Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting 26 May 2011
Extract of approved minutes

Present

Non-Executive Directors	Prof. Sir Christopher Edwards	CE	Chairman
	Sir John Baker	JB	
	Andrew Havery	AHa	
	Prof Richard Kitney	RK	
	Jeremy Loyd	JL	
	Karin Norman	KN	
	Sir Geoffrey Mulcahy	GM	
	Charlie Wilson	CW	
Executive Directors	Heather Lawrence	HL	Chief Executive
	Amanda Pritchard	AP	Deputy Chief Executive
	Lorraine Bewes	LB	Director of Finance
	Therese Davis	TD	Director of Nursing
	Mike Anderson	MA	Medical Director
	Catherine Mooney	CM	Director of Governance and Corporate Affairs
	Mark Gammage	MG	Director of Human Resources
In attendance	Axel Heitmueller	AHe	Director of Strategy and Business Development
	Dewi Harten	DW	ICP Project Manager
	Charlotte Mackenzie-Crooks	CMC	Volunteers Manager
	Liz Revell	LR	Interim Foundation Trust Secretary

1 GENERAL BUSINESS

1.1 Welcome and Apologies for Absence — CE

There were no apologies.

1.2 Declaration of Interests — CE

There were none.

1.3 Minutes of the Meeting of the Board of Directors held on 21 April 2011 — CE

The minutes of the previous meeting were approved as a true and accurate record with the following exceptions:

In the "Present" section Jeremy Loyd's initials to be JL rather than CW.

Under the Matter Arising relating to the Report on the Serious Untoward Incidents a sub-heading to be inserted to confirm that the discussion from Norland came up separately rather than as a part of the report on Serious Untoward Incidents.

Section 1.5 the second sentence should read paediatric respiratory rather than paediatric cardiology.

EBITA to read EBITDA.

The Chairman noted that "Good Reader" software can be downloaded to make it easier to edit papers when reading.

1.4 Matters Arising **CE**

1.6/Apr/11 Safeguarding Children Trust-Wide Training Report Update and Action Plan
TD reported that there were two costs: the education provision which costs £20k per year to run the courses and the cost of releasing the staff which is £70k per year.

1.6/Mar 31/211 Governors Report including membership report
This was addressed in the main meeting.

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

Imperial healthcare now has a new CEO, Mark Davies and HL is due to meet with him next week.

CE reported that new molecular labs had been opened at Hammersmith and that MA and he had visited the day before. It is now possible to sequence the human genome in days. This means that medicine can now be personalised but it has a cost and the challenge is how we can identify patients where this makes a difference. He noted a very interesting study looking at heart disease and other major medical problems in people of Indian Asian ancestry (The London Life Sciences Population Study - LOLIPOP). The expected risks of dying from coronary heart disease were double in this population. Researchers are looking at genes which may be Indian-specific.

1.6 Council of Governors Report. **CE**

TD noted that we now have data relating to ethnic breakdown. KN said it seems to be the black ethnic group which is under-represented but questioned who we were treating because in treatment terms we are over-represented.

JL said he was pleasantly surprised at this report but there were a lot of unknowns. He noted the socio-economic breakdown where some groups were under-represented and that may be a problem. CE noted that 2694 members had left and

2008 had joined so we are a little down but overall it was acceptable.

1.7 Chief Executives Report **HL**

HL reflected that many of the challenges at the moment relate to year end for 10/11.

For 2011/12 regarding the cost improvement programme (CIP) we had a target to reach 80% of CIPs identified by the end of May and it was a credit to all staff that this had now been achieved. She felt that this may no longer be a red risk, but advised that it should remain as such for another month. A further effort is being made to reach 100% by the end of June.

She and CE had met the sector Chairman, Jeff Zitron and Chief Executive, Anne Rainsberry. She noted that Imperial Healthcare had engaged consultants to help them explore their strategic and site options.

