NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

AGENDA ITEM xx/17

Senior Governor Report
Council of Governors, 30th October 2017

Changes to the Board of Directors

This is the final meeting for Wendy Williams, Chair of our Trust, so on behalf of all of us, I would like to thank her for her service and wish her well in the future. Our next Council meeting will be Chaired by Phil Edgington and I'm sure we would all like to wish him well in this important role.

Helen Porter, Director of Nursing & Quality is to retire from the Trust in February 2018. The Strategy Committee have benefitted greatly from Helen's lead in supporting Governors gain a greater understanding and contribution to the business planning process year on year. The recruitment process for Helen's successor will conclude in November 2017 and Governors will be notified accordingly.

Peter Kirkbride, Medical Director retired at the end of September 2017 and the new Medical Director Sheena Khanduri will join the Trust on 1st December 2017. During the interim period from 1st October to 1st December 2017, Dr Ernie Marshall will be the Interim Medical Director.

I'm sure the Council would wish to join me in thanking all three individuals for the valued contribution to the success of the Trust and wishing them well for the future.

Annual Members Meeting (AMM) – 28th September 2017

At the Annual Members Meeting a number of topics were raised which I have discussed with Wendy and the following are suggestions as to which Governor Committees should monitor assurance that these matters are being addressed:

Patient Experience Committee:

- Consideration of patient journey times and appointment times.
- The use of emerging technology for patient appointments.

Membership & Communications Committee:

- Consideration of targeted communication specifically to individual Members.
- How do we best notify Members of the Annual Members Meeting?
- How are we assured of NED's and Executives visibility across the organisation.
- Patient Safety Walk rounds.

Strategy Committee:

- Staffing concerns re private rooms.
- Will patients feel cut off in individual private rooms?
- Long term finance monitoring to make sure that the new build doesn't bankrupt the Trust.

- Assurance re an expanded home care service.
- Impact of the Royal Hospital demolition on our site.
- Development plans for the Wirral and Aintree sites.

Mersey Internal Audit Agency (MIAA) Governors Event - Person Centred Care, Friday 23rd June 2017

The above event was held at Haydock Park, the workshop was about helping governors build a better understanding of how to hold NEDs to account on the subject of person-centred care through framing effective questions.

As a governor how do you know the care that is being delivered in your Trust is person centred and what does that mean?

John Roberts, public Governor attended, attached is a copy of the presentations for information.

Events / discussion sessions

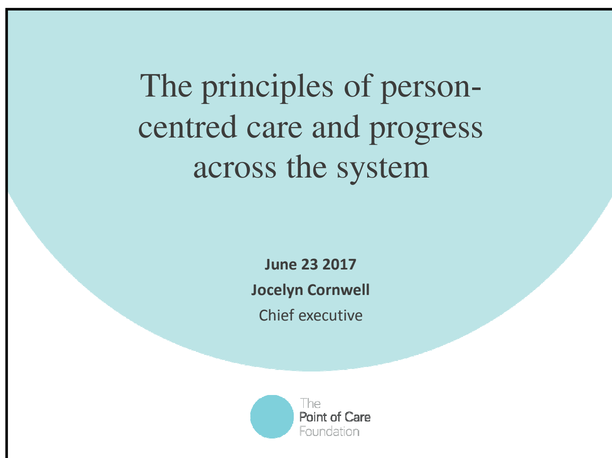
Recently we have received useful presentations about the new build, with more detail. For those who are interested the webcam address is www.cctvmon.com/Clatterbridge.html
With the proposed handover of our new hospital scheduled for 2020, we can keep up to date on progress by looking at the webcam.

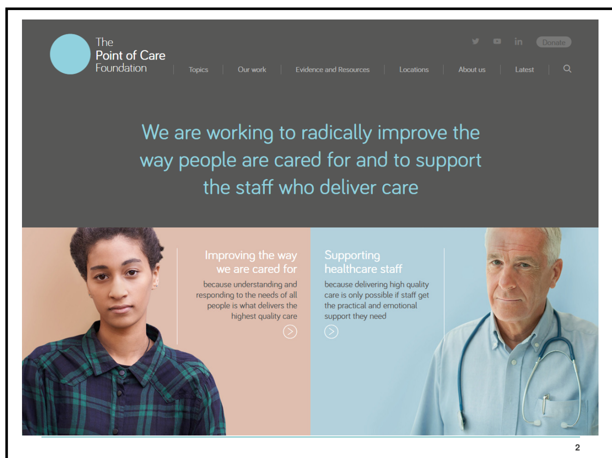
A number of courses are available to Governors during the next year. New Governors will be offered one directly applicable to them. Andrea Leather is the best source of information for other courses if you would find them helpful.

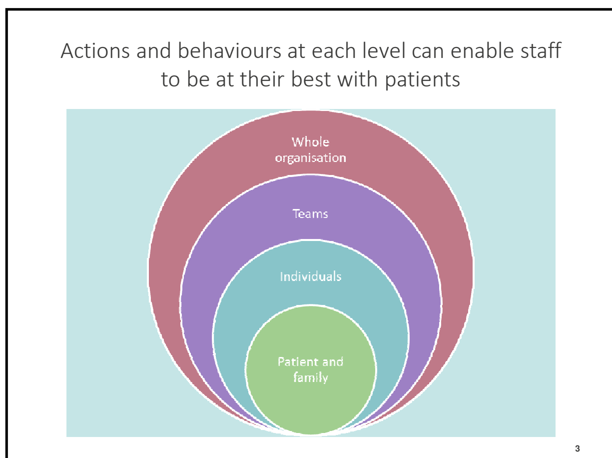
Over the summer we held elections for Governors, I would like to welcome new Governors who begin their term of office and this is their first Council of Governors meeting. If you wish to contact me I am happy to share my mobile number and email address either at the meeting or alternatively via Margaret Moore or Andrea Leather.

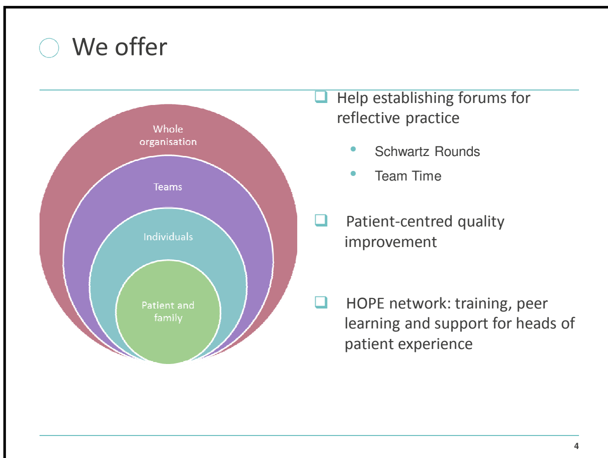
Can I also take this opportunity to remind/invite Governors to attend Trust Board meetings as observers, for dates of the meetings please contact either Andrea or Margaret at andrea.leather@nhs.net or Margaret.moore12@nhs.net.

