients at risk of VTE will receive appropriate preventive medication and the use of compression stockings, if indicated, to help prevent blood clots developing during hospital admission. We set a target of 90% of adult patients to receive appropriate medication and compression stockings.

During 2012/13 we performed monthly audits and on average, over 90% of adult patients received appropriate preventive medication, in line with the target we had set, but only 79% of adult patients received compression stockings.

When we explored the reasons for this we discovered that there was some confusion about who was responsible for prescribing compression stockings. After discussions with a wide range of staff, it was agreed that doctors in all specialties should take on that responsibility, except in areas where nurses or midwives were specifically trained. Nurses and pharmacists will encourage doctors to prescribe compression stockings, provided there are no reasons why it might be harmful to do so. A monitoring form for compression stockings was developed to make sure they are fitted properly and monitored daily to inspect skin condition.

VTE training
We said we would create an online training module on VTE prevention and treatment for all doctors working in the hospital to complement the training modules we already have for nurses. We wanted to make sure that all frontline staff are aware of the preventive treatments we use in this hospital and standardise training.

The VTE module is now available on the training database, and the focus next year will be on increasing uptake of completion for all doctors working in the hospital.

But most importantly….
Our goal is to have no hospital associated preventable VTEs by ensuring VTE risk assessments are completed, preventive treatment is prescribed, patients are educated and nurses and doctors are trained in VTE prevention.

We said that we would continue to undertake a thorough review (root cause analysis or RCA) of cases where patients with preventable VTE associated with a hospital admission, defined as during or within 90 days of admission, did not receive appropriate preventive treatment.

For 2012/13, we set ourselves a target of 25% fewer hospital associated VTEs than in the previous year — i.e. to have no more than 13 hospital associated preventable VTEs. Between April 2012 and March 2013, we have identified 13 hospital associated preventable VTEs. While we achieved our target for 2012/13, this is still too many and we will focus on addressing the contributory factors for preventable VTEs in 2013-14.

And finally….

The House of Commons presented the hospital with the national Lifeblood VTE award 2012 for 'Best Obstetrics VTE Prevention Programme,' in recognition of its exemplary leadership and dedication for innovative initiatives to help reduce VTE among pregnant women.

We were also selected to present our collaborative work on VTE prevention across all specialities at the International Forum on Quality and Safety in Healthcare 2013.

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

Nothing matters more for us than patient outcomes (was our care safe and effective?) and patient experience (is the patient experience central to everything that we do?)

We said that we would communicate the agreed Trust values of being safe, kind, excellent and respectful, and the related behaviours to staff, patients and their families as well as our other stakeholders. This is to let everyone know what is expected of them and help drive improvements in the key areas of communication, discharge planning and care of the older person. And we said that we would ensure that the Trust values informed everything that we do.

What we said we would do in 2012/13

Communication:

- 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:

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

Care of the older person:

- Roll out 'comfort' G rounds to all adult inpatient areas
- Continue to monitor our performance against the Care Quality Commission (CQC) G essential standards of quality and safety G relating to privacy and dignity through the senior nursing and midwifery clinical rounds
- Continue monthly audits of nutritional screening and continue to develop other measures to ensure our patients are well fed eg volunteer mealtime support
- Continue to provide training in dementia G for nurses, therapists and doctors—this objective is linked to a CQUIN G payment

What we actually did

- We launched the Trust values at our Open Day in May 2012

- A summary of Trust values and behaviours was published in October in *Trust News* G*,* which is distributed to all our members and other stakeholders.
- Individual teams and departments have been developing their own priorities associated with these values and behaviours.
- On interview we ensure job applicants understand that these values are expected of everyone who works at the Trust. They are included in all staff policies.
- We have agreed to site a 'patient experience board' in each patient area, which will display patients' feedback on how these values and behaviours are being put into practice.

Communication:
Over 400 appointment letters have been reviewed to check that the information is current and that the correct templates for each service are being used. The wording used in letters is now being revised to ensure that it is clear, precise and service specific where relevant and we are involving patients in this.

From May 2013, we will pilot outsourcing outpatient letters. This should speed up the service and enable us to track progress, from issue to delivery, If successful, individual letters will then be tailored to the specific specialty and include maps, directions and any other relevant information.

Information on ward routines has been developed for each of our adult inpatient wards, laminated copies of which are available for patients at their bedside.

Discharge planning:
We have worked on overhauling the discharge process with our community and social service colleagues, as part of a discharge transformation project. As a result we have introduced daily 'board rounds' where the multidisciplinary team discuss progress on preparations for the discharge of each patient

We have also:

Shifted the emphasis to patients being assessed as fully ready to go home for example, having the required support, rather than just being medically well enough to do so

Appointed an end of life care discharge co-ordinator to help patients Cope in their latter days

- Introduced an electronic discharge checklist for all members of the multidisciplinary team to use
- Begun work to implement nurse led discharge for patients.

We tested out a phone survey with 10 patients about their experiences of the discharge process in October and November. The survey asked about the advice and information given at discharge and if patients would recommend the hospital to others. Following evaluation of the survey questions, this is now being used in children's areas and a version is being developed for those using day care facilities.

Care of the older person:
'Care and comfort rounds are now routine on all medical and surgical wards, and will be implemented in other wards, starting in May 2013.

The senior nursing and midwifery clinical rounds are up and running across the hospital and cover the 16 CQC standards. As a direct result, we now have guidelines for intimate care and use 'red pegs' on curtained areas in wards to increase privacy.

We have updated our nutritional checklist for adult patients to make sure they are eating properly, and introduced a similar one for children. Volunteers continue to provide mealtime assistance on relevant wards.

Three of our staff have been trained to deliver dementia training to their staff, primarily healthcare assistants and junior doctors, and have prioritised wards where patients with dementia are likely to be admitted.

The David Erskine Ward has been refurbished to be 'dementia friendly' G (see below), and a similar upgrade is planned for the Edgar Horne Ward.

How did we perform in 2012/13?

Every three months we monitor and review complaints and concerns relating to communication, discharge planning, and the care of older people, to see what further improvements we need to make.

This includes sending recently discharged patients a short survey about their experiences of the process. These focus on key areas for improvement based on our previous years national patient survey findings. The survey results are reviewed at our Patient and Staff Experience Committee and Senior Operational Group, and action plans drawn up.

Volunteers have been helping to monitor how well adapted our adult facilities are for patients with dementia and their carers, by scoring each ward on defined criteria, such as atmosphere, the physical environment, and the types of activities provided.

Their audit of 7 wards and the Acute Assessment Unit showed that more needs to be done to improve the physical environment, including personalising bays and bed spaces, clearer signage, the addition of hand-rails, and the provision of larger social spaces.

Priority 3 (Patient Experience):
To be in the top 20% of acute trusts nationally for staff engagement G **and staff appraisals as measured by the NHS staff survey and to ensure our agreed Trust values inform everything that we do.**

Why do staff appraisals and engagement matter?

A growing body of evidence shows that, as one would expect, that there is a direct link between a satisfied and engaged workforce and the quality of care patients receive.

An appraisal provides both an individual and his/her supervisor the opportunity the opportunity to reflect on how well the individual has met agreed targets and objectives over the past year, to identify any training needs and areas for personal development, and to review any issues or concerns that the staff member or supervisor may have.

We have made good progress on this priority; although we did not achieve everything we set out to do, so we will be continuing our focus on our staff throughout 2013/14.

What we said we would do in 2012/13 and what we actually did

Celebrating staff achievements
We said we would hold the first Chelsea and Westminster Star Awards in May 2012 to recognise staff achievements. These attracted almost 800 nominations from patients and staff, and 20 staff and teams received an award.

Appraisals
We said we would increase staff appraisal rates to at least 87%. We didn't manage this, or achieve our goal of being in the top 20% for this, but we did record our best record to date, with 82% of staff appraised.

We said that we wanted to increase to 75% the percentage of staff appraised with a personal development as measured by the NHS staff survey which would put us in the top 20% of acute trusts. The relevant question was removed from the NHS wide staff survey this year and development review was incorporated into the appraisal question above which achieved 82%, which meant that we did not achieve the target of being in the top 20% of acute trusts for this measure.

We said we wanted to increase to at least 50% the percentage of staff reporting a well-structured appraisal, which is defined as one that helps an employee do their job better, highlights any training needs, and makes them feel valued by the Trust, We achieved 45%, which was below our stated target, but it still means the Trust remains in the top 20% of acute trusts nationally on this indicator.

Trust values
We said we would give every member of staff written confirmation of our Trust values by the end of June 2012. Every member of staff was given a folded colour leaflet, setting out the Trust values, with their August 2012 payslip. We also ran events and discussion groups for staff about the values.

We said we would review all aspects of staffing policy, including recruitment, appraisal, and training in light of these values, and amend practice accordingly. All new staff now receive a copy of the values in their starters' information packs, and these values are included in all job adverts, interview questions, job descriptions and person specifications, as well as the *Staff Handbook*, which is published annually. The appraisal form was redesigned to include evidence of behaviours based on these values, and the October issue of *Trust News* carried a pull-out poster that teams can use to develop their own priorities related to these values and behaviours.

These values and behaviours have also been included in the Corporate Induction Programme G, the Excellence in Care Programme G for health care assistants, and the development programme for staff nurses.

We said we would look for improvements in scores for the 16 questions in the national patient survey where we scored below average for our four key values of safe, kind, excellent and respectful. Six of these questions were not included in the 2012 National Patient Survey, but of the remaining 10, 2 remained the same and 8 improved. We will use the responses from this survey to refocus efforts on our priorities and track progress.

Staff engagement
The NHS staff survey results published in March 2013 show that the Trust remains in the top 20% of acute trusts nationally for staff engagement for the fourth year running—measured by questions relating to motivation, ability to contribute to

improvements, and willingness to recommend the Trust as a place to work or receive treatment.

Priority 4 (Clinical Effectiveness):
At least 75% of emergency general medical and surgical patients to be seen by a consultant within 12 hours of the decision to admit to hospital or within 14 hours of their arrival at the hospital

Why is this important?

In 2011/12 year we were the only hospital in England with low mortality rates across all four mortality indicators in the Dr Foster Hospital Guide. However, we recognise that there is more we can do to improve all aspects of patient care and safety.

Guidance from professional bodies shows that consultant-led care for emergency patients is critical to rapid decision-making of appropriate treatment, maintaining standards and improving the patient's care throughout their time in hospital. This is why we are committed to ensuring that emergency patients at our hospital are seen by a consultant within 12 hours of admission.

Feedback and analysis of complaints data show that involving consultants earlier 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 we actually did

Emergency General Medical patients admitted to the Acute Admissions Unit (AAU) are reviewed by the on-call consultant on twice daily ward-rounds – in the morning and in the evening. This means that we have increased the number of medical patients that are seen by a consultant within 12 hours of their admission.

Emergency General Surgical patients may be admitted to the AAU or to a more specialised surgical ward: regardless of their location, there are now twice daily ward rounds (one in the morning and one in the evening) conducted by the on-call General Surgeon to review these patients – This means that we have increased the number of emergency general surgery patients that are seen by a consultant within 12 hours of their admission.

Whilst performance at the start of the year was monitored through retrospective paper-based audits that were highly resource-intensive, we are now using our IT system to identify when patients were seen, thus improving the timeliness and efficiency of the monitoring process.

How did we perform in 2012/13?

The last year has seen significant progress towards achieving this objective.

Against a target of 75% emergency adult admissions to be seen and assessed by a relevant consultant within 12 hours of the decision to admit or within 14 hours of the time of arrival at the hospital in medicine and general surgery, we achieved 80%

As we met this target and are continuing to work towards 90% our stakeholders have agreed that we should replace this with a new challenge and have selected end of life care – see page 21 -but we will of course continue to ensure high performance on this crucial ambition.

But we have done more….

In addition to putting components in place to ensure patients can be reviewed by a consultant within 12 hours of their admission, the trust is making other innovations and investments to help deliver high quality emergency care, including:

- Our therapists are now working extended days throughout the week and also at weekends to ensure they can review patients during the evenings;
- At our Children's Hospital, where consultants already provide a resident extended hours service, we are recruiting more consultant medical staff so that we can have provide this service 24 hours a day, seven days a week;
- We now have additional consultant medical staff on our wards reviewing patients at weekends.

All of these contribute to increased patient safety and clinical effectiveness in what are a core part of our hospital's services.

During autumn 2012, the regional Health Authority reviewed adult emergency services at all London's hospitals against a set of service standards that had been developed for acute hospitals. Of the 56 separate standards that were assessed, Chelsea and Westminster Hospital met more than any other hospital in London. These standards covered a range of aspects of care, from safety through to patient experience and communication - and their achievement bears testament to the commitment of our staff to work flexibly to deliver high-quality patient care.

Our priorities for quality improvement 2013/14

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

Why is this important?

Venous thromboembolism (VTE) is one of the most common preventable causes of hospital deaths, and can be prevented by providing preventive treatment (see page 16 for more information).

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 2013/14?

- We will continue to complete VTE risk assessments for adult patients on admission to hospital, and prescribe appropriate preventive treatment, where required, but with the aim of achieving a target of above 95%, rather than 90%.

- We will continue to perform monthly audits on each adult ward to find out whether patients receive appropriate medicines and/or compression stockings to ward off blood clots. VTE link nurses will raise awareness of the issues with doctors and nurses on wards that don't perform as well as they should.

- We will continue to identify patients who developed a VTE during, or within three months of, admission, but who did not receive appropriate preventive treatment. In these cases, we will continue to perform in-depth (root cause) analysis to find out what happened, so that we can prevent it happening again.

- We will focus on addressing the contributory factors we found in preventable cases of VTE in 2012/13. These included no or inaccurate VTE risk assessments; delayed prescribing of preventive treatment on admission and/or after a procedure; and not giving patients preventive treatment when prescribed.

We will do this by:

- Continuing to provide monthly feedback on completed VTE risk assessments by ward and department, and following up on the areas which do not meet the 95% target

- Setting up a multidisciplinary G group to look at why preventive treatment was delayed or omitted, and looking in particular at those drugs that help prevent VTE.

- Continuing to educate medical staff about the importance of prompt prescribing of preventive treatment.

We will continue to offer our VTE patient information leaflet '*Are you at risk of blood clots?*' to all patients admitted to hospital, all pregnant women, and all patients requiring a lower limb plaster cast.

How will we track progress?

We will track progress by continuing to review weekly and monthly the number of adults who are assessed for their risk of VTE when they are admitted to hospital, those patients who acquire a VTE that could have been prevented (monthly), and check how many were given appropriate preventive treatment (monthly).

We will continue to monitor periodically whether patients receive the VTE information leaflet and take action if the results show compliance of less than 75%.

We will monitor monthly uptake and completion of our online training module on VTE prevention and treatment for all doctors, with the aim of achieving 75% over 2 years.

We will continue to perform monthly VTE ward rounds in the Maternity Department to check pregnant women have been given appropriate VTE risk assessments and offered appropriate preventive treatment. We will roll out the VTE ward rounds to medicine and surgical wards quarterly and provide immediate feedback to ward staff.

How will progress be reported?

Progress will be reported at the Thrombosis and ThromboprophylaxisG Committee G, the Trust Executive Quality Committee G and the Assurance Committee G.

Priority 2 (Patient Experience):
Continue to focus on communication, discharge~~,~~ and delivering safe and compassionate care to all our patients

Why is this important?

It is important that we continue to listen and respond to the feedback from patients and families and need to build on the work that we have taken forward over the past year. Our patients are telling us that there is room for improvement in how we communicate and in the discharge process. Our specific focus on the care of older people has been broadened this year; reflecting the need to deliver compassionate care to all our patients. We will make these our priority and part of our quality strategy.

Underpinning all of this work we will continue to integrate our Trust values so that every member of staff understands their responsibilities and has discussed their individual commitment in their appraisal and this is why we have maintained this as our third priority - see page 19.

What will we do in 2013/14?

Communication

Last year we initiated a range of measures to improve communication as described on page 10 and we will continue to build on this work to ensure that our communication is kind and respectful.

We will develop a number of different ways to listen to the experience of patients, to learn from this and make changes. Through Senior Team visits, Managers, Non Executives and Governors will speak directly with patients and families to understand their experience of care and treatment. This will build on our existing feedback from concerns and complaints whilst continuing to use a range of patient surveys.

To communicate our learning about the patients experience and the related improvements that we make, wards will have a 'You said – we did' board which will be updated each month.

We will improve the co-ordination, continuity and communication of care. To do this we will ensure that there is a clearly identifiable nurse in charge of each ward on every shift and develop specific expectations of this role. We will develop bed side plans of care within our wards to engage patients in their plan of care and enable continuity and communication between staff members. We will measure improvement through an evaluation of bed-side care planning through audits and through specific questions in our periodic patient surveys.

We will deliver training to appropriate groups of staff to ensure they have the communication skills to support patients who are anxious or distressed. We will also provide customer care training for staff to ensure that they communicate with kindness and respect.

Discharge

We know that there is a continuing need to revise and improve the discharge process for patients to ensure that we focus on achieving safe, timely and effective discharge. In response to this, we have established a project team with representatives from hospital and community services who will continue to focus a plan of improvements in our discharge process

We know that patients don't always know who to contact if they are worried following discharge. We will provide patients who are being discharged with a card and contact details so that they know who to get in touch with. We will monitor this through our periodic patient surveys

Having piloted post discharge telephone follow up, we will identify ways to increase the number of patients that we contact in this way following their discharge and the patients that this is most useful for.

Delivering safe and compassionate care for all our patients

We will develop our environment and the support we provide for people with dementia and their carers. To do this, the refurbishment of Edgar Horne ward will focus on ensuring it is more helpful for those with dementia. We will take forward further training for staff in meeting the needs of those with dementia and will develop access to information and support for informal carers of those with dementia

We will maintain the 'comfort rounds' that were implemented last year, and introduce these to our remaining ward areas. We will also evaluate the effectiveness of these with patients' families and staff.

We will establish a 'Preventing Harm' group with representatives from relevant professions and community agencies, which will focus on two key areas of harm – building on last years' work in reducing the incidence of falls, and on reducing the occurrence of pressure ulcers.

We will continue to ensure that we meet patient's nutrition and hydration needs through nutritional screening and protected mealtimes. We will work with our volunteer service to further develop our support to patients during meal-times.

Focussing on compassionate end of life care will be an additional priority – see page 21.

How will we track progress?

We will track progress through our quarterly board reporting to include the main indicators of performance for both patient and staff experience.

Complaints will be monitored against these three themes: communication and discharge as measured last year and a new indicator, complaints relating to attitude and behaviour for 2013/14 which will be used to measure compassion. We will continue to measure safety through regular monitoring of falls (see page 26) and pressure ulcers (see page 30).

We will also have a structured programme of both postal and real-time survey results to track our progress.

How will progress be reported?
Progress will be reported through the Patient and Staff Experience Committee and the Trust Executive Assurance Committee – see annex 6 for Trust Committee structure.

'HOMEWARD BOUND' – further enhancing discharge planning for our patients

This is a new development that started over the last year and is developing in every ward area. A patient focussed meeting comprising of a daily short 'board round' to ensure timely communication and effective discharge planning takes place among the multi-disciplinary team (MDT). These meetings differ from ward to ward and involve the Nurse in Charge, the Senior House Officers/FY1G, Discharge Co-ordinator, Physiotherapists and the Occupational Therapists.

Planning a patient's discharge in advance of their planned discharge date is extremely important as effective planning ensures that tasks that need to be completed are before the patient goes home. The role of the 'Board Round' is to make sure that the MDT are communicating this and are working together effectively towards a safe and timely discharge. The 'board round' is also designed to give teams a daily opportunity to update each other and to mutually agree on specific care goals, plans, dates and tasks to be completed.

The Board Round has been seen to improve multi-disciplinary communication, team work and efficiency, as well as patient care and communication. Each ward is unique and has a particular way of working. Craig Edlin (Clinical Lead for Rehabilitation) and Caroline Fenwick (Stroke Co-ordinator) highlighted - "It can be quite difficult to get off the ground and needs a lot of pushing, but once it's in place and you've found a way of embedding it in to the ward routine, it's a really effective way of working".

The daily Board Rounds are being rolled out ward by ward, so eventually every ward will have a daily Board Round embedded into its routine.

Priority 3 (Patient Experience):
To be in the top 20% of acute trusts nationally for staff engagement G and staff appraisals as measured by the NHS staff survey and to ensure our agreed Trust values inform everything that we do

Why is this important?

We want to ensure the highest quality care for patients being treated at Chelsea and Westminster and the highest quality environment for all staff working here. Research tells us that there is a positive relationship between staff motivation and wellbeing and patient experience. We understand the importance of all staff understanding the role they have in ensuring the highest quality of care for patients. To enable this we have focused on the four Trust Values and the behaviours underpinning these values: safe, kind, excellent and respectful. In 2012/13 we defined the behaviours that underpin everything we do and our values will continue to be a priority in 2013/14.

What will we do in 2013/14?

We will build on our values work to develop individual commitment in appraisals explaining how each individual will ensure they live the values of the Trust.

The feedback staff have given us through the annual staff survey has been used to develop a Trust-wide action plan, and local action plans, linked to the Trust values. These will be used as the main basis for taking action to improve our engagement with staff.

We will remain in the top 20% of Trusts for staff engagement as shown in our annual staff survey.

We will run four campaigns for staff throughout the year to focus on each value in turn: safe, kind, excellent and respectful. Each campaign will highlight aspects of patient experience related to the values.

We will build on our existing work to develop recruitment methods to assess values and behaviours so that we check whether staff are likely to meet our values when we recruit

We will increase appraisal rates to at least 90% in order to be in the top 20% of Trusts.

Staff will use examples of feedback from patients and other sources within their appraisal.

We will include the Trust values and patient experience themes and stories into our training programmes.

We will improve on three key areas of patient experience that have been highlighted in our annual inpatient survey.

How will we track progress?

We will track progress through our quarterly board reporting to include the main indicators of performance for both patient and staff experience. This will include our annual staff survey and in-year staff pulse surveys, and our staff engagement metrics. Appraisal rates will be tracked and reported monthly to Divisions and the Trust executive. The staff survey action plan will be reported through the Executive meeting.

How will progress be reported?

Progress will be reported through the Patient and Staff Experience Committee and the Trust Executive Assurance Committee - see annex 6 for Trust Committee structure

Priority 4 (Clinical effectiveness):
To improve choice and quality in End of Life care

End of life care is about the total care of a person who is seriously ill and who is not going to get better. This phase of a person's life may last for weeks, months or years although it is usually described as the last year or so of life before death.

End of life care extends to relatives too; they may also need information and support, both before and after their loved one dies.

Why is this important?

We only have one chance at looking after people well at the end of life. Bad experiences can blight what time patients have left and linger in the memories of those left behind.

If we know that someone might be in the last year or so of life, we can give them the information they are ready for and help them decide on a care plan that best suits their individual needs and preferences.

For example, some people may not want all the treatment on offer or may prefer to stay out of hospital. This means making sure that the right care is in place for them to be looked after at home. And it means making them as comfortable and free of pain as possible, and giving them the emotional and practical support they need.

A two year strategy…..

What will we do in 2013/14?

Our stakeholders said that we should be providing patients at the end of their lives with high quality care that focuses on dignity. They said we should direct our efforts to factors that improve the quality of life, rather than focusing solely on what can be measured. So we will:

- Draw on evidence from national audits, complaints, and local information to look at the service we are currently providing and how it might be improved.

- Survey relatives of those at the end of their lives to obtain feedback about our services. This will be part of our 2014/15 plans

- Start a service for volunteers to spend time with dying patients who have no visitors

Our stakeholders said that we should communicate well with the person at the end of their life and their family, and provide and document a care plan. They told us that the care we provide should take account of individual needs and preferences. So we will:

- Assess our end of life care service against national standards set out by NICEG: these include communication and information; individual assessment; care planning; and coordinated care.

- We will also look at guidance from the national End of Life Care Programme: *The Route to Success in end of life care – achieving quality in acute hospitals. 2010,* and from that and the assessment against NICE quality standards, agree a strategy for improving choice and quality in end of life care across the hospital.

- Ensure that patients choices around end of life care are recorded on the end of life care database 'Coordinate my Care' so that we and our colleagues in community services know what people want at the end of life and can support those choices

Our stakeholders told us that we should train our staff in end of life care. So we will:

- Assess the need for hospital-wide training in end of life care and provide training where needed.

And they said that when patients are dying in hospital, we should explain the Liverpool Care Pathway so we will:

- Train staff in how to discuss the Liverpool Care Pathway with patients and their relatives

How will we track progress?

We will track progress every four months in line with the meetings of the committee:

We will develop an end of life care strategy by the end of Q2, focusing on the elements that contribute to, and improve, quality of life. We will include complaints, and how we have responded to them.

We will review the report from the co-ordinate my care team to check how many patients we are adding and of those how many are offered conversations about future care

We will produce a report on training needs in end of life care, including the Liverpool Care Pathway by Q3 and we will use this to plan training for 2014/15

We will review progress on the new volunteer service including uptake

How will progress be reported?

Progress will be reported at the End of Life Care Committee G and at the Executive Quality Committee - see annex 6 for Trust Committee structure.

The Liverpool Care Pathway: integrated care for the dying
In common with many hospitals, the Trust uses a document to help staff give the best care to patients when they and their families agree that they are in the last hours or days of life.

The Liverpool Care Pathway, as it is called, helps staff to focus on what is really important, including pain relief, spiritual and emotional needs, and practical support.

The Pathway has attracted some unfavourable media coverage because it has not always been used as it should, and families have felt excluded from the decision-making process. As a result, it is the subject of a public consultation, and we will be

guided by the recommendations arising out of that consultation when they are published. In the meantime, we will do all we can to ensure that the voices of the dying and their relatives are heard and that we respect their wishes. We will also use our public forum, 'Medicine for Members' G to talk about the Liverpool Care Pathway and address misconceptions.

Our Palliative Care Service – a relative's story

From the moment we were linked in to the Palliative Care team at Chelsea and Westminster hospital, hope returned. For the first time since Mum's diagnosis I felt I could breathe. We desperately needed a constant - someone we could trust. We found an entire team - a cross-disciplinary one at that - the medical and nursing team.

As a result, Mum's life has been prolonged and on most days, Mum enjoys good symptom control. This has not come easy – it has taken absolute dedication, persistence and unwavering kindness from a first class team of medical professionals - 'our team'. It feels like a partnership, one which as Mum's primary Carer I have been welcomed into listened to and, most importantly, heard. There are no barriers, the team are always within reach and for that I am eternally grateful. I cannot stress enough how important that access and support has been for me – I would not have coped as well as I have without it. Mum would not be alive without it. This is a fact.

When we near Mum's end of life, as a daughter, I must be certain that '**we'** did all that we could - and some, for Mum. I will cherish and hold on to our team at Chelsea and Westminster hospital - I know they care and are routing for Mum, for us.

Peace and dignity at the end of life: The Butterfly Room

The Butterfly Room on the newly renovated David Erskine Ward aims to provide a peaceful non-medical environment for patients in the last days and hours of their lives, where they can die in peace and with dignity.

The Butterfly Room's facilities include a sofa bed and a kitchenette so that relatives can stay over and spend valuable time with their loved one. "We wanted to create a 'home away from home' environment, away from the hustle and bustle of the main ward," explains Ward Sister Lesley-Anne Marke, who developed the idea for the room.

"Because our ward specialises in palliative care, looking after many older patients with serious respiratory and rheumatology conditions, it is inevitable that some of these patients will die here. The Butterfly Room means that family members can have some privacy during this difficult time," she adds.

The Butterfly Room was made possible by a donation from the Friends of Chelsea and Westminster Hospital.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 16 May 2013

AGENDA ITEM NO.	2.3.1/May/13
PAPER	Approval of the Governors Commentary
AUTHOR	Melvyn Jeremiah, Public Governor
LEAD	Melvyn Jeremiah, Public Governor
EXECUTIVE SUMMARY	The latest draft of the Quality Account/Report has been circulated to Governors by email for information only. At the request of the Lead Governor the Governors Commentary on the Account/Report has been prepared by Melvyn Jeremiah and approved by Governor members of the Governors Quality Sub-Committee. This Commentary is attached for endorsement by the full Council of Governors in accordance with the constitution (which bars delegation from the Council of Governors to its sub-committee).
DECISION/ ACTION	The Council of Governors is asked to endorse the Commentary.

QA 2012-13 GOVERNORS' COMMENTARY

The Council of Governors Quality Sub-committee has continued its work as described in the Governors Commentary on last year's Quality Account. It has contributed its views on many aspects of the quality of the services provided by the Hospital and has endorsed the continued effort to improve the appearance and readability of the Account. The Governors encourage all Trust Members and others who are interested in the Hospital and its performance to read the Account.

Taken as a whole the key performance indicators show a successful year, with some areas which were below par improving. There is still some way to go with some of them, but measures are in place to secure further improvement. It is a tribute to the management of the Trust and the staff in general that this overall high performance has been coupled with a very satisfactory financial performance. This linkage is essential if the Trust is to continue to serve its patients and the public successfully. The Governors encourage the Trust in its forward strategic planning, taking full account of the opportunities which will arise through the reconfiguration of services following the Health and Social Care Act 2012. The Council of Governors is engaging with the Trust Board in this work, which will continue over the next three to five years.

The Governors are pleased that during the year work has continued within the Trust to embed its values (to be kind, excellent, safe and respectful) in everything that is done. Major adaptation of staff training has been completed and this will produce continuing benefits. The Governors have encouraged steps to improve patient and staff feedback and take action on what it has to say about services and the way they are delivered. As part of this individual Governors are joining with non-Executive Directors and Trust staff in ward rounds to talk to patients and front-line staff about these issues.

Last year's Commentary drew attention to the part Staff Appraisals should play in promoting Trust values and improving performance and delivery of services. It continues to be disappointing that the target set for the appraisal rate was again not achieved [in 2011/12 80% against a target of 84% and in 2012/13 82% achieved against a target of 87%]. The target set for 2013-14 is 90%. We consider that there should be a 100% appraisal rate, and the Governors will be encouraging further efforts by the Trust's management to that end.

