Board of Directors Meeting 3 March 2011
Extract of approved minutes

Present

Non-Executive Directors	Prof. Sir Christopher Edwards	CE	Chairman
	Andrew Havery	AH	
	Prof Richard Kitney	RK	
	Sir Geoffrey Mulcahy	GM	
	Karin Norman	KN	
	Charlie Wilson	CW	
	Sir John Baker	JB	
	Jeremy Loyd	JL	
Executive Directors	Heather Lawrence	HL	Chief Executive
	Mike Anderson	MA	Medical Director
	Lorraine Bewes	LB	Director of Finance
	Therese Davis	TD	Director of Nursing
	Amanda Pritchard	AP	Deputy Chief Executive
	Mark Gammage	MG	Director of Human Resources
	Catherine Mooney	CM	Director of Governance and Corporate Affairs
In attendance	Helen Elkington (in part)	HE	Facilities
	Gregg Hewitt (in part)	GH	IT Manager
	Liz Revell (Minutes)	LR	Foundation Trust Secretary

1 GENERAL BUSINESS

1.1 Welcome to Sir John Baker and Jeremy Loyd — CE

The Chairman (CE) warmly welcomed both Sir John Baker and Jeremy Loyd (new Non-Executive Directors) to the Board.

Apologies for Absence — CE

There were no apologies for absence.

1.2 Declaration of Interests — CE

There were no declarations of interest.

1.3 Minutes of the Meeting of The Trust of Directors held on 27 January 2011 — CE

Minutes of the previous meeting were approved as a true and accurate record.

1.4 Matters Arising — CE

1.5./Jan/11 Matters Arising
LB gave an update on progress regarding invoice discounting as in the matters arising paper. KN queried whether 0.3% fee for the purchase card was too high.
Action: LB to give an update at the 31 March Board.

1.6/Jan/11 Chairman's Report (Oral)
CE gave an update on the Education and Training Bill consultation. He reminded the Board that there will be a restructure of education and training as the money is currently held by the SHA, which will cease to exist by 2013. As Chelsea & Westminster is the host of the North West London, HIEC and the operational group

will prepare a response on behalf of the HIEC partnership Board. Medical Education England will become Health Education England which will also hold the budget for other professions and organisations will be responsible locally for training provision.

CE said that we have a number of key stakeholders and there are several different models being looked at. A clear model needs to be proposed as many proposals suggested by the Government are not workable.

1.8/Jan 3/11 Chief Executive's Report
The Chairman confirmed that he had written his thanks in ''Winter Watch' for the special effort made during December's snow and difficult weather conditions.

2.3/Jan/11 Serious Untoward Incidents
MG confirmed that we employ the triage nurses in the Urgent Care Centre.

3.2/Jan/11Safeguarding children.
HL said that a report was due to come to the Board but she had asked to see the new guidance and noted that there are 7 Levels of training, and she has asked for more work to be undertaken.
Action: Paper to 31 March Board

1.5 Chairman's Report (oral)

CE had met the new Chairman of the Charity (Christian Brodie) who has many ideas to attract donors. The Charity are launching the Sunshine Appeal for £5m for children. It is important that we are clear what we are raising money for and one idea is a neonatal research facility. We need to communicate ideas to the Charity and involve clinicians. CE noted that the Charity has employed a professional fundraiser.
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CE reported that the three local borough councils, Hammersmith and Fulham, Westminster and Kensington and Chelsea, are considering combining back room facilities and other provider services.

1.6 Council of Governors Report including Membership Report* CE

CE said the report was for noting as many issues had previously been covered. He asked the Board to note in particular the concerns around the proposed changes at the Royal Brompton hospital. He also said that we needed to debate at some stage the value of the membership and the Council of Governors and our links with them. We could start to use the constitution in a much more enlightened way.

