Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting 25th June 2009
Extract of approved minutes

Present

Non-Executive Directors	Prof. Sir Christopher Edwards	CE	*Chairman*
	Charles Wilson	CW	
	Colin Glass	CG	
	Karin Norman	KN	
	Richard Kitney	RK	
Executive Directors	Heather Lawrence	HL	*Chief Executive*
	Amanda Pritchard	AP	*Deputy Chief Executive*
	Lorraine Bewes	LB	*Director of Finance & Information*
	Mike Anderson	MA	*Medical Director*
	Andrew MacCallum	AMC	*Director of Nursing*
In attendance	Catherine Mooney	CM	*Director of Governance and Corporate Affairs*
	Dianne Holman	DH	*Interim FT Secretary*
	Mark Gammage	MG	Interim Human Resources Director *For paper 3.4*
	Amit Khutti	AK	Director of Strategy *For paper 3.3*

The meeting was called to order following a seminar on the KPMG Report.

1 GENERAL BUSINESS

1.1 Apologies for Absence **CE**

Apologies were tendered by Andrew Havery.

1.2 Declaration of Interests **CE**

None were tendered.

1.3 Minutes of the Meeting of the Board of Directors held on 28 May 2009 **CE**

CG noted that his comment on private work (section 1.5) was about understanding private provision rather than positioning to undertake it. Minute to read 'CG suggested that the strategic focus should be on understanding private healthcare provision.' Subject to the above

amendment, these were agreed as a correct record of proceedings.

1.4 Minutes of the Special Meeting of the Board of Directors held on 4 June 2009 **CE**

These were agreed as a correct record of proceedings.

1.5 Matters Arising **CE**

2.2/Apr/09 Performance Report – March 2009

Further to discussion at the meeting in May 2009 when HL suggested that only the Head of Midwifery signs off requests for agency staff from Mayday, AP reported on a trial in the previous month with the labour ward co-ordinators signing off requests. The result was that spend was less than the quota and it is evidence that the system is successful. There is to be a weekly review of this system.

2.3/April/09 Revised Complaints Policy

This will be discussed at the Members' Council in September 2009 and then brought to the Board.

2.1/May/09 Finance Report Commentary – April 2009

LB reported on the accounting for activity at off-site clinics. The main offsite clinics are maternity clinics and activity is monitored through the diaries of midwives. This is labour-intensive and a new process is being developed involving direct entry and this should be ready in a few months. There were no issues about the completeness of income in the plastics clinics.

5/May/09 ANY OTHER BUSINESS

CG reported that his actions on social networking and communication were in progress.

The Board noted the other actions and outcomes as described in the matters arising paper.

3.4 Workforce Annual Report (incl E&D) **AP**

MG was invited to join the meeting for discussion of this paper at this time to facilitate his schedule.

AP introduced the paper indicating that it was the responsibility of the Trust to bring this report to the Board and she set out the headlines. The Board needed to satisfy itself as to areas of concern. AP said she was assured that there was nothing unique in the results of the analysis of Trust's workforce compared to the NHS as a whole. AP also explained that the Trust has a statutory responsibility for Equality Impact Assessments, and training and delivery of the Single Equality Scheme.

MG clarified some aspects of the paper. Appendix 5, noting that the

lines on the graph did not match the percentage numbers in the right hand corner. The percentage numbers are correct. At Appendix 6, the figure of 0.84% for Medical staff is correct and the figure in the text at 3.2.2 was erroneous. There is no Appendix 17. A revised appendix 15b was circulated.

MG reported that the focus has been managing Bank & Agency costs. Key metrics have been set. MG noted that the sickness figures were reported as the lowest in London and made allowances for under-reporting. MG pointed out there were no obvious areas of concern in E&D. There were a few areas that he planned to look into further. These were promotions, employee retentions, and disciplinary action.

MG drew attention to Appendix 15b, the Recruitment Ethnicity Analysis, and the finding that some ethnic groups were more likely to be appointed than others. Country of origin was thought to be more of an issue than ethnicity and this information may be identified on the application by the place of training. MA commented that the country of training is an issue for the Deanery in the recruitment of junior doctors as the training may not be to the same standard as the UK.

MG discussed over-representation of BME staff in relation to disciplinary cases and noted that, looking at the cases, the decisions have been right but questioned whether or not the same diligence is applied across all staff groups.