Another issue which has been noted is poor take-up of mandatory training in some areas. On the face of it this is unacceptable though there is a suggestion that this may be due to some mandatory training being specified for staff groups for whom it would not be appropriate. This is to be examined closely and may affect the rate achieved this year. If it is confirmed that certain training should be mandatory for certain groups then the Governors support the Trust Board in their efforts to ensure that it does take place.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 23 May 2013

AGENDA ITEM NO.	2.4/May/13
PAPER	Draft Minutes of the Council of Governors Quality Sub-Committee meeting held on 19 March 2013
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Cathy Mooney, Acting Chair
EXECUTIVE SUMMARY	Draft minutes are enclosed.
ACTION	To note.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Quality Sub-Committee meeting, 19 March 2013

Draft Minutes

Attendees	Walter Balmford	WB	Patient Governor
	Martin Lewis	ML	Public Governor, Westminster 1
	Melvyn Jeremiah	MJ	Patient Governor
	Susan Maxwell	SM	Patient Governor
	Sandra Smith-Gordon	SS-G	Public Governor – Kensington & Chelsea 2
	Maddy Than	MT	Staff Governor
	Tera Younger	TY	Patient Governor
	Cathy Mooney	CM	Director of Governance and Corporate Affairs
	Tony Pritchard	TP	Deputy Chief Nurse
	Melanie van Limborgh	MvL	Head of Quality and Assurance
	Patricia Gani	PG	LINk representative
	Vida Djelic	VD	Foundation Trust Secretary

1 Welcome and Apologies **CM**

CM welcomed Walter Balmford and Tera Younger, patient governor to the sub-committee.

CM noted that Zoe Penn, new Medical Director was expected to join the meeting slightly later.

Apologies were received from James Dennis, Sharon Connell and Wendie McWatters, Therese Davies and Sian Nelson

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

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

- p.2 section 3 matters arising, 2nd para, 4th line 'out' should read 'outside'
- Under quality priorities pressure ulcers to be added.

It was confirmed that EDM did not work between hospitals.
The sub-committee discussed the pilot telephone questionnaire and the results were very positive. It was noted that the purpose of the call is to check if the patients are well following discharge from the hospital. It was suggested the pilot should be called a 'follow up' call.

3 Matters arising **CM**

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

<u>Discharge from A and E</u>
Further detail was provided – patents had been advised that the hospital

could not make a referral to the patient's GP and that the patient had to contact them. **TP to find out what information is provided to A&E patients on discharge.**

Junior doctors wearing white coats
TP said that he met with Zoe Penn, newly appointed Medical Director and discussed a number of issues, including white coats. It was noted that ZP is committed to junior doctors wearing white coats and this will be brought to their attention on induction.

The dissemination plan is to publicise via Daily Noticeboard, poster campaign in the hospital, etc.

Quality Priorities
The selection of priorities is on the agenda.

PG informed the sub-committee that the LINk will become Healthwatch on 1 April 2013 and noted the different structure of the new organisation which will be funded by the Department of Health. It was also noted that in addition to adults they will take on child services. Healthwatch will help sign posting people to advocacy. The current members of the LINk will carry on being members of Healthwatch.

It was highlighted that Christine Vigars, Chair of LINk received an award from the Mayer.

Comfort rounds update
SM had said she was interested. It was confirmed that this related to audits rather than the comfort rounds themselves.

It was clarified that the option of governors being attach to directorates had been superseded by a framework for visits to wards. It was noted that comfort rounds audits could be done while visiting wards.

ML said he talked to other governors at the recent FTGA event and noted that at some trusts governors do mystery shopping.

PG highlighted the usefulness of complete information being provided to patients on discharge from the hospital.

Waiting time increase
TP said Diane Samuels provided feedback - for urgent referral 3-5 days for non urgent 3 month. Waiting times have increased due to increased referrals and we are attempting to reduce waiting time.

4 Chair Quality Sub-Committee **CM**

CM noted some upcoming changes in the management structure which will impact on who will chair the meetings. It was noted that it will take around 3 to 5 months until the chairmanship has been determined. Meanwhile, the sub-committee will carry on assisting with the production of the Quality Account.

The sub-committee discussed the committee structure and whether there is the need for its existence.

5 Complaints Report **TP**

It was noted that the Q3 Complaints Report was not due yet but due to its link to the quality account, TP provided an overview of the content of the Q3 report :

- Slight reduction in formal complaints
- Complaints by department: Emergency, AAU and Labour wards
- Re complaints by subject: aspect of clinical care, attitude, behaviour and inadequate and conflicting information and care plan followed and explanation re decisions
- There are 4 type 3 complex complaints which require an investigation

6.1 Quality Account

CM described the process of identifying priorities for the Quality Account. External Auditor Report from the last year has showed that we are doing well compared with other foundation trusts i.e. C&W links its objectives to the Trusts strategy and a glossary was used. The size was in the lower range.

Priorities in the Quality Account
We have 4 priorities. The first one re VTE has been agreed and we are still collecting data so performance in not known yet. Re patient experience TD wants to change this slightly and also the staff one is still being reviewed.

The fourth one has been achieved and t was suggested that a new one could be about end of life care. The sub-committee strongly supported this and identified the following as areas to cover:

Involvement of family and the person – lots of communication and discussions with the patient and family.
Explain the LCP
Educate patients re the LCP (perhaps we can have something in a box in the report explaining this)
Document properly
How many people have a care plan?
How many patients are in a room on their own. The Butterfly room was mentioned – perhaps a 'box' for that too in the quality account?
That we mean end of life rather than dying
Quality and dignity
Individual needs and preferences
Training

It was highlighted that by the nature of the priority we would have to focus on process measures such as training rather than outcome measures such as quality of end of life care although Dr Cox was looking into a bereavement survey.

The discussion will be relayed to Dr Cox for inclusion.

Content and changes to the Quality Account
The sub-committee discussed having the Quality Account as required by the Department of Health and an additional shorter version which is patient friendly and readable. This version could be called 'extracts from Quality Account as selected by governors'. A reference to the full version of the Quality Account should be made in the abridged version. It was agreed that the Quality Account Planning and overview Group will look at this in more detail and it was noted that if it was an extract it could be worked on after the quality account is complete. . MvL highlighted that governors'

views and input on the main headings, content and length of the report are very important.

MT left

Timescales
Timescales were outlined in appendix 1 of the paper.

Areas of innovation and high quality
Areas of innovation and high quality were highlighted.
It was noted that more detailed discussion on this would follow on Friday, 22 March at a meeting of the Quality Account Planning and Overview Group.

Particular attention was drawn to section 3.6 content and other areas from the last year commentary. The highlights included:

Council of Governors - Appraisals
LINk - target for patient consultations with senior staff prior to discharge
Delivery of prescription medicines for vulnerable patients - reply provided
Appraisal rate by department
Dignity
Maternity experience
Local borough - highlighted VTE responsible consultant anaesthetist and surgeon
NHS North West London cluster - comments on VTE and in particular nil by mouth.

It was noted that the 2012/13 Quality Account will include the Council of Governors statement and that a governor should lead on this.

It was noted that the 2012/13 Quality Account will include the input from a wide variety of stakeholders, i.e. LINk. The priorities for quality improvement have been re-confirmed and there are plans to include a diverse set of patient, stories, innovations and quality initiatives.

CM invited the sub-committee to consider any other important issues for inclusion. It was suggested that there is an explanation of never events. A suggestion was to include shaping a healthier future consultation on the reconfiguration of A&Es but CM thought this might be more appropriate for the annual report.

6.2 Quality Account – local performance indicators prioritisation **CM**

Governors had been invited to submit their priority local performance indicators in advance of the meeting. It was highlighted that selection criteria might have been helpful but it was explained that it is important what matters to patients and public and the intention was that the choice should not be influenced.

CM referred to the performance indicators on p25-28 of the 2011/12 Quality Account and suggested that this information as presented is taken out and put in a section at the back and that a priority section is included in the main report.

Local Indicators selected by governors included:

Patient Safety

- pressure ulcers
- MRSA

Clinical Effectiveness
- Discharge
- Never events
- VTE

Patient Experience
- complaints for communication discharge and older people.

7 Spring Quality Awards **MvL**

A schedule for the Spring 2013 Quality Award was noted and these will be publicised soon.

The sub-committee were invited to consider nominations and those individuals and teams to be encouraged to apply. It was clarified that individuals can either nominate themselves or be nominated by other colleagues. It was noted that staff can reapply.

There was a suggestion for a letter of commendation from the CEO and the Chair is sent to those who are commended and be encouraged to reply next time.

A suggestion of quality awards being named after a member of staffed who had passed away and had made significant contribution to the Trust was discussed. A possibility of having a plaque to commemorate someone in a prominent area of hospital or a board listing names of special staff contributions was discussed. The sub-committee eventually decided that this was not within their remit.

9 Council of Governors funding report **VD**

The sub-committee noted the report.

Three new quality initiatives outlined were as follows:

- A dedicated 'easy and quick to read' abridged version of the Quality Account aside of the main document - to meet the requests of service users and stakeholders. This would bring improvements of information resources regarding the mandatory Quality Account and the information offered to patients and users of the Trust's services. **The sub-committee agreed to support this initiative for the value of £3000.**

- A patient and staff information resource to highlight the requirements to meet the Care Quality Commission (CQC) Essential Standards of Quality and Safety to distribute to Open Day visitors May 2013 and after that in the Trust. **The sub-committee agreed to support this initiative for the value of £3,500.**

- An internet/intranet resource for staff and governors to access with helpful tools and resources to meet the work of the Trust in complying with the Care Quality Commission Essential Standards of Quality and Safety. **The sub-committee agreed to support this initiative for the value of £10,000.**

The sub-committee agreed to support the funding of the above three projects totalling £16,500.

It was noted that MvL will seek approval from the Council of Governors on the three projects supported by the sub-committee.

10 Feedback from governors on patient experience

SM reported on feedback from a patient while doing 'meet a governor session' and details of the case will be passed to TP.

An issue of not receiving an acknowledgment letter upon complaint was noted.

SS-G observed one day that lunch trays were not being taken away at 3pm on Edgar Horne ward. The need for more hostesses was noted. It was also noted that the Edgar Horn needs new flooring.TP said there is a plan to refurbish this wadr and it will be dementia friendly.

SS-G asked where small general points about the hospital should be submitted. TP responded that the PALS was the right place to report this to.
A comment was made about the PALS office and sometimes patients find it hard to submit complaints; it was also noted that the phone lines have been busy recently. The need for more telephone lines or staff was noted.

TY raised a concern about dermatology appointment letters.

MJ said he will put his views on his recent admission to the hospital to TP.

11 Any other business

None.

12 Date of next meeting – 13 June 2013

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 23 May 2013

AGENDA ITEM NO.	2.5/May/13
PAPER	Chelsea & Westminster Hospital 2013/14 Annual Plan – Update to the Council of Governors
AUTHORS	Mark Harris, Business Development Lead
LEAD	Tony Bell, Chief Executive David Radbourne, Chief Operating Officer Lorraine Bewes, Director of Finance Axel Heitmueller, Director of Strategy
EXECUTIVE SUMMARY	This paper is the summary output of our annual planning process and it highlights the operating context, strategic response and clinical priorities for the period 2013/14-2015/16. Changes in the commissioning environment to reduce the demand for acute services and, in some areas, to reduce the tariff (e.g. 30% margin rate for emergency admissions) pose material threats to the Trust's clinical and financial position. The Trust is therefore: • focusing on developing a balanced portfolio of services – with a mix of specialised services, Major Hospital services proving acute care, and expanding elective services within the hospital and community settings for service lines where we offer high quality and financially sustainable services – including expansions of privately funded care; and • focusing on improving quality and efficiency across all services, and with particular emphasis on programmes of transformation along our emergency pathway, within surgery and theatres, and in our outpatient and appointments processes.
DECISION / ACTION	Our annual plan needs to be submitted to Monitor at the end of May, and signed-off by the Board on May 21st. The Council is asked to note the contents of our plan, which will be discussed at the Council of Governors Meeting prior to the Board Meeting on the 21st.

Chelsea & Westminster Hospital 2013/14 Annual Plan – Update to the Council of Governors on DRAFT Business Plan

1 Introduction

Following a discussion with the Council of Governors in March about the process being undertaken to inform the development of our annual plan, this document summarises the high-level output of our 'High Quality Planning'. The document sets out the strategic context within which the Trust is operating, the main priorities and actions underpinning our within our clinical strategy.

2 Strategic context and direction

2.1 Description of our clinical activities

At Chelsea and Westminster Hospital NHS Foundation Trust we provide a broad range of services within our clinical portfolio. These include specialised activities commissioned by NHS England; planned and emergency local hospital services and community clinics, commissioned at both the CCG and local authority level; and private patient activity.

Our main specialised services include paediatrics (including tertiary paediatric surgery), neonatal intensive care, burns, bariatrics, plastics and HIV. In terms of our local services we provide 24/7 adult and paediatric A&E services with co-located Urgent Care Centres (UCCs), a full maternity service and a range of medical and surgical specialties. In addition to our local hospital services we also provide community-based clinics in MSK, gynaecology and dermatology, and direct access sexual health services. The sub-sections below describe the high-level market analysis that we have undertaken as part of our business planning and set out the Trust's vision, objectives and delivery priorities for the planning period.

2.2 Demand-side analysis: changes in the commissioning environment

Demographics

The Trust is situated in the borough of Kensington and Chelsea (K&C) and our patient population is drawn primarily from this borough and the neighbouring boroughs of Hammersmith and Fulham (H&F) and Westminster. Our specialised services however have a broader population base covering most of North West London and further afield.

The population of the three boroughs of K&C, H&F and Westminster is approximately 560,000, within which people of 0-15 years accounts for 16% of the population, 16-64 years accounts for 74%, and 11% are aged 65 years and over. Overall the population size has been relatively static over the past five years as has the age composition. In terms of the very elderly population, people aged 85 years and over constitute approximately five per cent of the population and this too has been relatively stable over the past five years.[1] However, the population of the boroughs in outer London do show growth which needs to be taken into account for services that have a wider catchment area.

The health of people in K&C, H&F and Westminster is mixed compared with the England average. Deprivation is higher than average and about more than 20,000 children live in poverty, but life expectancy for both men and women is higher than the England average[2], which presents additional health care challenges commensurate with an more frail population.

Underlying trends in demand

Using the activity delivered by the Trust as a broad signal of demand, over the past three years we have experienced:

- growth of approximately three per cent per year in A&E attendances;
- static activity in terms of the overall number of non-elective admissions (including maternity), but an increase of three-to-five per cent in non-elective emergency admissions (i.e. in line with the increase in A&E attendances);

[1] Source: analysis of ONS mid-year population estimates (2006-2011)

[2] Source: London Health Observatory Health Profiles 2012

- growth of approximately five per cent per year in elective admissions; and
- demand for private activity that was constrained only by the regulatory cap imposed by our terms of authorisation (where income could be no higher than 3.7% of income).

Future demand and commissioned activity

In terms of emergency procedures the trends in population size and composition do not suggest a significant increase in underlying demand from our local population. However, despite these trends, over the past five years we have experienced consistent increases in A&E attendances and emergency admissions. Without external changes we would expect future activity to follow a similar pattern of increasing A&E attendances and emergency admissions. In addition however, plans to significantly reconfigure the A&E provision might fall within this planning period – implementation is expected to begin in 2015/16 – which would see more of the underlying demand flow to Chelsea & Westminster as neighbouring A&E departments are downgraded to Local Hospitals with 24/7 UCCs.[3]

In terms of elective procedures there is little in the population analysis to suggest changes in the underlying demand for services, but plans in specific service areas (e.g. Trauma and Orthopaedics) have incorporated assumptions about activity growth on the basis of a potential expansion in our market share where we have evidence of competitive advantage, particularly in terms of access times.

However, another factor we have incorporated into our planning is the local commissioners' work to reduce the local population's demand for both non-elective and elective services.

- Non-elective care demand management – we are working in partnership with commissioners and providers to reduce emergency admissions (or the conversion rate of A&E attendances into admissions), readmissions within 30-days of discharge following an episode of elective or non-elective care, and excess bed-days.
- Elective care demand management – commissioners have also asked for us to implement a range of measures that will reduce the number of Planned Procedures with a Threshold (PPwT), the number of non-GP referrals, and the ratio of new-to-follow-up outpatient appointments, in addition to the conversion of specified day-case activity into procedures in an outpatient setting.

In addition to the demand management initiatives our contract with commissioner also includes a range of performance indicators with agreed quality incentives and penalties for either achievement or underperformance. We have assessed the impact of these changes on the activity and income that the Trust forecasts for the planning period.

2.3 Supply-side analysis: the provider context within the health economy

Description of acute services in North West London[4]

Within NW London there are nine acute trusts. A wide range of services are provided at the hospital sites in NW London. There is a relatively high number of sites for the size of population and geographical area and the majority of the acute hospital sites (excluding the specialist trusts) provide very similar ranges of services.

Across the 11 acute hospital sites (this excludes the specialist hospitals of Royal Brompton, Royal Marsden and Royal National Orthopaedic Hospital) in NW London there are approximately 4,060 acute beds of which 3,450 are adult and 610 paediatric or maternity.

Analysis of 'five forces' acting within our health economy

The services within our Trust are, to a greater or lesser extent, exposed to a range of pressures in the local health economy derived from: competition within the acute sector; the threat of new providers entering the market; the threat of different services substituting for acute services; the relative strengths of suppliers; and the relative negotiating intentions of commissioners.

- ***Competition within the acute sector*** is particularly important in terms of elective services and maternity where patients have a choice of provider. Our planning has incorporated a range of comparative analyses

[3] N.B. The impact of reconfiguration is not included within the Monitor Plan Financial Model, but the Trust has carried out extensive scenario modelling, including around reconfiguration, as part of our Long Term Financial Model

[4] Data taken from *Shaping a Healthier Future Pre-Consultation Business Case – Volume One*

to ensure that we defend and grow sustainable services where we can offer comparably higher quality and faster access to diagnosis and treatment.

- ***New providers competing for activity*** is a factor that is most pronounced in services that are open to AQP contracting or tendering, for example MSK community services. We have undertaken internal business development to ensure that we can respond effectively to these new contracts to offset income lost through the movement of acute activity to these community settings.
- ***Service substitution*** that reduces activity in the acute sector has yet to create a noticeable change in the activity we see, but the Trust is mindful of detailed planning underway to implement Out of Hospital strategies that could move more activity towards primary and community care settings (e.g. diagnostics, step-up beds etc.). In some instances – e.g. for non-elective activity – the Trust is working in partnership to speed this transition so that patients with sub-acute needs are seen in appropriate care settings. This work is incorporated within our planning as a necessary step to respond to the reconfiguration of A&E and non-elective activity within North West London; full operational details and modelling of activity and income impacts is being undertaken throughout this year as part of an outline business case for implementation of the reconfiguration.
- ***Supplier effects*** have the potential to introduce significant cost pressures in areas such as drugs, consumables, equipment and maintenance, and estates. These cost pressures have been assessed in detail at the service level and mitigated through a range of Cost Improvement Schemes.
- ***Commissioner intentions***, as described above, have the effect of reducing activity in some services as well as the effective price (e.g. through the application of marginal or non-payment above agreed thresholds). Our planning has taken these agreements into account and has sought to utilise any freed capacity to increase other clinical activity, including for private patients.

2.4 Summary: strengths, weaknesses, opportunities and threats

Strengths	Weaknesses
• Strong reputation and brand recognition • Continued high performance in terms of access to A&E and elective pathways (4 hour A&E, 6 week diagnostic access, 31 and 62 day cancer waits, 18 weeks RTT) • A track record of financial sustainability and good governance • A balanced portfolio of specialised, local and community services • Excellent clinical and managerial staff • A teaching hospital with active clinical and operational research • Operate from modern facilities • Excellent location to access and service private patient demand • Good relationships with local commissioners and providers, developed through partnership working – e.g. Integrated Care Pilot and Academic Health Science Partnership	• Too often patients still experience fragmented care across pathways of care (particularly at interfaces between different providers) • Significant reliance of specialties on the continued operation of our A&E • Operate at high bed occupancy levels providing limited scope to manage significant fluctuations in demand – resulting in operational pressures and instances of 'black alert' status • Operate a single site with no access to step-up/down capacity • We have an ambitious programme of transformation that is reliant upon the effective implementation of new IT systems (e.g. EDM) but constrained capacity in this function • Our clinical services and administrative processes do not operate as efficiently as they could do: - Discharge processes could be better planned and patients moved to more suitable locations more quickly; and - Patient experience of our booking systems and outpatient communication could be significantly improved
Opportunities	**Threats**
• Expansion of our non-elective activity, and safeguarding of our interdependent services, through designation as a 'Major Hospital' as part of the reconfiguration of services across North West London • Targeted expansion of sustainable elective services to grow market share and income • Expansion of maternity services through the implementation of a new co-located Midwife-Led Unit • Expansion of private patient income following the removal of the previous cap • Potential transfer of paediatric cardiac and respiratory services from the Royal Brompton & Harefield estate	• Loss of acute activity to other acute providers • Loss of acute activity to new entrants in MSK and dermatology (under AQP and tendered contracts) • Loss of elective activity to primary care that is not replaced with other acute or tertiary activity • Commissioner intentions to reduce demand and apply financial penalties for activity above agreed thresholds • Failure of reconfiguration to proceed – following referral to the Independent Reconfigurations Panel – which reduces the opportunity for investment in Out of Hospital services • Loss of direct activity and income as sexual health

to the C&W Children's Hospital, with the transfer of the associated PICU
- Potential opportunity to acquire West Middlesex University Hospital NHS Trust following a process of due diligence

services move from NHS commissioning to local authorities under a new tarrif

2.5 Describing our strategic response

The clinical and financial context described above creates a range of pressures which shape the future planning of the Trust. Whilst within our clinical portfolio we have a breadth of services a large amount of activity and income comes from a relatively small number of services (nearly half of our income is derived from our top five services); and furthermore a number of our large services cost more to deliver than the income we receive to provide each episode of care. This creates a real challenge in terms of sustainability which must be met in part by transformations in the way we deliver care so that we maximise the efficiency of the services we deliver. In addition, we are committed to improving the experience of care for our patients which also will only be met through changes in the way we deliver pathways of care: for example we are working in partnership with community and social services to reduce internal and external delays and improve continuity of information so that inpatients feel that the transition at discharge is timely, seamless and supportive rather than delayed, fragmented and disorientating. In summary, operationally we recognise and are acting to address both a burning platform to secure financial sustainability and a burning ambition to improve care for patients.

As a response to these challenges the Board has agreed a range of outcomes, objectives and enablers that will form the foundation of our strategy over the next five to ten years. The Trust is therefore focusing on delivering:

- Safe and effective care
- Exceptional patient experience
- Financial sustainability

To achieve these outcomes we will:

- **Develop a patient-centred model to deliver 'always-events' and eradicate harm**
  - Work with patients and carers to understand their experiences of our services
  - Work with patients to co-design service improvements
  - Embed a culture of evidence-based service improvement to develop the most effective and efficient services
  - Encourage a culture of candour and improvement
- **Provide the right mix of unscheduled and scheduled services**
  - Establish ourselves as a Major Hospital whilst focusing on reducing avoidable attendances and admissions
  - Grow market share, or achieve designation, in elective services where we offer clinically excellent and operationally efficient services with exceptional patient experience
- **Integrate services inside and outside of hospital**
  - Develop and manage services that wrap around hospital inpatients so patients are treated in the most appropriate location and experience seamless transitions of care
- **Work with partners to take greater responsibility for the health management of a population**
  - Focus on prevention of avoidable illness as well as treatment
  - Support care planning, self-management and expert advice for patients with chronic conditions
- **Ensure that our clinical and managerial staff are enabled to do deliver these objectives by developing excellent**
  - ***People*** – recruiting and rewarding based on our values, developing and supporting staff to be excellent in their roles
  - ***Processes*** – supporting services with an effective toolkit (e.g. capacity and demand planning, an effective booking & appointments process), and ensuring that information is captured accurately and used to improve performance
  - ***Technology & Infrastructure*** – ensuring clinical equipment, IT and estates support clinical excellence
  - ***Research*** – creating an environment where systematically we translate what we know into what we do

- ***Education*** – providing an excellent clinical teaching environment, and ensuring development of all staff

3 Approach taken to support quality

The CQC visited the Trust in July 2012 and identified no concerns; all standards assessed were judged to have been met. The majority of actions from the visit in February 2011 have been completed. The one outstanding action regarding an online risk system is planned for this year.

Our four quality priorities are described in our Quality Account. The main goals, the risks and how these will be managed are as follows:

- To have no hospital associated preventable venous thromboembolism (VTE) – risks to delivery include the reliance on one individual to co-ordinate data and the completion of root cause analyses. This requires constant vigilance, monitoring and education. The risk are mitigated through well-established systems and leadership within divisions by Divisional Medical Directors.
- Continue to focus on communication, discharge, and delivering safe and compassionate care to all our patients – risks to delivery include the scale of what we are trying to achieve and that some measures are still to be defined. It requires constant vigilance. The risks are mitigated through having a strong steer from a senior level Staff and Patient Experience Committee and a strong focus from the Board.
- To be in the top 20% of acute trusts nationally for staff engagement and staff appraisals as measured by the NHS staff survey and to ensure our agreed Trust values inform everything that we do – risks to delivery include failure to meet the Trust target for appraisals. This will be mitigated through a further drive to complete appraisals and an increased focus on those not being completed.
- To improve choice and quality in End of Life care – risks to delivery include inadequate time and resources being allocated and the scope of the objective. This has been mitigated by realistic targets over two years and resources being identified from within the relevant teams

The Board derives assurance on the quality of its services and safeguards patient safety in a variety of ways. A yearly review of the quality governance framework is undertaken which assures the Board on the four areas of quality governance: strategy, culture and capabilities, structures and processes, and measurement. This assessment is RAG rated with proposed actions in areas requiring development. The Assurance Committee is a subcommittee of the Board chaired by a NED and attended by two other NEDs and two governors as well as the Executive Team. This committee oversees progress on quality objectives, indicators and other key areas of quality such as complaints and incidents, training and health and safety.

In addition, quality has been at the heart of our planning process: clinical services have been asked to undertake assessments as the basis for identification of improvement actions and the prioritisation of investment cases; and all CIP schemes are now routinely assessed in terms of the likelihood of adverse consequences and the magnitude of that impact on quality.

4 Clinical Strategy

4.1 Description of our approach to planning

We operate a Service Line Management approach to planning, allowing for analysis of quality, activity and financial performance at the service line level. Plans are then coordinated at the divisional level which allows for the divisional operational and medical managers to assess local plans before a wider discussion with the Executive Team through a series of 'Joint Review Meetings'.
Our planning approach has sought to build plans 'bottom up' and to ensure clinical engagement and ownership through a range of clinical workshops, joint review meetings and formal sign-off processes. Central aspects of the development of service line plans include:

- ***Demand forecasting*** – using analysis of population level data, internal activity data and HES data to see local trends in demand and referrals, and undertaking comparative analysis of waiting times to identify potential opportunities for growth in market share

- ***Capacity forecasting*** – looking at available clinician time and the physical capacity of outpatient, inpatient, theatre and diagnostic areas (taking into account throughput) to determine the available capacity to service demand
- ***Financial investment and cost improvement*** – using a mixed approach including service line reviews, comparative cost and performance benchmarking, and market testing through our procurement function to inform assessments of cost pressures
- ***Development of formal business cases*** where investment above delegated thresholds is sought which allows for comparison of the benefits and costs of schemes

4.2 A summary of our service line priorities

Chelsea & Westminster Hospital intends to remain a major acute hospital for NWL with supporting specialised services, whilst also growing secondary and community elective services where we have a competitive advantage and the development is financially sustainable. This is underpinned by some overarching strategic priorities:

- following the reconfiguration processes, prepare for designation as a Major Hospital with 24/7 A&E and the associated growth in activity in emergency care following the downgrading of neighbouring Charing Cross;
- achieve designation as a regional centre for burns, and improving specialist coding to ensure that complex work is properly recorded and receives the appropriate tariff;
- successfully implement service developments – set out in our 2012/13 plan – to provide a new Diagnostics Centre, set-up our community-based MSK service, and provide new co-located Obstetrics-Led and Midwife-Led Units;
- secure opportunistic growth in a small number of elective specialties, such as T&O (where we have already agreed to provide additional activity as part of a waiting list initiative); and
- undertake transformation programmes to improve our emergency care pathway, our theatre and surgical productivity, and out outpatients and appointments processes.

Other priority developments for our services include:

- ***In Medicine*** – expansion of ED and Acute model to meet AES standards and expanded activity (post reconfiguration), and growth in Gastroenterology work
- ***In Surgery*** – growth in General Surgery (Colorectal), Ophthalmology, Urology, Pain Management, T&O, Burns, and Bariatrics
- ***In HIV/Sexual Health and Dermatology*** – growth in screening via new Dean St Express, and expansion of our phototherapy service
- ***In Paediatrics*** – growth of elective paediatric dental work, maximisation of capacity to deliver activity under the tertiary surgical network, and the potential transfer of paediatric cardiac and respiratory services in partnership with RBH
- ***In Women's Services*** – development of an ambulatory unit in Gynaecology, implementation of a Midwife-led Unit and an Obstetrician-led Unit in Maternity, and focus on recruiting nurses into NICU to reduce bank and agency spend
- ***In Clinical Support*** – expansion of Endoscopy work, changes in staffing and rotas in Diagnostics to enable emergency cover in line with AES standards, and the potential expansion of our MSK community outpatients service

This clinical strategy will continue to be informed by regular 'Clinical Summits' aimed at developing long term clinical strategy, alongside formal clinical engagement in our annual 'High Quality Planning' sessions.

4.3 A summary of our clinical workforce strategy

The clinical workforce priorities will be modelled based on the Trust clinical and strategic priorities over the coming years which involve:

1. **Ensuring the workforce is fit for the future** – this will include workforce planning and remodelling to assure we have the right staff to deliver major acute hospital services with supporting specialised services, whilst also growing out of hospital services. This will encompass NWL Shaping a Healthier Future plans; collaborative working with hospitals on the Fulham Road and also plans for more integrated care models to serve our population/s. Where transfers of services occur this will involve transfer of staff (e.g. TUPE) and in some cases may involve expansion of our clinical staff resource to provide more acute or specialist care. Specifically, areas such as Emergency, Obstetrics and Gynaecology will see further medical consultant recruitment and remodelling to provide 24/7 cover for our patients. Specialities where we want to increase our market share will also see planned workforce growth such as Trauma and Orthopaedics, Gastroenterology and Sexual Health.

2. **Recruiting and ensuring our staff live our Trust values** – we will continue work to embed our Trust values of safety, kindness, respect and excellence in everything we do. Particular work will continue on ensuring we assess and select the right staff who will not only have the right qualifications and clinical skills to care for our patients but equally demonstrate the right values and behaviours to ensure our patients and their relatives/carers have an excellent experience consistently at any point in their care pathway or contact with the Trust.