She commented the Government's "listening exercise" and thinks that the Healthcare Bill will be delayed. The big impact to us of a delay will be no change to the private patient cap. We were fortunate to have had two ministerial visits, the Prime Minister and the Deputy Prime Minister, both of whom undertook listening exercises with staff and patients, respectively. She noted that Andrew Lansley is opening the new Outpatients Department on 9 June. GM said that one of the main points was that GPs cannot commission for some patients and he felt that the government were listening a bit late. CE noted that GP-commissioning had been changed to GP-led. He said that the challenge was how you could allow the relevant people to be involved without it being too unwieldy, and how you get GPs to commission for research and innovation.

AP reported on a Foundation Trust Network meeting which she went to on HL's behalf. The belief there was that there will be a delay in the Bill or the government will seek to push it through without primary legislation or will drop part three which is the economic regulation section. The FTN is lobbying for changes to primary legislation. They felt that the key issues are the need to include integrated care; the impact on secondary care with GP led commissioning and local accountability structures. Governors need to take on the role that Monitor play. It is felt that making governors do this is probably the right answer but Trusts need to be allowed to revisit their Constitution e.g. to have more appointed governors.

HL thanked everyone for their efforts on the Open Day and GM for judging the best stand. She said that the two particularly new and positive aspects to the Open Day were that we had attracted young people, and the health checks.

HL said regarding the Integrated Care Organisation, the joint directors and the lead managers have now been appointed

She noted the Unicef award for breastfeeding to maternity which is another indication of how well maternity are doing.

HL outlined the situation with Provision.

Regarding Electronic Document Management (EDM), HL said that from the NHS point of view EDM is a new development. There are two framework contracts used for acquiring an EDM solution but most of these are about scanning documents

rather than a full EDM solution. We are proposing to go through a framework route and asked for comments. She said we need people with some NHS experience.

Regarding the 'referral to treat' forms incident, MA explained that a form is filled in after every patient which identifies what has been done and what is going to happen with that patient. It is not a good method but it is one that most people use. It is these forms which had gone missing. MA confirmed that these forms were attached to the front end of the patient notes for each visit.

HL said we did know that we did not have a sufficient completion rate but no one thought it was due to missing forms. AP reported that there was only one 18-week breach as a result. GM suggested it should be an electronic system. HL said it was about the rigour of supervision and communication. We spent a lot of time communicating with doctors the need to fill in the forms and perhaps not enough communication with administrators on the importance of the forms. CE asked if we had found one set if could there be others missing. HL confirmed that all other areas had now been checked. We were fortunate in terms of the impact on patients. CE suggested that if the forms were numbered we might identify gaps.

HL noted the Freedom of Information Act (FOIA) request for claims information which has not yet become a public article. She confirmed that none of these claims were current. Most relate to children and one payment was relating to a high profile actress. HL noted that the staffing levels in obstetrics since 2003 which was the last incident leading to a claim, are now significantly higher; e.g. we now have 98 hour consultant cover. MA commented that losing the CTG trace means we could now lose millions because we are unable to defend ourselves and EDM would be a solution for this. MA said that the numbers are so small which is a problem in identifying trends; however we do not want a single big claim at any time. HL said she would like to see more about transfers into NICU. AP confirmed that any unexpected admissions are reported as an incident. With respect to the meningitis claim we have improved staffing levels since then and the mother is involved in working with us.

She noted the situation with overpayment of consultant and confirmed that that has not occurred for us. However, we do have an issue with long-term locums. They can be most cost effective for anaesthetics because we get more clinical sessions from them. CE said, however, that it was not good for appointments as there is pressure to appoint the incumbent and we need to address this.

2.1 Finance Report **LB**

LB reported that we are on track in terms of the cost improvement programme (CIP). At the time of the report we had achieved 50% of the CIP but we have now identified 80% (potentially 90% of this is recurrent). There is still a risk but she thinks it is now amber. Within the CIP a minimum must be 4% cash releasing and we are only at 2%.