Stephen Sanderson CBE
Senior Governor


The principles of person-centred care and progress across the system
June 23 2017
Jocelyn Cornwell
Chief executive
The Point of Care Foundation


The Point of Care Foundation
Topics
Our work
Evidence and Resources
Locations
About us
Latest
We are working to radically improve the way people are cared for and to support the staff who deliver care
Improving the way we are cared for
because understanding and responding to the needs of all people is what delivers the highest quality care
Supporting healthcare staff
because delivering high quality care is only possible if staff get the practical and emotional support they need
2


Actions and behaviours at each level can enable staff to be at their best with patients
Whole organisation
Teams
Individuals
Patient and family
3

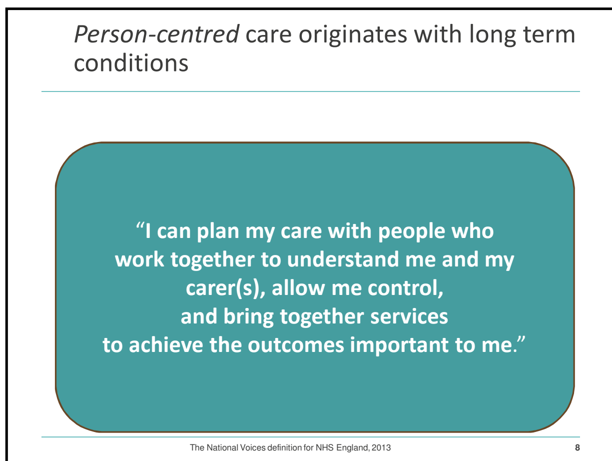


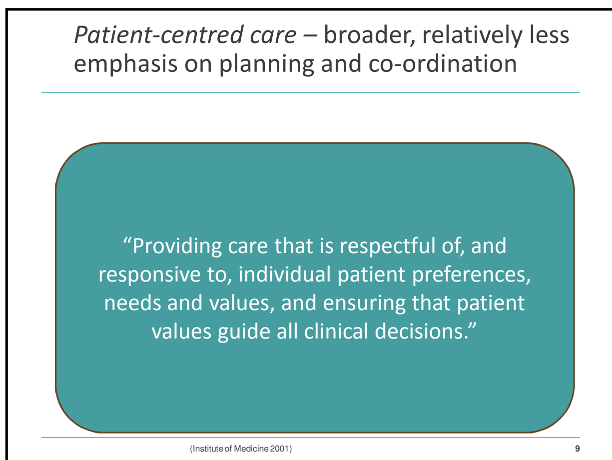
Overview

1. Definitions of person-centred care
2. The challenges
3. What helps?
4. Lessons from evidence and experience

5

Person- centred
care
7


Person-centred care originates with long term conditions
"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."
The National Voices definition for NHS England, 2013
8


Patient-centred care – broader, relatively less emphasis on planning and co-ordination
"Providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions."
(Institute of Medicine 2001)
9

Progress is poor, in primary care especially

- Primary care
  - 3.3% of patients with a long term condition had a written care plan
- Acute inpatients
  - 54% patients involved as they want to be in decisions
  - 34% involved to some extent
- Community mental health services
  - 59% know who coordinates their care and feel it's done well
  - 50% as involved as they want to be
  - 38% to some extent

10

The risk of too many, sound-alike words

PERSON-CENTRED

Personalised,
Coordinated and Empowering

Patient-centred

Relationship-centred

Individualised

Plain English works for everyone

KIND

Welcoming

friendly, warm, caring

involve relatives, friends

See me as a person

Care experiences are multi-dimensional

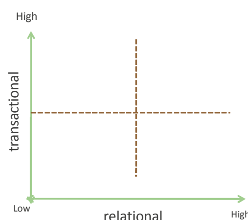
1. Respect for values, preferences, and expressed needs
2. **Coordination and integration of care**
3. **Information, communication, and education**
4. Physical comfort
5. Emotional support
6. Welcoming the involvement of family and friends
7. **Transition and continuity**
8. Access

Based on the Institute of Medicine (2000)

And are a mix of 'what' (T) and 'how' (R)

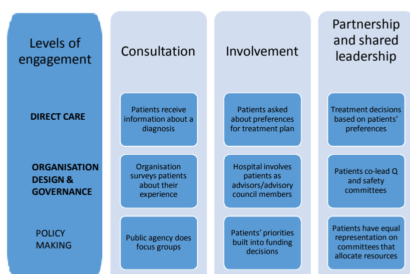
1. Respect for values, preferences, and expressed needs (R)
2. Coordination and integration of care (T)
3. Information, communication, and education (T+R)
4. Physical comfort (T)
5. Emotional support (R)
6. Welcoming the involvement of family and friends (T + R)
7. Transition and continuity (T)
8. Access (T)

Transactional (T) and relational (R) dimensions of care



Engagement with patients: important but at what level, and what is the goal?

Continuum of engagement



50 Reasons Not To Change

The problems are **adaptive**, not **technical**

Technical problems are typically:

1. Short term
2. High disturbance triggers an immediate action /response
3. Organisations and individual know how to solve the problem
4. The problem can be fixed fairly quickly
5. The real solutions are known and problems can be solved

Technical 17

Adaptive problems

1. Take a long time and are slow to manifest
2. Create on-going discomfort & stress as people try to work around them
3. Depend a great deal on leaders and their skills working with people
4. Leaders' tasks
   - Keep staff engaged with the uncertain process of change
   - Help them cope with frustrations
   - Have compassion for those disturbed by changes
   - Hold steady
   - Experiment, foster attitudinal and behavioural change

18

Clinical leadership is vital

Typically
- Critical for success and sustainability
- Nurses more willing to engage than others
- Doctors' involvement is key
- Influence with colleagues, wider team

19

Guidance, training support also needed

- Despite the policy rhetoric, the changes feel new
- Culturally challenging
- People are used to top down guidelines and protocols
- Freedom to make changes themselves feels new
- Teamwork and good project management are essential

20

THANK YOU

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www.pointofcarefoundation.org.uk

21

Tools and techniques to enable person-centred care

Mersey Internal Audit Agency

23rd June 2017

Bev Fitzsimons

@PointofCareFdn bevfitzsimons@pointofcarefoundation.org.uk

@fitzy45

The Point of Care Foundation

A surgeon's story

BMJ

BMJ 2013;347:f6728 doi: 10.1136/bmj.f6728 (Published 8 November 2013) Page 1 of 2

