Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting 29 April 2010
Extract of approved minutes

Present

Non-Executive Directors	Prof. Sir Christopher Edwards	CE	*Chairman*
	Andrew Havery	AH	
	Karin Norman	KN	
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*
	Andrew MacCallum	AMC	*Director of Nursing*
In attendance	Catherine Mooney	CM	*Director of Governance and Corporate Affairs*
	Natalie Hibbs	NH	*Management Trainee*
	Dr Roger Chin	RC	*Consultant Radiologist*
	Bill Gordon	BG	*Director of IT*
	Hannah Coffey	HC	*Director of Operations*

1 GENERAL BUSINESS

1.1 Apologies for Absence — CE

Apologies were received from Charlie Wilson, Prof Richard Kitney and Colin Glass.

CE welcomed Natalie Hibbs who was shadowing Mark Gammage.

1.2 Declaration of Interests — CE

None were tendered.

1.3 Minutes of the Meeting of the Board of Directors held on 25 March 2010 — CE

These were approved as a true and accurate record of the previous meeting. AMC said that with reference to the item on the nursing workforce, he would like the Board to note that there is still a generous skill mix in comparison with other Trusts.

1.4 Matters Arising — CE

1.7/Nov/09 Chief Executive's Report
LB confirmed that a paper on the Urgent Care Centre (UCC) would be available in May.

1.6/Mar/10 Council of Governors Report including Membership Report
AMC said that SN has been ill, so this has not been actioned as yet.

2.2/Mar/10 Performance Report – February 2010
MG said that we have purchased a telecom system which reminds patients of appointments. He noted that we have not shared the vision for out patients in a formal way.

CE said it is important to consider how complaints are seen by the Board e.g. complaints vs. vacancy rates. One of the lessons from Mid-Staffordshire was that the Board was not aware of complaints.

KN asked if there is data on how long it takes to answer calls with the new system. MG said that he was not sure but would find out. LB said that this functionality was available with the GU system.
MG to update regarding telephone answering system at the next Board. **MG**

1.5 Chairman's Report

CE said that there was a Chairs of Trusts meeting on Monday at SHA London. They discussed an update from the 'provider transformation directorate'.

In a discussion relating to the separation of PCT providing from commissioning one of the provider Chairs noted that Foundation Trusts appeared to be disadvantaged in their not being involved in picking up provider arms and that NHS London was using it as a way to support poorly performing Trusts. The polysystem programme was discussed with Ruth Carnall, Chief Executive of HNS London who suggested that it would be helpful if Heather O'Meara who is a key person on polysystem development came to a Board seminar.

CE said that HL, MA and he had had a meeting the day before regarding changes in the Northwest London landscape. The session was structured around attending work stations. A second day will be arranged to feed back on data collected on the first session.

1.6 Council of Governors Report including Membership Report

CE said that there had been a very useful update on strategy including the lower ground floor proposals which considered access e.g. an escalator.

The Council considered the Quality Account and recognised that this was a major change and an opportunity for the governors to input and this was very useful.

The Council of Governors agreed that there will not be a change in remuneration for the non-executive directors and the Chairman.

The governors' assessment of the Council of Governors performance is under way via a questionnaire.

An issue regarding the governors having a 'chelwest' e-mail account was discussed. It was agreed that they can have one if they wish.

The arrangements for the Open Day were discussed.

1.7 Chief Executive's Report including Netherton Grove update

Outturn Performance 09/10
HL said it looks as if we have achieved all targets.

MRSA Bacteraemia
She said it was disappointing to report 2 cases in one week when the target is 3. MA will follow this up. She noted that community acquisition will not count this year.
CE said the cases relate to samples being taken from a central line which we agreed should not be done. MA said it highlights the relentless need for training and supervision. It needs to be clear on the blood culture pack that doctors do not proceed without training.