CE congratulated the team on this achievement. HL said she felt we should stay on red until next month because there are still a lot of schemes that we need to make sure that we have plans in place for. LB said that key risk areas are about how much income has been signed and been agreed. We have now agreed the value of about 74% of contracts. There is one minor issue outstanding which when resolved will mean we are at 90% of contracts agreed.

CE said he would welcome an opportunity for discussion on the Dean Street model at a future Board meeting. He commented that if we do more and get more return in one division there is a corporate responsibility to share this.

KN asked whether we had taken into consideration the lead time for the cost improvement programme and HL confirmed that this was the case. LB said it is very important to consider how these CIPs will impact on clinical services and Monitor take an active interest in this. AP said that we had spent a great deal of time with the divisions working through the CIPs. It was made clear that there were certain no-go areas e.g. we cannot do any more ward skill mix reviews. We have been looking more at administrative and clerical staff. She noted that we have re-established the Productivity Board.

GM asked about the Prudential Borrowing Limit on page 7. LB outlined more details on two of the loans. We have been allowed to extend the loan facility for the long term decant for a year. Regarding the Netherton Grove loan we have asked for an extension until September 2012 which is three months beyond the final completion date to allow for slippage. This has been agreed.

2.2 Performance Report **AP**

AP reported that we finished Q4 at green. She noted that there were two important changes to the Monitor Compliance Framework. The first one was the *C.difficile* target which was set at 31 cases. As we have introduced a more sensitive test we think that this should be 49. We ended last year at 55 cases. TD said that Guys & St Thomas' Hospital are using the same test and there is increasing demand for this to be taken into account when targets are set. She said about 30% of Trusts are using this test. HL noted that she had written to the Department of Health on this issue about four months ago.

TD said that in month one we had only had one case of *C.difficile*. We now do a root cause analysis on every case of *C.difficile*. Information has been circulated on how to take specimens and we will continue to educate. It is important to try to prevent the spread.

The Chairman clarified the discussion which was that if a patient is on a proton pump inhibitor they are more likely to get *C.Difficile* infection. If there is a situation with a patient who has *C.Difficile* next to a patient who is on a proton pump inhibitor this increases the chance of the patient on the proton pump inhibitor getting *C.Difficile*. He had asked whether if this was the case, the patient could be moved.

He noted that he had discussed this with MA who had sought the views of Dr Azadian. He noted that there is an initiative to try to ensure people are not left on inappropriate acid reduction agents. A study at the Royal Free showed that 50% patients with *C.Difficile* were on proton pump inhibitors. Patient on proton pump inhibitors should be put on to H2 receptor antagonists especially if they are on a ward with *C.Difficile*. He did note that it was a balance of risks.

CE asked that if we introduced a policy that a patient with *C.difficile* who is on a proton pump inhibitor (PPI) and had to be moved to a single room could we do it? MA said there is nothing to say that this could not be possible. It would be ideal if a patient with *C.difficile* was put into a side room but if not, then with another patient

with *C.difficile*.

MA to discuss with Dr Azadian the possibility of patients with *C.difficile* who are also on PPIs being put in side rooms. **MA**

AP noted the new A&E indicator which will come in in Q2. Three indicators out of five is considered a failure and we are currently at this position. At this stage, the worst case is that we may fail two out of five.

AP noted that she has previously communicated to the Board the introduction of a range of key performance indicators as part of the contract. One issue is the consultant-to -consultant referrals which is an internal referral from one consultant to another. Commissioners would like to see more visibility around this. The risk is that this will provoke behaviour from us which is of financial benefit rather than patient benefit. We are looking at three areas; pathway referrals, urgent referrals and same speciality referrals.

AP noted the new quality targets and the new CQUINs (Commissioning for Quality and Innovation) incentives. The April performance has been good.

She thanked Geoff Mulcahy for meeting to discuss how we might think about the performance framework going forward e.g. how better we can reflect the patient experience and unit costs and the indicators of quality which we will monitor.

