Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting 24 June 2010
Extract of approved minutes

Present

Non-Executive Directors	Prof. Sir Christopher Edwards	CE	*Chairman*
	Andrew Havery	AH	
	Karin Norman	KN	
	Charlie Wilson	CW	
Executive Directors	Heather Lawrence	HL	*Chief Executive*
	Lorraine Bewes	LB	*Director of Finance*
	Mark Gammage	MG	*Interim Deputy Chief Executive/HR Director*
	Mike Anderson	MA	*Medical Director*
	Therese Davis	TD	*Interim Director of Nursing*
In attendance	Catherine Mooney	CM	*Director of Governance and Corporate Affairs*
	Lucy Hadfield	LH	*Interim Director of Strategy*

1 GENERAL BUSINESS

1.1 Apologies for Absence **CE**

Apologies were received from Colin Glass and Prof Richard Kitney.

CE welcomed Therese Davis, Interim Director of Nursing to the Board meeting.

1.2 Declaration of Interests **CE**

None.

1.3 Minutes of the Meeting of the Board of Directors held on 27 May 2010 **CE**

CE noted that an updated version had been provided. CW noted that he was present.

KN said that she had discussed the booking system and had suggested a system which would allow for e-mail cancellations. We have agreed to look at it. To add to the minutes and matters arising.
VD to correct the draft minutes in line with comments received. **VD**

1.4 Matters Arising **CE**

1.3/Apr/10 Minutes of the Meeting of the Board of Directors held

on 29 April 2010

CE reported that at the meeting with the Non-Executive Directors (NEDs) they had discussed and agreed specific roles, which helps define areas of interest. These are as follows:

CW – Estates and Infrastructure
KN – Assurance & Quality and Human Resources. CE confirmed that KN would be the NED for equality and diversity.
AH – Finance/Audit
RK – IT/Teaching and Research

The new NED would be asked to take a particular interest in the interface, the Council of Governors and the community i.e. an outward looking role.

AH noted that at the present we have one Assurance Committee, when we previously had two and suggested that we should consider two again. CE clarified that these are areas of responsibilities not committee structures. KN said that she is happy with the current arrangements and thinks it is about having a depth of knowledge and formalising areas of interest.

CE outlined areas of special interest for the NEDs.

The executive team to consider how this might work. **HL**

2.2/Mar/10 Performance Report – February 2010

This was not discussed

2.1/May/10 Finance Report – April 2010

This is on the agenda.

1.5 Chairman's Report **CE**

CE said that the important issues will be discussed at the Board Away Day tomorrow.

1.6 Council of Governors Report including Membership Report **CE**

CE said that the membership report was self-explanatory. It was unclear what the new government expected regarding growing membership and we would not want to spend a lot of money increasing numbers.

TD to check if membership leaflets go out with appointment letters. **TD**

1.7 Chief Executive's Report **HL**

CE asked TD for her views of the Trust having worked here before. TD said she was here seven and half years ago. Her personal style is that she likes to see what is going on and has spent time on the

wards. Her impression is that that the culture is very friendly, united and it is a positive place to work. She feels that this is quite rare, and could be due to the stable leadership e.g. CEO here for 10 years and staff know the executive. With respect to nursing, there are some very good leaders but she does not believe that care is what it should be. As a Trust we should be a leading light, we are one site and medium sized. She said that we need to get structures right within nursing, nursing is not as visible as it should be, and nurses are not senior enough in the structure. Regarding patient experience there are lots of strands of good work, but it is fragmented. We need to identify the key things patients want changed. She will be developing a patient experience strategy. She said that there are better devices than the Patient Experience Tracker (PET). CE thanked TD for her views.

2 PERFORMANCE

2.1 Finance Report – May 2010 LB

LB reported that overall the Trust is ahead of plan with EBITDA £600k ahead. We were able to bill for more income last year and we are realising the benefit this year.