KN asked, in relation to country of origin issues, if we are allowed to differentiate. MG responded that objective criteria are used in selection but there may be issues about the quality of training in certain countries. CW commented that the recruiter's experience of working with persons trained in a particular area may lead to bias.

MA said that the applications of junior doctors were processed by the Deanery. In the case of consultants, applicants who are working overseas are unlikely to be short-listed as it is not known at the time if they are likely to successful in obtaining visas to work in the UK. HL commented that the application process will consider how medicine is practised in the UK and that this may be a factor.

CW suggested that the increase in 'Black African' groups and the decrease in 'Other white' groups was a consequence of the slowdown in immigration from the European Union.

CE commented that the metrics indicate that the Trust is seen as a very tolerant community in relation to sexual orientation. CE also commented on the gap in sickness between Medical and Nursing/Midwifery Staff. MA explained that there may under-reporting of sickness in the medical staff group. MA asked whether we correlated sickness with indications for locum use to get better information. MG said this was not done but could be.

Appendix 9c was important as it demonstrated a major increase in agency use in 08/09 and emphasised the importance of focusing on the quota system.
KN asked if the analysis covered contracted staff. MG said it did not

because the Trust has no control over their ethnic profiling data. HL commented that their sickness was quite low. CW asked if professional training was covered and MG responded that it was not.

CW pointed out an error in the arithmetic calculation of the increase in monthly average turnover at paragraph 3.1.4. MG noted the error and expanded on the need to develop annual rolling averages to better understand this trend.

The Board gave their approval to extending the Single Equality Scheme to 30th September 2009. AP confirmed to the Board that the Equality and Diversity Steering Group which reviews the progress of equality action plans reports to General Matters and then to the Assurance Committee.

MG left the meeting.

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

CE reminded the meeting that two hours of July's board meeting would be dedicated to discussions on strategy. **Directors were asked to identify in the next week which were the key issues they felt should be discussed.** **ALL**

LB said that she intended to prepare a matrix of current services indicating key statistics e.g. background on EBITDA for services to facilitate the discussion. **LB**

CG suggested that the strategic plan needed to be developed by starting with an understanding of the Trust's customers' needs based on an analysis of its customer base and services provided. KN referred to a Kensington and Chelsea Report on how residents are using the Trust's services and asked if this information was available to the Trust and whether it applied to neighbouring boroughs.

HL responded by saying she felt that the strategic direction was driven by the Darzi programme and patient choice and further noted the complexity of the local population demographics. MA considered that the PCTs and specialist commissioners were the customers of the Trust as they buy our services and it was the needs of these groups that needed to be satisfied.

It was agreed that July's Board Meeting would begin at 1pm and there would be no seminar. All were asked to note the change in the usual arrangements.

1.7 Members' Council Report **CE**

This paper was noted.

2 PERFORMANCE **LB**

2.1 Finance

LB reported that the Trust had returned to plan in month 2 for EBITDA and the surplus which was enabled by a combination of the reduction in agency staff hours and a change in the case mix to less qualified

staff. Elective income is ahead of plan and there are high levels of non-elective admissions. The key risk in the position is the achievement of CIPs which is set at £10.5million which is 5.2% of income and an increase of £0.9million.

LB drew attention to the CIP table on page 8 of the paper and confirmed that the increased allocation had been allocated on a pro-rata basis. In Month 2, 65% was achieved with positive feedback from clinical areas. **The executive team would next look at the corporate areas and report the details to the Board next month.** **LB**

CE asked to have a look at the profitability of private patient business to assess whether or not it was an under-performing area. LB said a Private Patients Strategy Group was being set up . The focus has been on implementing a reporting system to have confidence in the reporting analysis. AP confirmed that any areas of non-profitability will stop. **It was agreed that a report would be presented on this area in another 2 to 3 months.** **LB**

CE said that the issues of private income and the increased need for private income in view of the financial situation needs to be raised with Monitor. LB suggested that one strategy might be to just exceed the cap and see what came back from Monitor.