1.7 Chief Executive's Report HL

HL reported on a number of issues which included:

The Budget and update on Commissioning Contracts 2011/12

This began in September 2011 with collection of information and continued with activity modelling in October 2010 through to February 2011. Contractual discussions have commenced from January and continued through February 2011. HL commented that there had been regrettably slow progress on this and the baseline is still not agreed. LB said that this is being actively managed and there is a deadline of 14th March. HL noted that we had never had to resort to arbitration and the issue is maternity. AH commented that the process had felt more positive last time. LB said that the PCT commissioners in North West London had not signed their contracts and we are the only acute Foundation Trust.

HL said a previous report stated that that there was a £1b gap, of which £700m is with the PCT and £300m with acute sector, but she clarified that it is the other way round. CE asked LB to comment on how she sees the process going. LB said that she thinks there will be a trend towards consolidating and noted that we are dealing with a situation where 500 staff are being reduced to 150. She confirmed that we cannot

confirm a CIP until the contract is agreed. JB commented that we should seek to avoid confrontation. LB agreed and said the issue is what they are prepared to fund. HL said she has been emphasising shared services and partnership working as part of business planning. CE commented that 10% is very ambitious.

The Ombudsman Report into Care of Older People detailing investigations into complaints made in relation to the standard of care provided to older people by the NHS;

The Memory Assessment Service which will provide more support to patients with dementia and their carers;

The Inpatient Survey 2010, the results of which are detailed in a later paper, provides disappointing results on ten questions. HL said we must improve the patient's experience particularly in relation to privacy and dignity, communication and discharge arrangements;

The Lower Ground Floor Outpatients Centre, which generally met with approval, but is not yet completed so contingency plans had been put in place; HL outlined progress with phase 1 and 2. The self checking kiosks will be operational at the beginning of April.

JB commented that the elderly is a significant challenge and is there anything in getting to be 'leading edge'. CE agreed and gave as an example of a patient journey: an elderly patient arriving on AAU and then getting transferred, it can seem very confusing. We should try and see things from their perspective and think about things that can help. HL agreed.

2 PERFORMANCE

2.1 Finance Report Commentary – February 2011 **LB**

LB reported that the Month 10 position showed a reduction in the EBITDA of 1%, largely due to reduced income from elective work related to winter pressures, not being offset by increase in incremental income. In terms of a forecast we are on track for a net surplus. CE commented that displacing an elective for an emergency and getting 30% for the emergency is not sensible. LB said this is recognised in the tariff as an attempt to stem readmissions figures. Commissioners deliberately put this in and it is designed to ensure we work together to decrease emergency admissions. Despite the Bruce Keogh letter there has been no real impact. HL said we need to focus on why emergency surgery is £1.4m down. The non-elective year to date position is down on plan and we do not quite understand why.

LB outlined a governance near-miss related to the private patient cap. JB asked if there were any sanctions as a result of breaching the cap. LB said that we immediately get a red risk on our governance rating. Her view is that this is a short term problem which will be solved after 2012. One Trust who was is in breach had very heavy monitoring put in place. LB said that Monitor take a risk-based approach. JB thought that the variance was "trivial" but LB pointed out that the issue was highly political.

CE queried why non-reciprocal overseas patient income counted against our cap. LB explained the scope on non-reciprocal agreements and confirmed that overseas private patients count against our quota. Audit's view is that if we deliver the service we should get the income. JL asked if an overseas patient walked out without paying whether that would become a bad debt. LB confirmed this and that it is more difficult to monitor out of hours. She said it is a real issue for next year's planning. CE commented that the private patient cap is based on income so if we are making 10% CIPs we also have to reduce our private patient income so losing out twice. JB offered the Board's help in sorting this difficult issue, if it would be helpful to highlight externally. LB said that the cap was 3.5% based on the original definition and is now 3.71%. She has been through this with the auditors and made adjustments e.g. not

including amenity beds. LB said we should have predicted this and revised the baseline. She confirmed that the target has been rebased.