The income variance of £700k is related to in-year over-performance. Non-elective work is behind the 09/10 outturn. Pay is on plan. The big issue is non pay. A number of Cost Improvement Programmes (CIPs) around non pay have not been delivered. Pay CIPs are also not being completely delivered but there is some under spend on pay and we are looking to see if we can take it as a part of the CIP. There will be more focus on this in the month 3 report.

We have done very well in agreeing our main contracts, but have not signed up Wandsworth. The breakdown is outlined on p.5 of the report and the timescale is July/August to get it signed off. She noted that we had accrued for this.

CE asked about section 4.1.1 and why the pay expenditure was higher than budget. LB replied that that was one off back pay.

HL reported that the advertisement for the Director of Patient Flow is in the Sunday Times and there will be an executive search as well. This post replaces three areas, patient flow currently managed by Hannah Coffey, estates, currently managed by Mark Lynn and replaces the Director of Information Technology. She said that it was important to be clear that this is not a new role.

KN queried the combination, suggesting that estates and IT need different skills. HL said that IT and estates are integral and MG confirmed that the search agency were not surprised by the combination but that it was innovative for the NHS.

HL said that the North West London strategy work is now on hold and we will reflect on this tomorrow.

Community services that we jointly bid for with the Royal Marsden

Hospital have been put on hold. Separately, Richmond Community Services had asked us to bid for outpatient services and clinicians presented in three services – Oncology, Neurology and Gynaecology.

In answer to a question from KN, HL replied that the work for bids is undertaken by the Director of Strategy and their staff in conjunction with the relevant divisional team. KN asked if more resources are needed as they will pay for themselves. HL said that the implementation part is the hard work, and we need the front line services to work on this.

AH asked if HL felt that the expertise is in place. HL confirmed that it is and we have produced high quality bids. One thing that has been highlighted recently is the limited number of people who can use the Dr. Foster tool. Also timelines are very short and we need to be more slick getting the papers we need and would benefit from a resources to help with this.

MA commented that bids have been centrally led which allows us to get the vision right. HL said work is ongoing in surgery, working though each speciality and getting them to identify their vision.

MA said that musculoskeletal therapy is an area of growth in primary care. The Trust has a group of therapists with a special interest and this attracts patients.

AH asked if we are training GPs with correct skills. CE said it is a major debate. GPs would like training extended from 3 to 5 years but it is not a GP problem, it is a medicine problem. We need doctors who can work between hospital and general practice.

2.2 Performance Report – May 2010 **MG**

MG reported that there are concerns with *C.difficile* and MRSA performance and also slot issues. The target for non availability of slots is 4% and we have 31% and we need to understand demand and capacity by clinic. The other area of concern is discharge summaries. Five consultants make up approximately one third of those that fail so we are following up with them.

He noted that the dashboard is used by us to manage performance, including our own RAG rating. It does not directly link to Monitor ratings e.g. our red could be Monitor orange.

AH commented that we may be told that there is no 18 week target but we will want to keep this. CE agreed. MG highlighted the additional paper on the changes to the Operating Framework emphasising that we will continue with the targets as they are in our contracts. CW noted that meeting targets is included in the NHS constitution. HL said that the executive would like the support of the Board to say that the 18 weeks and A&E targets will remain. This was agreed.

AH asked if we could prioritise i.e. having some targets longer and

some shorter. HL said it not in our gift currently. MA said it should allow us to be more flexible and ensure that clinically appropriate procedures can get done in the correct time.

3 ITEMS FOR DECISION/APPROVAL

3.1 Impact of CIPs — HL

HL noted that the figure on p.2 should read £22.5m not £225m. She said that savings in the pay category is only 30% of the total.

HL drew attention to the two areas in the report that may impact on patient care. Regarding the combined medical and surgical assessment unit she said areas of concern were raised by the Critical Care Outreach Team (CCOT), who came up with an alternative proposal and this and the concerns expressed are being discussed with the directorates. She noted that whilst there was support from the ICU consultants to centralise level one patients they also supported the CCOT's point of view in relation to other patients in the hospital and it is important that we continue with the early warning system.