LB responded to comments sent in by Andrew Havery concerning the reasons for decline in paediatric gastroenterology, general medicine, neurology, rheumatology. LB explained in for the most part the changes were due to getting a more accurate attribution of overheads. In Paediatric gastroenterology, there was a greater share of nursing costs. In general, the changes reflected data rather than underlying deterioration. **LB proposed to track unit costs to give the Board more information.** **LB**

2.2 Performance Report Commentary – May 2009 **LB**

LB reported that there were some concerns in Month 2. The Trust met its Monitor targets but did not meet its existing commitments. There were breaches of the 26-week inpatients, 13-weeks outpatients, ethnic coding and cancelled operations targets.

LB was confident that the situation was retrievable. In Month 1 when the 18-week target was being developed there were 5 breaches, but this has now been contained.

3 ITEMS FOR DECISION/APPROVAL

3.5 NED Appraisal Process **CE**

The Board discussed the proposed arrangements for the NED appraisal process. Some NEDS felt that the structure was too rigid. HL was of the view that a robust approach was a requirement to avoid failure and as a unitary board, the appraisal should complement the 360 degree appraisals for the executive directors.

The Board agreed to the process for the current year and to make

revisions as required in the light of experience.

3.6 Nominations – Governance Arrangements **CM**

The revised arrangements were brought back to the Board for approval. **HL asked for further information on the provisions of the Constitution for the appointment of the Executive Directors.** **CM**

4 ITEMS FOR INFORMATION

4.1 Audit Committee Minutes – May 2009 **AH**

LB informed the meeting that these minutes were in draft and since circulation there were minor amendments.

4.2 Assurance Committee Minutes – May 2009 **CW**

The Board was invited to comment on this paper, if necessary, at the next Board meeting.

4.2a Local Supervising Authority Interim Audit Report

` CE explained that the matter of the statutory supervision of midwives was raised at the Assurance Committee and it was suggested that the matter was brought to the attention of the Board. AMC tabled the paper, 'Local Supervising Authority Interim Audit Report'.

AMC explained the role of statutory supervision and the role of the Local Supervising Authority (LSA) to which supervisors are directly accountable.

The Trust was found to be only partially compliant in our last LSA Audit. There were no significant concerns raised over the last three years.

AMC noted that the audit had picked up on issues which were already known to the Trust. AMC discussed the report and said that he felt that it had been referred to the Nursing and Midwifery Council prematurely.

In relation to the draft recommendation, AMC said that it was the responsibility of supervisors to check on the eligibility of agency midwives. AMC said that a system is now in place.

Concerning the supervision of students, AMC informed the Board that the Trust whilst terminating its arrangements with Thames Valley university had agreed to midwifery students remaining to the completion of the course.

The audit also recommended actions to reduce the high vacancy factor.

AMC informed the Board that there was an improvement action plan and that a re-audit would take place in November 2009. The Head of Clinical Governance would be helping to check evidence was robust.

The Board could expect compliance in November 2009.

CE suggested that the supervisory arrangements for midwives may be linked to the Trust's local problems in the Maternity Department. AP supported this saying that there were inherent risks in a supervisory system outside of the organisations with assessment done in confidence.

Following discussions on the merits of statutory supervision, AMC explained the origin of this supervisory system for midwives which was introduced at the time of the registration of midwives.

It was agreed that HL would raise the issue of midwifery supervision with the relevant body. **HL**

4.3 Swine Flu Update **AMC**

CW noted that that the worldwide death rate as indicated by the text in paragraph 2.1 was 0.4% and not 0.002% as stated.

In response to Andrew Havery's comments, AMC reported that isolation was the measure to stop those admitted with flu like symptoms infecting other staff and patients. HL reminded the meeting that the report was a communication and not a detailed plan which we ought to have at another time.

CW asked at what stage staff would be vaccinated. MA confirmed that at the present time the vaccine was still in production and anti-virals were being used.

It was agreed to present Swine Flu Action Plan to the Board **AMC**

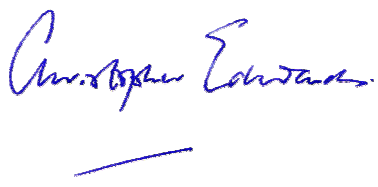
5 ANY OTHER BUSINESS

There being no further business, the meeting was adjourned.

6 DATE OF THE NEXT MEETING – Thursday, 30th July 2009

NB: These minutes are extracts from the full minutes and do not represent the full text of the minutes of the meeting. For information on the criteria for exclusion of information please contact the Foundation Trust Secretary.

Signed by



Prof. Sir Christopher Edwards
Chairman