NEWS

Patients' actual care pathways often differ markedly from doctors' perceptions

Nigel Hawkes

London

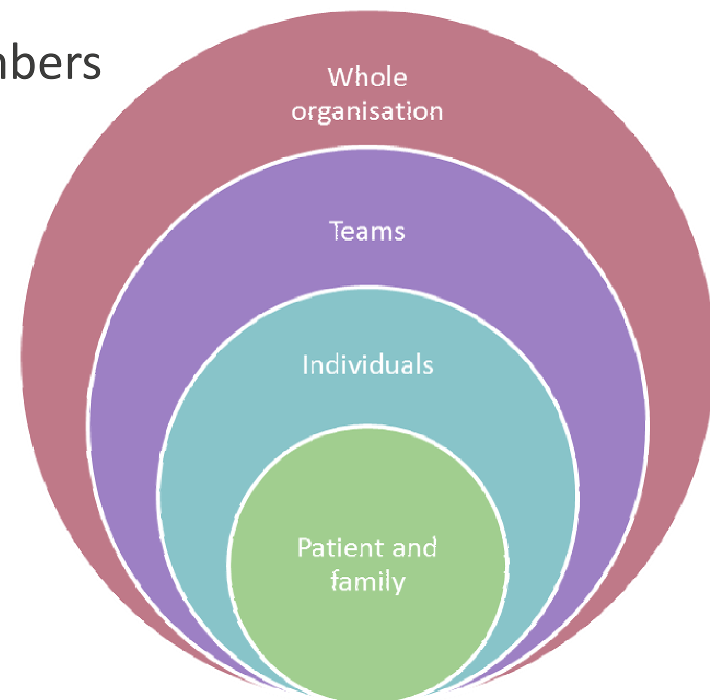
Hiro Tanaka
Consultant orthopaedic surgeon
Aneurin Bevan
University Health Board

Our starting proposition

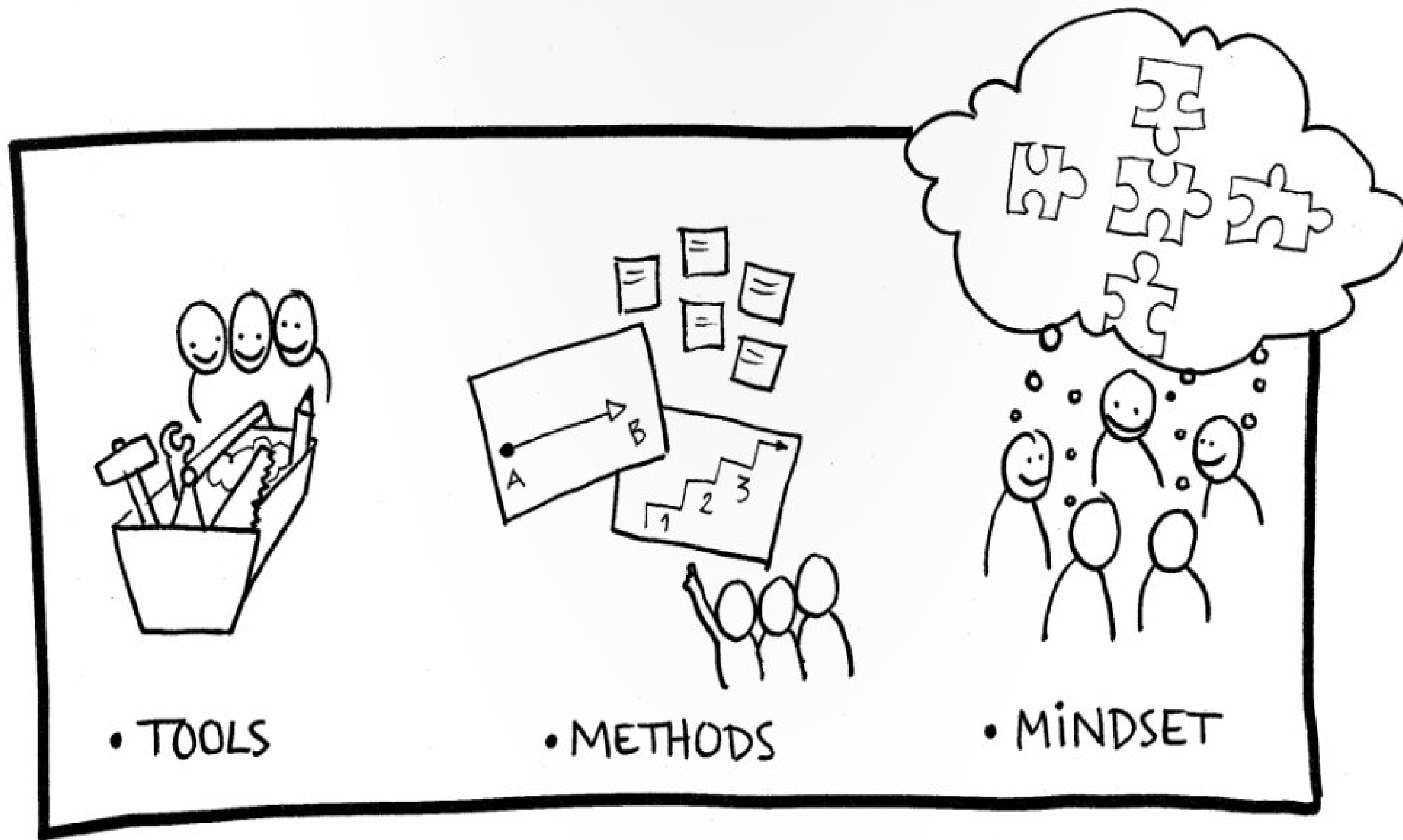
- The lens is patients’ experience
- All improvements are rooted in patients’ and staff experience
- Patients are central to all activities
- The goal: equip staff with skills and confidence to understand patients’ experiences and include them in quality improvement

The impact

- Formalise the connection between staff and patients' experience of care
- Provide staff with the time, space and structure to get inside patients' shoes
- Build powerful bonds between team members
- Reconnect people with their reasons for entering their profession
- For people who do not see patients face to face, provide a stronger sense of meaning in their work