3. **Staff Innovation and use of technology** – this will involve investment in IT and training of staff to ensure we are equipped to communicate, provide information and schedule bookings via a variety of media to meet our present and future populations' expectations of our modern services. We will also focus on workforce innovation and skills to translate the latest research into clinical staff skills to provide the best clinical care for our patients so they stay in hospital for less time.

4. **Staff who can provide patient services in and out of hospital settings and within the community where appropriate** – this will require remodelling of pathways, roles and contracts away from solely acute settings so staff are skilled and able to deliver care throughout the patient journey.

5. **Review of corporate/business support functions to optimise productivity** – we will work on modelling possibilities for providing the most efficient administrative and support functions. This will include review of services that can be improved through better use of technology such as EDM and electronic patient scheduling and bookings. It will also include review of services where greater economy of scale, the most productive use of time and added value to the business may be achieved in partnership with West Middlesex, via our Fulham Road Collaborative shared working or via outsourcing options. For example we have already merged our procurement and soft services provision, plus contracted out our Occupational services. Other opportunities will be explored in areas such as IT, Payroll, Estate and Facilities, Governance and HR.

6. **Review of pay and reward strategies** – in April 2013-14 we will commence work to review our pay and reward strategies so we are able to recruit, retain and develop talent and leaders to meet our patient needs and expectations. Both the recommendations from the Francis Report and revised Agenda for change terms and conditions provide the building blocks from which to assure we assess, reward, support and manage staff well based on delivery of excellent patient outcomes and objectives alongside the right skills, competencies and values. We will work on improving our objective and performance management systems and further improving our appraisal rates.

7. **Staff wellbeing** - Staff wellbeing and benefits strategies will continue to grow and play a big part in the wellbeing, morale and retention of our staff and their experience which will in turn have positive effect on patient experience. This will be measured via our staff survey results, internal HR metrics and delivered via internal initiatives such as the fast-track direct referral to physiotherapy service launched in 2012 and our mini health MOTs for staff.

8. **Recruitment, retention and QIPP initiatives** – We recognise that having our own permanent trained and able staff who live by our Trust values is the best way of achieving the best experience for our patients. In addition, we will always need and value a small proportion of flexible resource to support our services, however we need to keep this proportionate and focus on initiatives to reduce high cost agency temporary cover and sickness absence cover by developing speciality specific recruitment, retention and agency reduction plans. This will include areas, such as NICU nursing where it has been difficult to recruit

and retain nurses on NHS pay rates due national shortages compounded by the competitive London labour market. This will include skill mix and role review, local staff feedback via 'pulse' surveys and also a review of incentive options. In other clinical ward areas , we will develop roles to care for our ageing population and with that people with long term conditions, and/or dementia and will educate staff Trust-wide on changing health needs so they are empowered and able to provide care in the right way for each individual.

In addition, in non-clinical areas we will focus on a reduction of short term contractors/agency staff and we will to develop an in house Project Management Office to support the clinical divisions to work on Trust wide initiatives to improve patient experience and flow.

9. **Education and training** – We aligned all education and training functions and provision in 2012/13 and formed a new education and training board. Going forward, key workforce priorities will be to deliver excellent leadership and clinical leadership programmes so we have excellent role models to our staff. Mandatory training will also be reviewed to assure it is appropriate and fit for purpose plus easy to access via a variety of mediums and compliance will form a key condition of staff incremental progression.

10. **Research** – We will continue to support our clinical staff to be research active by maintaining Principal Investigators across our main specialties and supporting other staff to become involved in research programmes, for example, by: working with charity partners to fund PhDs and Research Fellowship placements; providing in-house multi-professional training and awareness programmes; supporting a Research Champion Programme to create links between clinical and research teams; retaining a core team of research associates; and supporting staff to participate in improvement science projects run in partnership with the NWL CLAHRC.

Productivity and efficiency

Productivity and efficiency gains built into the forward plan

A number of CIP programmes have been put in place, largely led by the HR department, to provide Bank and Agency efficiencies. These include a number of schemes looking at reducing the reliance and use of Agency staff, moving them to Bank and Contracted where possible; directorate trajectories are being set to measure in-year performance; there are also targeted schemes of reducing sickness and improving recruitment turnaround times, aided through the appointment of a new and dedicated member of staff reviewing these processed in detail. In addition, there will be a continued recruitment drive, targeting specific hard to recruit to areas.

In relation to theatre productivity there is potential to improve active times in theatres. The key enablers to achieve this are review and development of the scheduling process; development of the patient pathway; and a programme of clinical engagement to promote ownership of the issues and acceptance of change.

With emergency readmissions rates, bed occupancy and length of stay, transformation boards have been set up to review both the emergency and elective care pathways. Key aspects of this are the development of the current ambulatory care service, maximising its potential; and secondly of more potential is the improved discharge programme of acute physicians leading patient discharge process, with a dedicated clinical team who will review patients on wards daily to assess appropriateness of discharge and continue to manage their post discharge care. The total financial value of the planned efficiency gains for all Transformation work is £4.5m in 13/14, £5.4m in 14/15 and £4.2m in 15/16.

CIP Process and governance

CIP development, approval and resourcing:

The CIP requirement is identified through the Trust's financial planning process which reflects our strategy for services and capital investment. Once the level of capital investment to achieve the Trust strategy is identified we are able to calculate the level of internally generated cash we need in order to fund either the capital investment or service any loans we may utilise.

With a target EBITDA agreed the Trust assesses all internal and external financial factors such as inflation and shifts in activity and demand, and the impact these have on profitability. At the end of this assessment the Trust will have a gap between the target EBITDA and the level of EBITDA which would be achieved without CIP

– this gap is in essence the CIP target for the Trust. This assessment and resulting CIP target is then approved by the Trust Board which delegates the agreed budgets to the Management Executive for the financial year, which are in turn devolved to the clinical and corporate divisions in line with our Service Line Management structure.

Central support

The Trust does not operate a designated Project Management Office (PMO) with responsibilities for managing and reporting the identification and delivery of CIP for the Trust; this responsibility sits within the divisions themselves. However, to support divisions to identify and implement CIP initiatives central support and resources are provided. This approach can free managers and clinicians from their day jobs to identify and deliver the requisite initiatives and stimulate innovation and the adoption of good practice. Funding has been reserved recurrently from 2013/14 for transformation initiatives (£1.6m) and the Trust's Dragons Den initiative (£200k) which is available to services that identify transformation initiatives. In addition the Trust also has central CIP initiatives such as procurement, prescribing, workforce redesign and Facilities & Back Office re-engineering which will deliver CIP for departments centrally that they can utilise to achieve their locally devolved targets.

Monitoring and assurance

In recent years the Trust has developed an extensive system of monitoring and assurance for CIP identification and delivery including weekly monitoring reports to the Trust Management Executive and monthly updates for the Trust Board including Non-Executive Directors. This monitoring includes local risk assessment of individual schemes in terms of likelihood of delivery in line with planned implementation dates and anticipated value of the CIP.

Other key indicators monitored are the split of CIP identified and achieved by Income, Pay and Non-Pay with a minimum requirement of all services to achieve cost reducing savings of at least the national Gershon efficiency target in year and recurrently (4% during 2011/12 and 2012/13).

The existing controls and assurance scheme has worked well as is demonstrated in the CIP achieved in previous years. However we have identified improvements to this system to ensure it is more proactive in its nature and ensure that any CIP scheme is fully assessed to determine what impact it is likely to have on the clinical quality of services and to mitigate that impact, for example:

- We have implemented bi-weekly CIP review meetings chaired by the Chief Operating Officer and Director of Finance which will track the identification of CIP and progress on delivery plans to ensure that all service areas are on track to achieve their targets. Where areas are identified as being at risk of not achieving their CIP targets they are expected to identify schemes to mitigate this which would include non-recurrent under-spends against existing budgets.
- We have stipulated that all CIP schemes with a value greater than £100k per annum should be run with a project management methodology and specifically reviewed by the service lead clinician to ensure that any impacts to clinical quality have been evaluated and where necessary mitigated. Trust-wide templates for this project based approach have been developed and are submitted to the bi-weekly CIP review meetings for assurance that schemes are on track to achieve their CIP target, this template also requires the lead clinical to sign that a clinical impact assessment has been undertaken.

Services are required to assess each identified CIP scheme for the risk of slippage in implementation and must ensure that appropriate mitigation or substitution is identified and implemented.

Clinician Involvement and Quality Assessment:

The Trust requires that all CIP are approved by clinicians who have responsibility for clinical quality to ensure that any CIP does not have an adverse impact on the clinical quality of a service and if any impact is identified that actions and changes have been identified and implemented in order to mitigate this impact. The Trust has also now required that all CIP schemes be formally approved by Divisional Medical Directors and that this be officially documented to ensure this process is being followed and that all CIP have been subject to clinical appraisal.

Any CIP initiatives which have trust-wide implications are reviewed and agreed by the Medical Director and Director of Nursing to ensure that clinical quality is not adversely affected by such schemes.

Historic performance

The Trust has successfully delivered challenging cost improvements in previous years. This experience has been used to establish a clear and accountable approach to ensure the delivery of identified savings through CIPs. The table below sets out the historic CIP delivery for the Trust and planned level of CIP for the 3 years to 2015/16.

This table shows that the Trust has a strong record for achieving the necessary levels of CIP to support achieving our financial strategy. During 2012/13 the Trust successfully delivered £7.1m of CIP through a combination of cost reductions and revenue generation schemes.

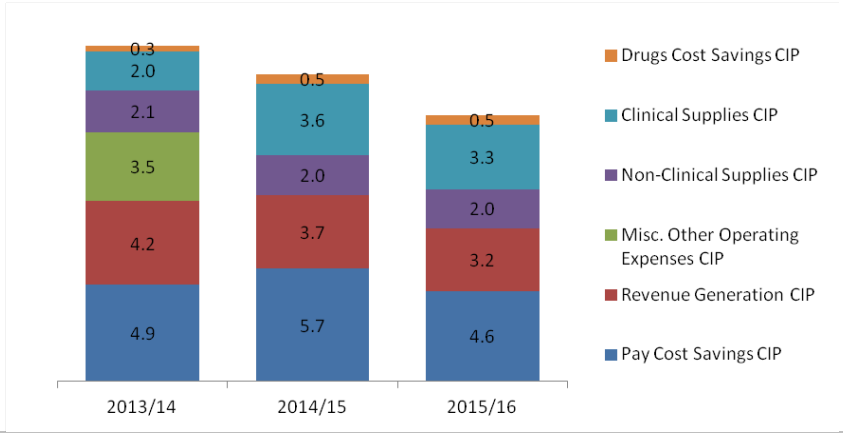
The main drivers of successful delivery of CIPs include: strong design with 'bottom-up' and realistic analysis of the opportunity; regular executive-level discussion of progress; early development of implementation plans with identification of the required factors to enable delivery; and regular monitoring of the delivery through divisional and executive structures, including quarterly planning and performance reviews between the Executive Team and the divisions.

	2011/12		2012/13		2013/14	2014/15	2015/16
	Plan	Actual	Plan	Actual	Plan	Plan	Plan
	£m	£m	£m	£m	£m	£m	£m
Pay Cost Savings CIP	8.300	5.733	7.932	5.393	4.858	5.693	4.557
Drugs Cost Savings CIP	0.490	0.696	0.600	0.745	0.280	0.500	0.500
Clinical Supplies CIP	3.815	3.921	2.728	1.895	1.978	3.599	3.255
Non-Clinical Supplies CIP	2.050	3.776	4.940	3.822	2.114	2.011	1.962
Misc. Other Operating Expenses CIP					3.471		
Revenue Generation CIP	5.000	6.803		5.227	4.247	3.697	3.175
Total	**19.655**	**20.929**	**16.200**	**17.083**	**16.949**	**15.500**	**13.450**
% Achieved		***106%***		***105%***			

CIP Profile

The Trust has a target CIP over the next 3 years of £45.9m, broken down as follows: 2013/14 £16.9m, 2014/15 £15.5m and 2015/16 £13.5m. As is shown in Figure 1, pay cost savings and revenue generation are the largest categories of scheme.

Figure 1 – Profile of CIP schemes (2013/14-2015/16), split by theme



There are 5 key CIP themes across the Trust that have been identified and developed by divisions and directorates, where each area is expected to deliver against a centrally determined CIP target. In addition there are locally identified and driven schemes, specific to each individual service area. Whilst the responsibility for the delivery of CIPs is devolved, the identification of CIP opportunities is not completely locally driven. The Trust utilises benchmarking when identifying opportunities for CIP with a variety of sources including local (e.g. internal benchmarking and North West London reconfiguration), national (e.g. Dr Foster) and international (e.g. Advisory Board and G.E.) benchmarking tools and consultants in line with the Trust

aspiration of achieving upper decile performance in all the services we provide in terms of clinical quality and financial performance.

The Trust takes a combined approach of seeking to achieve major transformational changes on a division or trust-wide basis alongside locally identified and delivered incremental changes.

CIP enablers

As outlined above the Trust devolves management responsibility to divisions and directorates for CIP identification. The clinical leadership of each area is a key sponsor of each individual CIP scheme, with sign-off a key requirement by clinical leadership (both nursing and medical). Where a CIP scheme requires an invest-to save approach, including those that require capital expenditure, the CIP schemes are net of revenue costs and where appropriate capital expenditure required is set aside in the Trust's capital programme. As part of the Trust's business planning process CIP templates help facilitate the clinical engagement and the requirement to identify the relevant enablers.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 23 May 2013

AGENDA ITEM NO.	2.6.2/May/13
PAPER	Governors' Questions
AUTHOR	Cynthia Conquest, Interim Deputy Director of Finance
LEAD	Tony Bell, Chief Executive
EXECUTIVE SUMMARY	The question raised by Steve Worrall Has the move to GUM commissioning by Local Authorities and the possible opt out of tariffs by some authorities affected the provision of open access services and the future development plans for our GUM services? Response: The Sexual Health services provided across London are open access and the changes in tariff have not affected the Trust's provision of open access services. Any patient can visit whichever clinic they wish to and until this year, providers have been able to charge PCTs for treating their residents. Sexual Health demand has grown significantly and consistently for the past five years and there is no evidence to suggest this demand will diminish in future. The call centre, booking appointments for all 3 Sexual Health clinics, continues to experience record demand month on month. However, the early indications from Local Authorities is that they wish to get some assurances of a fixed price for Sexual Health budgets meaning that they wish to introduce either a block contract or a cap and collar approach. This would mean that Chelsea and Westminster would either not be paid for growth over a certain percentage or would be paid at a marginal rate for activity growth and this could have a possible effect on open access. This is still in discussion with Commissioners and the Trust's CEO is writing to David Nicholson (CEO of NHS England) to highlight the problems with contracting for sexual health services, which were meant to transfer at 'steady state' in the first year of transfer from PCTs to councils. The Trust is also organising an Advisory Board in June with the main stakeholders to discuss Sexual Health and promote the Chelsea and Westminster service.
DECISION/ ACTION	To note.

Council of Governors Meeting, 23 May 2013

AGENDA ITEM NO.	2.6.3/May/13
PAPER	Governors' Questions
AUTHOR	Axel Heitmueller, Director of Strategy and Business Development
LEAD	Tony Bell, Chief Executive
EXECUTIVE SUMMARY	The question raised by Dr Anthony Cadman I would suggest that we ask the main board what preparations they have made for the oncoming competition to Chelwest services which are currently forecast by the management consultants such as Bain Consulting. • I can table a brief summary of those expectations. "International consultants are recording the continued expansion of health provision services in UK this year by 6%. These will comprise firstly the hospital competition of elective operations. Eg see the brochures of Lister and others. However they foresee by 2014 serious publicly advertised and promoted versions of typical hospital services from incoming overseas firms such as Apollo the world's largest hospital owners. These types of firms are expected to takeover some of the NHS hospitals which will be closed down in this and next year. At the same time they list many other items such as follow up services to existing procedures to avoid NHS waiting times, a wide range of test and analysis services, many dispensary units in places like supermarkets and out of town retail centres plus on the spot "cuts bruises, injuries dressings, minor infections " etc which can be similarly sited and also sited at work places and larger offices. Whilst some of these are away from current hospital services the adjustments to the competition will call for replanning, relaying out of hospital space and other costly changes which will affect the expenditure under the Chelwest finance departments control. What plans are in hand to fund reserves and reorganisation to handle this competition. The new NHS Act prevents the Ministry from any obstruction to these incomers and at any event their advertising will be aimed at the public who seek speedier availability of such services. The best example currently observed may be the flood of instantly purchasable tests, x rays, scans, typified by the full page advertisements. The simple fact is that competing services are getting into position already. Unfortunately the "procedure" market for elective work appears particularly vulnerable as the NHS costs are higher due to low productivity and higher overheads. The overseas firms have very large capital funds available to whoever puts forward convincing business marketing plans. So far there is no indication that NHS hospitals built on PFI may expect any financial relief.

	There can be no doubt that the NHS will face increased competition not just from external companies but also from within the NHS as commissioners are required to put more and more services out for competitive tender. Chelsea and Westminster Hospital NHS FT is in a very fortunate position to be one of the highest performing NHS organisations in the country with a strong balance sheet and no Public Finance Initiative (PFI). The Trust has an excellent reputation for many of its services and will be a strong contender for services that are put out for tender. However, there is no time for complacency and the Board and the Executive are currently considering a number of responses to both increased competition but also wider changes in the health economy and the fiscal environment to ensure that the Trust remains competitive and provides the best possible care. We have also just appointed a new Head of Communications and a key new part of her role is to develop the Trust's marketing capability to ensure patients and commissioners know about our services. Furthermore, additional service development capacity and capability will be put in place to support divisions in developing new and innovative services as well as maintain a high level of efficiency. We are therefore confident that the Trust is in a strong position to weather stiffer competition and it is also worth noting that there remains a degree of uncertainty about the actual extent of this competition given continued political concerns in relation to EU competition law and potential risks to service continuity in cases where providers fail.
DECISION/ ACTION	To note.

Council of Governors Meeting, 23 May 2013

AGENDA ITEM NO.	2.6.4/May/13
PAPER	Governors' Questions
AUTHOR	Cathy Mooney, Director of Governance and Corporate Affairs Mark Gammage, Director of HR
LEAD	Tony Bell, Chief Executive
EXECUTIVE SUMMARY	The question raised by Susan Maxwell **What is the format of the whistleblowing structure which is in place at C&W?** Response: We have a Trust Raising Concerns (Whistleblowing) Policy in place which encourages openness. This details the avenues for raising concerns which include speaking to the manager, Human Resources or other internal or external bodies if staff feel unable to approach their line manager. We have systems and processes in place which allow individuals to raise issues including through staff side bodies – and we have a paid convenor at the Trust – and other external professional bodies. The fact that we have a well-attended JMTUC which meets monthly is an example of a good process which should allay fears that staff do not know how to raise issues. The policy states that concerns about patient safety should be addressed to the Director of Governance or Corporate Affairs or the HR Director. At any stage, staff may approach their union representative or independent NHS Whistleblowing Helpline on 0800 724 725. The policy is presently being reviewed in light of our recent experience with a whistleblower allegation where the policy was found to lack detail on the process once an allegation had been made; and in light of the Francis report. **What assurances do staff who are brave enough to come forward have that their jobs/promotion prospects are not in jeopardy?** Response: The Policy is developed on the basis of openness to assure patient safety and standards and states under employee responsibilities; "It does not matter if you are mistaken or if there is an innocent explanation for an individual's concern, you will not suffer any form of retribution, victimisation or lose your job as a result of raising a genuine concern under this policy." We also emphasise this openness and the protection on our Trust website: http://www.chelwest.nhs.uk/about-us/transparency/quality-safety/raising-concerns

	The Policy and practices also refers to the Public Interest Disclosure Act and staff rights under this. **What assurances can we governors have that whistleblowing incidents are not covered up?** Response: This is not specifically and explicitly covered in our current policy and is one of the amendments being made. There have been no whistleblowing allegations in the last 7 years to the Director of Governance and one was received in Jan 2013. The policy was found to be inadequate in terms of assurance. For this incident the Director of Governance has overseen the investigation, the report will then be approved by the Chief Nurse as a Board lead and also by a NED. . This is to ensure that it has been investigated thoroughly and recommendations are appropriate and will have high level scrutiny. In addition the NED will have a responsibility to ensure the whistleblower is protected from any consequences of the allegation. In the revised policy whistleblowing incidents will be reported to the Board as soon as they are received. **May we have sight of whistleblowing incident reports?** Response: As above there have been no whistleblowing allegations in the last 7 years to the Director of Governance (since the current post holder started) and no records of any previous incidents. One was received in Jan 2013 and the report is going through the assurance process as described.
DECISION/ ACTION	To note.

Council of Governors Meeting, 23 May 2013

AGENDA ITEM NO.	2.6.5/May/13
PAPER	Governors' Questions
AUTHOR	Tony Pritchard, Deputy Chief Nurse
LEAD	Tony Bell, Chief Executive
EXECUTIVE SUMMARY	The question raised by Anna Hodson-Pressinger: I would like to encourage the nursing staff of all levels to do their first year IN a hospital as a nurse helper as the Government are suggesting to encourage those choosing this as a career to be able to experience the hands-on-care that is needed in being a nurse. As this is first and foremost the important thing. As i.e. we went around on the Peat meeting now PLACE, assessment day and we witnessed the nurses not helping the servers at a suppertime service to help the patients accept their food and encourage them to eat it. This is apart from the volunteers who come especially for those who can't feed themselves. Nursing must be based in the care of day to day basics of personnel care, and as the lead hospital in this country we should be setting the example of the fundamentals of care nursing and giving those who are choosing this as a profession the first hand knowledge from the outset of what nursing is really about, showing them and giving them daily needs first hand for a year to find out whether they are really suited to the job and what is really important. Response: Francis recommendation 187 said: 'There should be a national entry-level requirement that student nurses spend a minimum period of time, at least three months, working on the direct care of patients under the supervision of a registered nurse. Such experience should include direct care of patients, ideally including the elderly, and involve hands-on physical care. Satisfactory completion of this direct care experience should be a pre-condition to continuation in nurse training.' We would welcome the recommendation that all students are exposed and have experience of working in a care environment prior to commencing their nurse training and this reflects our belief that the provision of kind and compassionate care must be central to our nursing roles. Through this approach, we can start to ensure that future student nurses are recruited not just for skills and academic ability but also for their values and behaviours that can be tested and measured within the clinical setting. More detailed consideration is required between trusts and Higher Education Institutions in relation to the implementation of this proposal,

	including how we would assess individuals values and behaviours reflective of care and compassion throughout this period.
DECISION/ ACTION	To note.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 23 May 2013

AGENDA ITEM NO.	2.6.6/May/13
PAPER	Governors' Questions
AUTHOR	Cynthia Conquest, Interim Deputy Director of Finance
LEAD	Tony Bell, Chief Executive
EXECUTIVE SUMMARY	The question raised by Martin Lewis: Do we have plans to charge health tourists, other than A&E? Response: The Trust already charge overseas patients for treatment they receive throughout the hospital except for treatment provided within A&E itself. It is legal requirement for the hospital to charge those patients in accordance with the *Overseas Visitors Hospital Charging Regulations*: The hospital is not allowed to charge patients for treatment they receive within the physical location of the A&E Department however if the patient is referred on elsewhere in the hospital for urgent treatment, or if the patient is moved outside A&E for urgent treatment e.g. ITU, another ward, maternity unit, then the patient would be billed for that treatment. The patient is treated as an NHS patient and will wait for treatment as an NHS patient in the relevant department throughout the hospital. The patient is billed for the care received generally in line with NHS prices and there is provision to recover administrative costs too from the patient. Overseas visitors will only be referred from A&E for urgently required treatment; any non-urgent treatment should not be referred. An overseas patient can choose to be treated as a private patient at any point and will then be subject to the usual private patient billing, prices and treatment access procedures. If anyone wants any further information about overseas visitors the following website is useful to access: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127054/GUIDANCE-October-2012-FINAL.pdf.pdf It should also be noted that since last October, once per month we supply a list to the UK Borders Agency of all overseas patients with unpaid bills and then patients are refused entry to the UK if they owe funds until the debt is cleared. We have had success with this scheme and have around 10 patients since the scheme started who have been refused entry and have got in touch to pay their bills in full.
DECISION/ ACTION	To note.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 23 May 2013

AGENDA ITEM NO.	2.6.7/May/13
PAPER	Governors' Questions
AUTHOR	Cynthia Conquest, Interim Deputy Director of Finance
LEAD	Tony Bell, Chief Executive
EXECUTIVE SUMMARY	The question raised by Prof Brian Gazzard: The governors understand that again this year there will be a 10% CIP, can we have reassurance of how during this process front line services will be protected and the quality of care maintained. Does the CIP apply to management services as well and if it does how is this being met? Response: For 13/14 the CIP target for the Trust is £16.9m which is approximately 5% of the trust turnover or around 8% of controllable spend (controllable spend is defined as where expenditure budgets are amended for exclusions such as drug budgets, MADEL funded Junior Doctor posts, CNST etc. where CIPs cannot be made). As always the CIP target is divided up across all clinical and non-clinical departments; with a minimum of 4% CIP of controllable spend allocated to all departments and up to a 15% target in some non-clinical areas; thus management services are included in the CIP requirement. Management CIP schemes are looking at a number of options, included the review of back-office functions to see what efficiencies can be made both within C&W and across the Fulham Road Collaboration; and developments in IT processes are also a key area for review within management executive areas. In order to ensure that the front line services are protected and the quality of care maintained, each relevant CIP scheme will have to complete a Quality Impact Assessment form (QIA). The QIA form has been developed by Therese Davis (Chief Nurse) and has been reviewed by the wider Exec team. This form will review the impact of CIPs on services & patients and will require sign off by Divisional Leads, the Chief Nurse and Medical Director, ensuring that all risks and impacts have been assessed and considered.
DECISION/ ACTION	To note.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 23 May 2013

AGENDA ITEM NO.	2.6.8/May/13
PAPER	Governors' Questions
AUTHOR	Cathy Mooney, Director of Governance and Corporate Affairs
LEAD	Tony Bell, Chief Executive
EXECUTIVE SUMMARY	The question raised by Alan Cleary: "Official documents refer to established Trusts missing out on the chance to develop their Governors to their full potential and [that they] may not be reaping all the benefits of Foundation Trust status as a result. Salisbury Foundation Trust took up the challenge as long ago as 2009 with their first summary for Governors of their funding, income and expenditure. Chelsea & Westminster Governors with a background in general management and relevant professions were encouraged by policy statements at Away Day last year, suggesting that background material would be provided them in readily-assimilable form essential to understanding the scale and ways by which the Trust proceeds in managing its administration, procurement, contracts, accommodation, land and buildings, funding, income, expenditure, personnel and provision of services. No such material has emerged yet. When might it be expected?" Response: It was felt at the agenda sub-committee that the release of public Board papers would go quite some way to the governors understanding more about the way the Trust was run. These will be made available in the governors' room, on the website and on request to Vida. The Board performance report has been revised and will help with clarifying performance issues. The finance paper is also being reviewed. The Board is happy to respond to further questions and provide further information to aid understanding as requested.
DECISION/ ACTION	To note.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 23 May 2013

AGENDA ITEM NO.	2.6.9/May/13
PAPER	Governors' Questions
AUTHOR	Dr Sarah Cox, Consultant Palliative Care
LEAD	Tony Bell, Chief Executive
EXECUTIVE SUMMARY	The question raised by Alan Cleary: "Can a brief explanation be given for Governors to reconcile the Trust's practice in relation to disclosure of patient data during end of life care, with the Health Secretary's policy to strengthen patient privacy on confidential data use?" Response: The Trusts practice in relation to disclosure of patient data around end of life care conforms to the same guidance and principles as at any other stage of life. There is an external end of life care database (coordinate my care) to which we upload patient sensitive information including end of life choices and wishes, but only after express consent to do so from the patient, or if they lack capacity, after a best interest decision in line with the Mental Capacity Act 2005.
DECISION/ ACTION	To note.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 23 May 2013

AGENDA ITEM NO.	2.6.10/May/13
PAPER	Governors' Questions
AUTHOR	Tony Bell, Chief Executive
LEAD	Tony Bell, Chief Executive
EXECUTIVE SUMMARY	The question raised by Alan Cleary: "A committee of MP's instructed that.....The DH should produce a succinct statement regarding how commissioning, performance management and regulation are defined, and how they (and the organisations responsible for them) relate to each other..... If the statement has been received, can a copy be provided, if not presumably the Trust has prepared one for management purposes which can be circulated instead?" Response: Briefing for staff attached.
DECISION/ ACTION	To note.

A quick guide to the new NHS

The new health and care system became fully operational from 1 April to deliver the ambitions set out in the Health and Social Care Act.

Locally, Clinical Commissioning Groups (CCGs)—made up of doctors, nurses and other professionals—will buy services for patients, while local councils formally began their new roles in promoting public health.

Health and Wellbeing Boards will bring together local organisations to work in partnership and Healthwatch will provide a powerful voice for patients and local communities.

- Reproduced from Gov.uk

1. The role of the Department of Health in the new system

The Department of Health's purpose is to help people live better for longer. We lead, shape and fund health and care in England, making sure people have the support, care and treatment they need, with the compassion, respect and dignity they deserve. The new and changing health and care organisations work together with the Department to achieve this common purpose.

We enable health and social care bodies to deliver services according to national priorities and work with other parts of government to achieve this. We set objectives and budgets and hold the system to account on behalf of the Secretary of State.

The Secretary of State for Health has ultimate responsibility for ensuring the whole system works together to meet the needs of patients and the public and reflect their experiences.

2. What the changes to the health and care system mean for patients and local communities

Most people won't notice any immediate difference to how they get the care they need: they will still contact their GP when unwell, or their local council with ongoing personal care needs, and they will continue to receive healthcare free at the point of need just as before. However, some important underlying changes are being made to how the health and care system is run.

These changes are about giving local communities and patients more say in the care they receive and doctors and nurses more freedom to shape services to meet people's needs, to improve the quality of the support, care and treatment we all receive.

For instance:

- greater direct control over planning and commissioning means that doctors, nurses and other health and care professionals can better shape what kind of support, care and treatment is available locally.
- more emphasis on preventing illness and helping people stay independent in older age or disability means we can improve everyone's long term health and wellbeing.
- more power devolved to local groups and organisations means that communities now have more influence than ever over how their local health services support them.
- opening up to a wider range of health care providers, including independent and charitable organisations, means that there will be more choice for patients and greater pressure on services to improve.