3.2 Assurance Committee Report on CQC Standards Compliance **CW**

CM outlined the process of assurance which was a peer review by directors followed by a review at the Assurance Committee. She confirmed that through all stages there had been changes to the assessment indicating that this approach had been effective.
CW confirmed that the approach had been rigorous.

The paper with all the actions following the Assurance Committee on Monday was circulated. This paper outlined the outstanding action points from each of the standards.

The Board agreed the assessment.

3.4 Volunteers Report

TD introduced Charlotte Mackenzie-Crooks (CMC) who is the Volunteer Manager. She said that CMC does a tremendous job and the volunteers provide very positive benefits to patients.

CE asked whether there was some ambivalence regarding the role of volunteers with respect to the role of nursing staff on the ward. CMC explained that volunteers provide companionship at mealtimes e.g. sitting with and helping patients who take a long time to eat. They do not deal with patients with any clinical risk e.g. of choking.

CMC circulated the leaflet which advertises that patients can request a volunteer. This went live on 31 March and there have been three to four requests so far but further advertising is required.

CE commented on the fact that it takes three months to get approval for a volunteer to work here. CMC agreed and said that it can be difficult to explain to people why so many checks are required e.g. CRB. She has about forty requests a week of which six may become volunteers. She talks to potential volunteers on the telephone or communicates via email to determine their motivation.

HL asked what guidance is provided to volunteers on how to behave. CMC said there is a screening process followed by an induction process with herself regarding what is expected in terms of safeguarding and behaviour. Patient befrienders get trained by the ward based patient support co-ordinator (Serena Venticonti) who runs a ward-based programme and monitors volunteers for the first three visits.

JL asked to what extent volunteering was a pathway to employment e.g. as an internship. CMC said that we run work experience programmes and the demand for them is huge but the ability to set up programmes and find managers who have the time limits this. JB asked how quality is monitored and how do we know that volunteers improve the patient experience. CMC said there was no measure at the moment other than requests for volunteers and thank you letters. She is planning to do a survey in three to four months time.

HL said that the time between 5pm to 9pm when staff are stretched would be ideal for volunteers as well as at lunchtime. CMC said that more people do volunteer during the day but some do come in just for the evening. She confirmed that there were about 150 volunteers. HL asked how we keep people on board with the new ward based initiative. She said that there is good communication with the volunteers.

JL asked if their work was controlled in any way by targets. CMC said that they are driven by a cultural belief in what they are doing but that there are no specific targets. She confirmed that she does put in bids for funding such as “Big Society” but had not been successful so far although she had been successful in getting other funding e.g. the Friends are funding the ward based volunteers. In terms of numbers, she said that 200 would be the limit of manageability of volunteers although with the patient support co-ordinator now in post she could manage 250.

CE asked whether the government apprenticeship fund was relevant and CMC confirmed that this was not relevant because apprenticeships were paid posts. HL said that, however, we could get people as volunteers which could help us identify areas where apprenticeships might work. MG confirmed that we do have apprenticeships but not many.

CE congratulated and thanked CMC for all her good work and agreed with JL that volunteers are one of the ways of finding out how well the hospital is doing. We need to think more about the interface with work.

3.6 Monitor Annual Plan Sign-off **HL**

HL said that Monitor requires a three year plan but this is set against a situation of great change.

KN highlighted page 15 regarding risks and mitigation and said she thought we could strengthen the mitigation. HL agreed.

A typo was pointed out on page 10 first column (an extra 'the') and on page 11 two columns on the right hand side were repeats.

KN asked if we should mention Royal Brompton Hospital's loss of paediatric cardiac surgery on page 15? MA said it was a small loss initially and there would be more of an impact over time. He did not think this would have an impact in a three year cycle.