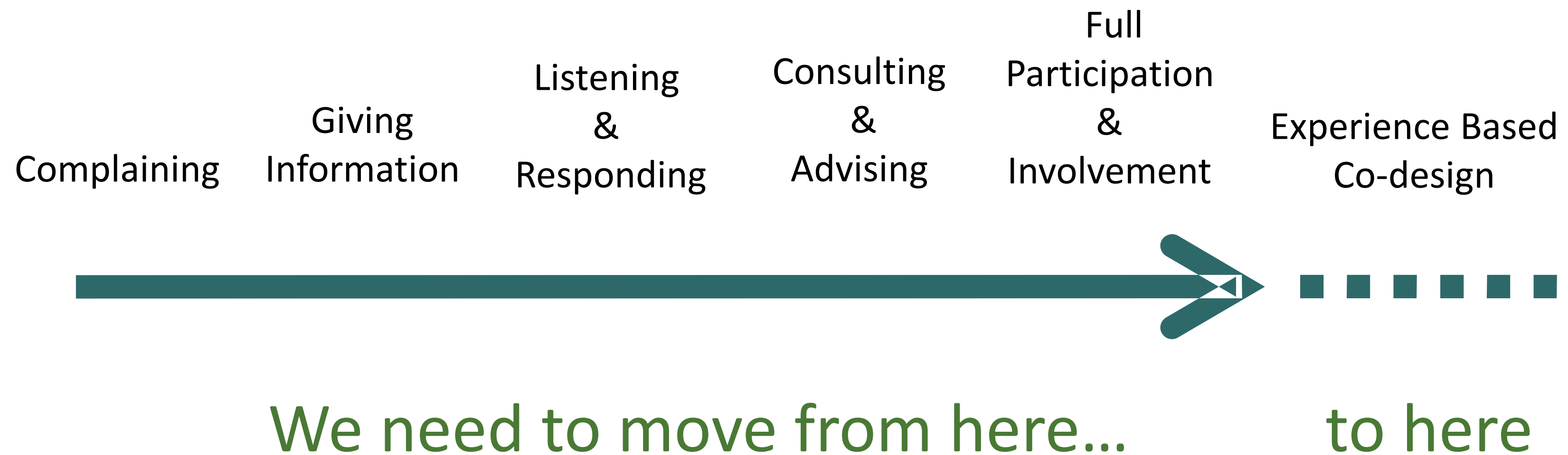


Patient focus and true collaborative work with patients changes minds

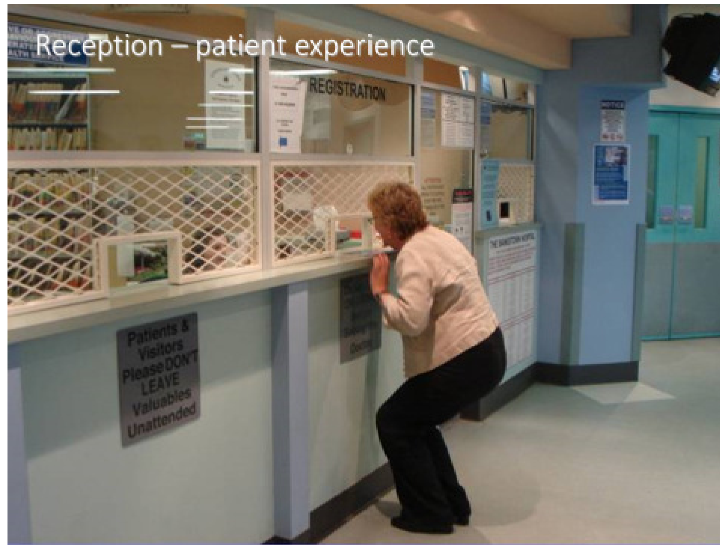


Sources of data on patients' experiences

Continuum of patient influence



Observations of care



Reception – patient experience

Exercise: In pairs "*When I was a patient …*"

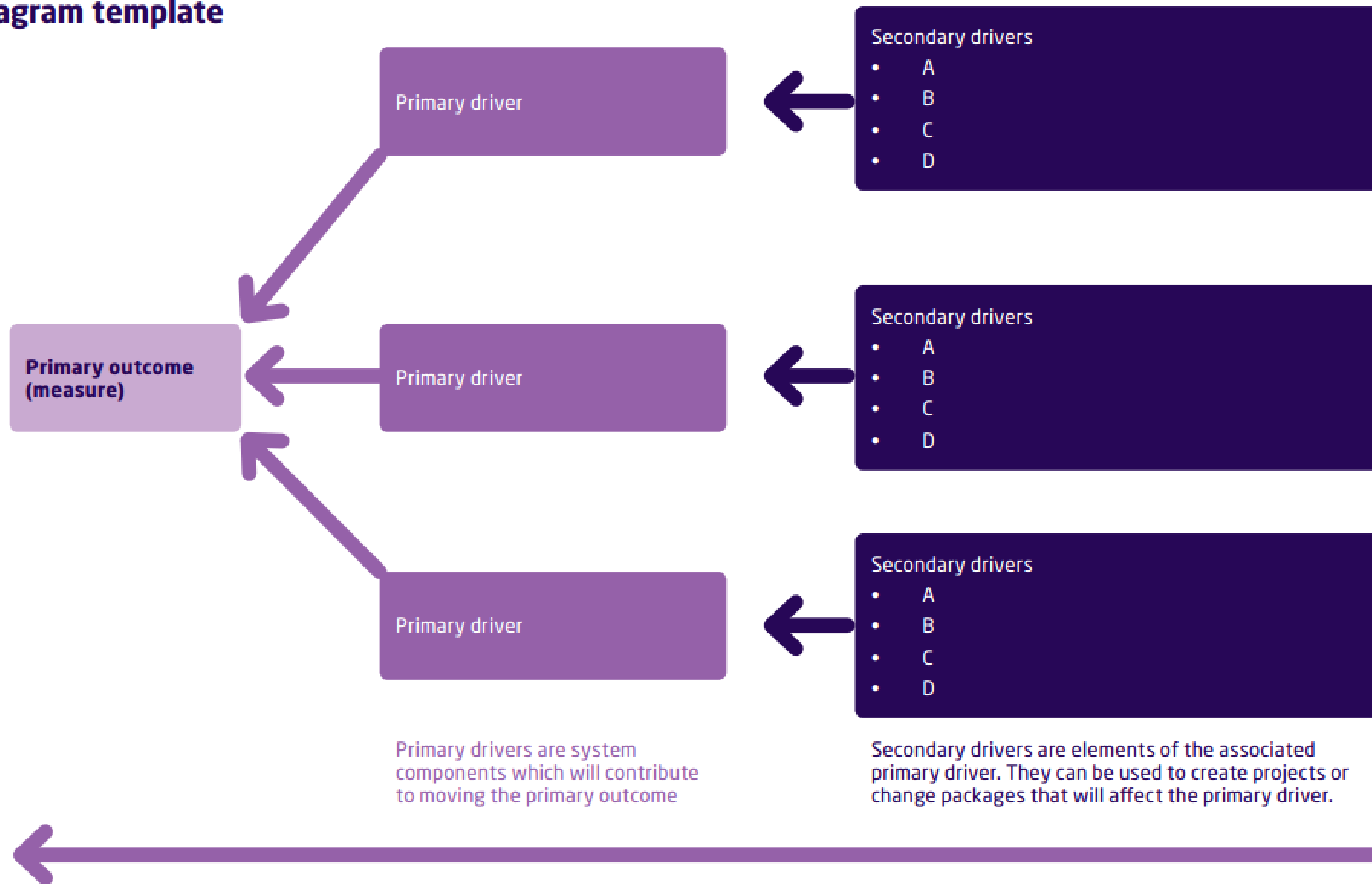
5- 10 minutes

- What aspects of care did your particularly appreciate?
- What would you change, if you had been able to?
- How easy would this be to change?