3. How health and care organisations will work together locally

- Clinical Commissioning Groups are made up of doctors, nurses and other professionals who use their knowledge of local health needs to plan and buy services for their local community from any service provider that meets NHS standards and costs—these could be NHS hospitals, social enterprises, voluntary organisations or private sector providers. This means better care for patients, designed with knowledge of local services and commissioned in response to their needs.
- Health and Wellbeing Boards in every area ensure that services work together to respond to communities' needs and priorities. They will involve people and community organisations, including elected representatives, in deciding what services the community needs—this will inform CCGs and local authorities when they commission services.
- Local Healthwatch, which are represented on Health and Wellbeing Boards, give patients and communities a voice in decisions that affect them. Local Healthwatch will report their views and concerns to Healthwatch England so that issues can also be raised at a national level.
- Local Authorities commission care and support services and have a new responsibility to protect and improve health and wellbeing. They use their knowledge of their communities to tackle challenges such as smoking, alcohol and drug misuse and obesity. Working together with health and care providers, community groups and other agencies, they prevent ill health by encouraging people to live healthier lives.

4. How health and care organisations will work together nationally

- NHS England supports NHS services nationally and ensures that money spent on NHS services provides the best possible care for patients. It funds local Clinical Commissioning Groups to commission services for their communities and ensures that they do this effectively. Some specialist services will continue to be commissioned by NHS England centrally where this is most efficient. Working with leading health specialists, NHS England brings together expertise to ensure national standards are consistently in place across the country. Throughout its work it promotes the NHS Constitution and the Constitution's values and commitments.

- Public Health England provides national leadership and expert services to support public health and works with local government, the NHS and other key partners to respond to health protection emergencies.

- The NHS Trust Development Authority supports NHS trusts to improve so they can take advantage of the benefits of foundation trust status when they are ready.

- Health Education England makes sure the healthcare workforce has the right skills and training to improve the care patients receive. It supports a network of Local Education and Training Boards that plan education and training of the workforce to meet local and national needs.

- The National Institute for Health and Care Excellence (NICE) provides guidance to help health and social care professionals deliver the best possible care for patients based on the best available evidence. NICE involves patients, carers and the public in the development of its guidance and other products.

- The National Institute for Health Research (NIHR) and its clinical research networks form a health research system in which the NHS supports outstanding individuals, working in world class facilities, conducting leading edge research focused on the needs of patients and the public.

- The Health and Social Care Information Centre supports the health and care system by collecting, analysing and publishing national data and statistical information and will deliver national IT systems and services to support health and care providers.

- NHS Blood and Transplant manages the safe supply of blood to the NHS as well as organ donation and transplants across the UK.

- The NHS Litigation Authority resolves fairly all claims made against its scheme members, helping the NHS to learn from them to improve patient safety.

- The NHS Business Services Authority carries out a range of support services to the NHS, patients and the public, including payments for community pharmacists filling prescriptions and dentists carrying out NHS treatment.

5. How the interests of people using health and care services are protected

As the new system brings more freedom for those who plan, commission and provide services, new and existing health and care regulators will safeguard the interests of patients and the wider public.

- The Care Quality Commission (CQC) measures whether services meet national standards of quality and safety, ensuring that people are treated with dignity and respect. Healthwatch England works as part of the CQC.

- Monitor protects and promotes the interests of people using health services by making sure that NHS services are effective and offer value for money. Licensing providers of health care will be one of the main tools Monitor will use to do this.

- The Health Research Authority works to protect and promote the interests of patients and the public in health research.

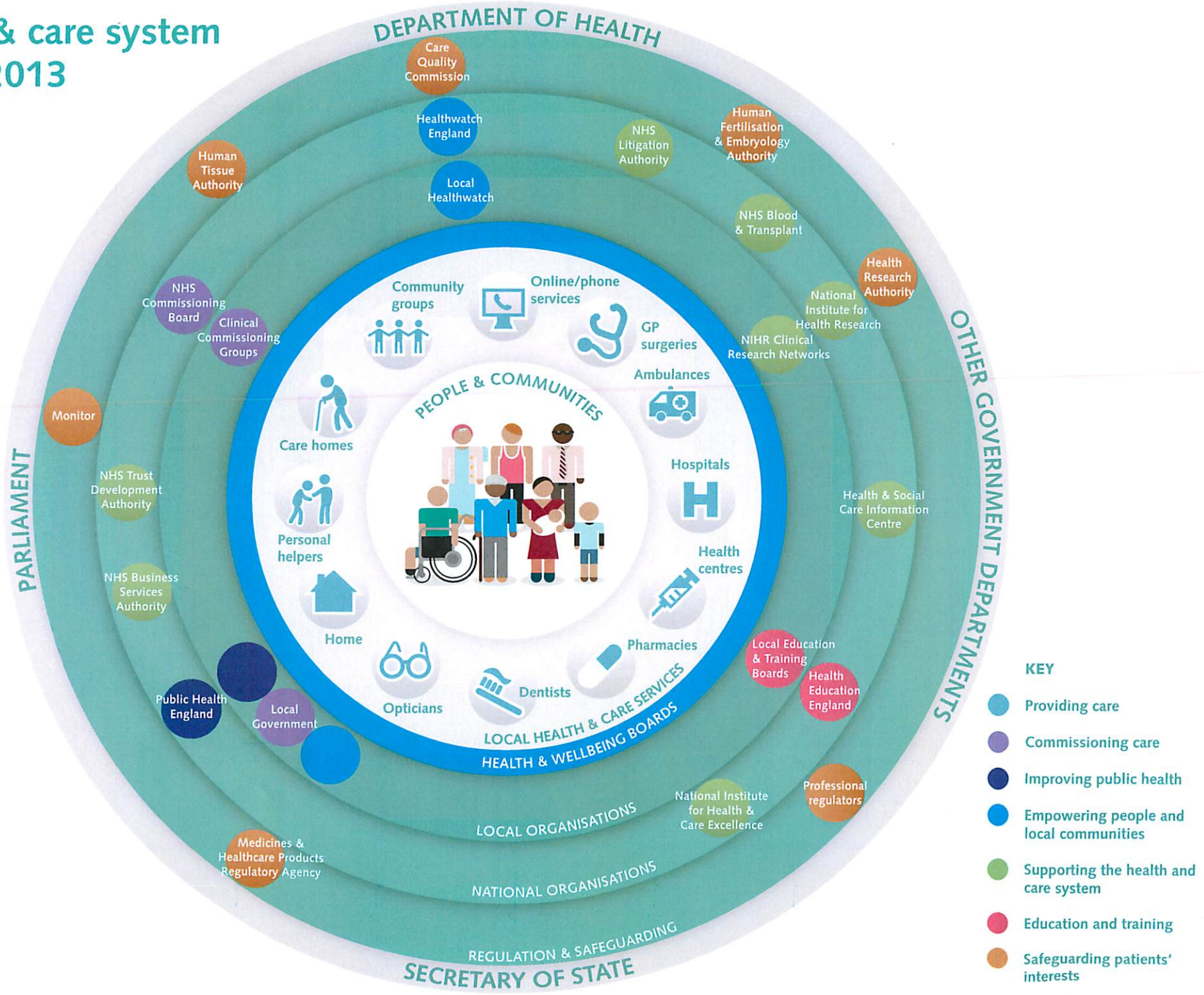
- The Medicines and Healthcare Products Regulatory Agency makes sure that medicines and medical devices work and are safe to use.

- The Human Tissue Authority regulates human tissue, such as donated organs, to ensure it is used safely and ethically, and with proper consent.

- The Human Fertilisation and Embryology Authority regulates fertility treatment and the use of embryos in research.

- Most health and social care professionals must be registered with one of the independent regulators, such as the General Medical Council, who help protect patients and public by ensuring that professional standards are met.

The health & care system from April 2013



Council of Governors Meeting, 23 May 2013

AGENDA ITEM NO.	2.6.11/May/13
PAPER	Governors' Questions
AUTHOR	Cathy Mooney, Director of Governance and Corporate Affairs
LEAD	Cathy Mooney, Director of Governance and Corporate Affairs
EXECUTIVE SUMMARY	The question raised by Alan Cleary: "A committee of MP's has recorded that .....While the NHS Litigation Authority has performed an important role in setting standards, its involvement in scrutiny of NHS bodies leads to burdensome duplication of time and effort for both Trusts and regulators.....How has this duplication been resolved or does it remain a continuing feature?" Response: The NHSLA is not undertaking any regular reviews this year in order to review its processes. There is no information yet on the nature of a revised assessment scheme but it is anticipated that it will take these concerns into account.
DECISION/ ACTION	To note.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 23 May 2012

AGENDA ITEM NO.	2.7/May/13
PAPER	Council of Governors Performance Evaluation Report – response to questionnaire
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper outlines the responses to a survey undertaken by the governors.
DECISION/ ACTION	The Council of Governors is asked to consider and identify actions to be taken forward.

Council of Governors Performance Evaluation Report
Response to Questionnaire

1.0 Introduction

This paper outlines the responses to a survey undertaken by the governors.

2.0 Background

Monitor published results of its national survey of NHS Foundation Trust governors in July 2011.

The governors agreed to use the relevant questions to undertake their review.

3.0 Proposal

To consider and identify actions to be taken forward.

4.0 Action/Decision

The Council of Governors is asked to consider and identify actions to be taken forward.

Introduction

Out of 27 governors, in total 16 questionnaires were completed either online or in hard copy.

Overall response rate was 59% (42%Monitor).

6%=1 governor	3 governors=19%	5 governors = 31%	7 governors = 44%	9 governors = 56%
12%=2 governors	4 governors=25%	6 governors = 37%	8 governors = 50%	10 governors= 62%

	About you					
No	**Question**	**Appointed**	**Patient**	**Public**	**Staff**	**% Overall Response**
1	**What type of governor are you?**	1	7	5	3	16
	%Chelsea and Westminster Governors	6	44	31	19	
	%Monitor results	16	11	55	18	42

		Less than 3 months	**3-6 months**	**6-12 months**	**12-24 months**	**Longer than 2 years**	**Since the Trust was authorised**
2	**How long have you been a governor?**		**3**			13	
	%Chelsea and Westminster Governors		19			81	
	%Monitor results	6	9	13	23	43	34
81% of governors have been in the post longer than 2 years (43% Monitor), with 19% in post between 3 to 6 months (9% Monitor).							

3	Question	Every or almost every meeting	At least one in two meetings	At least one in three meetings	At least one in four meetings	Less than one in four meetings,	Less than one in four meetings, but do attend	Never attend any meetings	Don't know	% Overall Response
	How many Council of governors meetings do you attend?	11	3	2						
	%Chelsea and Westminster Governors	69	19	12						
	%Monitor results	86	8							
69% of governors say they attend every, or almost every, meeting (86% Monitor) and 19% attend one in two meetings (8% Monitor)										

4	Please indicate the frequency of each of the following. Please tick one box for each statement.	Always	Most of the time	Sometimes	Never	No opinion/ Do not know	Not applicable
4.1	**Agenda and supporting documents are circulated in good time for each meeting.**	12	2	1	1		
	%Chelsea and Westminster Governors	75	12	6	6		
	%Monitor results	67	25	7	1		
4.2	**Minutes are circulated after every governors meeting**	12	4				
	% Chelsea and Westminster Governors	75	25				
	% Monitor results	78	10	3			
4.3	**Minutes of the meeting are circulated in good time for the next meeting**	11	5				
	%Chelsea and Westminster Governors	69	31				
	%Monitor results	67	25	7			
4.4	**Action points are followed up by the governors responsible**	4	7	2		3	
	%Chelsea and Westminster Governors	25	44	12		19	
	%Monitor results	50	36				
4.5	**The Chair follows up the action points for which he or she is responsible**	10	3	2		1	
	%Chelsea and Westminster Governors	62	19	12		6	

	%Monitor results	71	20	5			
4.6	**The attending executive board members follow up the action points for which they are responsible**	4	6	1		5	
	%Chelsea and Westminster Governors	25	37	6		31	
	%Monitor results	53	32	7			
4.7	**Governor meetings are productive**	3	8	2	2	1	
	%Chelsea and Westminster Governors	19	50	12	12	6	
	%Monitor results	39	39	19			

75% of governors say that agenda and supporting documents are always circulated in good time for each meeting (67% Monitor) and 12% most of the time (25% Monitor).

75%% say that minutes are always circulated after every governors meeting (78% Monitor) and 25% say most of the time (10% Monitor).

69% say minutes of the meeting are always circulated in good time for the next meeting (67% Monitor) and 31% most of the time (25% Monitor)

25% say action points are always followed up by the governors responsible (50% Monitor) and 44% most of the time (36% Monitor).

62% say the Chair always follows up the action points for which he or she is responsible (71% Monitor) and 19% say most of the time (20% Monitor).

25% say the attending executive board members always follow up the action points for which they are responsible (53% Monitor) and 37% most of the time (32% Monitor).

50% of governors say that governors meetings are productive most of the time (39% Monitor) and 19% say always (39% Monitor).

Comments received were as follows:

Q.4.7 – I feel that Council of Governor meetings would be a lot more productive if the chair moved proceedings along when governors go off on a tangent and take us away from the subject under discussion.

Sometimes the meeting does not keep to the agenda and people bring in irrelevant points.

Would be good to get the papers at least one week before the meetings in order to read them. They have been late in the post

Very well run and productive. Our hospital is at the top of its league for very good reasons.

A culture of complacency and concealment predominates in relation to essential information and decision of meeting. Governors' are side-lined – Economics at LSE Professor Spealling, March 2012.

	About your role as a governor							
5	**For each of the following statements, please tick to indicate the extent of which you agree or disagree:**	**Strongly agree**	**Tend to agree**	**Neither agree nor disagree**	**Tend to disagree**	**Strongly disagree**	**No opinion**	**Not applicable**
5.1	**Overall, I am clear about my roles and responsibilities as a governor**	6	7		2	1		
	%Chelsea and Westminster Governors	37	44		12	6		
	%Monitor results	40	48	7		1		
5.2	**I am clear about what the local healthcare priorities are for my Trust**	6	6	2	2			
	%Chelsea and Westminster Governors	37	37	12	12	6		
	%Monitor results	38	49	8	3			
5.3	**I am clear about what the priorities are for my Trust's patients/service users**	8	4	2	2			
	%Chelsea and Westminster Governors	50	25	12	12			
	%Monitor results	44	45	8	2	1		
5.4	**The governors at my Trust are good at communicating what the Trust is doing for the local community**	2	4	6	2	2		
	%Chelsea and Westminster Governors	37*		37	25*			
	%Monitor results	59*			12*			
5.5	**The governors at my Trust are good at communicating what the Trust is doing for patients services**	5	5	1	3		2	
	%Chelsea and Westminster Governors	62*		6	19*		12	
	%Monitor results	66*			10*			
5.6	**The governors at my Trust are good at communicating what the Trust is doing for the Trust membership**	5	4	2	3	2		
	%Chelsea and Westminster Governors	56*		12	31			
	%Monitor results	66*			10*			

5	For each of the following statements, please tick to indicate the extent of which you agree or disagree:	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	No opinion	Not applicable
5.7	I understand what it means to hold my Trust's executive board to account (to be replaced with NEDs in 2013)	8	4	1	1	2		
	%Chelsea and Westminster Governors	75*		6	19			
	%Monitor results	90*			40			
5.8	I feel I have the power as a governor to hold my Trust's executive board to account (to be replaced with NEDs in 2013)	6	3	1	2	2	2	
	%Chelsea and Westminster Governors	56*		6	24*		12	
	%Monitor results	70*			17*			

* strongly agree and tend to agree
* tend to disagree/strongly disagree

44% of governors tend to agree that they are clear about their roles and responsibilities as a governor (48% Monitor) and 37% strongly agree (40% Monitor).

37% of governors tend to agree they are clear about the local healthcare priorities for the Trust (49% Monitor) and 37% strongly agree (38% Monitor).

50% of governors strongly agree they are clear about the priorities for the Trust's patients/service users (44% Monitor) and 25% tend to agree (45% Monitor).

37% of governors strongly agree/tend to agree that the governors are good at communicating what the Trust is doing for the local community (59% Monitor). 37% say they neither agree nor disagree and 25 tend to disagree/strongly disagree (12% Monitor).

62% of the governors strongly agree/tend to agree that the governors are good at communicating what the Trust is doing for patient's services (66% Monitor). 19% say tend to disagree/strongly disagree (10% Monitor).

56% of governors strongly agree/tend to agree that the governors are good at communicating what the Trust is doing for the Trust membership (66% Monitor). 31% say tend to disagree/strongly disagree (10% Monitor).

75% of governors strongly agree/tend to agree that they understand what it means to hold the Trust's executive board to account (90% Monitor). 19% say tend to disagree/strongly disagree (40% Monitor).

56% of governors strongly agree/tend to agree they have the power as a governor to hold the Trust's executive board to account (70% Monitor). 24% say tend to disagree/strongly disagree (17% Monitor).

Comments received were as follows:

This will become easier when we start attending board meetings.
Questions 5.4, 5.5 and 5.6 need qualifying, in that I cannot speak for ALL the governors. There are those who could be called 'active' governors (whose work is geared to communication about Trust activities on behalf of patients, public and Members in particular), and those who only come to the quarterly meetings, and I don't know how active they are outside the Trust at communicating on behalf of the Trust.

The Board including NEDs is jointly and severally responsible as in all corporate organisations. Regardless of any subsequent interpretations by some jobsworths/ bureaucratic have an MBA and very experienced in large corporations.

	About how you work with your Trust					
		Very well informed	**Fairly well informed**	**Not very informed**	**Not at all informed**	**Don't know**
6	**Thinking about the information you need to perform your role as a foundation trust governor, how well informed do you think the Trust keeps you about its activities?**	6	7		1	**2**
	%Chelsea and Westminster Governors	81*			6	12
	%Monitor results	94*				

* very well informed and fairly well informed

81% of governors believe that the Trust keeps them very well or fairly well informed about its activities (94% Monitor).

Comments received were as follows:

It's getting better than it used to be.
As staff governor probably easier to keep informed.

We are among the top hospitals in the country, no ifs not buts, no maybes for good reasons of excellence. But still striving always to 'up our game' with humility.

		Very confident	Fairly confident	Not very confident	Not at all confident	Don't know
7	**Thinking about your Trust's strategy or forward planning, how confident would you feel in explaining this to a new governor?**	4	7	2	2	1
	%Chelsea and Westminster Governors	25	44	12	12	6
	%Monitor results	34	9	1		
44% say they feel fairly confident about explaining the Trust's strategy or forward plan to a new governor (9% Monitor) and 25% feel very confident (34%) whereas 12% do not feel confident (1% Monitor).						

	Check this	Very satisfied / Fairly satisfied	Neither satisfied nor dissatisfied	Fairly dissatisfied	Very dissatisfied	Don't know
8	**In your role as a governor, how satisfied or dissatisfied are you with the amount of contact you have with members of the Board of Directors?**	12 EDs 3 NEDs	2 5	1 5		1 3
	%Chelsea and Westminster Governors	75* EDs 19* NEDs	12 31	6 31		6 19
	%Monitor results	74* EDs 65* NEDs				
*Very satisfied and fairly satisfied 75% of governors feel very satisfied/fairly satisfied with the amount of contact with EDs (74% Monitor) and 19% are satisfied/fairly satisfied with the amount of contact with NEDs (65% Monitor).						

Comments received were as follows:
Difficult question to answer as membership of the board has changed since Heather and Amanda left and is still changing since Mike left.

I feel sure that the dissatisfaction concerning lack of contact with NEDs (or knowledge of their impact on the Trust) will change now that the Board meetings (or part thereof) will be open to the public. This, along with the proposed arrangement of NEDs joining governors on ward rounds, will hopefully give us governors a greater insight. I'm hoping contact will be mutually beneficial, since I'm sure that NEDs cannot have an altogether favourable opinion of the governors if the Council of Governors meetings are their only point of reference.

Don't know the non execs or what they do.
Only met NEDs at Annual Governors' Away Day and once met another NED at the Clinical Summit for first time.

9	Please indicate the extent to which you agree or disagree with each of the following statements:	Strongly agree	Tend to agree	Neither	Tend to disagree	Strongly disagree	No opinion
9.1	The Chair of my Trust keep me as a member of the governing body, informed about the activities of the executive board of my Trust	4	7	2		1	2
	%Chelsea and Westminster Governors	25	44	12		6	12
	%Monitor results	47	38		5		
9.2	I wouldn't hesitate to approach the Chair with a query or issue	10	5		1		
	%Chelsea and Westminster Governors	62	31		6		
	%Monitor results	74	16				
9.3	I wouldn't hesitate to approach any executive board member with a query or issue	9	4		2	1	
	%Chelsea and Westminster Governors	56	25		12	1	
	%Monitor results	59	26				
9.4	Overall, my Chair is doing a good job	10	4	1		1	
	%Chelsea and Westminster Governors	62	25	6		6	
	%Monitor results	68	21				
9.5	My executive Board is supportive of the Council of Governors and view it as an asset	2	7	4	2	1	
	%Chelsea and Westminster Governors	12	44	25	12	6	
	%Monitor results	43	33				

25% of governors strongly agree (47% Monitor) and 44% tend to agree (38% Monitor) with the statement 'The Chair of my Trust keep me as a member of the governing body, informed about the activities of the executive board of my Trust.' 12% neither agree nor disagree, 12% no opinion or do not know and 6% strongly disagree.

62% of governors strongly agree (74% Monitor) and 31% tend to agree (16% Monitor) with the statement 'I wouldn't hesitate to approach the Chair with a query or issue'.

56% of governors strongly agree (59% Monitor) and 25% tend to agree (26% Monitor) with the statement 'I wouldn't hesitate to approach any executive board member with a query or issue'.

62% of governors strongly agree (68% Monitor) and 25% tend to agree (21% Monitor) with the statement 'Overall, my Chair is doing a good job'.

44% tend to agree (33% Monitor) and 12% strongly agree (43% Monitor) with the statement 'My executive Board is supportive of the Council of Governors and view it as an asset'

Comments received were as follows:
I think the Board appreciates that the trust has to have a Board of Governors, but it is not always seen as, or indeed is, an asset.
Things are changing but I would say that until fairly recently one got the impression that the board regarded the governors as a necessary nuisance

9.4 … I feel that the chair gives far too much leeway. Whilst giving a certain amount of leeway is kind, where a governor waffles on (mostly off topic) I do not see it to be in the best interests of moving the meeting along. Eventful and successful as the careers of some governors may have been (and we hear about them ad nauseum), we are there to discuss the interests of the Chelsea and Westminster NHS Foundation Trust.

9.5 … While the Board may be supportive, I'm not convinced they view us as an asset.

The chair needs to be more challenging of governor's behaviour at meetings.
Some governors are very dismissive of others and are difficult to approach.

	Training and briefings			
		Yes	**No**	**Don't know**
10	**Thinking back to when you first became a foundation trust governor, were you given any training or briefings to enable you to do the role**	13	2	1
	%Chelsea and Westminster Governors	81	12	6
	%Monitor results	84	15	
81% say they were given training or briefings to enable them to do the role when they first became a FT governor (84% Monitor) and 12% say they have not (15% Monitor).				

		Yes	No	Don't know
11	**Since any initial training or briefing you may have had, have you been invited to any further training or briefings to help you develop in your role as governor?**	10	6	
	%Chelsea and Westminster Governors	62	37	
	%Monitor results	80	17	
62% say they have been invited to further training or briefings to help them develop in their role as governor (80% Monitor) and 37% say they have not (17% Monitor).				

		Very satisfied	Fairly satisfied	Neither	Fairly Dis.	Very Dis.	Don't know
12	**Thinking about all the training and/or briefings the Trust has provided, in general how satisfied are you with the quality?**	3	8	2	1	1	**1**
	%Chelsea and Westminster Governors	19	50	12	12		6
	%Monitor results	34	46		6		
50% of governors are fairly satisfied with all the training and/or briefings the Trust has provided (46% Monitor), 19% very satisfied (34% Monitor), 12 % neither satisfied not dissatisfied and 12% fairly dissatisfied (46% Monitor).							

Comments received were as follows:
Again this is a difficult question to answer. Since my induction I have not had any training directly provided by the Trust but I have learnt a lot by attending FTGA Development Days.
I have nothing to add to what I said in my Performance Evaluation Questionnaire last year, which was that I received a very good induction with lots of informative manuals. The Trust has always allowed me to attend any FTGA meetings in London, which are invaluable for information purposes. It's also very helpful to talk to other FT governors to hear how they tackle membership problems and to exchange ideas on engagement.

I'm looking forward to some formal training within the Trust in view of the increased powers of FT governors.

A guidance booklet would be useful on roles, areas of activities, how the hospital runs etc. If a mentoring process was established to match a new governor with an experienced one – that would be really useful.

As staff governor in touch with other governors.

		Yes	No	Don't Know
13	**If you felt you did need training to help you in your role as a governor, do you think you would be able to secure it from your Trust?**	15	1	
	%Chelsea and Westminster Governors	94	6	
	%Monitor results	81	4	
94% say they would be able to secure training from the Trust if they needed training (81% Monitor) and 6% say no (4% Monitor).				

Final Question

14	**Final question - is there anything else you would like to add?**
	I feel this questionnaire is so worded that it is difficult to provide meaningful and useful answers. Frank face-to-face discussions with small groups of governors would be much more useful. Such a large number of governors prevents useful discussion at meetings as some governors dominate discussions and it is important to identify what really are the key issues from a patient point of view. There should be a clear agenda item about feedback and patient complaints so the governors really understand what is happening on the ground. I think the Trust management has become less wary of the governors as they begin to appreciate that governors have put themselves forward to help the hospital. Governors perhaps need more guidance in how to help and when to stand aside. Since I am still in the early stages of being a Governor, I have only limited experience to apply to answering the above questions. The Chairman allows some governors to go 'on and on' at the Council of Governors meetings. More interaction with NEDs and governors. Questions to widespread to be useful. With 3,500 professionals at C&W ably governed and managed, we are and should be the arbiters and architects of our destiny (corporate) and 'captains of our ship'; for the common good and pubic benefit. We share superb values. Last year at a conference I attended a distinguished Professor of Economics said 'The non-medical side of the National Health Services is run on a culture of complacency and concealment with a well-developed propaganda machinery creating notable false impressions. The only route to saving it is through strong local authority management on the lines through which it originated'. Prior to 1974 I was privileged to work as a solicitor for Blackpool and Bournemouth Councils. Health Services were largely managed by local government officers alongside committed medical officers of Health. Standards were high with myself in a key enforcement role. That model should be nation-wide to achieve the best results.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 23 May 2013

AGENDA ITEM NO.	2.8/May/13
PAPER	Report on Senior Nurse/Governor Rounds
AUTHORS	Tony Pritchard. Deputy Chief Nurse
LEAD	Therese Davis, Chief Nurse and Director of Patient Experience and Flow
EXECUTIVE SUMMARY	Following a meeting with a number of Governors this paper sets out next steps for Senior/Nurse/Governor rounds.
DECISION / ACTION	For Information.

Re Senior Team Members, Non Executives and Governors Visits to Clinical Areas

Following an initial presentation and our discussion at the last Council of Governors meeting, I have since met with a number of Governors to discuss these visits in more detail, and how to take our plans forward.

1. **What is the purpose of the visits?**

These visits offer an opportunity for you to be linked to a defined ward or department in the Trust, and to visit this area regularly along with a nominated senior Nurse / Midwife and member of the trust management team.

Through these visits, you will be able to meet with patients and families to discuss their experience with them, become acquainted with the day to day work of the area and also meet with the staff work in this ward or department.

Senior Nurses / Midwives have now started these visits in their nominated clinical areas and are linked with senior managers. Feedback from patients, families and staff ab0ut these rounds has been very positive

These visits are in addition to our twice monthly Wednesday CQC rounds, in which the senior nursing and midwifery team assess our essential standards of quality and safety. Governors are always welcome to join us for these as well.

2. **How do the visits work?**

As a Governor, you are invited to link with a ward or department in the hospital (see enclosed list of areas)

The nominated Nurse / Midwife for this area will conduct a visit each week. They will liaise with the senior manager and Governor linked with this clinical area to plan the dates and times of these visits.

The visits are for around 1.5 hours during which you can meet staff, patients and families in your chosen clinical area.

It is unlikely that the nurse / midwife, the senior manager and Governor will all visit together on every occasion.

If more than one Governor is interested in linking to the same area, this is not a problem.

Conducting the visit with a senior nurse / midwife is helpful as they will be able to introduce you to staff in the area and support you in these visits.

3. **What happens next?**

If you are interested in linking with one of our wards and departments, and joining these visits, please identify the area that you are interested in and let me know by Friday April 12th

The Nurse / Midwife linked to your chosen area will then contact you to plan dates and times for these visits.

We will need to complete a CRB check which is a standard requirement for all our staff and volunteers and you will also require a name badge and identify pass

We will provide you with some key do's and don'ts relating to infection control, safety and confidentiality, and the nurse / midwife that you are linked with will discuss these with you prior to your visit.

Tony Pritchard

Deputy Chief Nurse

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Guidance for Governors Visits to Clinical Areas

We welcome you to the wards and departments of the hospital. The following provides some guidance for Governors when undertaking visits to clinical areas. If you have any questions or need more information, please feel free to discuss this with the senior nurse / midwife that you are linked with.

ON ENTERING /LEAVING THE UNIT OR WARD

- Wear a visible name badge and trust security badge
- Follow our 'bare below the elbows' policy when visiting clinical areas. Jackets should be removed, sleeves rolled above the elbow and any wrist watch removed
- Gel your hands when entering and leaving the ward or department, and between individual patients
- Introduce yourself and explain your role to the nurse in charge of the unit/ward
- Seek advice from staff about any patients in the area that may not be appropriate to meet with

WHILE ON THE WARD

- Introduce yourself and explain your role to patients and families
- Maintain patient's confidentiality at all times
- Respect and maintain patient's privacy and dignity at all times – knock before entering single rooms and respect privacy when curtains are drawn around cubicles / beds, and seek the patient's agreement to any discussion.
- Be sensitive to any emergency situations that arise during your visit and the need of staff to deal with this, and the possible need to leave the area.
- Discuss experience with patients and families and raise any issues or concern with the staff in the area
- Provide any feedback on your visit to the staff working in the area

PLEASE NOTE

Please refrain from

- Visiting clinical areas by yourself without making yourself known to the nurse in charge
- Visiting an area if you are ill yourself (such as a cough, cold, diarrhoea or vomiting)
- Providing direct assistance to patients such as repositioning, mobilising or feeding
- Accessing patients clinical care records
- Entering rooms where patients are isolated for infection unless discussed with staff first
- Offering advice to patients about their clinical treatment
- Disclosing confidential information to others

Thank you for taking the time in visiting the wards / departments of Chelsea and Westminster Hospital.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 23 May 2013

AGENDA ITEM NO.	2.10/May/13
PAPER	Council of Governors Funding Report
AUTHOR	Vida Djelic, Foundation Trust Secretary Paul Morris, Lead Nurse, Mental Health
LEAD	Vida Djelic, Foundation Trust Secretary Paul Morris, Lead Nurse, Mental Health, Part A
EXECUTIVE SUMMARY	This paper provides an update on the Council of Governors budget for the FY 2012/13 and 2013/14. A funding request is enclosed in part A
DECISION/ ACTION	The Council of Governors is asked to note the report and approve the request for funding.