KN asked if we will get a report. MA responded that it is clear that the instructions were not followed. KN said that we need to know how to ensure it does not happen again.
It was agreed that MA will report back to the Board on actions to be taken. **MA**

In-Patient Survey 2009
HL outlined the results of the in-patient survey and confirmed that it covered adult inpatients only. She outlined some of the issues e.g. sharing bath or shower areas should have been resolved. Noise at night is an issue.
AH asked if we could make sure the Patient Experience Tracker (PET) is used appropriately e.g. maintaining confidentiality.

Parliamentary and Health Service Ombudsman (PHSO)
HL said that this item was for information.

Hounslow and Richmond Community Services
HL said that she discussed this with Cally Palmer, Chief Executive of The Royal Marsden NHS Foundation Trust (RMH) with regard to making a joint bid. HL said she had discussed this with the CEO of Guys and St. Thomas' Trust and asked what due diligence had been done prior to their recent bid. He had said that most is done with the PCT after getting preferred provider status. She suggested that the RMH would lead on the chronic illness side and we would lead on sexual health, women's health and children. We have appointed Lucy Hadfield, Interim Director of Strategy, who will start due diligence.

Kensington and Chelsea PCT
HL outlined Kensington and Chelsea PCT paper on south polysystems. She said she thought it was useful to share their thinking. She noted that they still needed a hub for a polysystem in the south.

2 PERFORMANCE

2.1 Finance Report – March 2010 **LB**

LB said that there was a favourable variance of £0.5m against the Monitor plan which is a financial rating of 4. Issues to take forward include that non pay was behind budget by £1.8m. Three factors contributed to this. These were higher activity levels, continued pathology over performance against contract and the effect of year-end accruals. March was very busy.

CW was not present at the meeting but asked for more information on theatre consumables and LB outlined the issues.

She said an important area was theatre consumables and we need to make sure can explain the figures. She said we are looking at having internal audit to help explain and we are not eliminating the possibility that goods are being taken although we do not suspect anyone and there is no evidence of this occurring. The review to date cannot justify usage. CE said there had been a case where expensive consumables had been bought with no reference to a budget.

LB said controls had been introduced for non-pay. Theatre nurses order on demand and then recharge. There is a need to have some scrutiny in this area.

She noted that pay position was only £400k over, which is a good result

LB highlighted key points in the executive summary.

KN asked about clinical supplies. LB said that these were such things as dressings and surgical equipment. It was noted that this was 9%-10% over budget for the FY 09/10.

To KN questions regarding an update on actinobacter, HL responded that we still have it and are working around it. MA said that actinobacter is very difficult to get rid of.

2.2 Performance Report – March 2010 **LB**

KN was not present for this item.

MG said performance against the Monitor selection of indicators has been achieved for 2009/10. A great deal of work was involved and we should recognise that.

We expect to achieve an 'excellent' rating for quality of services in the Care Quality Commission 2009/10 periodic review and an 'excellent' for finance.

He drew attention to appendix 3 which was a draft Board dashboard which includes key performance indicators. He noted that we had additional contractual indicators.

AH asked if this was a complete set of what have to do and want to do. LB said she had enclosed the complete list of indicators as she wanted the Board to understand how large the list is.

HL said she was concerned that data could be misleading e.g. we had reported a 30% vacancy rate overall in Medicine but the rate was 60% in one ward.

CE said that the Board recognised how closely staff work together to deliver a good performance.

AH asked how the indicators were picked. MG said that the critical ones had been identified e.g. those that were contractual and managers had been asked to identify their priorities. He confirmed that all mandated ones are on.

The Board approved the draft Board dashboard.

3 ITEMS FOR DECISION/APPROVAL

3.1 Assurance Framework and Review of Corporate Objectives Report Q4 — CM

KN was not present for this item.

CW asked for clarity on what was meant by a focus on both uptake and measurement of training. MG explained this.

The Board noted the progress on objectives and changes in risk in year.

3.2 Corporate Plan

3.2.1 Three Year Financial Plan — LB

Part 1 of 2 papers sets out assumptions for the 3 year revenue and capital plan which provide the basis for the Monitor Annual plan.