JB highlighted the development of HR services on page 40. He said that when he had been at Dean Street he asked one of the senior staff what stood in the way of being better and bigger. The manager said that although he was the budget holder there were things he could not do and job descriptions can take six months to clear. JB asked whether this was correct and if so, could we improve the bureaucracy? MG said that this was partly true. Currently he and AP go through every single request to ensure there is sufficient control. This is not sustainable and he would like the divisions to take the responsibility. HL said that we need to take particular care with consultants because they are high cost. She agreed that over three years that the divisions have their own systems helping people to do their jobs. MG confirmed that there was no freeze on nurses and that the delay would not affect this group.

JL asked whether this document was public and, if so, in relation to the private patient cap do we need to be so explicit. LB said that it does get reinvested in NHS care but JL felt that this needed to be spelt out more explicitly.

The annual plan was approved subject to the above changes

3.7 Integrated Care Pilot update **HL**

AH noted that he had circulated four papers relating to the NHS London Integrated Care Pilot the day before; the Hosting Agreement, the Establishment Agreement, the IT Managed Service Agreement, a Memorandum of Understanding and a revised paper. He apologised for the short notice but these papers had only just been released.

AH said there were two areas of concern: indemnity and liabilities. The pilot had outlined liabilities for providers. Since then a "double-lock" vote has been introduced so acute providers can veto any decision that might result in a liability. Imperial Healthcare had signed off on all the agreements yesterday following a review by their lawyers.

Clinical liabilities will stay as they are. Regarding financing, money has been taken from several sources but includes money taken from acute providers. However, we can get some back; e.g. our time commitment of clinicians attending multi-disciplinary meetings will be reimbursed. There are three income sources: consultant fees, extra activity in A&E and, if it works, maybe a bonus. This is highly unlikely in the first year.

AH confirmed that we do not have any concerns and asked the Board if they are happy to recommend the sign-off of the Establishment Agreement. JB asked whether our lawyers had reviewed it. AH said that we had relied on Imperial Healthcare lawyers.

CE said that when this service is taken out of the hospital it decreases the core business and this is not addressed and perhaps could be picked up in the evaluation.

It was confirmed that HL, LB and AH had read earlier versions. KN asked why we were getting it later than everyone else. AH confirmed that everyone had received it the day before.

CE confirmed that this was a pilot over a limited time. He congratulated AH for working very hard on the money and liabilities side and this was now clear. He confirmed that as a Trust we do need to be part of it. HL added that the financial risk of not joining would be very significant.

The Board approved the sign off of the Establishment Agreement.

3.9 Workforce Annual Staff Report (including the Equality & Diversity Annual Report 2010/2011) **MG**

MG said that we had covered a lot of this in the seminar and, in summary, there were no issues. Regarding applications he said that there are lots of applications from certain groups who do not meet the person specification.

Regarding employee relations, 28% of our work is related to BME staff which is the same as seen in other organisations. He said it was difficult to say whether there was some inherent prejudice. KN noted appendix 10 and that three groups tend to have more cases than others.

MG noted our target for appraisals and although the increase from 39% to 41% does not seem much it had been based on the upper quartile. He outlined the distribution of bands illustrated in appendix 1 and said that we had fewer Band 2 and Band 3 posts and more Band 7 than other organisations. This is partly because we contract out the lower grades and also because we are a specialist service and, therefore, will have highly banded specialist posts.

3.10/ 3.10b Staff Survey Update and Action Plan **MG**

MG outlined the action plan and the relation to the Quality Account. As a general theme we are focusing on how we use the time we have and that perhaps we do not use it as well as we would like because we are not as structured as we would like to be.

3.11 Audit Committee Annual Report

LB reported that the Audit Committee agreed that the Trust's risk management, control and governance processes are adequate and effective and may be relied upon by the Board.
The Board accepted the Audit Committee Annual Report.

3.12 Audited Annual Accounts

LB reported that the Audit Committee met on Tuesday, 24 May so the final report

was tabled.

She said that there were two parts to the accounts, the directors briefing and the audited annual accounts.

The Audit Committee had raised issues which were highlighted in green. Regarding the 10% increase in income, she noted that the Commissioner's demand management initiatives had been planned but had not yet started to impact and there was some advantageous pricing as a result. On page 3 she noted staff costs had increased; this was due to a number of staff that we are hosting, for example, HIEC.