Council of Governors Funding Report

1.0 Background

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

2.0 Funding Overview for 2012/13 and 2013/14

Of the £80k circa £73k has been committed to the activities listed in the table below which were approved by the Council of Governors.

Of the £80k circa £55k has been committed to the activities listed in the table below which were approved by the Council of Governors. It leaves circa £25k available for the reminder of the year 2013/14.

3.0 Use of funds FY 12/13 and FY 13/14

TABLE 1

Date Presented	Projects	Amount Committed	Decision	Spent to date
June 2010 and recurring	Quality Awards	£2,000	Agreed 2012/13 FY	£1,000
December 2011	Open Day 2012	£15,000	Agreed 2012/13 FY	£12,904.22
December 2011	Engagement Activity - Membership mailing (Jan 2013)	£10,000	Agreed 2012/13 FY	
December 2011	Engagement Activity - 12 Members' News monthly emails (April 2012-March 2013)	£2,520	Agreed 2012/13 FY	£1,080
December 2011	Engagement Activity - Annual Members' Meeting + 2 associated events (Sept 2012)	£5,000	Agreed 2012/13 FY	
December 2011	Engagement Activity - 5 'Medicine for Members' events	£5,000	Agreed 2012/13 FY	£283
December 2011	Engagement Activity - Christmas event (Dec 2012)	£5,000	Agreed 2012/13 FY	
February 2012	Small Membership branded gifts for the Open Day May and Annual Members' Meeting September 2012	£1,500	Agreed 2012/13 FY	£1,873.55
February 2012	Members Recruitment Campaign for Open Day May 2012	£2,340	Agreed 2012/13 FY	£2,500
May 2012	Open Day 2012 advertising via letterbox drop and in the local press	£4,793	Agreed 2012/13 FY	£4,093
May 2012	Giggle Doctors	£4,600	Declined	-
July 2012	Membership recruitment session September – additional funding	£1,260	Agreed 2012/13 FY	
July 2012	Open Day 2013	£20,000	Agreed 2013/14 FY	
December 2012 February 2013	Free-standing banner in Information Zone Additional funding for a free-standing banner in Information Zone	£250 £28	Agreed 2012/13 FY Agreed 2012/13 FY	 £278

February 2013	Membership branded gifts for the Open Day May 2013 recruitment	£3,455.74	Agreed 2012/13 FY	
February 2013	Free-standing banner to promote membership			£273
February 2013	Members Recruitment Campaign for Open Day May 2013 and elections	£2,340	Agreed 2013/14 FY	
February 2013	Members Recruitment Campaign and promotion of the Annual Members Meeting (within the hospital)	£1,170	Agreed 2013/14 FY	
February 2013	Members Recruitment Campaign and promotion of Governor Elections (incl. within the community)	£1,170	Agreed 2013/14 FY	
February 2013	3 membership mailings per year	£10,000	Agreed 2013/14 FY	
February 2013	Annual Members' Meeting	£5,000	Agreed 2013/14 FY	
February 2013	Medicine for Members seminars	£5,000	Agreed 2013/14 FY	
February 2013	Christmas at Chelsea and Westminster	£8,000	Agreed 2013/14 FY	
February 2013	Members' e-News	£2,600	Agreed 2013/14 FY	
April 2013 (via email)	Information resource booklet for patients, users of Trust services, governors and staff	£3,500	Agreed 2012/13 FY	
April 2013 (via email)	Intranet/internet resource for staff, governors and users of the Trust's services regarding the CQC standards	£11,000	Agreed 2012/13 FY	
	TOTAL 2012/13 FY	**72,636.74**		**£21,861.82**
	TOTAL 2013/14 FY	**55,280.00**		

4.0 Progress report re projects for FY 2012/13

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

4.2 For an update on projects re the Members Recruitment Campaign see membership report paper 2.16.

4.3 Quality Awards – this was presented to the Council of Governors in February 2013.

Part A

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Proposal to purchase MyLife Reminiscence Systems

Description of system

- MyLife reminiscence Software is a touch screen technology that enhances the life of those with Dementia. This is achieved through Digital Reminiscence and Life Story work and engages the individual and stimulates them, so as to help in reducing agitation.

- The simple and easy to use programs work with touch-screen technology. The software comprises of several simple, engaging games and thousands of digital media content items, drawing upon carefully selected photographs, T.V. shows, music and film clips from the 1930′s onwards. All of this has been specifically chosen for people with cognitive impairment, encouraging them to reminisce and share their memories.

- Digital Reminiscence Therapy is a form of cognitive stimulation therapy that has been proven to help with cognitive decline.

- It has been shown through research that it can help carers and family member s communicate more effectively when often communication is difficult.

- It is widely acknowledged that engaging with individuals with cognitive impairment in a constructive manner helps to reduce incidents and also the use of tranquilisers.

- The system also has the ability to construct patients story books about their life and relatives and carers can upload photos and any other documents or media to personalise for that particular patient. It can also be used to obtain carer and patient feedback that would help improve services.

I would envisage it being used primarily on Edgar Horne ward which is currently being adapted and refurbished to make it Dementia-friendly. As part of the changes to the core function of Edgar Horne Ward we are looking at having activity coordinators who would use the MyLife systems to engage with Patients and their carer's.

Costs

Below is a breakdown of the costs as provided by the manufacturer and I would initially like to purchase 2 units and 2 trollies that would enable patients who are bed bound to participate in the activities.

The cost of 2 units plus 2 trollies is £5,370 (+VAT)

Number of Units	Software	Hardware	Digital Life Story Book, Skype, email and text messaging	Annual Software Support	Web ex training	Cost per unit
2	£1,300.00	£750.00	£50.00	£400.00	F.O.C.	£2,500.00
4	£1,300.00	£650.00	£50.00	£400.00	F.O.C	£2,400.00
6	£1,200.00	£650.00	£50.00	£400.00	F.O.C	£2,300.00

Action

The Council of Governors is kindly asked to approve the funding request of £5,370 exc. VAT.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 23 May 2013

AGENDA ITEM NO.	2.11/May/13
PAPER	The tenth FTGA National Development Day 14 March 2013 – feedback
AUTHOR	Alan Cleary – Patient Governor Susan Maxwell - Patient Governor
LEAD	Alan Cleary – Patient Governor Susan Maxwell, Patient Governor
EXECUTIVE SUMMARY	This paper provides feedback from the tenth FTGA National Development Day held on 14 March 2013
DECISION/ ACTION	The Council is asked to note the paper.

FGTA Development Day

The FGTA Development Day on 14th March was held at a convenient venue in comfortable surroundings and received a well-balanced keynote address from Robert Francis QC speaking to his Report. His slides were promised to be included on the Association website. He was not pressed on the issue of absence of any prosecutions and terms of imprisonment for the worst of the miscreants. Inevitably as a former prosecutor I could not resist contrasting this with the fate that same day of the individual who had foolishly fiddled his driving records. In a separate conversation Mr Francis agreed that discrete, localised machinery for medical and social care services represent the best prospect for long term success, closely linked and delivered through a high-achieving local authority responsible for enforcing and auditing clear standards.

In the time available it was not possible to range over the more detailed factual background for which I commend the attached article of 22nd February 2013 from the popular press which was appreciated by those Association delegates to whom I passed copies.

Of the choice of four so-called breakout sessions I chose the last. It was chaired competently by Richard Lindley formerly of ITN and BBC news with Mike Fowkes Mid-Staffs Lead Governor as the principal contributor. I learned there that several Trusts have adopted the practice of Governors – only unannounced visits to wards and outpatient facilities. All find it reassuring and (after some initial misgivings) wholly satisfactory as a quality control feature. At least one Trust has established a Governors – only Committee which receives reports of all such visits with a depersonalised summary then going to the Board. Of course our own Trust could have featured as the positive pioneer in this if we had debated and developed (rather than casually rejected out of hand) Captain Coolen's similar suggestion here three years ago.

Apart from these useful features and the pleasure of meeting compatriots from The North the rest of the day was something of a timewaster for me. The abler board members (and there are several) remained quiet except during coffee breaks. The standard of chairmanship was less than exemplary. Many of the questions clearly had not been thought through in advance and little attention given to the value of likely answers to them.

I had hoped that the pressure of current issues might have stimulated a more professional approach but clearly this is something still awaited for the future.

At the AGM, accounts lacked essential features, approval was sought to authorise detail of material which had long been published already and procedures were irregular.

I would question whether continued membership of the Association represents sound value for our Trust. I believe it is really part of an overall system of unsatisfactory administration which is creaking ominously.

Alan Cleary
Patient Governor

RETURN TO THE KILLING FIELDS

A chronicle of deaths foretold

SIR DAVID NICHOLSON, the NHS chief executive who refuses to resign, once joked that Andrew Lansley's disastrous NHS reforms were "so big, you can see them from space". On that basis, the Mid Staffs scandal is so rotten you can *smell* it from space.

When the Bristol heart scandal whistleblower Dr Steve Bolsin was asked in 1998 how to avoid future disasters in the NHS, he said simply: "Never lose sight of the patient." Thirty-five babies died in Bristol due to substandard care over a four-year period, and the unit was dubbed "The Killing Fields" by staff (as revealed in *Eye* 793). A decade and a half later, Robert Francis QC has found that 1,197 people died at Mid Staffordshire hospital between 1996 and 2008, 492 of those deaths happening between 2005 and 2008. How could the NHS, with record funding, published death rates and armies of regulators lose sight of so many patients, some of whom died in appalling conditions? And who is responsible? Francis provided detailed answers to the first question and completely ducked the second.

In avoiding any direct criticism of named policies, politicians or senior NHS managers who oversaw this lengthy disaster, Francis has put another nail in the coffin of accountability in the NHS. The fact that no one in the Department of Health saw the need to accept responsibility and resign over Mid Staffs shows a staggering lack of insight.

Most hospital chief executives the *Eye* has spoken to think Nicholson should resign; but all are too frightened or simply "not allowed" to say so publicly, such is the culture of fear in the NHS. There are plenty of brilliant managers who would do a far better job than Nicholson, but they won't get a chance. Nicholson, remember, was the interim chief executive of the health authority overseeing Stafford Hospital in August 2005 and, later that year, sat on the panel that appointed the cost-cutting chief executive Martin Yeates. Nicholson then strolled into his next job as chief executive of the NHS Commissioning Board unopposed.

GOING NOWHERE: Sir David Nicholson (below), the NHS boss who refuses to budge; and Robert Francis (right), the inquiry chairman whose report found... no one to blame

The sense of relief among politicians on both sides at the "no one at the top to blame" line was palpable. David Cameron dished out platitudes and called on the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) to strike off incompetent or callous frontline staff – but any competent regulator would have done so already. Health secretary Jeremy Hunt says he wants police to investigate the hospital; but the NHS generals whom both Labour and the coalition have shared, are sitting pretty. What smells like corporate manslaughter gets washed away, as far from Whitehall as possible.

Ignoring Francis already

Francis was commendably insistent that the legally-enforced gagging of whistleblowers must end (see *Shoot the Messenger*, *Eye* 1292) – a practice Commons health select committee chairman Stephen Dorrell accepts is "corrupt". But the NHS is at it again.

On 14 February Gary Walker, the former CEO of United Lincolnshire hospital (one of 14 trusts being belatedly investigated for persistently high death rates), bravely broke his gag to tell Radio 4's *Today* programme how he had been bullied, sacked and silenced for saying how targets for non-emergency patients were endangering emergency admissions.

His story implicates both Nicholson (to whom Walker had written, warning him of the dangers) and his managing director of commissioning, Barbara Hakin OBE, who was CEO of East Midlands SHA. The BBC put the allegations to the Department of Health, and within hours a letter from the trust's lawyers threatened Walker with the loss of all his pay-off if he didn't shut up.

Last June the *Eye* referred Dr Hakin to the GMC for failing to protect either Walker or his patients, and the GMC is investigating at the customary speed of a glacier. Dorrell, as select committee chair, told *Today*'s John Humphrys that he had been "in correspondence" with Walker for two years. Walker claims Dorrell never replied to his letter and *must* now be called in front of the committee to hear his evidence against Hakin and Nicholson. The committee must also ascertain if anyone at the DoH tipped off the trust or its lawyers, Beachcroft, who issued the sinister and threatening letter to Walker.

Knighthood for a whitewash?

One wonders what version of his report Robert Francis was reading at the press conference on 6 February. He looked like a man held hostage. The interminable delay in publication to allow for rewrites had reportedly been because those he was minded to criticise had launched vigorous legal defences. In the end he opted for a ridiculous "no scapegoats, blame the system" approach. This was endlessly debated after the Bristol Inquiry report in 2001, when a culture of "fair blame" was proposed. Ill thought-out, untested, rushed and brutally-enforced reforms undoubtedly contribute to NHS disasters, but individuals also have to be held accountable for their actions. Patients and staff trust a system that is just. But the judge delivered no justice.

Had Francis had the time to wade through the Bristol Inquiry evidence, he would have found where to place overall responsibility. On 9 February 2000, Rohan Pirani, lead counsel for the Department of Health, delivered an unequivocally clear statement of accountability: *"If I may move on, sir, to the area of responsibility and accountability, and make it absolutely clear again that the Department of Health accepts that it is responsible and is accountable for any failings of the systems that were in place during the period covered by the Inquiry. Ultimate responsibility rests with the Department of Health and the secretary of state."*

On 1 April this year, the Health and Social Care Act will destroy whatever lines of accountability exist in the NHS. The secretary of state will be off the hook completely; the NHS Commissioning Board becomes a bank with no responsibility for the delivery of healthcare; and no one knows what the Department of Health will do. Foundation trusts will have even more independence and power to bury bad news, while clinical commissioning groups and regulators are unlikely to have the clout to uncover it. The patient voice, in the form of "Healthwatch", will be as weak as ever. The Francis Inquiry was a final chance to make the NHS accountable to patients and it has failed.

Lest we forget

If you only have time to read one Francis report, make it his first independent inquiry, published in February 2010. The stories behind the harm are staggering. An old man forced to stay on a commode for 55 minutes wearing only a pyjama top; a woman whose legs were "red raw" because of the effect of her uncleaned faeces; piles of soiled sheets and vomit bowls left at the end of beds, a woman arrived at 10am to find her 96-year-old mother-in-law "completely naked... and covered with faeces... It was in her hair, her nails, her hands and on all the cot sides... it was literally everywhere and it was dried." Another woman who found her mother with faeces under her nails asked for them to be cut, but was told that it was "not in the nurses' remit to cut patients' nails".

The care was so bad that as many as 1,200 people died unnecessarily, often in appalling conditions. The poor care was known about for years and flagged up by successive mortality data alerts. The problem was that no one acted on the data or listened to the patients and relatives. And whistleblowers

were threatened and silenced. Whoever oversaw such a climate of fear in the NHS has to go.

Nicholson refuses to budge

David Nicholson has been chief executive of the NHS since 2006, and of the strategic health authority that sheltered Mid Staffs beforehand. Having sat on the appointment panel that decided Martin Yeates would be a good CEO, his fingerprints are all over Mid Staffs. But despite being the accountable officer for the NHS, Francis decided he wasn't accountable.

Nicholson's statement to the most recent public inquiry said: "The point at which I became aware of the severity of the Healthcare Commission's concerns about patient care at [Mid Staffs] was shortly after Sir Ian Kennedy met with Alan Johnson [*former Labour health secretary*] on 4 February 2009." And yet Francis heard evidence that in May 2008, representatives from the Healthcare Commission, including Sir Ian Kennedy, had met Nicholson and described "an overwhelming response from local people on the questions of quality of care" at Mid Staffs, particularly from Cure the NHS. Nicholson cautioned them that they should "remain alive to something which was simply lobbying... as opposed to widespread concern." Nicholson does not recall saying this.

He told the inquiry: "The board of Mid Staffordshire failed in its statutory duties to provide good quality care and managing within the resources provided. That no other hospital failed so profoundly and persistently in this period, serves to emphasise the singular rather than the systemic nature of this case." The inquiry counsel's closing submission said: "There are highly likely to be other examples within the health service of poor management, poor governance and poor care and it is the system's duty to uncover them. This approach is supported by the many letters which the inquiry has received from all over the UK about failures of care in other trusts... with respect to him [Nicholson], this seems to us to be a very dangerous attitude to take."

The fact that 14 other hospitals that have had high death rates for years but are only now being investigated shows how much bigger the problem is than Mid Staffs. The DoH has belatedly realised that avoidable death is a bad thing.

Nicholson accepted in his evidence that the NHS had been too focused on finance: *"Quality was not the organising principle of the NHS, it wasn't the thing that was driving us during that period."* Had the Department of Health and Labour government noted the recommendations of the Bristol Inquiry, it certainly would have been.

From Bristol to Mid Staffs and back

Bristol and Mid Staffs have similarities, in that the problems dated back a decade before any action was taken to protect patients, despite many levels of the NHS being aware of the poor care and high death rates, or at least having access to a sea of data that pointed to a serious problem, if only they'd been bothered to look.

In both, the scandals would have remained buried had it not been for a highly organised, determined and ethical group of relatives who simply would not go away until they got a public inquiry. As with Bristol, the biggest danger to patients in the NHS would be to dismiss it as an isolated incident in one hospital. Appalling care still occurs in pockets across the NHS, but in the absence of effective regulators, it usually only comes to light if patients, relatives or whistleblowers make an extraordinary effort to expose it.

In Bristol, whistleblower Steve Bolsin was prepared to sacrifice his career by taking his concerns outside the hospital when its managers refused to act. Despite legislation designed to protect whistleblowers following Bristol, such action remains a career death wish in the NHS. The few staff who tried to blow the whistle on Mid Staffs were bullied, threatened and in one case suspended, in an attempt to keep the scandal "in house".

That attempt was futile because the appalling care was so obvious to patients and relatives. In Bristol, no one doubted that the surgeons were trying their best, but their best was simply not good enough and they lacked the insight to stop when there was clear evidence that too many babies were dying.

At Mid Staffs, some staff still managed to deliver compassionate care in the most stressful circumstances; many became terse and uncaring when their working conditions were terrible; and a few simply shouldn't have been working in the NHS. Unnecessary deaths did not just occur in a war zone emergency department or because of callous neglect of the elderly, but across all age ranges and in many specialties, including surgery, some of which was "grossly negligent", according to the Royal College of Surgeons.

Mid Staffs is currently one of many bust trusts, struggling on government handouts and shutting its emergency department overnight to save money and lives. It was always too small to be viable as a foundation trust; and the disastrous decision to push it down that route contributed to staff cut-backs that made the hospital so dangerous, and bred a culture of denial, demotivation and desensitisation. Twenty-one years after the *Eye* broke the story of the Bristol scandal, child heart surgery still hasn't been safely reorganised into fewer, better resourced units. Bristol is in trouble again, with further allegations of avoidable deaths, harm and understaffing in its child heart surgery unit.

Asleep at the wheel or wilfully blind?

After the Bristol Inquiry, campaigners tried to pursue a charge of corporate manslaughter against the NHS, a charge that requires "a controlling mind" being wilfully blind to the suffering, rather than just asleep at the wheel. The politicians were clearly asleep – none more so than Andy Burnham (pictured above), Labour health secretary from June 2009 and now a shadow of his former self. But in June 2007, as minister of state for delivery and reform at the Department of Health, he announced: *"I am delighted that Mid Staffordshire general hospitals NHS trust has now reached a high enough standard to be considered as an NHS foundation trust... I would like to congratulate all of the staff of the trust on this achievement."*

This statement was about as inaccurate, falsely reassuring and incompetent as it's possible to be. Francis found that Burnham's

"Which way up do you want it?"

understanding of how the system for gauging NHS trusts' suitability for foundation status operated "differed from the reality". His "belief that it identified trusts which were 'high performing' was at odds with the fact that there was little, if any, focus on an assessment of an applicant's current ability to deliver services compliant with standards."

Burnham backed Mid Staffs' application for foundation status in 2007 after seeing a four-line summary from his civil servants. But the high death rates (127) at Mid Staffs for that year were openly published online and in the *Daily Telegraph*. The DoH and Burnham claim they were completely unaware of them. Unbelievable.

The importance of death

In 2001, the Kennedy Inquiry into Bristol had made 198 recommendations about safe and humane healthcare that could have been cut and pasted into the Francis report, leaving him just another 92 to come up with. Sir Ian observed: "There was no systematic mechanism for monitoring the clinical performance of healthcare professionals or of hospitals." And until there was, there was no chance of identifying, or acting quickly on, other disasters in the NHS.

Death is only one measure of the quality of healthcare, but it's a crucially important one. It's relatively easy to spot, one-off, irreversible and – when avoidable – it's the biggest harm the NHS can do to you. It also must be registered by law, so it's harder to hide in the chaos of inaccurate, incomplete and "missing" handwritten NHS records.

It was a comparison of death rates in different units that revealed the Bristol heart scandal; but it was only when *Private Eye* published them in 1992 that action started to be taken. When the unit was finally staffed properly in 1995 with careful monitoring of results, the death rates came tumbling down from 29 percent to 4 percent in two years.

A key lesson from Bristol was that a vital step to a safe NHS was accurate, publicly available comparative data on death across the service, combined with a duty to investigate higher-than-expected death rates quickly and thoroughly. This message was later reinforced by the Shipman Inquiry in 2002, where a single GP managed to disguise hundreds of deaths over many years. Dame Janet Smith, who chaired the inquiry, recommended death rates be accurately monitored across the NHS and any statistical outliers swiftly investigated.

In hospitals, at least, Standardised Mortality Ratios (HSMRs) have been measured since the mid-1990s, and published annually by Dr Foster since 2001, in collaboration with Professor Brian Jarman and Paul Aylin at Imperial College. A score above 100 is higher than expected. The 1998-99 HSMR for Mid Staffs was 108. The HSMRs from 2001-02 to 2007-08 were all significantly high. These figures were in the public domain, available to all who cared to look. The Department of Health and successive Labour health secretaries (Alan Milburn; John Reid; Patricia Hewitt; Alan Johnson; and Burnham) should have been monitoring and discussing them with their NHS chief executives (until September 2006 Sir Nigel Crisp; then Nicholson).

High death rates are common in the NHS, and can be caused by a hospital having sicker patients, "miscoding" their diseases or providing poor quality care. A high HSMR is a warning sign that has to be investigated to find the root causes. There

are plenty of good examples of hospitals responding to high death rates and staff concerns, and improving care as a result. So what happened in Mid Staffs?

Fix the data, not the problem

In April 2007, Mid Staffs' HSMR was 127 – one of the highest in the country. The Labour government, the DoH, the strategic health authority, primary care trusts and health regulators should all have known this. In addition, a series of more specific mortality alerts — indications that patients may be exposed to greater than expected risk — were issued to Mid Staffs.

On 3 July 2007, the Dr Foster Unit at Imperial College sent Martin Yeates, the Mid Staffs boss, a mortality alert for operations on the jejunum (small bowel). Over the next four months the unit issued three further mortality alerts concerning aortic, peripheral, and visceral artery aneurysms; peritonitis and intestinal abscess; and other circulatory disease. Copies of three of these mortality alerts went to the Healthcare Commission (now the Care Quality Commission).

Chris Turner, who worked in the emergency department at Stafford Hospital in October 2007, described it to the public inquiry as "an absolute disaster". Staff were threatened almost daily that they would lose their jobs if they did not get patients through the department within the four-hour target, he claimed. The result was "significant numbers of patients in distress and, as a department, we were immune to the sound of pain". On 5 December 2007 a meeting was held between Monitor and Mid Staffs for its application for foundation trust status. Monitor was told: "Our HSMR is currently 101: we do not have a problem with mortality."

So how did Mid Staffs manage to fix its figures without fixing the problem of appalling care? The 101 figure turned out to be a screenshot of the only point in time when Mid Staffs death rate approached 100.

Dr Phillip Coates, the trust's clinical governance lead, told the inquiry that the party line was that there was a "coding problem" and also a "problem with the Dr Foster/Jarman methodology". "Instead of acknowledging that patients may have been dying unnecessarily and trying to identify what we should do about it, our reaction was that we needed to find some way to get the figure lower and we started taking the view that it came down to a coding problem."

In March 2007, the Department of Health under Nicholson had relaxed the rules on palliative care coding, meaning any patient who had an "incurable illness" could be given the palliative care code, rather than those genuinely at the end of life under a palliative care consultant. This had enabled a private coding company, CHKS, to go to Medway hospital in Kent and work wonders overnight by coding many patients as "expected to die" and therefore on the palliative care route.

Brian Jarman has shown that exactly the same happened one year later at three trusts in the West Midlands – David Nicholson's old patch, including Mid Staffs. Overnight, palliative care deaths had risen to 35 percent of deaths at Mid Staffs, making it the largest hospice in the UK but without any of the compassion. And the mortality ratio had gone down to a much "healthier" level.

Change the diagnosis

Another way to reduce mortality alerts is to change the diagnosis. Patients come in with a fractured hip, and the longer the delay in operating, the more likely they will die, often from pneumonia. But if they have the pneumonia longer than the fractured hip, their primary diagnosis can be recoded as the former, and they vanish from the hip fracture mortality alerts.

Using this method, the number of people dying after fracturing their femur at Mid Staffs fell from 87 percent to 40 percent, even though the number of people dying didn't change. This entirely legal recoding was overseen at Mid Staffs by Texan coder Sandra Haynes Kirkbright (pictured). She had a philosophy degree and had learned how to "code" patients in the American insurance model of care.

Haynes Kirkbright recalls meeting HSMR guru Brian Jarman. "I said: 'I think you're going to see a change in the HSMR'; and he said: 'Coding can't change the HSMR'. I went: 'OK it can't'. But it totally can."

By 2009, a patient with a hip fracture was seemingly five times less likely to die if admitted to Mid Staffs than to the average English hospital, and Mid Staffs was seemingly one of the five "most improved" trusts for HSMR reduction in the country. And it might have got away with it, had it not been for the pesky Healthcare Commission.

'All that is wrong with NHS management'

The belated Healthcare Commission investigation, which reported in 2009, was triggered by complaints from Julie Bailey and Cure the NHS, and helped by local journalist Shaun Lintern.

It was led by fearless investigator Heather Wood, whom the Care Quality Commission later attempted to gag. Writing in the *British Medical Journal (BMJ)*, Wood describes Mid Staffs as a symptom of a serious underlying illness in the NHS. "In all the investigations involving acute hospitals that I led on behalf of the Healthcare Commission, we found clear evidence of poor care on general wards, even when the focus was specifically on, for example, outbreaks of *Clostridium difficile*. Where some poor care may, arguably, stem from a fault line in the training of nurses, we found evidence that the poor care and failure to control infection were related to the determination of managers to drive through financial restraint and achievement of targets."

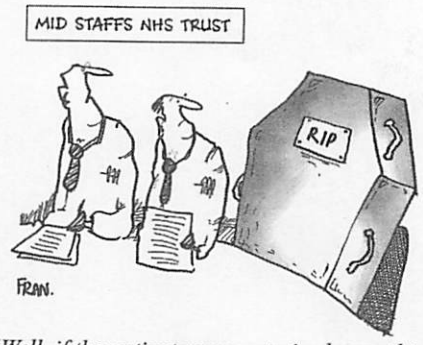
Wood has all the evidence that Mid Staffs was certainly not a one-off and could still be happening elsewhere, and believes that a change of culture in the NHS can only happen with a change of leadership.

BMJ joins the denial

The *BMJ* has recently printed some excellent analysis of Mid Staffs – but at the time it misjudged events.

On the day the Healthcare Commission report finally exposed Mid Staffs in 2009, for example, the *BMJ* chose to publish a paper from Birmingham University questioning the validity of using death rates to identify poor quality care, by authors who were already known to be deeply sceptical about them.

Prof Jarman, of Imperial College, has no problem with academics challenging his work openly and fairly. But the research was commissioned by West Midlands strategic health authority, and senior employees from the SHA and Mid Staffs trust were on the steering committee for the research – a clear competing interest the *BMJ* chose not to declare as such. The *BMJ* also agreed with the authors' request to publish on the same day as the damning Healthcare Commission report, leading editor Fiona Godlee to ask: "Was the *BMJ* used as part of a concerted effort to discredit the HSMR?" A *BMJ* investigation decided "No." As Francis observed: "The University of Birmingham reports, though probably well-intentioned, were distractions. They used the Mid Staffordshire issue as a context for discrediting the Dr Foster methodology." Roger Davidson, head of external affairs at the Healthcare Commission at the time, said in evidence to the public inquiry that the publication in the *BMJ*, on the day the commission planned to publish an investigation into Mid Staffs, "looked to me like a planned attempt at a spoiler".



"Well, if the patient representative has nothing to add, we can move on to the fantastic success of the revised mortality measurements..."

This *BMJ* paper may have had the effect of not just pushing Mid Staffs further into denial, but giving other NHS hospitals with high death rates an excuse for not investigating thoroughly.

Why Nicholson won't go

Nicholson should be held to account over Mid Staffs, but he was carrying out the orders of his political masters. The political imperative was always to bury the bad news with the patients, silence dissent and deliver only good news to Downing Street.

As Sir Ian Kennedy observed in Bristol, too much power in the NHS is concentrated in the hands of too few people, which is both unhealthy and dangerous.

David Nicholson is seen as indispensible both by those on the political left, who trust the former Communist Party member not to betray his roots and sell the NHS off to the market, and those on the right because he sticks to budget. His predecessor Sir Nigel Crisp resigned over a £600m overspend (less than 1 percent of the NHS budget at the time). Nearly 1,200 patients have died unnecessarily in one hospital alone, and probably many more thousands across the NHS, and yet to make Nicholson responsible would be to accept that the hugely disruptive market reforms he has enacted for Labour and the Coalition are also at fault.

Nicholson has had seven years in office and his management style simply isn't suited to the compassionate, open, devolved, fear-free safety culture the NHS needs. There are plenty of gifted senior managers in the NHS (or from outside) more suited to the job. He recently disclosed that he has diabetes and is one of 700,000 NHS employees struggling with their weight. He should step down, get fit – and sit on a local Healthwatch board to learn how powerless the patient voice is. Then he should do what the politicians most fear: publish his memoirs.