The Board approved a draft budget for 10/11 previously. Detailed work confirms the position set out to the Board in March of the need for cost improvement plans (CIPs) of 10% in 2010/11.

She said we had been hard on ourselves to assume that there will be no CQUIN income and so we have assumed achievement of 75% of CQUIN income now. A previous paper had said 50%.

LB referred to p.7 which includes a summary on progress, which was slow. 24% of CIPs were unachieved. We need to clarify savings from some areas e.g. Fulham Road alliance, OP restructure and medical secretaries. HL said there is less in the high risk category now than previously. The gap in CIPs is now £5.5m.

KN asked about the situation with private patients. HL responded that we were near the cap and there was not much scope. Regarding the Assisted Conception Unit (ACU), HL has been to the Lister Hospital and they are keen to work with us. The Board had previously agreed that the ACU does need a partner due to its size.

LB summarised the assumptions and drew attention to the diagram in

Appendix 6. The main challenge is income threat over the next 3 years.

The plan assumes a £106m capital programme in the next three years and to deliver minimum level 4 in 10/11. At this stage the plan assumes 10% savings in 10/11, 10.3% savings in 11/12 and 5.4% savings in 12/13.

HL and LB share a concern that to deliver another 10% next year would be unachievable and we need a step change in service profile or require an acquisition or a review of capital.

She said that £40m capital relates to the Netherton Grove Project and questioned how much of the remaining £60m we really need.

KN asked what incremental high income initiatives are worth going for and what capital investments would give a good return. HL thought that the electronic document management was an example if we could proceed quickly.

LB said that energy had been scaled in but it assumed savings with an ESCO.

The Board returned to this discussion after discussing item 3.3.

LB asked the Board for their view on what we were going to submit to Monitor. LB drew attention to appendix 5 'summary of in year changes' which did demonstrate some potential upsides. Dean Street is the busiest sexual health clinic in London and the second busiest in the country. She noted that growth in maternity depends on a small build and getting mothers home quickly.

KN asked about the sub group of the Board looking at potential staff changes. CE responded that a further meeting was happening soon.

KN asked if we could do anything in areas where we were backlogged. MG said that commissioners may not pay for increased activity.

CE suggested that this should be discussed further at the May Board meeting.

3.2.2 Three Year Corporate Plan **LB**

It was suggested that the three year corporate plan is sent to the Board for comments as some Non-Executive Directors were not present.
LB to circulate three year corporate plan. **LB**

3.3 Strategic Options Assessment **HL**

HL outlined the executive summary.

She said we have done well on ratings, quality and finance but we cannot stay the same size.

She drew attention to p.8 and said we are probably in the middle because of HIV. This shows that we are not big enough and people

below us are not surviving.

CE suggested that as we do not have three of our non-executive directors we need to organise an away day in the next few months to discuss further.

HL asked what the EBITDA financial models would have to be, to be a W&C hospital.

Build financial models around options. **LB**

3.4 Monitor in-Year Reporting and Monitoring Q4 Report **LB**

This was noted.

QUALITY

3.5.1 Draft Quality Account **CM**

CM highlighted parts of the Account. She said it was important that HL approved the statement on quality. She drew attention to changes in objectives such as the one on VTE, and elective surgery, and the addition of a fourth priority on falls. The Board was asked to note the statements on assurance. She also explained how the local indicators on p31 were agreed. The Board approved the draft Quality Account.

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2.5.2 Draft Quality Improvement Plan **CM**

CM outlined the draft quality improvement plan. She said that it had now been discussed with the Divisional leads and there was support for the themes described.

The Board approved the Quality Improvement Plan

3.5.3 Mid Staffordshire Report **CE**

Andrew Havery was not present.

CE said that the Board had been asked to read the report prior to the meeting.