MA referred to 7.2 re outpatient dispensing. Quite often patients are given the initial supply and sometimes other supplies which is contrary to national guidance but which we do for patient convenience. The guidance is that we give medication needed urgently or which GPs cannot prescribe. This proposal will save money because of decreased dispensing. HL said that there were concerns when this was first raised. Referring to the GP is partly a matter of principle and also allows GPs to initiate appropriate prescribing. CE suggested a different approach of working with GPs and tackling the problem in partnership. He said we should try and come up with an innovative solutions e.g. should we be phoning the GPs to make an appointment?

MA clarified that it was not the cost of the medicines that would be saved but pharmacy staff costs to dispense the medicines. It was felt that the principle was quite important in terms of patient care and GP relations and more important than the savings.

LB asked if this is something the CLAHRC could look at but MA felt that this would be too slow. HL said that CLAHRC was working on an information sharing protocol.

In relation to stopping outpatient dispensing for certain drugs CE confirmed that the Board felt that this was not appropriate. An alternative solution should be developed in conjunction with GPs and considering IT solutions.
Alternative solutions to be explored. — **MG**

HL returned to her CEO report and the issue of the UCC. She noted we have reduced the financial deficit to £250k by decreasing staffing for us and the GP partnership. The proposal is based on 10% per annum growth in minor attendances which she does not think will be realised. When the polyclinic opens in Earls Court, numbers may

decrease further. LB said we are looking to close the gap completely but HL does not think we will achieve this and thinks the PCT has to contribute to the capital costs. LB said that the current tariff is £77 per patient for minor attendance. If the payment is anything under £82 then they are not contributing to the capital. It is a 5 year contract, so LB is proposing that we recover capital over the 5 years. However, the key risk is not having the work at all.

AH asked to what extent will demand overall increase? LB responded we do not have any experience but our GP partners have seen this at Charing Cross and anecdotally minor A&E attendances have increased and non-elective admissions have decreased. LB said the impact at St. Mary's was unknown.

HL said she would like a review built into the contract for the impact of Earls Court polyclinic, which will take some time. CE said that UCC is the way to build relationships with GPs. The Charing Cross Hospital and St. Mary's both have them and so we should also.

LB said she was trying to find a mechanism for sharing the financial risk for the impact of Earls Court polyclinic if attendance numbers decrease.

3.2 Inpatient Survey 2009 - results and the way forward **TD**

TD introduced the paper which summarises the inpatient results. She highlighted p.2 table 1 and 2 and noted that lower scores are better. She confirmed that the survey cannot be broken down by ward or speciality and that the numbers are small. The survey will take place again in September, surveying patients who were in hospital in August.

AH said this is the first one where we are not disappointed, so credit is due. We have improved in areas where we have highlighted problems previously. KN highlighted non availability of hand gel which is still a problem. HL said that this was being looked at but KN suggested we should use the governors.
TD to review. **TD**

CE noted the results for B7+ about patients sharing the bathroom or shower with a member of the opposite sex. HL said that there is some money in the capital budget for upgrading facilities.

TD said that noise, discharge delays and food were the key areas where we need to do better. A new contract for food was put in place in July 09, and this survey was two months later so it will be interesting to see how we do this year.

KN asked if we can afford to pay more for food. HL said this will be looked at and may come out of the shared services work. KN asked why noise from other patients is high here. CE said we had a very open structure and this is often difficult in modern hospital. HL said it may be related to our clientele.

3.3 Netherton Grove (oral) **HL**

HL emphasised that we do need to get to a position tomorrow to make a decision.

3.4 Standing Orders, Scheme of Delegation and Standing Financial Instructions* **LB**

LB said that there were sections in the Standing Financial Instructions that we would like to change to reflect the Divisional structure. For example, on pages 18, 20 and 21, the changes are that General Managers can authorise up to £25k, and non Board Directors up to 50K. This is to be replicated where relevant elsewhere in the report.
The Board agreed these changes.