Over the years Nicholson has enacted reforms to the NHS he clearly thought were bollocks; but he has collected a very decent salary, pension, expenses and a knighthood for his troubles. Now the fixer has been found out, he could finally blow the lid on the damage constant political meddling does to the health service. But does he have the courage?

M.D.

Foundation Trust
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AGENDA

National Development Day: Understanding crisis

Date: 14 March 2013

Venue: Church House, Dean's Yard, Westminster, London SW1P 3NZ

0930	Registration; tea and coffee
1020	Chair's welcome
1030-1125	Andy Burnham, Shadow Health Secretary JAMIE REED, SHADOW HEALTH SEC.
1140	Breakout sessions: Paul Devenish, Monitor *Monitor's Continuity of Service Regime and the role of governors during FT failure* Tony Halsall, NHS Confederation *Your relationship with the board in times of trouble* Dr Richard Taylor, National Health Action Party *How can governors help to avert crisis?* Mike Fowkes (lead governor, Mid Staffs), Raymond Sheehy (lead governor, Oxleas NHS FT) and Angela Woodcock (governor, James Paget NHS FT) together with chair Richard Lindley (lead governor at the Royal Free London NHS FT and formerly a reporter and presenter for ITN and BBC Panorama). *FTGA directors in crisis-hit trusts: a panel discussion*
1245	Lunch Lucy Hamer, CQC and CQC/FTGA project participants *Informal drop-in session with participants of the CQC governor engagement project. This project looked at building relationships between governors and the CQC at a local level and identified positive ways to work together.*
1345-1445	Robert Francis QC
1500	Richard Douglas, Director General of Policy, Strategy and Finance
1600	Chair's thanks. Hilary Brown, director, FTGA *The FTGA's first research project on governors' roles in assuring the quality and safety of patient care.*
1615	AGM
1645	Close

Jamie Reed – Shadow Health Secretary

Andy Burnham had to take part in a Parliamentary debate on 14th March, which clashed with his speaker engagement at the FTGA. Jame Reed MP, the Shadow Health Secretary, was asked to speak in his place.

As a governor, who expected that AB would speak about, and answer questions on, the Health & Social Care Act and how the new powers given to governors would impact on Trusts, it came as a bit of a let-down that Jamie Reed took the opportunity afforded him to engaged on a political shake-down of the new Act and to give forth about how the Labour Party would rescind much of it.

His speech commenced with him telling us he was a patient himself, that his family were patients too, and how important this made the NHS to him personally.

He predicted that the Polls were exciting, with a prediction that Labour would return to power in 2015.

He then went off on a mixed bag of statements, which wasn't easy to follow … as the enclosed FTGA summary attached shows.

To date (May 13th – some two months later) - the FTGA have still not been supplied with a copy of his speech for governors to reference, hence the FTGA quick summary supplied herewith.

Jamie Reed MP Shadow Health Secretary

MP Copeland West Cumbria

Andy is at Parliamentary debate. Thanks to FTGA for help to shape communities and to governors. All want to serve our communities and ensure health is best it can be here and internationally. This is a time of change in country and NHS. £20bn saving, big top down reorg, all are vitally important, thanks to Robert Francis his work and the events at trust. As NHS patient, son patient, father, must build upon the NHS work. Polls can and do change, now Labour is predicted to return in 2015. Now we are engaged in full review, we don't pretend to have all answers, as volunteers hope you can be involved in these changes.

In late Jan Andy Burnham policy review, first chance to rethink health policy, big moment and chance to change health debate. Too long debate has been based on regulation, competition. Struggles to find answer, want to change debate, FTs have key role in all of this, this is start of conversation, and it represents direction of government right now, Health era of austerity.

We need better results, it's clear that NHS is in fragile condition, not time for top down reorganisation. We now changes must be delivered to ensure

This can't be planning for no change, urgent qs of 21c

How do we give families support, and how to remove mental health stigma. How to ensure that costs down.

These are huge questions that require real scale and ambition. The world looked different before, people dying on NHS waiting lists. Big ambition was labour before, labour make big changes stories of older people neglected, isolated in own homes many in this room will be familiar with these experiences.

One question must ask is why, is it reg failures, we look at Francis for answers, nurse training failure, these may on be symptoms not the cause. Shadow health review team, speak to NHS staff and patients, to dev thinking, NHS and hospitals have to change to reflect new demographics, wards today aren't staffed, aging soc, one nurse said, someone in 80s but now more older people, hospitals hadn't changed to reflect these changes. Hospitals were still operating at 20 c standards. The lesson is hospitals are designed for last century and facing demo challenge this century. Who def of health: a state of complete mental health social, NHS not set up to achieve this vision, third social aspect left out. Now last bit = social bit which was left out. Deep in NHs so much happens to help health outcomes, doesn't pay for OT even if they work, truly create a preventative mentality,

patient centred. NHS tries to meet physical , mental, social, one person 3 care services, most of 20 c most about it works, with chronic or terminal illnesses, families were living closer, now aging soc, gaps are increasingly dangerous, complex blur, not possible to disaggregate, still trying to do that, disjointed system, one persons needs aren't met, in mental health physical health overlooked, 15 years die younger, in acute mental health needs over looked. What can be achieved, on a practical level. Need coordination of care, people face same story again and again, care is ground down, patients passed around, and clinicians on phone and not with patients. Severe disabilities, lack of coordination, early intervention needed, but it's not at its heart. Services don't provide what people need, quality people want, protecting institutions that bind us together is needed. Incentives of NHS working in wrong direction. Happy to pick up 1000 hospital bill, people fail at home and drift into care. Councils face difficult targets, care services are being whittled away, NHS is safety net, in la defence, they are facing institutional logical. Bad for patients, families etc. 30-40% beds are offered we leave system, general hospitals will be like old wards, people liked up in corridors, fast track to care homes, we can get better results for people from 1000 bn on NHS and 50bn on social care, need incentives in the right place, must take away manufacture mentality, intentions that are utterly meaningless. Never forget that all working in public services must operate as public service. Is it time for full integration of HC service? Physical mental social, whole person care, when we start to think of one budget one service works.

If we start to think of it this way as a decisive shift. NHS hospitals would . Commissioning acute trusts could change overnight. Could create positive . Integrated care home to hospital.

In Torbay, hospital has done this 200 beds removed. They have one point of contact for all care needs. OT visit homes, aid supplied in hours not days, care worker helps to get patients back home ASAP. What a diff this could make.

His mother, with multiple needs, social care on ward would provide better care, culture of prevention , one service. Whole person care, make sense to separate general care from xx care. Party politics, institutional politics. We will betray NHS, moving forward there are no comfort zones, with changes we propose, we can put entire debate on diff footing. Local A&E would be more streamlined. A&E doesn't need to close and would never make a mistake . Never make most of saving unless . Need to consider primary and secondary care, breaking divide in Torbay, managing care, nerves of care in one budget world start to lose fear. NHS hospitals need the opportunity to embrace change will be better in this environment than in any qual provider world.

This is view shared by public. Those that care they cannot understand challenges of accelerated .. Market based healthcare internet cost more mot NHS. We should protect the NHS, better interaction, intervention around corroborations, look to US, best providers coordinate the three from home to hospital. We need to universalise that method here.

Even if NHS coordinates more care, it is essential private and votary markets. We want to empower patients with choose to die at home, we will work system would have to provide what people want rather than other, held to account by power full patient voice, consultation. Change is ambitions, at

moment commissioning health services, CCGs, challenge is shift to communities, housing planning, leisure, marmot vision, improving public health is central to everything. Andrew Langley should have done this, labour wants to support HWB and CCGs with advice, we will repeal HSCA 2012 and this contributes to evolutionary change. La and hospital .

Need for radical change, labour made it clear that FTs should be heart of NHS. Services tailored to their needs, wefts should be at heart, FTs help to deliver improved service, obtaining ft status, and making this work for patients and communities includes patients and govs. Genuine connection and accountability of trust, membership is rep of community. Inc minority, roles by ft govs is vital, annual report, accounts and auditory report must be at meeting of cog. Now these are public, Francis report shows some trusts have little or no openness, fair to say ft govs often approach trusts about how business is conducted. Labour takes this seriously, hopefully govs can say how this can be maintained.

Politicians are likened to actors, probably all time low, govs may be familiar with this view, actors use breaking through fourth wall, this does break through forth wall , I don't care what your allegiance is. Take part in our policy process. We want govs to id problems and suggest solutions. If we do nothing, fear will grow. We aren't meeting their needs, FTs have imp role to perform dev of NHS. My guess is you are up to challenge. My guess is you are up to this challenge and this is why we appointed you.

Questions: scb – integration, health and social care, struggling to integrate at the moment, I'm from first FTs trying to merge, nightmare, huge cost, LA has layers of bureaucracy, what will happen to FT sector if this continues,

A – with mandate of all FTs becoming FTs by 2014, it should be easier for integration, there is real prospect that your type of integration is subject to EU law, system as it stands has to change, reorg . Watch this space for what Andy will say in future.

Q - Policy review and encouraging govs to get involved, how? A – timetable is this year, drop Jamie.read@parliament.co .uk

Q – Allison Pollock excellent book, labour is driving through, if review is happening. Drive of mid staffs to be an FT was the cause of the problem and Andy Burnham helped that happen. A – Andy's comments I can't comment on but your questions are being answered in a genuine way now, right now not meeting needs of this country need urgent steps.

Q – Chair of trust has dual roles and Francis alluded that govs are mere ambassadors, private cog meetings is wrong. These are serious issues. A – Everyone who is committed to transparency, we are keen to explore and are looking at it.

Q – joined up health care if you can do joined up gov, issues are profound, 1k for every admission to and e. There are solutions, i.e. avoiding cheap booze. He agrees.

Q – missed q but answer is its difficult to engage communities, my own exp is starting to integrate gap in 2006, this was better for services in area, however since then, whole service and commissioning. CCGs can't tell us about services, it doesn't understand finances, new trust, merge,

answer is we don't know how this will happen now, unfortunately hunt doesn't know either. Standard of local gov isn't universal. Involved in huge experiment.

End

This is the start of a conversation, he encourages govs to get involved. This is beginning of conversation.

Hilary brown

Stakeholder gov, uni of BHM. Fellow in health services management sector. 3 legged = research, consultancy and pat exp.

18 month research programme. Appointed research exec. He is pharmacist by trade.

Talk by Robert Francis QC

What came across, very strongly, throughout this presentation by Robert Francis was his sincerity and his deep concern about what happened at Mid Staffordshire NHS Foundation Trust. He started his talk with stating what the Public Inquiry was …

What it is about …

To examine the operation of the commissioning, supervisory and regulatory organisations and other agencies, including the culture and systems of those organisations in relation to their monitoring role at Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009 and to examine why problems at the Trust were not identified sooner, and appropriate action taken.

And what it is not …

There is a tendency when a disaster strikes to try to seek out someone who can be blamed for what occurred, and a public expectation that those held responsible will be held to account. All too frequently there are insufficient mechanisms for this to be done effectively. A public inquiry is not a vehicle which is capable of fulfilling this purpose except in the limited sense of being able to require individuals and organisations to give an explanation for their actions or inaction.

He paid tribute to the relatives of those who had died who fought long and hard to get an inquiry into what went wrong and there followed 49 slides which spoke for themselves, with Robert Francis practically reading them through. It is for this reason that I recommend the slides be photocopied and read in conjunction with the following FTGA noted summary of Robert Francis's presentation, which includes the question and answer session at the end.

SM.

FTGA's shortened version of Presentation by
Robert Francis QC

Pleased to speak to at conference of FT govs who are important part of hospital services engagement.. General comments:

Not surprising that hospital services are subject to so much public interest. We will all rely on them at one time or another and we're proud to have a national health service. Challenges presented by endless challenges in medicine. Things do go wrong with individual patients, but we assume that we didn't need to concern ourselves with the system itself, but now times have changed.

What can't be in cured must be endured etc, etc– Florence nightingale quote
What are you complaining about, don't you know there's a war on? We mustn't tolerate this can't attitude anymore.

See slide 1&2

I was not set up as a royal commission to improve the NHS. However the holes in the system were such that it soon became clear that there were wider lessons to be learnt. The report wasn't just about individuals, lessons to be learnt are for everyone to learn from and to then apply them. Reflect properly on stories from mid-staffs and apply in their own activity and demonstrate to everyone that they are doing that.

Who is important? – carers, families, patients. They ensured that 2 public enquiries were held. Without these people the reports would not be written and lessons would not be in course of being learned. They have become difficult people with a story to tell, who want to be listened to. These are the people we should listen to. They are the people we should be worrying about. What about their complaint requires action. Spot the town slide (Stafford not on it). Symbolic as it's such an unremarkable place that it often is missed off maps. It became isolated. Poor care can flourish in places like this.

See building slide

1986 legionnaire's disease outbreak. Chief execs office at back, far from front door, hard to find and away from all clinical activity. Symbolic. Union reps lived in mobile homes on the lawn.

Warning signs slide

MPs, clinical staff, gov all said they didn't know that things were going wrong. They asked why the public had told them. Warning signs were all there.

Neglected patients, poor records slide.

Patients without advocates slide. Many don't have family who will stick up for them. One thing govs can do is take up the case for patients who can't speak for themselves.

Insufficient staff slide.

No training no hygiene slide.

Ignoring suffering slide.

Then there was the suffering that was just ignored. Govs would demand action if they heard stories like this.

No care, no dignity slide

A patient death slide.

This patient died. List of systemic failures. This report was not seen by the report. SHA didn't follow it up.

Impact on staff. Staff generally conscientious, but becomes very stressful when working in this kind of environment.
You walk away slide.

Don't become immune to the sound of pain yourselves. It's easy to talk about systems, through put etc, but don't forget sound of pain. Staff become disengaged. Self interested disengagement slide.

Credit to him for being honest. We have to be sure that people aren't put in that position.

Why wasn't this exposed? Slide

You need to think about the impact on patients of the things you are hearing at all times. You need to look at cumulative effect of concerns. Governors not given sufficient support or resources. If you listen to patients, everything else fails. If you as govs see something unacceptable it is your duty to do something about it, even if strictly speaking, 'it's not your job.' Ensure that the right questions are being asked. Confidentiality should be rejected. It's always possible to give you the info you need, they can cut out the confidential bits.

Systems business not patients slide

Health and safety exec still considering this systemic failure. No one deals with a case as bad as that. Told monitor they had not problems with mortality when they hadn't bottomed out what the figures meant. Y is that a large no. Of our patients wouldn't recommend us to friends and family? What does that mean? Affects reputation of hospital.

Recommendations slide.

What will the gov say in response to enquiry? Whole point is that some recommendations are very complicated and will require gov implementation. But lots of recommendations can just be done now if everyone's attitudes change from cleaners to chief exec of NHS. Don't wait, go and do something about it.

Cross cutting things. Whatever we do the patient must come first. Must involve patients in everything we do. Need common values – insist on them that everyone is signed up to including contractors and suppliers. Must reinforce these values every day. It's all about patients.

Value slide.

Fundamental standards slide.

CQCs book of outcome – put it down. Does it help you when you're on a ward to tell if standards are being breached. Publish don't own these standards. Need set of standards which public tells us we need. Need to come from the public themselves. Examples slide.

If you phrase things like that you and I could go around a hospital and check that they are happening. Clinical staff must be on side and CQC police them. No one should tell you that you can't afford to keep a patient clean etc, if that's the case you shouldn't be providing a service at all.

Sanctions slide.

Guidance slide.

How to make these standards a reality. Staffing standard as such does not help. Boards. Govs etc need to know what's going on. Have we got enough staff and the right type of staff.

Candour slide.

Organisational responsibility. Need to do something about despicable behaviour about staff who try to stop bad behaviour. Whistleblowers. No legislation to protect them. Need some!

Openness slide.

At the moment things are done to complainants in the same way that they are done to patients.

Transparency

Info for public must be open and honest.
Compassionate Caring slide

Need more support for our nurses and recruit people with right values and can demonstrate that they can apply them. Health Care Support Workers.

Leadership slide

Make them accountable in a way that they are not at the moment.

Info slide.

Would like to see everything online and available to review by public.

Govs slide.

Have enormous power and often don't seem to know it. Need to be equipped to have this level of responsibility.

Real life slide

There was a feeling that the board was controlled by the chair of the trust.

Obstacles slide

Big problem is authority. How many vote? If they won't change the law, then there should be a vice chair who controls the agenda. Govs have great theoretical power, but not enough support or training.

Question and Answer Session

Q: How many excess deaths were there in mid staffs.?

RF: Nobody knows. 400-1200 roughly. Sadness about this trust is that no one went to find out factually what the situation was. Need someone reviewing what is happening on the ground.

Coding is really important as can make figures inaccurate and they can be manipulated. Means a good result is not necessarily a reassuring one.

Q: Before you started to tell us about report, you said you say a few words about you lots. Indicative of how people view govs.

RF: Public don't know who govs are or what they're for. Govs should be fantastic conduit for concerns from outside trust reach in trust.

Q: CQC to police recommendations. Radio 4 programme recorded CQC inspections. What happens in my town when staff gone home at night time. Need to protect those who don't have advocacy.

RF: Inspection is the only thing that's been sown to work in terms of uncovering problems. Changing methods of inspection, more experts with the right skills. Patients. And at night.

Q: Many conduit for getting report at mid-staffs. Report wasn't ignored. How much were PCT and SHA responsible for failings.

RF: Both PCT and SHA entirely preoccupied with being reorganised. Reality of what SHA could o was limited. PCT could only measure with access target which didn't tell them enough. Net with wide holes. People in system knew holes were in the net

and should have been more acutely sensitive and conscious. Reacting in no different way to anyone else anywhere in the country. Cultural issue.

Q: Mid staffs – NHS high risk business, yet we have appallingly low standards. 1.2 m patient safety incidents annually 3000 pa result in death. Why do we put up with this and why isn't this higher on the agenda? ¾ of avoidable not being recognised and not doing anything about it.

RF: 'list of never events which occur. List of never event is wrong. Need list of things which are not tolerated. As other industries due. Individuals have power and duty to do something about it. Current system lacks criminal sanctions. Drs and nurses subject to disciplinary. Got to define the rule very carefully. If nursing can't comply, make that organisations responsibility. Make it easier for nurse or doctor to complain. How long are we going to tolerate our loved ones dying and being covered in filth. If it happened to a child at home the carer would be prosecuted, why doesn't this apply in hospital?

Interjection: It's everybody's responsibility. At Bournemouth FT they have a Governor's scrutiny committee. Finding out what care really looks like at night.

Q: Recommendations also require spirit to get behind them. What is the spirit?

RF: Take away the anger you feel and transmit it to others so they feel that they don't want to be part of a system that would let that happen. Takes time, patience and a lot of restraint. Medical cases complicated. Govs role to listen and ask the stupid question.

FOUNDATION TRUST GOVERNORS ASSOCIATION

DEVELOPMENT DAY

14 March 2013

LESSONS FROM STAFFORD

Robert Francis QC

Three Serjeants' Inn, London

"What can't be cured must be endured," is the very worst and most dangerous maxim for a nurse which ever was made. Patience and resignation in her are but other words for carelessness or indifference—contemptible, if in regard to herself; culpable, if in regard to her sick.

Florence Nightingale, Notes on Nursing (1860) pages 92-93

40 minute overview...

- What it was about and not about
- What went wrong in Stafford
- What the system did and did not do
- What needs to be done now
- The role of FT Governors

What it's about ...

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... and not about

There is a tendency when a disaster strikes to try to seek out someone who can be blamed for what occurred, and a public expectation that those held responsible will be held to account. All too frequently there are insufficient mechanisms for this to be done effectively. A public inquiry is not a vehicle which is capable of fulfilling this purpose except in the limited sense of being able to require individuals and organisations to give an explanation for their actions or inaction.

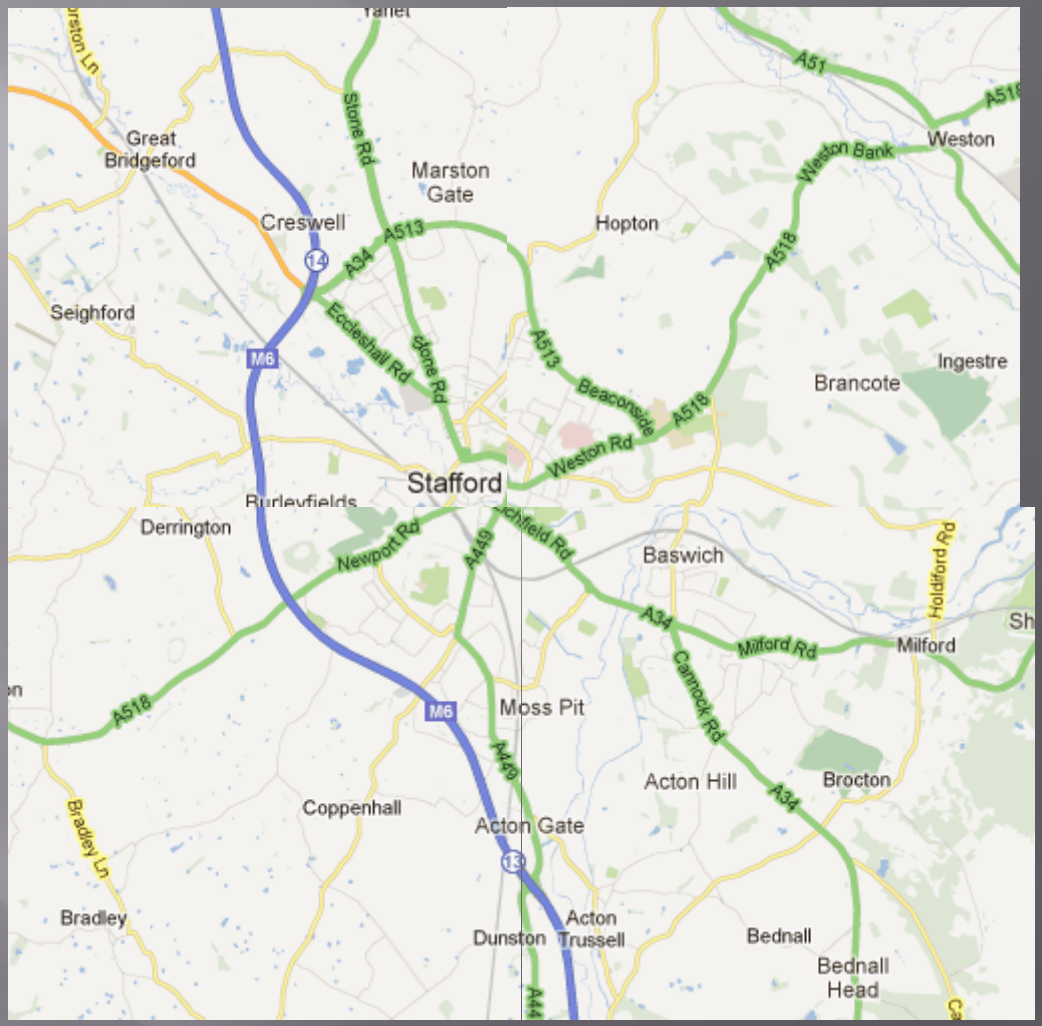
Public Inquiry Report para 106

But who is important?


Another Government
Whitewash
© PA

Spot the town...

The Times and The Sunday Times e-paper - The Times - 10 Oct 201...



Union reps office

CEO office

Cooling towers–
Badenoch Inquiry
1986

Warning signs

- Patient stories
- Mortality
- Complaints
- Staff concerns
- Whistleblowers
- Governance issues
- Finance
- Staff reductions

Neglected patients, poor records

- *We entrusted my mother into this hospital to be cared for, to be looked after. But when you think about it, logically, 31st October she was admitted, she died on 6th November and within those few days this hospital let her fall over three times and she had been admitted because she was unstable on her feet. Well, as we thought, immobile. We don't know she was walking about in the wards until we received incident reports and as I said we were never ever made aware by any of the nursing staff that there was a problem.* [Evidence of patient's son]
- *There is no accurate completed incident form relating to your mother's fall on EAU on 2 November 2008. The three completed incident forms contain misleading and inaccurate information. A review of the nursing and medical records has identified the recording of the three falls which your mother sustained. Unfortunately the entries for the first fall do not give an accurate time of the fall, which in turn are misleading, because the entries span over two consecutive dates.* [Reply to complaint]
- This episode indicates serious lapses in the Trust's duty to care for the safety of an obviously vulnerable patient. [my conclusion]

1st Inquiry report page 66

Patients without advocates

I think that is fine as long as it isn't dependent upon [this], because there are a lot of people who do not have relatives who are fit and able to go in and so what happens to them? You see, the most vulnerable are going to be the ones who, because they have little support or they don't have relatives who can go in and help, what happens? I mean, we helped others in the ward, didn't we, while we were there. We were going round and we were taking lids off drinks and we were helping to put things in reach.

Evidence of a family asked to help feed their elderly relative – 1st report page 90

Insufficient staff

… I think it is absolutely atrocious that on a ward that deals with elderly people that there is nobody, you know, keeping watch to see the patients who are prone to falls. I mean, there just weren't the staff around and [my mother-in-law]wasn't the only one who was unsteady on her feet. It is diabolical really to think that they can let it happen. You know, maybe you can excuse one but when they know a patient is prone to them, I'm appalled, absolutely…

Ward 10 was an exceptionally large ward in those days. I don't know what it is like today but it was like a crossroads, basically, and the reception desk was in the middle of these crossroads. Nurses – nursing staff were very few and far between when we were there. Ward sisters, there was only about one which we could ever relate to. We could never find them.

Family of elderly confused patient to 1st inquiry 1st report age 68

No training no hygiene

She had got a cloth, like a J-cloth, and she cleaned the ledges and she went into the wards, she walked all round the ward with the same cloth, wiping everybody's table and saying hello, wiping another table and saying hello. Came out of there, went into the toilets and lo and behold, she cleaned the toilets with the same cloth, and went off into the next bay with the same cloth in her hand. You can't believe what you saw, you really couldn't believe what you saw.

A visiting relative in 2006

Ignoring suffering

The daughter of a patient in ward 11

In the next room you could hear the buzzers sounding. After about 20 minutes you could hear the men shouting for the nurse, "Nurse, nurse", and it just went on and on. And then very often it would be two people calling at the same time and then you would hear them crying, like shouting "Nurse" louder, and then you would hear them just crying, just sobbing, they would just sob and you just presumed that they had had to wet the bed. And then after they would sob, they seemed to then shout again for the nurse and then it would go quiet...

No care, no dignity

The daughter-in-law of a 96 year old patient

We got there about 10 o'clock and I could not believe my eyes. The door was wide open. There were people walking past. Mum was in bed with the cot sides up and she hadn't got a stitch of clothing on. I mean, she would have been horrified. She was completely naked and if I said covered in faeces, she was. It was everywhere. It was in her hair, her eyes, her nails, her hands and on all the cot side, so she had obviously been trying to lift her herself up or move about, because the bed was covered and it was literally everywhere and it was dried. It would have been there a long time, it wasn't new.

A patient death
Systemic failure of safety?

A detailed investigation has been undertaken including obtaining information from 14 members of staff and considering a substantial number of documents. The following problems have been identified:

- failure to control diabetes
- failure to administer prescribed drugs
- failure to undertake nursing handovers properly or at all
- failure to complete nursing records adequately or at all
- failure to conduct medical ward rounds properly
- failure to make adequate or proper notes of ward rounds and care plans
- failure to give the patient a diabetic menu
- failure to report this matter as a SUI in a timely fashion
- failure to report to report to the Coroner

Extract from Trust investigation report

It would appear that there were several systemic failures and issues which caused the SUI to occur in this particular case. Unfortunately, it cannot be said that these failures are an isolated incident and unlikely to re-occur. It is clear from talking to the staff (and examining other medical records) that similar issues are occurring regularly.

Extract from Trust investigation report

Impact on staff

I mean in some ways I feel ashamed because I have worked there and I can tell you that I have done my best, and sometimes you go home and you are really upset because you can't say that you have done anything to help. You feel like you have not – although you have answered buzzers, you have provided the medical care but it never seemed to be enough. There was not enough staff to deal with the type of patient that you needed to deal with, to provide everything that a patient would need. You were doing – you were just skimming the surface and that is not how I was trained.

A nurse

"You walk away"

The nurses were so under-resourced they were working extra hours, they were desperately moving from place to place to try to give adequate care to patients. If you are in that environment for long enough, what happens is you become immune to the sound of pain. You either become immune to the sound of pain or you walk away. You cannot feel people's pain, you cannot continue to want to do the best you possibly can when the system says no to you, you can't do the best you can.

A doctor who started in A&E in October 2007

Self interested disengagement

Perhaps I should have been more forceful in my statements, but I was getting to the stage where I was less involved and I was heading to retirement … I did not have a managerial role and therefore I did not see myself as someone who needed to get involved. Perhaps my conscience may have made me raise concerns if I had been in a management role, but I took the path of least resistance. In addition … most of my patients were day cases and there was less impact on those patients. There were also veiled threats at the time, that I should not rock the boat at my stage in life because, for example, I needed discretionary points or to be put forward for clinical excellence awards

Evidence given to the Public Inquiry

Why wasn't this exposed?

- Not considering impact on patients of concerns, reorganisations, information
- Not looking at cumulative effect of concerns
- Lack of support and expertise
- Not listening to patients
- Assumptions that others dealing with it
- Not communicating safety relevant information
- Barriers to information sharing

System's business not patients

- Standards which missed the point
- Focus on finance, corporate governance, targets
- Regulatory gaps
- Balancing "bad" news with "good"
- Assuming compliance not fearing non compliance
- Accepting positive information, rejecting the negative

Recommendations

- Common values
- Fundamental standards
- Openness, transparency and candour
- Compassionate, caring, committed nursing
- Strong patient centred healthcare leadership
- Accurate, useful and relevant information
- Culture change not dependent on Government

Values – clarity and commitment

- Put patients first
  - Staff put patients before themselves
  - Staff do everything in their power to protect patients from avoidable harm
  - Openness and honesty with patients regardless of consequences for themselves
  - Direct patients to where assistance can be provided
  - Apply NHS values in all their work
- Make NHS Constitution the shared reference point for values
- All NHS and contractors to commit to NHS values

Fundamental standards

- What the public see as absolutely essential
- What the professions accept can be achieved
- Enshrined in regulation by Government
- Compliance measured by evidence based methods
- Policed by CQC [including governance required to meet these standards]
- Distinguish from enhanced quality standards subject to commissioning

Fundamental standards *Examples*

- Prescribed medication given
- Food and water to sustain life and well being supplied and any needed help given
- Patients and equipment kept clean
- Assistance where required provided to go to the lavatory
- Consent for treatment obtained

Fundamental standards
Sanctions

- *Persistent failure* – stop/close the service
- *Death or serious harm caused by breach* - criminal liability for individuals and organisations , unless not reasonably practicable to comply
  - *?Defence for individual to have reported obstacles to compliance*
  - *Prosecution matter of last resort/serious cases*
- *Isolated incidents:* no tolerance: investigate reasons and correct.