CE said that there are lessons to be learnt. It was a very sad report and the emphasis in the report was that hospitals are about individual patients. Data was disguising problems. The Board worked on assumptions and took a strategic role and did not concern themselves with the operational role. There was a weak professional role in management decisions. There was a failure to meet the challenge of elderly patients. We are in the process of addressing this here through the Medicine review.

KN asked if were going to come up with some actions. CE responded that we will and the pity was that not all Board members were present. He said we should take care that because we are a double excellent Trust that we think we are without some of the problems experienced by the Mid Staffordshire.

CE asked HL to think how we could involve the Board more in understanding what and where the issues are. **HL**

AMC said he was interested in how to prevent serious breakdowns, what are the tripwires we can anticipate. We could better engage the governors as a critical friend. We had a good approach through the Quality Sub-Committee. There is a danger of going into a bureaucratic approach.

CE agreed. When the directors of Mid Staffordshire had met with 'Cure the NHS' group, they were horrified at what they heard. He said governors are in a position to hear stories.

KN said there was no system to relay information. There are some things that she saw which were different to what was presented at the Board.

MA said the best way to highlight information was a formal complaint, which ensures an issue gets addressed.

KN asked about the process we have in place to follow up. HL said we have executives out and about. We are also looking at using the governors, however, this will require some training.

CE said it was very useful discussion. He wondered how governors best interface and agreed that formal complaints are useful.

KN said that she was concerned that the formal process does not lead to a change. AMC said he did not necessarily agree. He thinks we need to be better at demonstrating actions. We do look at incidents and complaints across the Trust to identify trends e.g. complaints about admissions led to our objective for this year.

CE said the issue was about poor communication between the Mid Staffordshire Board and management about addressing problems. CE said we need to think of the optimal way to get issues to the Board when a problem arises or suggesting other possible ways.

3.5.4 Risk Report Q4* **CM**

This paper was noted.

3.5.5 NHS Staff Survey 2009 **MG**

This item was taken as read.

3.6 Sustainable Development Management Plan **HC**

HC outlined the purpose of the paper and noted that MG/AP were responsible at Board level.

A Sustainable Development Committee has been set up and the Trust has recently appointed a Sustainable Development Manager through Norland Managed Services to ensure delivery. She confirmed that this was part of tender we submitted. This post was responsible for infrastructure of the building e.g. meters and staff engagement.

KN enquired how much the post cost and HC confirmed it was equivalent to an 8a post.

HL asked how many Trusts were in the table on page 4 and about the assessment model. HC said there were 5 Trusts and it was a self assessment tool designed to identity where an organisation stands in six key areas, e.g. procurement. A lot of work is required to do the assessment.

CE asked if we had a prediction of the Return of Investment (ROI) for Combined Heat and Power (CHP). He referred to point 2.1 referring to allocation of an allowance of 6,967 tonnes of CO_2. HC said she does not know**.**

KN asked what 'in competition' meant. HC responded it is a ranking system. We could make money if at top of table and lose if at bottom. She said it would be based on actual energy consumption next year.

KN asked if we would get 'low hanging fruit' first. HC confirmed this and said that we will rank actions on the energy efficiency performance and this will be done in May 2010.

KN asked if we are in line with the European legislation and it was based on size of organisation. HC confirmed that we were.

CE congratulated HC and said he thought it was a good start.

To confirm ROI for CHP. **MG**

Medicine Improvement Group

CE took the opportunity of HC's presence to ask AMC to report on the Medicine Improvement Group.

HL said there was a variety of concerns including a high vacancy rate.

CE said that he and HL had seen a patient's husband and his two daughters the day before, and the picture painted was very much in area we focused on. The main challenges are in the elderly patients with multiple problems as highlighted in Mid Staffordshire report. CE outlined problems in the admissions unit e.g. no-one following patient through in a coherent way.

It was agreed to have a medicine group which meet weekly and a no blame culture. KN asked about remit of the weekly group. CE responded that they undertook more detailed analysis of this issue.