3.5 Assurance Framework Report and Review of Corporate Objectives Report Q1 **CM**

CM presented the paper which outlined the objectives and risks for 2010/11. She noted that there were two significant areas of concern at this stage. The first related to the objective on improving the patient experience as initiatives would need to be in place for patients who were in hospital in August for the survey in September. The other was a red financial risk around the cost improvement programme.

The Board noted the report and agreed the risk ratings.

3.6 Register of Seals Report Q1* **CM**

This item was taken as read.

3.7 Board of Directors Governance Arrangements **CM**

CM said that this paper was the result of discussion at the Board seminar last month and there were a few areas outstanding. CM drew attention to the length of Board papers and she said that this was rarely adhered to. CE said the commentary should be limited to 4 sides and the rest should be an appendix and it was a good discipline to keep the main paper short.

CM reported on discussions that she had had with the Deputy Director of IT re paper free Board meetings. He had said that the iPad would be a way of doing this and improving efficiency although papers may need to be changed so that they could be viewed on one screen and members would need to adjust to no paper. It was agreed to pursue this as a trial. CE noted KN's comment about preferring paper.

CE said the new structure will affect who should attend the Board. He said we should focus on Divisions and their strategic vision and factor in a presentation from each Division. We will need a long build in time.

CE said people should be involved in taking decisions that they have

to carry out and it was important that Divisions feel they have a role, and are not there to be monitored or to just observe.

3.8 Annual Members' Meeting 2010 – Proposal **HL**

HL confirmed that the Lower Ground floor is available. She outlined areas to discuss in points 1 and 2 and these will be agreed between her and the Chairman.

She said there were concerns about the burns DVD. She said that TD made one about learning disabilities at the Royal Free, which was taken on nationally and that might be a possibility. Another option was the child that was transferred from Haiti. Simon Eccles had been involved. We could show part of the film or a presentation with slides.

Karen Norman left the meeting.

3.9 Western Extension of congestion charge zone **HL**

HL said that this was now the formal consultation and if the Board reaffirm its position from earlier.

AH declared his interest as he has publicly stated his support to abolish it.

CW also declared a personal interest which was to keep it, however he supported the Board decision to campaign for its removal.

MA said that we are the only acute hospital within the zone and suggested that this should go in the letter.

The Board was supportive of the campaign.

3.10 Communications income generation potential **CW**

CW presented the paper. He said that 'health messaging' has broken the dam and the question was whether we can we go a step further.

He said the magazine is an easier decision. It needs some tweaking for a broader audience e.g. currently staff governor results are published and there are internal numbers rather than outside numbers. The website a little more delicate.

It was agreed to start with advertising in the magazine. CW said that not a great deal of redesign was required to incorporate advertising and thinks it will mainly be local retailers. There will need to be editorial checks.

CW said that he and the head of communications would look at how much to sell the space for.

MA noted that 35,000 hits a month is a lot. CW said he was not very familiar with advertising on the web.

CE reported on KN's comments which were that she agreed it was a good idea to consider advertising in the magazine but not on the website as she finds adverts on web pages distracting and annoying.

It was agreed to go ahead with advertising in the magazine. Must apply the restrictions outlined in section 5 of the paper. We can use that experience and then look at web advertising. It was agreed to do a work up of how it would look with advertising.

4 ITEMS FOR INFORMATION

4.1 Assurance Committee Minutes – 10 May 2010 CW

This item was taken as read.

4.2 Audit Committee Minutes – 20 & 24 May 2010 AH

This item was taken as read.

4.3 Finance & Investment Committee Minutes – 18 May 2010 CE

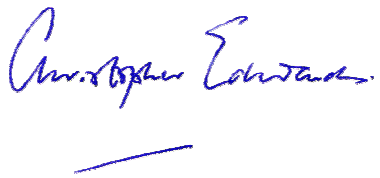
This item was taken as read.

5 ANY OTHER BUSINESS

This item was taken as read.

6 DATE OF THE NEXT MEETING – Thursday, 29 July 2010

Signed by



Prof. Sir Christopher Edwards
Chairman