Fundamental standards *Guidance*

- NICE to provide evidence based guidance and procedures which will enable compliance with fundamental standards in each clinical setting.
- NICE also to provide evidence based means of measuring compliance
- Guidance to include measures for staff numbers and skills in each clinical setting required to enable compliance with fundamental standards.

Candour

- Statutory obligation
  - Individual professionals under a duty to inform the organisation or relevant incidents
  - Healthcare provider organisations under a duty to inform patient
- Statutory sanction
  - Wilful obstruction of these duties should be a criminal offence
  - Deliberate deception of patients in performing duty should be a criminal offence
- No censoring of critical internal reports and full information for patients
- ?Remedy for patients for non performance of duty of candour

Openness

- Welcome complaints and concerns
- Gagging clauses to be banned
- Independent investigation of serious cases
- Involving complainants , staff
- Real feedback
- Real consideration by Trust Board
- Information on actual cases shared with commissioners, regulators, and public
- Swift and effective action and remedies

Transparency

- Honesty about information for public
- Balanced information in quality accounts about failures as well as successes
- Independent audit of quality accounts
- Criminal offence of reckless or wilful false statements by Boards re compliance with fundamental standards
- Truth not half truths to be told to regulators
- Criminal offence to give deliberately misleading information to regulators
- CQC to police information obligations including information on enhanced quality standards

Compassionate Caring Committed Nursing

- Aptitude assessment on entry
- Hands on experience a prescribed requirement
- Standards of training standards, assessment , appraisal for core values and competence to deliver
- Named nurse [and doctor] responsible for each patient
- Code of conduct and common training standards for HCSWs
- Registration requirement for HSCWs plus power to disqualify/share info re concerns
- Reward good practice; recognise special status of care of elderly
- Review Knowledge & Skills Framework

Strong patient centred leadership

- Recruit and train for values
  - Staff college open to all candidates and recruits
  - Voluntary accreditation
- Leadership by example
- Code of conduct prioritising patient safety and wellbeing, candour
- Accountability through disqualification for serious breach and deficiencies
- Keep possibility of wider regulation under review

Caring, compassionate, committed nursing

- Recruit for values and commitment
- Demonstrate hands on skills
- Foster and support ward leadership
- Identify nurses to be responsible for individual patients
- Training standards for HCSWs
- Register HSCWs

ACCURATE USEFUL RELEVANT INFORMATION

- Individual and collective responsibility to devise performance measures [R262-267]
- Patient, public, commissioners and regulators access to effective comparative performance information for all clinical activity
- Improve core information systems

Power and duty of governors

- To hold non-executive directors to account individually and collectively
- To represent interests of members and public
- To appoint and remove chair and non-executives [3/4 majority required for removal]
- Approval of appointment of Chief Executive
- Remuneration and terms of non-executives

National Health Service Act 2006 schedule 7 paras 10-18

Real life

- *To be perfectly honest, it was a huge learning curve for everybody and I can't say that it was an effective body at all and when we gained foundation status, I don't think anybody, either the Trust or the council of governors, were really clear about their role or how to put it into play.*
- *When I did ask at one meeting when I was feeling particularly brave or stupid, how this [HSMR] worked, we were told it is very complicated. Everything was always very complicated.*
- *We were controlled... if we had to put any other business, it had to be two weeks before so nobody ever did. We always got the minutes of the meeting and the agenda like three days before a meeting. Nobody was encouraged or indeed dared to ask a question*

Obstacles?

- Limited electorate and authority
- Trust Chair = Governors' Chair
- Trust Chair sets the agenda
- Trust provides the training and support
- *Foundation trust (FT) governors have great theoretical power without great accountability – they are reliant on the goodwill of the chair and Board, and there is little consistency in their role between FTs.* [1st report page 482]
- Inconsistency in practice?

88. I am not here for myself. I am here for Gill and the rest of the dead. I am not being sanctimonious, I could walk away at any time but I am not going to. When they took Gill away from me they took away my contentment. I don't want anyone else to suffer that. Bereavement comes to us all but it is how it comes to you that is important.

Extract from written evidence of Mr Street WS0001000717

FOUNDATION TRUST GOVERNORS ASSOCIATION

DEVELOPMENT DAY

14 March 2013

LESSONS FROM STAFFORD

Robert Francis QC

Three Serjeants' Inn, London

Richard Douglas CB
Director General, Strategy, Finance and NHS

I've been a civil servant nearly all of my life and in finance 30 years. People often ask me why I'm in the public service. What Robert talks about is exactly why I'm in public finance. Unless we get the money right we can't get these other things right. There is a lot of link between what Robert said and between what I will say.
This is not meant to be a crash course in understanding NHS finances. I want to talk about the financial context that we're on now and for the foreseeable future. And also then more about what are the things we need to look out for?

If you're thinking about avoiding financial crisis, what should your role be?
Can I talk first of all about the financial context in which we all operate now? We face in the NHS the same basic set of financial challenges facing every health system in the developed world.

There are three factors: population size, structure and mix.
A challenge faced by rising expectations. As we get wealthier as countries we quite rightly expect more continually in terms of healthcare. As we push back the boundaries of science we discover more we can do.

In the context of those two pressures we're in a position where the public finance is clearly under severe pressure. You see and hear that every day.

So - let's look at the population. What's really happening? We'll look first of all at the age population. What's projected to happen over the next 20 years?

There will be an increase of the population over 65 from 16% to 22%. That's a pretty big number; an increase of more than 30% over that period.

Partly but not entirely as a result of our changing population what we're seeing is more and more people with multiple conditions of increased complexity of what the system has to deal with. The numbers of people with three or more long-term conditions has increased by 50% over the last decade.

They're not the only things that drive costs. If we look at the price we pay for things in our system they again rise between 1 and 2 per cent a year on top of inflation. Whatever inflation level is other costs rise a bit above that.

I talked about rising expectations in the population. I talked briefly about the impact of medical advances. It's quite difficult to put number around that but there is on average a cost increase of 1.5-2% a year.

Without any efficiency improvement at all, the underlying costs of our system increase by somewhere in the region of 4% a year above inflation.

To deliver just the service that we've got now, you need to find about 4% a year in efficiency unless you're going to get more money.

We've effectively met these demands on our system by continually increasing the amount of money that goes in. Over that life of the NHS we've grown the spending each year by about 4% a year above inflation.

In the ten years running up from around 1999 we were increasing t about 7% a year above inflation. That general pattern has been around 3.5-4%ish mark.

We have a settlement by the Treasury up to 2014-15. That light blue shaded line is effectively government spending on things other than benefits. It's basically the government spending that is under control of departments. The spending period that we're currently in is protected in real terms.

If you project forward you see that reduction in overall discretionary spending increases.

The point I want to make is what is clear that we're not going back to the days where we used to get 4% real terms growth. We're really going to be looking at staying broadly protected in real terms at best.

So essentially where does that take us? Well we start form at a national position reasonably strongly.

I'm cautious about using national numbers. What really matters is what happening in every organisation. Overall we're about £400m on the foundation trust side of the business in surplus. That's the difference between the money that's going in and what's being spent. If you look at the distribution we have a number of orgs that are doing incredibly well and a number over here that are very unhealthy and you have the vast majority that are along there in the middle with very thin margins. They're getting by each year but there isn't any fat there.

What we're going into is a challenge where we're being asked to deliver 4% efficiency savings with not a lot of fat to help. This is a big challenge for boards and staff in organisations where you are governors.

As this position remains tight, what are the indicators of potential impending financial problem where you should be focusing on and asking questions and challenging your boards as necessary?

I don't think any of it is rocket science. It's what I've seen over the last ten years where I've seen problems arise in organisations. Most of this is about how you see an org managing itself and performing.

1. It's never just finance. That's a slight exaggeration but it's very very rare. If an org loses control of the finances it will usually have lost control elsewhere. It rarely happens on its own. The first indication may not be financial at all. There may be issues about staff engagement and satisfaction. Don't think you will spot a finance problem just by looking at the numbers.

2. Things don't happen overnight in orgs. Nobody in our world goes into financial crisis overnight. There are a lot of events that will throw an organisation over the edge financially. If it appears to emerge suddenly it's usually because it's been masked in some way. This is where I agree with Robert about financial transparency. How can it be masked? With short-term savings; withholding vacancies when you know they have to be filled; by support coming in from outside orgs i.e. short-term support from local commissioners. Beware of anything that looks like short-term fixes.

3. Periods of major change are periods of highest risk. Like a big new building scheme, a major service change, major changes at board and senior level - that's the most acute time of crisis.

4. Don't trust the finance director to deal with finance. If the only person in your org who appears to be on top of the numbers is the finance director I'd be worried. That's because finance is about how you manage an organisation. Finance directors can provide data and challenge but they can't manage finance on their own.

5. If something looks too good to be true, it usually is. If you're faced with the challenge of delivering 4% savings a year and someone comes along and tells you it's easy to do, it's probably untrue. It's not easy to deliver savings on this scale. It needs painful choices and management.

6. Confrontational relationships usually end in problems. Again a number of times I've seen financial problems emerge in orgs as a result of a culture that's based on win-lose between different NHS orgs. Mainly this has been between commissioners and providers where either one side or the other thinks they can put one over the other one. I've seen it a number of times particularly the middle part of the last decade where it was between sometimes quite aggressive FTs feeling that they could put one over on their local commissioner. Going out of your way to bankrupt your main customer is not wise. Watch out for that sort of confrontational relationship.
Thinking about what is your role as a governor.

You're not expected to be financial analysts or to know the detail of the NHS financial regime. That's not your job and we shouldn't expect that of you and the DH doesn't expect that of you. But you do have a number of very key roles and responsibilities. In meeting those responsibilities the key thing to be able to do is to have the right information in the right form to ask the right questions. Three things I particularly say:

1. Get financial info from the org in a clear form that's free from jargon. If it's not clear, give it back and ask it to be made clearer. In that, again echoing Robert, never be afraid to ask a stupid question. Stupid questions usually get clever answers. I've seen groups of firms of accountants go into an org and sign off accounts but who haven't seen the wood from the trees. A few basic questions would have revealed that the org was going to be in trouble in six months' time.

2. Always ask the 'what if?' question. There is a tendency in just about every org to have a bias towards optimism. People will think the best will always happen. When you see the forward plan, when you're consulted on M&A, keep asking 'what if it doesn't work out? What is your contingency plan? What will be the impact of this?'

3. If you focus at normal terms on getting the financial info clear, double that, treble that, quadruple that scrutiny at a time of major change in the organisation.

4. Again echoing Robert - listen to what people are saying in the org. You get an awful lot from the staff. They can often see what's happening financially before it's gone up to board level. Listen to what patients are saying about standards.

It's a really big challenge that NHS orgs face in the coming years. I believe that it is a challenge that we can rise to but it's not going to be easy. There is a really big role for you as governors in providing that challenge to orgs. Asking those stupid questions because that's how we'll get the answers.

Questions and Answers

Q: I don't believe that my Trust are the right people to give me the information I need to make a decision. What is the DoH doing to give governors support in terms of having access to having independent advice re whether to merge or buy another trust?

A: We don't expect governors to be financial analysts. If you got to the board where you believe that your boards are not revealing the truth that is a more fundamental issue than just finances.

Q: The question of Significant Transactions is causing a lot of concern in my trust. The board and the chair would like to adopt the 25% Monitor framework which would mean they could spend £70m without our approval. The Monitor panel recommendations aren't binding. With that kind of financial consideration, where would you set the ST for that trust?

A: Look at the nature of a transaction as well as the value. I'm cautious about just having financial numbers. Have the reference of the Monitor panel and their views not being binding. I would be very surprised if the trust didn't take their recommendations very seriously.

Q: Why are you putting pressure on drug companies?

A: 4% is not just a price issue. One of the things that is really important to us, if I look at the way that savings have been driven, is that there hasn't been the level of savings around procurement that there has been in other areas such as staffing. What I'm looking at is how we can help trusts get a better bargain for stuff.

Q: One of the reasons for Mid Staffs was financial targets. Also is it true that you're going to bail out the PFI trusts and care goes out of the window?

A: I didn't set out something there about the Nicholson challenge. I just set out the facts. To avoid what happened at Mid Staffs we've got to manage saving efficiency in a better way. It's not about the financial target. This is about the recognition of what money we're going to have to live with. On the PFI thing the Secretary of State announced last year about six or seven hospitals where support would be given for the PFI schemes.

Q: You mentioned international comparisons. I guess you know the equivalents for other developed economies. The problem we've got as governors is that as an election approaches our NHS colleagues say nothing, and it becomes an entirely politicised battle between the parties. Who is going to stand up for the NHS and say that we spend x amount on the NHS, France spends x etc... Can we as governors say that we are being asked to shred the NHS to try and keep things going and aspire to the ambitions set out in the report but nobody gives us the funds?

A: The debate about the overall funding of the NHS has got to be a political one. It's a political decision. What we do in the DoH is have a very straightforward discussion in the treasury about what we get for what sort of money.

Q: One of the things that surprises me about the NHS and FTs is that they don't have any buying power. We lose so much money that way.

A: You're absolutely right. On the overall procurement of non-drugs we do have some mechanisms that allow bulk purchase. What I'm working on now with trusts is how we get more for our combined power.

Q: I would like to point out to fellow governors that we have a fantastic challenge form Nicholson but we have a fantastic opportunity too. We can make massive savings with leaner thinking. Productivity savings have massive positive impact on patient quality too. What I would ask fellow governors to consider is what KPIs can you give to you trusts to demonstrate that they are delivering ongoing efficiency? We're faced with two options - have the cuts so we cut services and quality or we do more for less. If we want to do more for less we need to ensure that our trusts are planning processes by which they can do that. That's productivity. I'd like to ask you what those KPI's should be.

A: There is something about procurement. I think other area that people need to focus on is around the benchmarking. Looking around the NHS there are loads of things that different organisations can learn from each other.

Q: The question of the level of training we have as governors when we're confronted about the process of an acquisition. We cannot predicate whether that process is working on the existence of trust. We have been presented with very good and clear information as the process goes on. There will come a point when we will have to say yes or no. If we don't have financial understanding of that, what criteria are we going to use?

A: What I think there should be and I haven't discussed this with Monitor is what you can draw on from the external auditors of an organisation. There may be something in there that that route could be used. I'm not making up policy on the hoof here but it is something I will take back to Monitor.

Q: Re the 25% on Significant Transactions, if we merge that will go up to £120m. Are you telling us that figure of 25% was passed in front of you as DG of finance?

A: It hasn't specifically been put in front of me. The responsibility around the setting of a number rests with Monitor, not the DoH. It's one of those things I will take away with me to Monitor to discuss it with them.

Q: How much of the £7bn saved has been ploughed back into services? Also, why does the DoH give the Treasury £300bn over the last year when health is supposed to be protected?

A: Re the money that's been saved - it stays where it is. It rests where it's been generated. On the money given back to the Treasury - any amount underspent at the end of the year goes back into the Treasury. What we've been working on with the Treasury is how we can retain more of that. That's the system we operate under.

Q: No mention has been made of the private sector. At our hospital, our finance director is making up the shortfall with private care so that the two are integrated. We as governors are very strong in keeping the NHS side going. What we worry about financially is that we are given these figures by the private side. How do you make sure that the private side is not taking over?

A: It can't interfere with the aim of what an NHS hospital is. It cannot interfere with local services. You're not there to build private work. You're there to build NHS services.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 23 May 2013

AGENDA ITEM NO.	2.12/May/13
PAPER	Healthwatch Kensington and Chelsea Report
AUTHOR	Paula Murphy, Interim Director, Healthwatch Central West London
LEAD	Paula Murphy, Interim Director, Healthwatch Central West London
EXECUTIVE SUMMARY	This report updates the Council of Governors on Healthwatch Kensington and Chelsea and seeks the views of the Council on joint working possibilities.
DECISION/ ACTION	Healthwatch KC would welcome the views of this Council on areas for prioritisation in 2013/4 as set out in section 2.4.

23 May 2013

REPORT FROM HEALTHWATCH KENSINGTON AND CHELSEA to the COUNCIL OF GOVERNORS, CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST

This report updates the Council of Governors on Healthwatch Kensington and Chelsea and seeks the views of the Council on joint working possibilities.

1. The establishment of Healthwatch Kensington and Chelsea

1.1 Following a robust procurement exercise to commission local Healthwatch (LHW) services, the Royal Borough of Kensington and Chelsea along with the London Borough of Hammersmith and Fulham and the Westminster City Council have notified Hestia Housing and Support of success as the delivery agency for each of the three geographical 'lots' as of April 1st. The tri-borough Healthwatch legal structure (a charity) will be known as Healthwatch Central West London.

1.2 Regular engagement with the Foundation Trust will continue and Healthwatch Kensington and Chelsea will attend Council, Quality and Membership Sub-Committee meetings.

1.3 The aim of Healthwatch Kensington and Chelsea (Healthwatch KC) is to give residents and communities a stronger voice to influence and monitor the provision of health and social care services provided within our locality. Healthwatch KC would welcome the views of this Council on areas for prioritisation in 2013/4 as set out in section 2.4.

1.4 Healthwatch Kensington and Chelsea has a statutory seat on the Health and Wellbeing Board and will continue to refer issues to the Health, Environmental Health and Adult Social Care Scrutiny Committee.

1.5 In addition to the LINk powers, Healthwatch also has a statutory sign-posting function and will refer to the separately commissioned independent NHS Complaints Advocacy Service.

2 Role for Healthwatch Kensington and Chelsea

2.1 It is envisioned that the local Healthwatch Kensington and Chelsea representatives to the Foundation Trust will participate fully in discussions and represent the public and patient voice through effective two way feedback.

2.2 It is anticipated that the Healthwatch KC representatives will continue to support the Foundation Trust to continuously improve patient experience and outcomes. This includes our work on nutrition, quality and

safeguarding.

2.3 Healthwatch is also keen to look at quarterly data and the patient experience of making complaints to the Foundation Trust.

2.4 Further to our community engagement and priority planning for Healthwatch Kensington and Chelsea, we have identified the following key areas of focus for our 2013/14 work plan:

Priority	**Healthwatch KC contribution**
Hospital discharge (Bi-borough priority with Healthwatch HF) **Source:** local community, LINk and HWB Strategy	**Previously reviewed**: Red Cross 'Next Steps Pilot,' reablement service, homecare and the patient experience of discharge from Charing Cross. **Issues**: person centred planning, information and communication. **Desired**: To enhance the quality of the secondary to primary and health to social care transfer of responsibility.
Mental health (Healthwatch CWL priority) **Source:** local community, LINk, JSNA, HWB Strategy, Marmot	**Previously reviewed**: personal budgets, befriending, dignity in older people's units and community services. **Issues**: care planning, medication, co-morbidity, crisis planning, access to training and employment **Desired**: To enhance the quality of community services to prevent unnecessary hospital admissions and support independent living. To support homeless and rough sleepers to access health and care services. (HW West'r lead)
Out of Hospital Care (Bi-borough with Healthwatch HF) **Source:** local community, LINk, CCG, HWB	**Previously reviewed**: homecare and maternity services. **Issues:** understanding the changing health and social care landscape, awareness of out of hospital services, access to GPs **Desired:** improved understanding of the local needs of local older people and 'under 5's' to support effective OOH usage. New HW signposting supports aims of OOH strategy.
Young people and sexual health	**Previously reviewed:** experience of local young

(Healthwatch CWL priority) **Source:** local community, LINk, JSNA, HWB Strategy, RBKC, PH, Marmot	people with sexual health. **Issues**: awareness of services, nature of provision, responsibility (or lack of) for sex education. **Desired:** improved local qualitative knowledge of the attitudes and experiences of local young people to build on recent JSNA.
Experience of making complaints **(HW CWL priority)** **Source:** local community, HWE	**Previous:** anecdotal evidence of barriers to making complaints about health services locally. Priority area for Healthwatch England (see 2.5 below). Learning from Francis. **Issues:** complaint procedures for integrated services. How to complain to NHW England? Awareness of correct complaint handling procedures. Access to quality reporting to identify issues trending to prevent complaints **Desired:** Clear accessible complaint procedures for health and social care available from each provider and supported by HW signposting service. Clear reporting available to HW to inform service improvements and work planning.
Cancer **(HW CWL priority– K&C lead)** **Source:** local community, LINk, cancer charities, FTs, JSNA, Marmot	**Previous:** dedicated LINk working group. Only LINk with a focus on cancer in London. Trained screening ambassadors and held a BME cancer event for 200 local people to raise awareness of the importance of screening in 'hard to reach' communities. Ongoing work on quality with the Royal Marsden and Royal Brompton. **Issues:** ensuring PPI in cancer services re-design London Cancer Alliance (LCA), access to screening in 'hard to reach' communities and Imperial waiting lists. **Desired:** improved engagement with the LCA, access to local patient experience.
Personalisation **(HW CWL priority)** **Source:** local community, LINk, LAs	**Previous:** report on local experiences of direct payments and PB support. Support for the Service User Board. **Issues:** consistency of assessments, information and communication, engagement with service users. Confusion over the tri-borough vision.

	Direct payments for mental health? **Desired:** community seeking co-productive approach to the vision for personalisation tri-borough.
Learning disability (HW CWL priority – H&F lead) **Source:** local community, CCG, RBKC, NWL CSU	**Previous**: joint working on annual health check events, cancer screening, Healthwatch engagement, re-instatement of dedicated Imperial post, development of health passports. **Issues:** provision of GP health checks, roll-out of passports, access to services, consistent user engagement in quality monitoring of services. Findings from Winterbourne, Death by Indifference reporting. **Desired:** joint working between Dignity Champions and Quality Checkers to improve quality assurance of LD services.
Dementia (HW CWL priority – Westminster lead) **Source:** local community, LINk, JSNA, HWB Strategy	**Previous: '**enter and views' of dementia services. Co-hosted awareness event with Forum for Older Residents. **Issues:** Improved understanding and access to early diagnosis of dementia and supports. **Desired:** Expansion of Dignity Champions to include Dementia Champions. Tri-borough is a dementia friendly community with good levels of awareness and support for people to live with support in the community wherever possible.

2.5 Healthwatch KC will submit evidence to Healthwatch England and the Care Quality Commission. Healthwatch England is developing a strategy to support Local Healthwatch to ensure local consumers of health and social care can exercise their right to be heard and their right to redress. Healthwatch Central West London will report on the local environment to benchmark against the national picture.

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Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 16 May 2013

AGENDA ITEM NO.	2.13/May/13
PAPER	Low turn out for Council of Governors elections
AUTHOR	Chris Birch, Deputy Chairman, Membership Sub-Committee
LEAD	Chris Birch, Deputy Chairman, Membership Sub-Committee
EXECUTIVE SUMMARY	Attention is drawn to the worryingly low number of Trust Members who vote in Council of Governors elections and the need to do something about it.
DECISION/ ACTION	The Council is asked to agree the proposal the committee made and to suggest other things that might be done.

Low turn out for Council of Governors elections

1.0 Introduction

At the meeting of the Membership sub-committee on 21 March, I presented a short paper on the worryingly low turn out for Council of Governors elections. One of the decisions of that meeting was that the problem should be brought to the attention of the Council of Governors. Hence this paper.

2.0 Some facts

When I was first elected to the Council of Governors (then known as the Members' Council) in May 2007, there was only one vacancy for a patient governor and only two candidates. I got 961 votes and my unsuccessful opponent got 375. This means that only 1,336 patient members voted. At that time there were 5,898 patient members of the Trust, so only 22.65% of the electorate voted. Not very brilliant. At the last general election there was a turn out of 65.1%.

Subsequently we stopped publishing the voting figures, but the voting figures for successful candidates in the November 2012 elections were published on our website, and Vida obtained for the Membership sub-committee the figures for the unsuccessful candidates as well. Only 670 members of the 5,992-strong patient constituency voted. That is 11.2%, less than half the percentage turn out five and a half years previously.

This is particularly surprising and worrying as our elections last November were at a time when NHS reorganisation and the future of our hospital had been very much in the news, and more than 11,000 people completed our 'Safe in our hands' postcards and more than 6,500 people signed our online petition.

I find the actual figures and the marked decline in the votes between 2007 and 2012 deeply worrying.

The facts for the public and staff constituencies are no less worrying. In the public constituency there were three vacancies. There was no candidate for Kensington and Chelsea Area1 and only one candidate in Wandsworth Area 2, so consequently no one voted. In Hammersmith and Fulham Area 2, 125 members voted out of 1,064, ie 11.7%.

In the staff constituency there were vacancies in four of the six classes, but in three of these there was only one candidate, so they were elected unopposed. And there was no candidate in the management class, so not one of our staff members had the opportunity to vote.

3.0 The Health and Social Care Act 2012

The new Act places great emphasis on local responsibility and accountability. Governors have an integral role to play in this and are required to represent the interests of the members of the Trust and of the public and to relay information about the Trust, its vision and its performance to the members and the public.

4.0 Conclusion

If less than 12% of our members are sufficiently interested to vote in the Council of Governors elections, something is seriously wrong.

5.0 What should we do?

In addition to deciding to bring the problem to the attention of the Council of Governors, the Membership sub-committee asked the Communications team to prepare a bold

publicity campaign about the elections including much greater use of Trust News than in the past.

It is hoped that the Council will have further ideas for dealing with this problem.

The next elections are in July, so we don’t have much time.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 23 May 2013

AGENDA ITEM NO.	2.13.1/May/13
PAPER	Election to the Council of Governors – communication plan
AUTHOR	Vida Djelic, Foundation Trust Secretary Layla Hawkins, Head of communications & marketing
LEAD	Vida Djelic, Foundation Trust Secretary Layla Hawkins, Head of communications & marketing
EXECUTIVE SUMMARY	This paper provides an update on the election process and draft communications plan which was discussed by the Membership Sub-Committee.
DECISION/ ACTION	For discussion.

1.0 Introduction

As most governors are awe we are going to hold elections for seats on the Council of Governors. We have two governors coming to the end of their term tenure and a further two vacant seats from the November 2012 election (four seats in total).

Elections will be held in the following constituencies of the Council of Governors:

- Patient - 1 representative
- Public - 2 representatives
    - Hammersmith and Fulham Area 1
    - Kensington and Chelsea Area 1
- Staff – 1 representative
    - Management

2.0 Election timetable

The timetable, as agreed and approved by the Idox Elections is as outlined below.

Publication of notice of election	Not later than the fortieth day before the day of the close of the poll	Wednesday	8 May 2013 (-40)
Final day for delivery of nomination papers to returning officer	Not later than the twenty eighth day before the day of the close of the poll	Friday, By 12 Noon	24 May 2013 (-28)
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll	Tuesday	28 May 2013 (-27)
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll	Thursday By, 12 Noon	30 May 2013 (-25)
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll	Thursday	13 June 2013 (-15)
Close of the poll	By 5.00pm on the final day of the election	Thursday	4 July 2013
Election results	The day after close of the poll	Monday, by 12 Noon	8 July 2013

3.0 Communications

A proposed communication plan is outlined below.

Council of Governors election communications

Aims:

- To encourage more Governor nominations from existing members
- To encourage a higher uptake in voting from existing members
- To help increase the overall membership with a renewed advertising campaign

Please be aware that starred items will have cost implications, which will need to be approved by the Council of Governors.

Aim	Action	Responsibility	Deadline
To encourage more Governor nominations from existing members	Governor application pack distributed to all existing members by post with self-addressed freepost envelopes* - featuring case studies, actual time it takes to be a Governor, achievements made by Governors This would be costly exercise and we will publish Governor Information Pack VD is working on the website; SN also invited Capita recruiters to spend 3 days in the hospital w/c 7 May and w/c 13 May to recruit new members and to promote elections	Council of Governors/FT Secretary/Communications	Distributed 1 week May (design issues associated with this – might need external support)
To encourage more Governor nominations from existing members	Press release and quotes to local newspapers covering public constituency patches	Council of Governors/FT Secretary/Communications	2 week May
To encourage more Governor nominations from existing members	Second postal drop with contact details of a Governor for people considering taking up the role	Council of Governors/FT Secretary/Communications	2 week May
To encourage more Governor nominations from existing members	Open day stand	Council of Governors/FT Secretary/Communications	11 May
To encourage more Governor nominations from existing members	Speech at medicines for members VD to invite a governor	Council of Governors/FT Secretary/Communications	20 May
To encourage more Governor nominations from existing members	Strapline image on website	Communications	12 May
To encourage	Staff briefing – consider	Communications	3 May

more Governor nominations from existing members	asking a staff governor to attend and talk through role		
To encourage more Governor nominations from existing members	Email noticeboard campaign for staff	Communications	From now
To encourage more Governor nominations from existing members	Social media campaign	Communications	From now
To encourage more Governor nominations from existing members	Strapline image replicated on all PCs	Communications	From 11 May
To encourage a higher uptake in voting from existing members	Governor hustings held at the hospital and in venues at all the public constituency locations – one for each area	FT Secretary	Last two weeks of June
To encourage a higher uptake in voting from existing members	Postal pack to incorporate letter from Chairman expressing why it's important to vote	FT Secretary/Communications	13 June
To encourage a higher uptake in voting from existing members	Reminder mail out to the constituency members asking them to vote*	FT Secretary/Communications	3rd week June
To encourage a higher uptake in voting from existing members	Last chance to vote press release	Communications	3rd week June
To encourage a higher uptake in voting from existing members	Message on telephony system* (can we have the voiceover from one of our governors?)	FT Secretary/Communications	13 June until end of election
To encourage a higher uptake in voting from existing members	Message on information screens across the hospital	Communications	13 June until end of election
To encourage a higher uptake in voting from existing members	Through existing communications Trust News	Communications	13 June until end of election
To help increase overall membership	Quarterly advert in Local Council magazines to encourage membership*	Council of Governors/FT Secretary/Communications	Starting June Across four Boroughs meaning 16 adverts over the year

To help increase overall membership	Community roadshows in targeted shopping centres (being mindful of previous experiences using this medium, so a focus to be on smaller community shopping centres as opposed to Westfield)*	Council of Governors/FT Secretary/Communications	Tbc
To help increase overall membership	Council appointed canvassing in Boroughs where membership levels are lower than expected*	Council of Governors/FT Secretary/Communications	Tbc
To help increase overall membership	Mail out to all that signed up to safe in our hands campaign asking whether they would to join as members*	Council of Governors/FT Secretary/Communications	Tbc
To help increase overall membership	Refresh of membership packs and information on Chelwest website/intranet. To have distinct membership branding. To incorporate case studies of members	Council of Governors/FT Secretary/Communications	Tbc
To help increase overall membership	Advert in local newspapers to also cover dates of Board meetings held in public*	Council of Governors/FT Secretary/Communications	Tbc
To help increase overall membership	Social media campaign on a quarterly basis: • Achievements of Council of Governors over the previous quarter • Tweeting of medicine for members seminar • Tweeting of Board meetings • Tweeting of annual meetings	Council of Governors/FT Secretary/Communications	Tbc
To help increase overall membership	Through existing communications on a quarterly basis – Trust news, noticeboard, posters, information stand	Council of Governors/FT Secretary/Communications	Tbc
To help increase overall membership	Consider reviewing benefits given to members and what we can do to make it a more attractive prospect	Council of Governors/FT Secretary/Communications	Tbc
To help increase overall membership	Consider using mobile services to encourage uptake	Council of Governors/FT Secretary	Tbc – I will also be talking to Chelsea Football Club about a formal partnership with them and this

			could involve membership recruitment

4. Action

For discussion.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 23 May 2013

AGENDA ITEM NO.	2.14/May/13
PAPER	*Draft Minutes of the Council of Governors Membership Sub-Committee meeting held on 21 March 2013
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Martin Lewis, Chairman
EXECUTIVE SUMMARY	Draft minutes are enclosed.
DECISION/ ACTION	For approval.