Turning insights into improvement goals

- **Step 1 – Understand the current state and create urgency for change**
- **Step 2 – Write the ‘ideal care experience’ – write it in the first person**
- **Step 3 – Analyse**
  - Where are you doing well?
  - What should you do more of?
  - Where are there gaps?
  - What needs improvement
- **Step 4 – Devise a ‘driver diagram’ – the ‘plan on the page’**
  - To understand what are the main influences on quality
  - To understand what is already being done to promote improvement
  - To make a clear link between the actions you take and their anticipated impact
- **Step 5 – Generate ideas for improvement**
- **Step 6 – Implement and review**

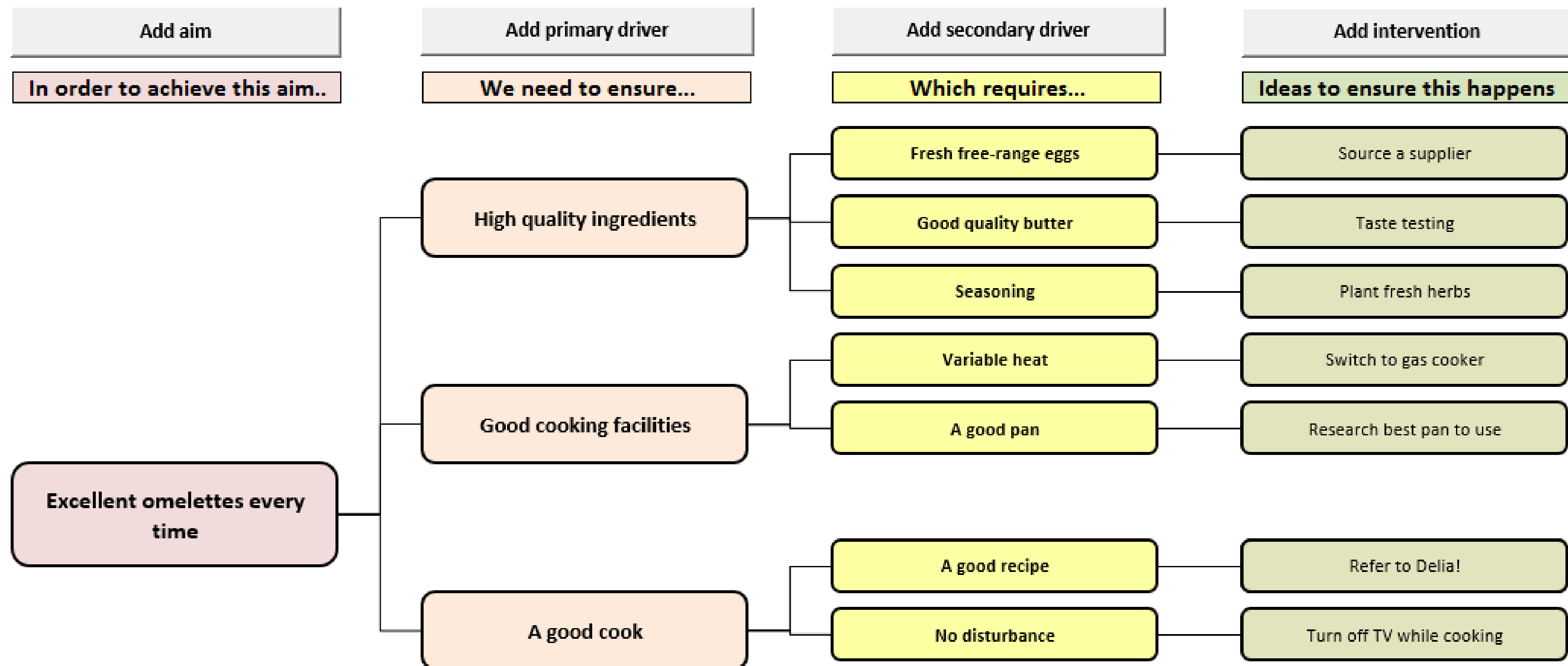
Driver diagrams

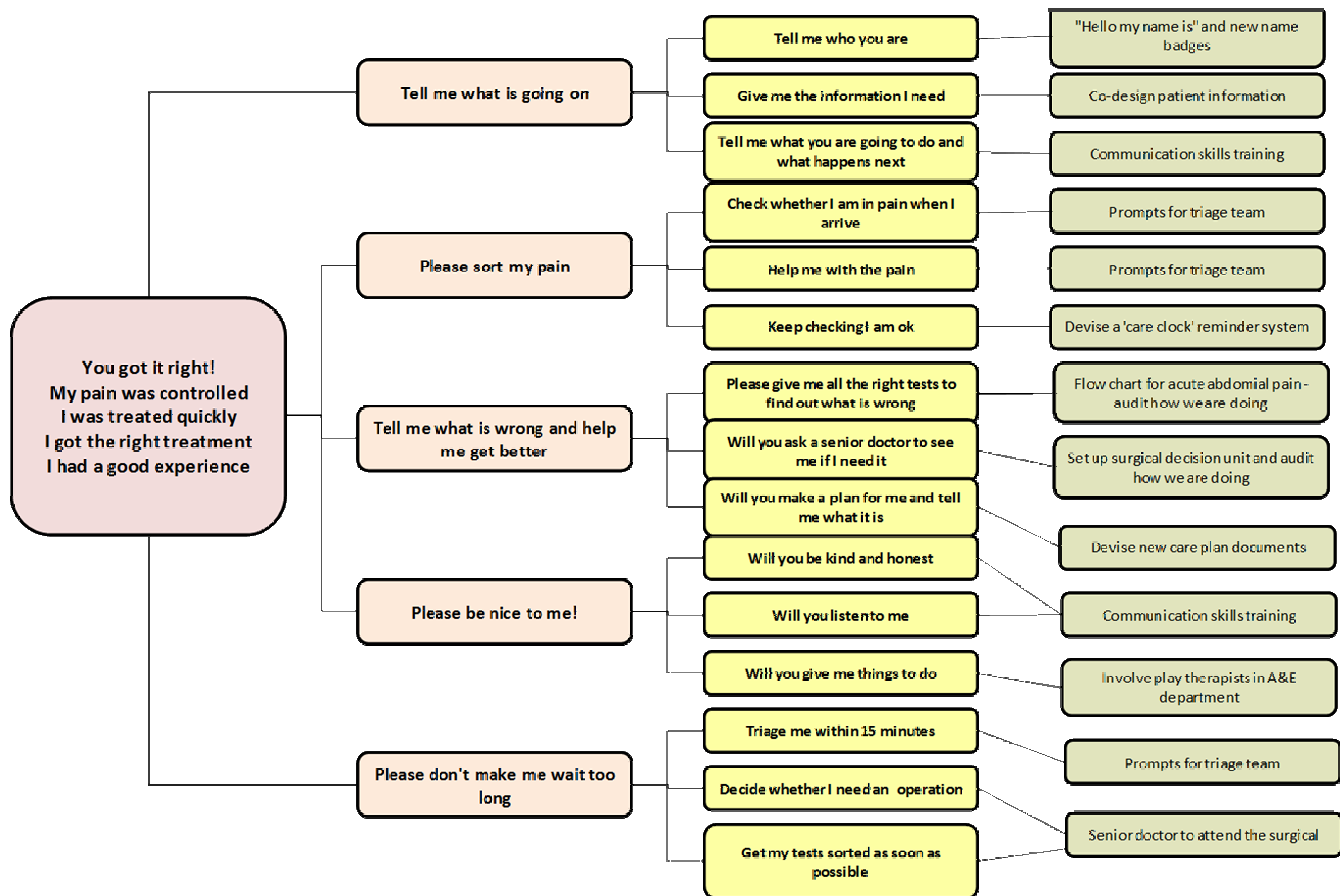


http://www.ihi.org/about/Documents/IHI90DayResearchandDevelopmentProcessAug10.pdf

Source: Institute for Healthcare Improvement

An example



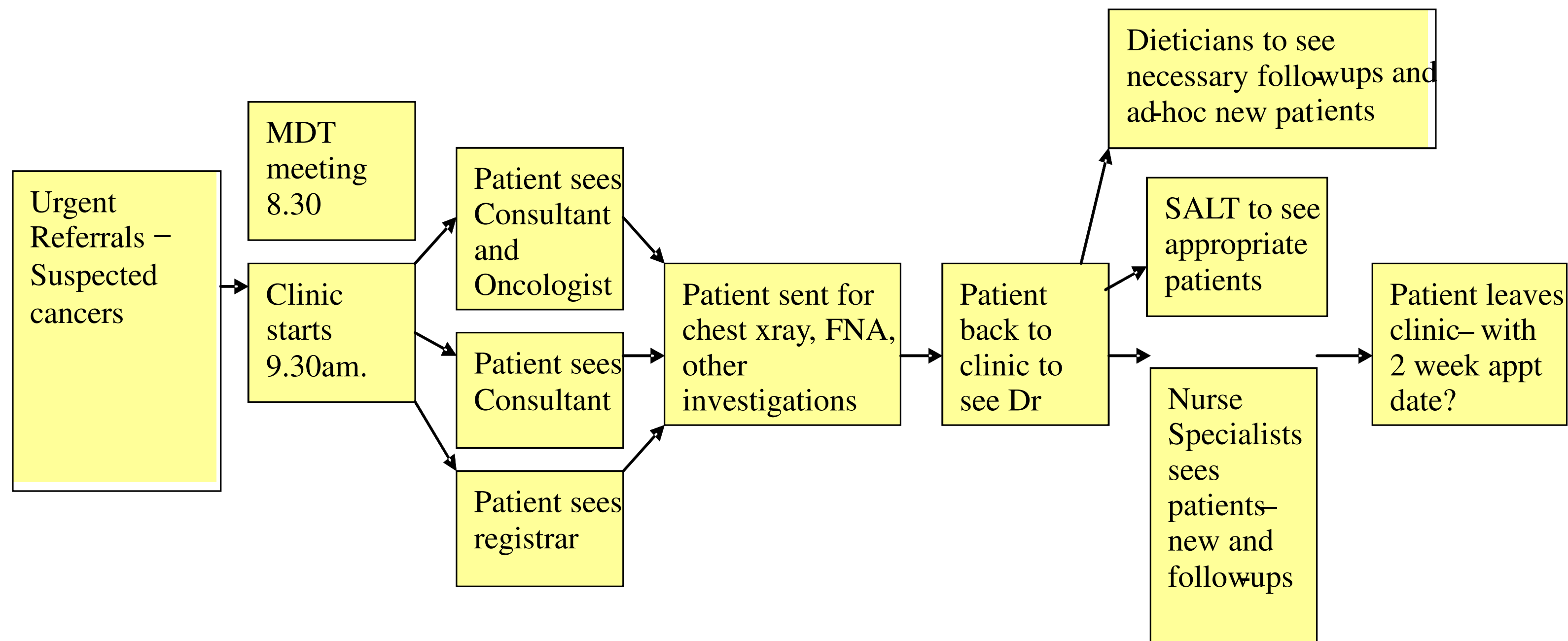


You got it right!
My pain was controlled
I was treated quickly
I got the right treatment
I had a good experience
Tell me what is going on
Please sort my pain
Tell me what is wrong and help me get better
Please be nice to me!
Please don't make me wait too long
Tell me who you are
Give me the information I need
Tell me what you are going to do and what happens next
Check whether I am in pain when I arrive
Help me with the pain
Keep checking I am ok
Please give me all the right tests to find out what is wrong
Will you ask a senior doctor to see me if I need it
Will you make a plan for me and tell me what it is
Will you be kind and honest
Will you listen to me
Will you give me things to do
Triage me within 15 minutes
Decide whether I need an operation
Get my tests sorted as soon as possible
"Hello my name is" and new name badges
Co-design patient information
Communication skills training
Prompts for triage team
Prompts for triage team
Devise a 'care clock' reminder system
Flow chart for acute abdomial pain - audit how we are doing
Set up surgical decision unit and audit how we are doing
Devise new care plan documents
Communication skills training
Involve play therapists in A&E department
Prompts for triage team
Senior doctor to attend the surgical