Executive Director costs had increased by 12% because we had to cover two posts with agency staff. She noted that the non-executive Director costs had also increased because of the new Non-executive Directors.

She noted that on page 5 section 5.1 salaries and wages increased by 2% and pensions had increased by more. There was a question at the Audit Committee as to why this had occurred. She said it was a function of the number of people who are joining the pension scheme. AH confirmed that the Audit Committee were happy with this report.

The Audit Committee recommended that the accounts be signed.

3.13 External Auditors Report **LB/AH**

LB said that item 3.13 was the external auditors report to the 24 May Audit Committee. A partner presented the report and there were a couple of minor tests outstanding which are now resolved, apart from their review post the 31 March which they will do tomorrow morning and which they will address at the point of signing.

There were two aspects: an opinion on truth and fairness on the accounts which was unmodified; and an opinion on whether we had systems in place to ensure value for money. The latter provides for an exception report i.e. a report is made if it is believed that we do not have systems in place. There was no exception report.

The auditors provided a limited assurance audit report on the Quality Report which will be separately signed off. This has been delegated to HL, CW and CE.

The report sets out the areas of key audit risk and what tests have been carried out. There is a schedule of errors outlined in appendix 1 but none were significant. There was a reclassification of income versus expense but this was an immaterial amount. We identified adjustments were needed to the re-evaluation which is outlined at the bottom of the page. It was confirmed that the letter for HL and CE to sign is outlined on page 23/24. The sections are standard except section 18 which is a specific one they have asked us to confirm.

LB reported that it was a very smooth audit compared with last year. Deloittes were much more on the ground and much more involved than previously. She confirmed that the fees were outlined on page 22. LB confirmed that the audit partner had signed and there was nothing outstanding.

Further changes to the Annual Governance Statement were that on page 5 a

sentence had been added and there were two other changes which were to explain the ratings.

JB said he wanted to emphasise that it was felt that there were some weaknesses in the data collection so it was wrong to imply that everything was alright.

CE said that this was a new area for auditors and questioned whether they were trained to do it. JB said he thought it was about applying statistical tests to data. He said the discussion at the Audit Committee was more a criticism of Monitor's methodology than the auditors. He felt the system was flawed e.g. there was no materiality specified for example there was an error in one data item out of 490. AH said the audit was a mixture of compliance and statistical testing. HL said she was concerned that we had had the same audit before on the cancer wait indicator and we apparently had not learnt. LB pointed out that the sixty-two day indicator had improved in the areas highlighted last year and external audit have identified areas which had not previously been identified.

CE confirmed that the Board noted the concerns and accepted the report

3.14 Code of Governance **CM**

CM noted that there had been a detailed review of the revised Code of Governance at a previous Board meeting and this paper identified two areas for discussion.
After some discussion it was agreed that the Trust was not in conflict with the Code relating to external assessors.

Regarding code provision C.2.3, it was agreed that attendance records are available and we comply with the Code provisions.

3.15 Register of Seals Report Q4* **CM**

This item was starred.

4.1 Assurance Committee Minutes – 28 March 2011 **CW**

This item was taken as read.

4.2 Audit Committee Minutes – 24 March 2011 **AH**

This item was taken as read.

4.3 Finance & Investment Committee Minutes – 17 March 2011 **CE**

This item was taken as read.

5 ANY OTHER BUSINESS **CE**

There was none

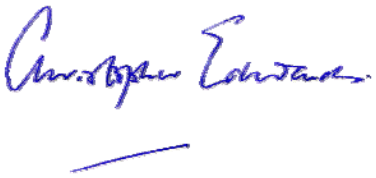
6 DATE OF THE NEXT MEETING **CE**

Thursday, 27 July 2011

Note: Items were discussed in the order 3.4, 3.11, 3.12, 3.13 and then as stated on the agenda
RK left the meeting at 4pm

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