Council of Governors Membership Sub-Committee, 21 March 2013
Draft

Attendees	Martin Lewis	ML	Chairman
	Chris Birch	CB	Patient Governor
	Anna Hodson-Pressinger	AH-P	Patient Governor
	Susan Maxwell	SM	Patient Governor
	Wendie McWatters	WMW	Patient Governor
	Maddy Than	MT	Staff Governor
In attendance	Katie Drummond-Dunn	KD-D	Communications Manager
	Sian Nelson	SN	Membership Manager
	Priti Bhatt	PB	Equality and Diversity Manager
	Vida Djelic	VD	Foundation Trust Secretary

1. Welcome & Apologies **ML**

Apologies were received from Samantha Culhane, James Dennis and Melvyn Jeremiah.

2. Minutes of previous meeting held on 24 January 2013 **ML**

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

3. Matters arising **ML**

The sub-committee noted that all matters arising were complete except for the one regarding the future Medicine for Members event on 'who governors are and what they do' which is to be scheduled in.

4. Membership Engagement and communication calendar of events **KD-D**

KD-D outlined the papers and note that the Medicine for Members seminars are scheduled every other month and topics suggested by members on p.4

Topics suggested by the sub-committee for the future Medicine for Members included:

- infection control
- young mums
- complementary medicine
- pain control and invite the specialist nurse to present
- gastroenterology and Gastric cancer
- end of life care

It was suggested that members are surveyed on the topics of interest.

Topics for May and July events were agreed.

It was noted that that ML and SM chaired the last two Medicine for Members events.

CB queried why the roles of governors did not appear on the list of future topics as this was previously agreed.

WMW suggested that due to recent opening of the new diagnostic centre governors should be invited to visit it.

5 Chelsea and Westminster Star Awards **KD-D**

The Sub-Committee noted that Katie Piper accepted the invitation to attend the Star Awards event on 18 April 2013.

KD-D highlighted that the three shortlisted candidates would be informed on the coming Monday and would be invited to attend the awards ceremony which will be held on 18 April at the Chelsea Football Club.

CB commented that it was difficult to shortlist candidates based on a very little information provided about nominees. He suggested that the requirement should be minimum 100 words for the next year nominations.

KD-D

6 Open Day May 2013

KD-D provided an update on the organisation of the event.

It was noted that WMW was assisting with selecting the VIP for the event; GV is working on the design; special zone for 20th anniversary - a special uniform and display; a big board to write on good thoughts – graffiti.

CB conveyed apologies for not being able to attend the afternoon part of the Open Day. He said that he will attend the morning part of the event.

It was noted that governors stand will be allocated in the Info Zone.

6.1 Agreement on the artwork for the freebie bags and mugs for Open Day 2013 **SM**

The Sub-Committee noted the two possible designs for the membership goodie bags and agreed the most preferred design.

7 Membership Recruitment Update

SN outlined the paper.

The sub-committee noted the ethnicity figures provided on p.3 and p.4. It was noted that the membership comprises of white mostly. Although we have a high number of white it is representative of the local population.

SN commented that in order to achieve the equality recruitment events should be held jointly for all ethnicity groups rather than specifically targeting one group only.

The importance of the Equality and Diversity Manager attending the sub-committee meetings was noted and it was suggested that she is invited to attend the future meetings regularly. **VD to write to PB.**

CB queried the membership figures of the trust total membership on the cover paper 15,272 and the figure provided in the table 1 which did not tally. SN said she will check the figures with Capita. **SN to provide the correct figure.**

Other points from CB included:

- Re 3.1 we do not need to maintain members but keep black recruiting
- Queried whether the Trust needs 900 general members
- Re 4.6 was excellent.
- Re 5.2 recruitment strategy – to be more focused on increasing number and engagement with Black , Ethnic and Minority Groups
- Re Ethnicity of public members - White are doing better than other

SN emphasised the need for maintaining the membership numbers.

With reference to pint 5.2 recruitment strategy SN said that that is what Trust aims to achieve and that regard she had discussed with PB the possible involvement of Engage. It is unclear at this stage whether they would be involved.

PB said that she understands that the membership is represented by the population but there is a lack of black representation. She felt that there needs to be more focus on engaging with the ethnic groups and suggested that Capita provides more detailed membership report. It was noted that she is looking at making proposal to Engage organisation which is in our catchment area.

CB noted that the sub-committee value PB's attendance and emphasised the importance of her regularly attending the future meetings.

The sub-committee discussed a suggestion by a governor re the membership form in relation to compliance with the Equality and Diversity legislation. SN commented that this information is not required by Monitor and therefore not provided via the membership report. It was confirmed that the membership application form needs to be updated in order to be compliant with the Equality and Diversity legislation. **SN/PB to work together on this.**

7.2 Mobile Health Clinic Bus **WMW**

SN highlighted that the appropriateness of the ethnic profile needs to be considered before organising the Health Buss Clinic. PB added that we should look at census data in order to be able to decide.

PB suggested the possibility of organising a diversity event. It was agreed that this should be considered for the future.

7.3 Trust News **CB**

CB outlined the background and noted that it could do more to win the interest from members. He noted that post Francis Inquiry Report the Trust News is even more important. SM suggested that two issues a year should be sent to members with the focus on members and their concerns.

CB said he discussed a number of ideas for the Trust News with Axel Heitmueller, Director of Strategy and Business Development and suggested to share these with the Membership sub-Committee and the new Head of Communications. He noted that the letter page and character need to change to be more patient friendly and also to contain both positive and negative news. SM felt that the Trust News is more staff oriented and suggested there should be 2 pages devoted to members with some patient stories.

KD-D provided some examples of less positive stories featuring in the previous editions of the Trust News; one example included 'you said – we did'.

8 Equality and Diversity update **PB**

This was discussed earlier in the meeting.

It was noted that the BME Staff Network existed in the past.

A possibility of having Caribbean Jazz and singers from the Princeton University was raised. KD-D responded that she will contact the Arts.

9 Low turn out for the Council of Governors elections **CB**

CB commented on a low turn out at the Council of Governors elections and commented that according to the total membership number in the patient and public constituencies at the last election less than half of members voted.

CB presented a paper on the low turn-out for Council of Governor elections and proposed the following actions:
1. VD to consult the Chairman and make an early decision about the date or dates of Council election or elections in 2013.
2. Communications team to prepare a bold publicity campaign about the election or elections including a much greater use of Trust News than in the past.
3. To bring this problem to the attention of the Council of Governors.

The Membership Sub-Committee agreed to the proposed actions.

VD said that the next election is planned for June 2013 and the election process is due to start around the end of April/beginning of May. She added that the ways of communicating elections to the members so far have been via Trust News, Daily Communication, website and posters in the hospital. The Notice of Election is sent by the Returning Officer, OPT2VOTE, to all members in the constituencies in which election takes place.

VD added that an important aspect of the election process is encouraging members to nominate themselves and SN has always assisted by arranging for Capita

recruiters to spend 3 days, during the nomination process timescale, in the hospital trying to recruit new members as well as encouraging members to nominate themselves.

VD said that the low turn out at voting is partly due to the fact that very often only one nomination is received per a seat and therefore the seat is uncontested and election does not take the place.

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

This paper was noted.

11 Any other business

None.

12 Date of next meeting – 16 May 2013

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 23 May 2013

AGENDA ITEM NO.	2.15/May/13
PAPER	*Membership Engagement and Communications calendar of events
AUTHOR	Katie Drummond-Dunn, Communications Manager
LEAD	Thérèse Davis, Chief Nurse and Director of Patient Experience and Flow
EXECUTIVE SUMMARY	This is the programme of membership engagement and communications activity following the approval of funding at the Council of Governors meeting on 14 February 2013.
DECISION/ ACTION	To note this update.

Membership Engagement & Communications Calendar of Events 2013/14

Date/Month	Event/Activity	Lead	Cost/Funding source
April 2013			
Friday 5 April	Members' News Issue 1	Communications Manager	£210 (Council of Governors)
w/c Mon 18 Apr	Membership mailing for all public and patient members (including covering letter from Chairman, Trust News and A5 flyers about future events for members)	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 2013			
Fri 3 May	Members' News Issue 2	Head of Communications	£210 (Council of Governors)
Sat 11 May	Open Day	Communications Manager	£20,000 (Council of Governors)
Monday 20 May	Medicine for Members seminar – Pain Management	Communications Manager	£700 (Council of Governors)
June 2013			
Friday 7 June	Members' News Issue 3	Head of Communications	£210 (Council of Governors)
July 2013			
Friday 5 Jul	Members' News Issue 4	Head of Communications	£210 (Council of Governors)
TBC	Medicine for Members seminar	Communications Manager	£700 (Council of Governors)
August 2013			
Fri 2 Aug	Members' News Issue 5	Head of Communications	£210 (Council of Governors)

Date/Month	Event/Activity	Lead	Cost/Funding source
TBC	Membership mailing (including covering letter from Chairman, *Trust News*, Annual Members' Meeting invitation)	Communications Manager	£10,000 (Foundation Trust budget)
September 2013			
Friday 6 Sep	Members' News Issue 6	Head of Communications	£210 (Council of Governors)
Thursday 19 Sept	Annual Members' Meeting	Head of Communications	£5,000 (Council of Governors)
TBC	Medicine for Members seminar	Communications Manager	£700 (Council of Governors)
October 2013			
Friday 4 Oct	Members' News Issue 7	Head of Communications	£210 (Council of Governors)
November 2013			
Friday 1 Nov	Members' News Issue 8	Head of Communications	£210 (Council of Governors)
TBC	Medicine for Members seminar	Communications Manager	£700 (Council of Governors)
December 2013			
Friday 6 Dec	Members' News Issue 9	Head of Communications	£210 (Council of Governors)
TBC	Christmas at Chelsea and Westminster event (mini Open Day)	Communications Dept	£8,000 (Council of Governors)

Date/Month	Event/Activity	Lead	Cost/Funding source
January 2014			
Friday 3 Jan	Members' News Issue 10	Head of Communications	£210 (Council of Governors)
TBC	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 other future events)	Communications Manager	£10,000 (Council of Governors)
TBC	Launch of Star Awards nominations – Patient Choice category and Council of Governors Special Award	Communications Manager	Not from Council of Governors budget (Star Awards funded by Chelsea and Westminster Health Charity)
TBC	Medicine for Members seminar	Communications Manager	£700 (Council of Governors)
February 2014			
Friday 7 Feb	Members' News Issue 11	Communications Manager	£210 (Council of Governors)
TBC	Closing date for Star Awards nominations – Patient Choice category and Council of Governors Special Award	Communications Manager	Not from Council of Governors budget (Star Awards funded by Chelsea and Westminster Health Charity)
March 2014			
Friday 7 Mar	Members' News Issue 12	Head of Communications	£210 (Council of Governors)
TBC	Medicine for Members seminar	Communications Manager	£700 (Council of Governors)

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 23 May 2013

AGENDA ITEM NO.	2.16/May/13
PAPER	*Council of Governors Membership Report
AUTHOR	Sian Nelson, Membership and Engagement Manager
LEAD	Thérèse Davis, Chief Nurse and Director of Patient Experience and Flow
EXECUTIVE SUMMARY	The paper outlines a current membership figures and plans for recruitment during 2013/14.
DECISION/ ACTION	The Council of Governors is asked to review.

1.0 Membership size and movements

Table 1 below shows the size and movement of membership for the year April 2012 to end of March 2013 by cumulative totals and by membership type.

Table 1. Size and movement of membership

OVERALL MEMBERSHIP OVERVIEW	Last Year 1 Apr 12 – 31 Mar 13	Current Situation 30 April 13
As at start	**14,858**	**15,268**
New Members	1,811	10
Members leaving or changing constituency	1,401	191
TOTAL	**15,268**	**15,087**
PUBLIC MEMBERSHIP OVERVIEW	**Last Year 1 Apr 12 – 31 Mar 13**	**Current Situation 30 April 13**
As at start	**5,942**	**5,850**
New Members	225	3
Members leaving or changing constituency	317	104
TOTAL	**5,850**	**5,749**
PATIENT MEMBERSHIP	**Last Year 1 Apr 12 – 31 Mar 13**	**Current Situation 30 April 13**
As at start	**5,685**	**5,994**
New Members	573	7
Members leaving or changing constituency	264	87
TOTAL	**5,994**	**5,914**
STAFF MEMBERSHIP	**Last Year 1 Apr 12 – 31 Mar 13**	**Current Situation 30 April 13**
As at start	**3,231**	**3,424**
New Members	1,013	0
Members leaving or changing constituency	820	0
TOTAL	**3,424**	**3,424**

2.0 Membership Joiners and Leavers January to April 2013

2.1 Public Membership

Table 2 below shows public membership joiners and leaves between January and April 2013 (Q4 2012/13). There were 17 members of the public who joined and 13 who left membership during this period.

Month	Jan	Feb	March
Joiners	3	3	11
Leavers	3	3	7

Table 2. Public Membership joiners and leavers January to April 2013

2.2 Patient Membership

Table 3 below shows patient membership joiners and leavers between January 2013 and April 2013 (Q4 2012/13). There were 5 patients who joined as members whilst 94 left patient membership during this period

Month	Jan	Feb	March
Joiners	2	2	1
Leavers	81	4	9

Table 3. Patient membership joiners and leavers January to April 2013

2.3. Staff Membership

Total staff membership at the end of March 2013 (Q4 2012/13) was 3,424.

3. Public Membership Ethnicity

Figure 1 shows public membership ethnicity. At the end of Quarter 4, 2012/13, the highest proportion of ethnicity is within the white category, and the lowest representation remains in the 'mixed' group.

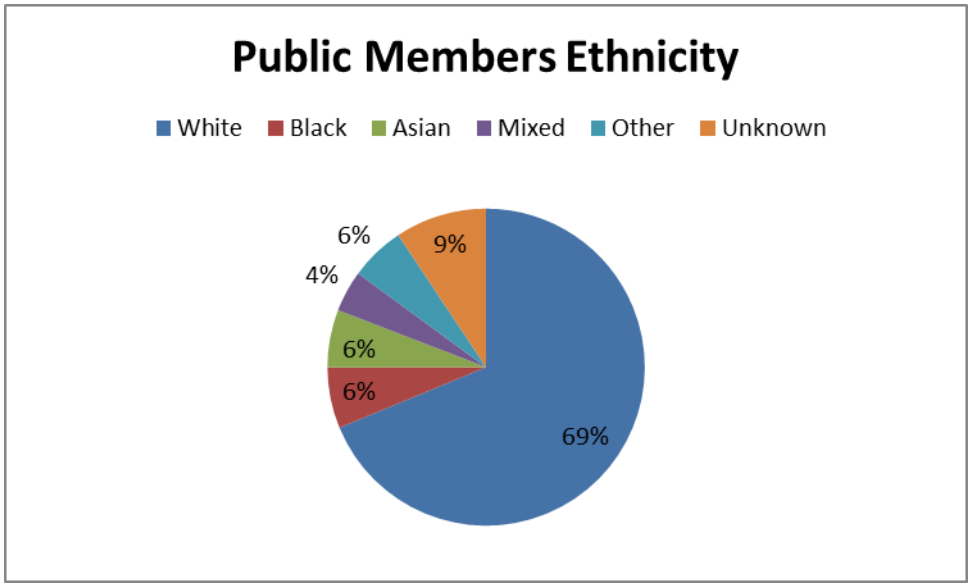
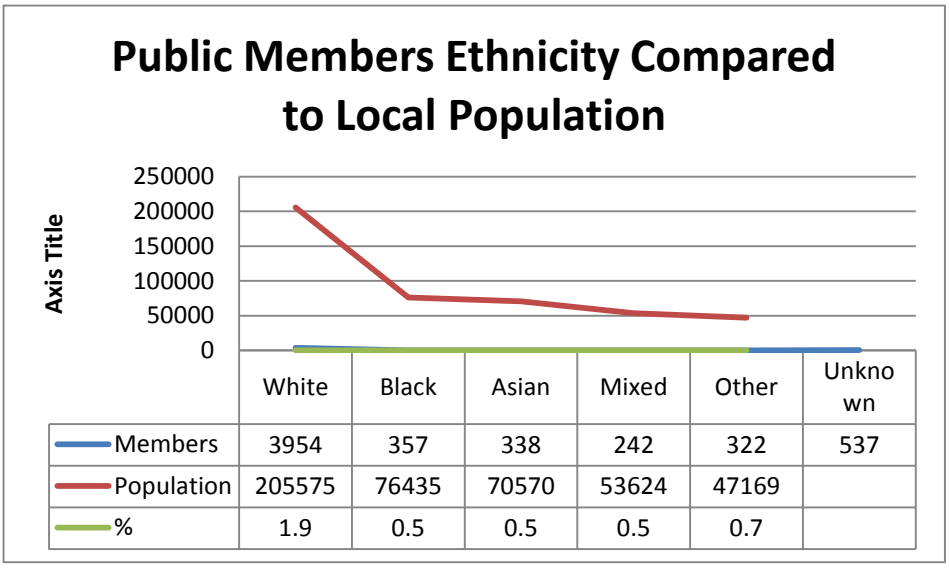


Figure 1. Public Membership Ethnicity end of March 2013 (Q4 2013/14)

3.1. Public Membership Ethnicity – comparison against local eligible population

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



	White	Black	Asian	Mixed	Other	Unknown
Members	3954	357	338	242	322	537
Population	205575	76435	70570	53624	47169	
%	1.9	0.5	0.5	0.5	0.7	

Figure 2. Public Membership Ethnicity - comparison against local eligible population. End of March 2013 (Q4 2013/14).

4.0 Public Membership Age

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

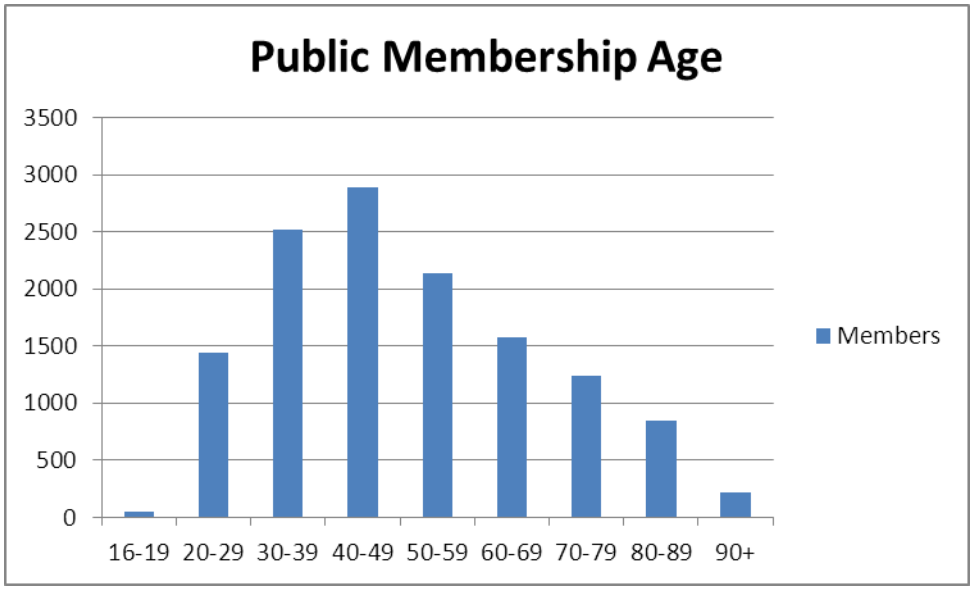
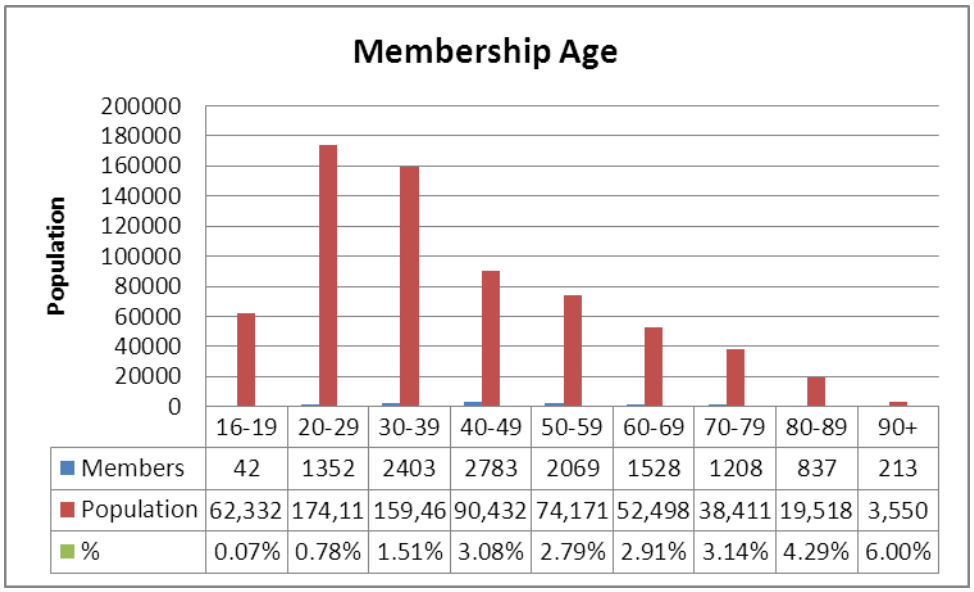


Figure 3. Public Membership Age

4.1 Public Membership Age – Comparison against local eligible population

Figure 4 shows the public membership profile in comparison to the local eligible population. The representation rises from 40 years and peaks in the 80-89 and 90+ year group.



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

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

5.0 Public Membership - Socio-economic grouping

Figure 5 below shows public membership by socio-economic groups. At end of March 2013 (Q4 2013/14) the highest representation remains in the ABC1 category*

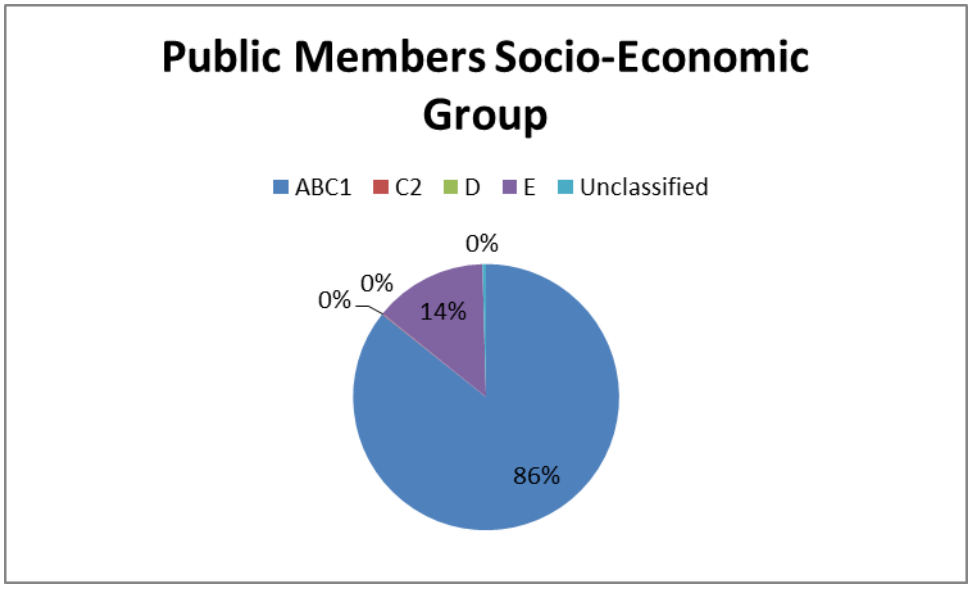


Figure 5 Public Membership - Socio-Economic Groups*

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

6.0 Membership Recruitment

6.1 From 1st April 2012 to end of March 2013 a total of 1811 members joined and a total of 1401 members left the trust.

It has been requested through the Membership Sub-Committee that membership reports are re-scheduled to report quarterly. This will enable consistency of information, enabling the same report to go to the Membership Sub-Committee meeting, the Council of Governor meetings and the Board. In addition, this method will show the impact of membership movement over a significant amount of time.
Reports would be published at the end of each quarter and available as follows during 2013/14.

	Dates	**Reports available**	**Membership Sub-Committee**	**Council of Governors**	**Board**
Q1	April – June 2013	July	2nd July	18th July	25th July
Q2	July-September 2013	October	14th November	12th December (Inc. Q1, Q2)	31st October
Q3	October-December 2013	January	**TBC**	**TBC**	**TBC**

Q4	January-March 2014	April	**TBC**	**TBC**	**TBC**

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

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

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

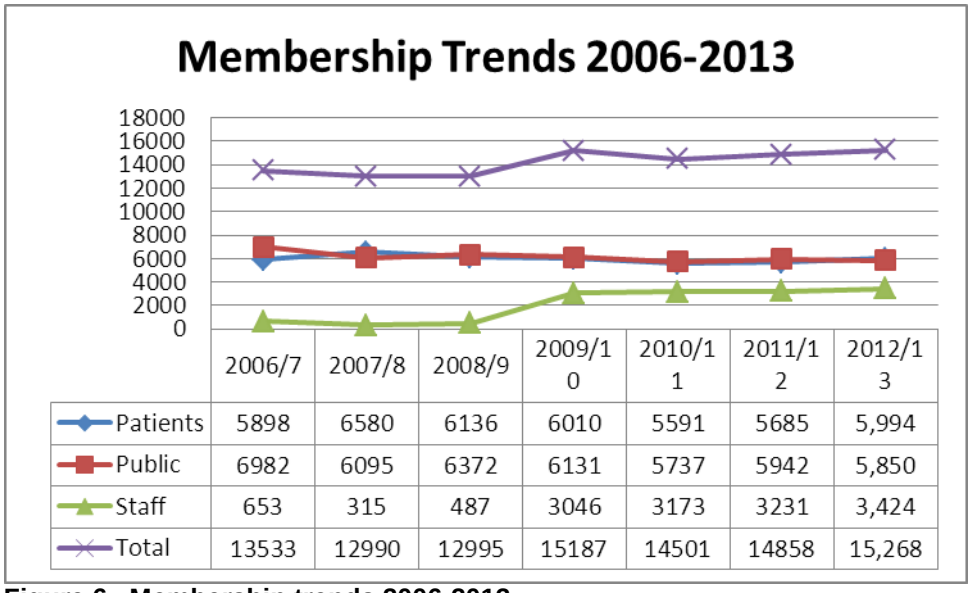
6.5. The Patient Advice and Information Service support membership promotion. Visitors to the PALS office, when appropriate are offered a membership application form. Application forms are sent with patient response letters and the team will continue to actively promote membership.

6.6. A member's email contains over 3,000 emails registered. This is now used for low cost, rapid response membership consultation.

6.7. The Communications team concentrate on Membership engagement and a plan for membership events has been agreed for 2013/14.

6.8. Membership recruitment campaigns are planned for 2013/14 – the first has taken place in May 2013 including Open Day. The aim is to recruit 900 new members throughout the year to ensure membership numbers are maintained.

6.9. Figure 6 shows the trends in Trust membership from 2006-2013.



	2006/7	2007/8	2008/9	2009/10	2010/11	2011/12	2012/13
Patients	5898	6580	6136	6010	5591	5685	5,994
Public	6982	6095	6372	6131	5737	5942	5,850
Staff	653	315	487	3046	3173	3231	3,424
Total	13533	12990	12995	15187	14501	14858	15,268

Figure 6. Membership trends 2006-2013

7. Recruitment Campaigns

7.1. Recruitment campaigns are scheduled for four times throughout 2013 with an aim of 900 new members to counteract those members that leave membership.

7.2. The first event completed was week of May 7th – this included Open Day on 11th May 2013. The recruitment event aimed to gain 300 new members, promote Open Day and the Governor Elections. The recruited 300 new members which will be shown on the Q1 2013/14 report.

8.0 Developing a Representative Membership

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

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

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

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

9.0 Summary

9.1. The hospital gained Foundation Trust status in 2006 and at year end 2006/07 totalled 13, 533 members. Membership numbers peaked in 2009 when staff members' status changed from 'opt in' to 'opt out'.

9.2. We need to continue our focus on recruitment to maintain our membership numbers whilst also seeking a representative membership. Beyond this, we have introduced initiatives such as 'Medicine for members' to actively encourage the engagement of members in the work of our hospital.

10. Membership Recruitment 2013/14

The below table summarises key recruitment events scheduled for 2013/14.

Month	Event	Total Recruited	Report	Funds Approved
May 2013	Members Recruitment Campaign Promotion for Open Day May 2013 And Governor Elections	300 members	Q1 2013/14	£2,340
June 2013	Members Recruitment Campaign (Inc. within the community)	Aim - 300 members	Q1 2013/14	£2,340
September 2013	Members Recruitment Campaign and promotion of the Annual Members Meeting (within the hospital)	Aim – 150 members	Q2 2013/14	£1170
October 2013	Members Recruitment Campaign and promotion of Governor Elections (Inc. within the community)	Aim – 150 members	Q3 2013/14	£1170