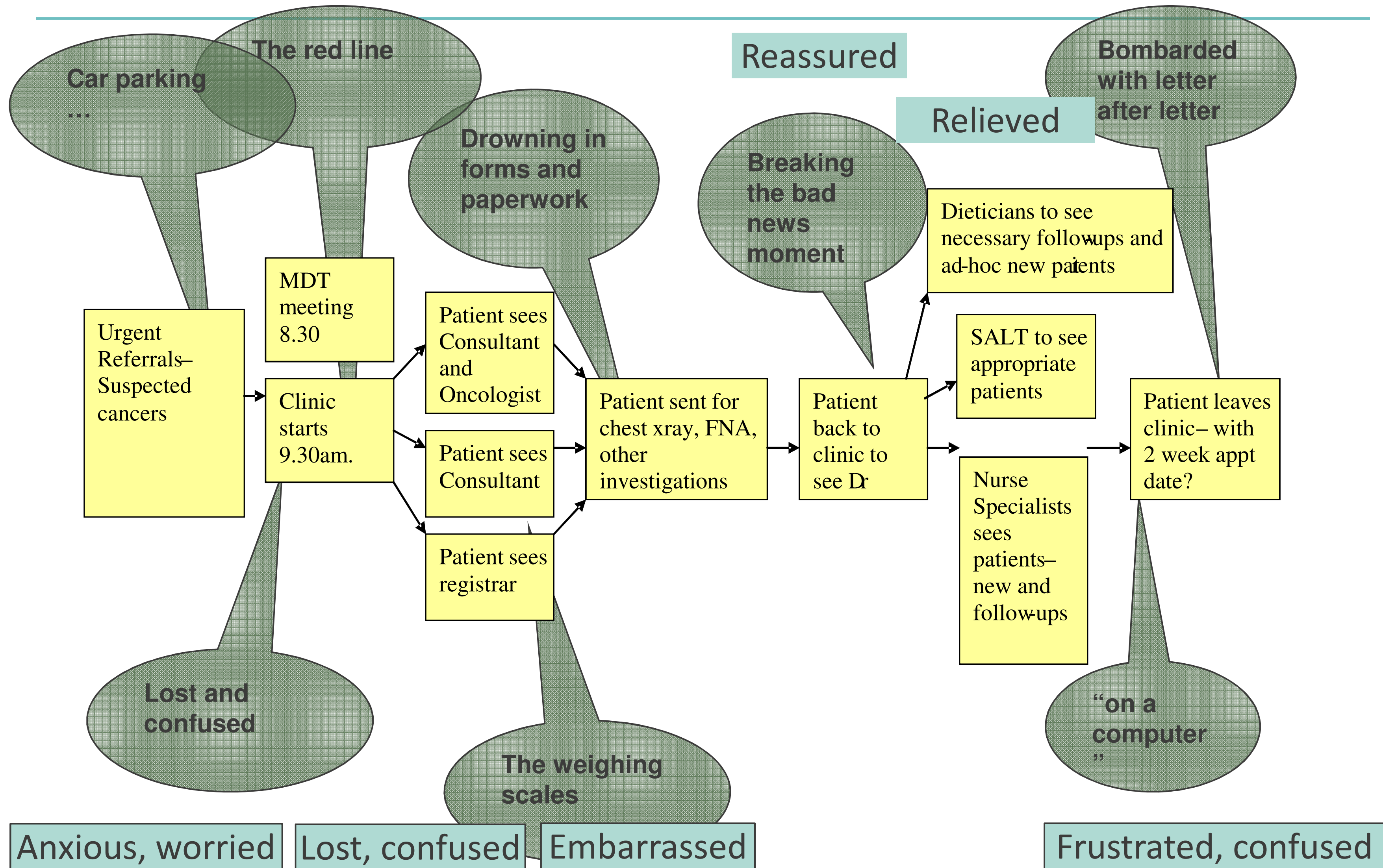
Process and emotional mapping

- Process maps are visual tools to represent how work gets done, who does it and the efficiency of the workflow
- A process is just simply a series of steps that we go through in order to complete a task, or achieve some kind of specific purpose
- A way of capturing the complexity of processes involved in a task, often inherent knowledge within those performing the task
- Adding emotional ‘touchpoints’ identifies the highs and lows in a process, and can help identify priorities for improvement

An example – from the service perspective



…and the bubbles – bringing process design and experience design together



Generating ideas for improvement

Idea generation – deep dive vs snorkelling

A process for engaging frontline staff – be as inclusive as possible

Encourages creativity – all ideas are good ideas

Lets staff think in a different way

Generates energy and enthusiasm – values people, values their time

Focuses on the positive

Builds momentum to support action

The 9 steps of snorkelling

1. Identify your design challenge
2. Storytelling
3. Brainstorming
4. Cluster ideas by theme or topic – easy / difficult; cheap / expensive
5. Voting
6. Summarise
7. Top ten ideas
8. Prioritise
9. Prototyping – plan your prototypes and small tests of change

Work with volunteers - more activities on the wards

Work with car park provider – free parking for relatives when patients are at the end of life

Set up a surgical decision unit to speed things up

Work with bereavement services – sympathy cards

Access to food for relatives

Change the time of ward round so nurses can contribute

“Sisters clinic” for relatives

Devise an asthma clock to empower parents

Creating and sustaining improvement teams

- Simple, low bureaucracy infrastructure – meet briefly and often
- Clinical and managerial leadership
- Wide stakeholder engagement – who will be affected by this work, who might help or hinder?
- Common goals and clear success factors
- Manageable scope
- Time and headspace
- Quick wins
- Celebration and acknowledgement

My Care, My Voice

Council of Governors

Proposed Schedule of Meetings for 2018

Date	Room	Start Time	
Mon 4th December 2017	R&I Conf Room 3	5.30pm	Strategy Committee
Thurs 11th January	R&I Conf Room 3	5.30pm	Membership & Communications Committee
Tues 16th January	R&I Conf Room 3	5.30pm	Patient Experience Committee
Mon 29th January	R&I Conf Rooms 2&3	5.30pm	Council of Governors
Wed14th March	R&I Conf Rooms 2&3	5.00pm	Governors' Discussion Meeting
Thurs 15th March	R&I Conf Room 3	5.30pm	Membership & Communications Committee
Tues 20th March	R&I Conf Room 3	5.30pm	Patient Experience Committee
Mon 26th March	R&I Conf Rooms 2&3	5.30pm	Council of Governors
Thurs 14th June	R&I Conf Room 3	5.30pm	Membership & Communications Committee
Tues 19th June	R&I Conf Room 3	5.30pm	Patient Experience Committee
Mon 9th July	R&I Conf Rooms 2&3	5.30pm	Council of Governors
Thurs 27th September	To be confirmed	To be confirmed	Annual Members Meeting
Fri 5th October	Off site	All Day	Council & Board Away Day
Thurs 11th October	R&I Conf Room 3	5.30pm	Membership & Communications Committee
Tues 16th October	R&I Conf Room 3	5.30pm	Patient Experience Committee
Mon 29th October	R&I Conf Rooms 2&3	5.30pm	Council of Governors
Wed 7th November	R&I Conf Rooms 2&3	5.00pm	Governors' Discussion Meeting
Mon 3rd December	R&I Conf Room 3	5.30pm	Strategy Committee

Patient Experience Committee

draft Actions/Decisions/Approvals from meeting held: 10th October 2017

Item No.	Date of Meeting	Item	Action(s), Decisions Made, Approval	Action by	Date to complete by	Date Completed
30/17	10.10.17		**Attendees:** Angela Cross Matt Duffy Mike Sullivan Shaun Jackson Ian Boycott-Samuels Pauline Pilkington Helen Porter Sue Relph **Apologies:** Luke Millward-Browning Doug Errington **Notes/Actions:** Margaret Moore			
31/17	10.10.17	**Notes/Actions of last meeting**	The notes/actions were agreed as a true record from the meeting held 13th June 2017. Shaun Jackson said that although it was not an action he felt concerned regarding an AOB point from the last meeting regarding the 8-vacancies for oncologists. Helen Porter advised that the Trust had now recruited Advanced Nurse Practitioners to help alleviate pressures. Also, we are currently advertising for consultants and offering flexibility around job plans.			