CE said it is a complex issue e.g. staff satisfaction affected by poor care. HL asked whether it would be appropriate to continue with the model of care of the elderly physicians that we have. MA said he was concerned that the care of the elderly physicians were not used as much as they could be.

3.7 Electronic Document Management

HL

HL introduced Bill Gordon and Dr Roger Chin, and the background to

the need for an electronic document management system.

She said that there are two elements, back scanning and forward scanning.

AH asked if there would be a full audit trail. RC said that was important and we needed to be sure that when an amendment was made there is a record of what was there before.

KN asked how it dovetailed into the central system. HL responded that she thinks that this may not occur considering the current economic climate.

RC said one of benefits was we can change work practices to incorporate electronic records, so will be ahead of the game. We will be able then to incorporate our information into any future systems.

HL said the issue is about how quickly we can implement document management and decrease costs such as reducing number of porters and medical records staff.

AH asked if retention schedules were incorporated. MA responded that there was a schedule of retention currently, which is relevant to paper and electronic records.

CE asked about the position of old records. RC confirmed that we will assess the benefits e.g. old notes, patient unlikely to re-attend, we would scan their notes. For more frequent patients we would replicate them as they are, or use a more sophisticated approach such as an automated system.

CE said the Board is being asked for approval for development of the specification. We cannot understand the economic case until this has been done. We need to test the market. To KN's question who would be doing this HL responded that it would be Lorraine Bewes, Bill Gordon and Prof. Richard Kitney. The group would expand late on to include clinicians and Hannah Coffey for operations. RC noted that engagement with stakeholders had occurred through Kainos.

LB said only the medical records will be covered, not corporate records.

CE referred to Appendix 4 which provides a summary of the results of the financial appraisal and rankings. He said we cannot afford to introduce this and carry the staff as well. RC agreed and said PACS is an example where we realised benefits i.e. we disposed of the film archive and redeployed or lost posts naturally.

To KN's question if we will hold into old records LB responded that we will not.

CE asked would there be a future where patients would access their own records? RC responded that he envisaged that this would be done via a patient portal.

In response to a question from AH, RC confirmed that security and

back up will be under our control. HL said the Care Community are involved but slow and clunky.

HL said the strategy is the next stage, but we have to do this first.

KN asked if there would be any commercial benefits. CE said he was supportive of the idea.

HL thanked Bill Gordon and Roger Chin for presenting to the Board. CE confirmed that he expects that this will come back to the Board.

The Board approved the progression on development of the specification.

3.8 Nursing and Midwifery Structure Update **AMC**

AMC reported that Medical and Surgical wards had made good progress on skill mix. He was having discussion with Divisional leads on delayering.

He confirmed that he still had to come back on skill mix for other areas.

3.10 Infusion Pump Project **LB**

Infusion Pump Project demonstrates contract benefit of market testing.

LB confirmed that Carefusion is widely used. AH commented that there is a very big difference and asked if the quality was acceptable. AMC confirmed that it has been evaluated. AH suggested we should ask for a refund.

The Board approved the contract.

3.11 Remuneration Committee TOR* **HL/MG**

This was not discussed due to lack of time.

3.12 Register of Seals Report Q4* **VD**

This was not discussed due to lack of time.

4 ITEMS FOR INFORMATION

4.1 Assurance Committee Minutes – not available **CW**

4.2 Audit Committee Minutes – 29 March 2010 **AH**

This item was taken as read.

4.3 Finance and Investment Committee Minutes – 23 March 2010 **CE**

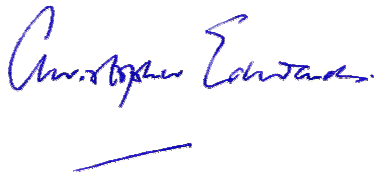
This item was taken as read.

5 ANY OTHER BUSINESS

None.

6 DATE OF THE NEXT MEETING – Thursday, 27 May 2010

Signed by



Prof. Sir Christopher Edwards
Chairman