			Matter arising from last meeting: ➢ 13/17 – CCCA blinds – this is still outstanding as no PEAT walkabout has taken place since the last Committee meeting *A survey had been carried out among patients who decided it would be preferable to see out of the windows rather than have blinds.*	**HP**	**10.10.17**	**10.10.17**
			➢ 24/17 – see item 33/17			
			➢ 27/17 – Committee to email Sue Relph re: suggestions for action plan: *Nobody has emailed Sue but this request is ongoing indefinitely.*	**ALL**	**a.s.a.p.**	**This is an ongoing request**
			➢ 28/17(a) – C3 email problem: *MM advised the Trust has a new provider for membership data and the problem should now be resolved.*	**MM**	**a.s.a.p.**	**10.10.17**
			➢ 28/17(b) – Report from Cheryl Rosenblatt re: July CoG meeting/training: *CR not present at this meeting as she is no longer a Governor.*	**CR**	**July '17**	
			➢ 28/17(c) – Governors Discussion Group – *Ian Boycott-Samuels suggested advising all Governors about our informative talks given by various members of staff and inviting them to attend. Pauline Pilkington said maybe it could be filmed and put on the Trust public website.*	**ALL**	**10.10.17**	**10.10.17**

32/17	**10.10.17**	**Radiotherapy Treatment Room**	Pauline Pilkington provided the Committee with a very comprehensive presentation showing how new patients are advised on what to expect before and during their treatment. Angela Cross thanked Pauline for providing an informative session regarding the patients experience in the Radiotherapy Treatment Room.			
33/17	**10.10.17**	**Patient Experience Report (to reflect patterns re: complaints – AMM theme)**	Helen Porter explained that this Quality Report is produced quarterly (this issue covers 4-months) and gives a brief synopsis of all complaints received and their outcome. The report also highlights a breakdown of subject matter shown in various graphs.			
34/17	**10.10.17**	**Detailed Review of Individual Complaints**	Referring to the details of three complaints that had previously been available to members via the password protected section of the public website, Sue Relph drew attention to the key issues, highlighting where appropriate any emerging themes or specific lessons learnt concerning patient experience or areas for future action by the Trust.			
35/17	**10.10.17**	**Thank you letters**	Two individual letters were presented and the Committee.			
36/17	**10.10.17**	**Patient Story**	Helen Porter explained this patient's story was the first one from Haemato-oncology. The Committee agreed it was a very positive response.			
37/17	**10.10.17**	**Any other business**	(a) Angela Cross commented about the lack of Patient Safety Walk Rounds, Helen Porter has chased this up as they will be re-instated.	**HP**	**a.s.a.p.**	

			(b) Ian Boycott-Samuels asked if the website could be updated. (c) Angela Cross asked if a Non Executive Director could be assigned to this Committee.	**MM** **MM**	**a.s.a.p.** **a.s.a.p.**	
			Date of next meeting: **Date:** TBA **Time:** 5.30pm **Venue:** R&I Centre – Room 3			

Meeting of Audit Committee 26 July 2017

The Audit Committee:

- Approved the Annual Anti-Fraud Report which is a consolidated summary of previous reports received
- Approved the schedule of losses. There is only 1 item to report to 30th. June:
  - As reported in the previous reports relating to a payment of £632 per quarter for an injury sustained by an employee.
- Reviewed the schedule of debts greater than £5000 outstanding for longer than 90 days
- Noted the current position on Financial procedures

The Audit Committee received the following reports from the Internal Auditor:

- Charitable Funds (Covering Governance and Financial Arrangements) – Significant Assurance with all actions to be completed by July 17

Note: All risks identified by internal audit are recorded and categorised by level of risk on the audit tracker system which is reviewed every audit meeting to ensure that all risks and recommendations are cleared over time, which should increase the assurance that can ultimately be taken. In the summary above there are no Critical or High level recommendations unless stated.

The Audit Committee noted the following reports from the External Auditor:

- Confirmation that all work for 2016/17 was completed within the mandatory deadlines
- Outline planned timetable for 2017/18
- Briefing notes on a variety of topical matters where the Audit Committee reviewed that the Board was informed and taking appropriate action appropriate.

The Audit Committee received and noted a report on Cyber Security indicating progress

Meeting of Audit Committee 25 Oct 2017

The Audit Committee:

- Noted the schedule of losses for the financial year to date totalling £2049. There are 3 items to report to 30th. September:
  - As reported in the previous reports relating to a payment of £632 per quarter for an injury sustained by an employee. Total £1264
  - Loss of I-pad by member staff away on business £450
  - Theft of mobile phone from gym £335
- Noted the schedule of debts greater than £5000 outstanding for longer than 90 days
- Noted the current position on Financial procedures noting a major upgrade is due
- Noted 4 items where Single Tender Waiver items had been approved

The Audit Committee received the following reports from the Internal Auditor:

- Research Funding & Governance - Limited Assurance - 2 High level Recommendations
  - Recommendations to be actioned by March 2018
- Quality Spot Checks - Limited Assurance – 3 High level Recommendations
  - Recommendations to be actioned by Feb 2018
- Incident Management Significant Assurance
  - Recommendations to be actioned by Oct 2017

- Conflicts of Interest/Gifts & Hospitality – Phase 1 Gap analysis

  Note: All risks identified by internal audit are recorded and categorised by level of risk on the audit tracker system which is reviewed every audit meeting to ensure that all risks and recommendations are cleared over time, which should increase the assurance that can ultimately be taken. In the summary above there are no Critical or High level recommendations unless stated.

The Audit Committee noted the following reports from the External Auditor:

- Progress report on the External Auditors delivering their responsibilities as External Auditors
- Briefing notes on a variety of topical matters where the Audit Committee reviewed that the Board was informed and was taking appropriate action where appropriate.
- Received and noted a Key Financial indicators report comparing CCC to other Foundation Trusts

The Audit Committee received the second Anti-Fraud Report for 2016/17 Financial year showing updates against the work program agreed by the audit committee.

The Audit Committee noted and received the financial the annual accounts of the charity and CPL together with verbal assurances from External auditors.

The Audit Committee received and noted the Risk management Annual Report

a