The Board confirmed that it supported LB notifying the re-basing to Monitor

2.2 Performance Report Commentary – February 2011 **AP**

AP noted that the dashboard was in the supplementary rather than main papers in error. She explained that there were a number of targets and each one we fail contributes to an overall rating. We are currently rated as amber-green. A new target had been introduced from January, which is screening emergency patients for MRSA for which there was a 100% target. We had only screened 57% in the first month, meaning we were automatically amber-green. CE asked why this had not been achieved. AP said that one issue is whether the reporting is right and the other is compliance. We are working with the matrons and clinical nurse leads to improve compliance and it has improved e.g. there was 88% compliance in one ward last week. TD agreed and said that an example of a reporting error was a patient who was admitted to the observation unit who was counted and should not have been. TD said that the DH definition is all relevant patients and some Trusts do not screen all patients and perhaps we have set the target too high compared with others. We will be looking at the wording and will come back to the Board with a proposal.
Action: To propose the MRSA screening target for the Board to approve.

AP confirmed that our performance on MRSA has been very proactive and there is a high level of confidence we will achieve our target. She explained two new targets – single sex and A and E. Regarding single sex we need to make a declaration of compliance to Monitor by the 31 March. It will be quite a lot of work to guarantee single sex accommodation for every patient and we cannot do that at the moment.

For the A and E target the 4 hour waiting time has been replaced with 8 measures and 5 are part of a compliance framework. For Monitor it is a serious breach for any organisation to breach two out of five on more than one occasion. The measures were published on 17th Dec so there has not been much time and there was a lot of work to ensure that the data quality is high and we can report accurately. As an example of the difficulty in data collection she described a measure of length of time from the ambulance arriving to first assessment; in an emergency, staff do not stop to enter data.

CE expressed concern about the relationship between patient care and targets. Having too much bureaucracy is not sensible in terms of quality assurance. AP said that the Royal College of Emergency Medicine set the targets and are very clear that it is about improving quality. There was a discussion about the values of targets and JB emphasised the role of the Non-executive Directors in being spokesmen. CE said that evidence is required that targets are not benefiting patients. JL commented that targets can enshrine mediocrity and four hours is too long to wait. CE agreed and said that 18 weeks is too long also. GH said that there was a lot of discussion about compliance and targets and asked what we would measure ourselves on if we had a choice and what would we get rid if? CE said he had noted a new cadre of people who were not there before but it is difficult to turn the clock back. JB said that he had identified seven different organisations during his induction that we had to report to and probably very few people are aware of the extensive reporting requirements. AP said that having worked in No 10 she was aware that targets had been intended as a short term plan. Eventually patients would vote with their feet, and there would be no need for waiting times and targets etc. However, politicians are not confident that the market is mature enough. GM felt that this was a naïve stance.

3 STRATEGY

3.1 Strategy Update **HL**

HL noted that the strategyupdate had been covered in the seminar on corporate objectives which had taken place immediately before the Board.

3.2 Budget and update on commissioning contracts **HL**

This had been addressed earlier in the CEOs report.

3.3 Integrated Care Organisation Update **HL**

HL explained the background and said that integrated health care is the way forward. The ICO sets out to create a seamless care pathway for elderly patients and patients with diabetes, joining up more effectively primary and secondary care, as well as social care and voluntary sector providers. The ICO aims to deliver financial savings, better patient care and an improved professional experience. However savings would come from reduced emergency admissions to acute hospitals. Care would be provided according to multi-disciplinarily team care plans supported by a new IT system that extracts necessary information from participants existing data source (£1m investment). We have been invited to join following expressing concern about competition but the details remain unclear.

Our view is that it is better to be part of it than not but we are unclear in what way. We do not know what the IT investment would be and our clinicians are concerned about what happens to the data. The figures are possibly wrong.

MA said that clinicians feel they could be 'boxed in' around certain pathways. The pathway for diabetes is very clear but frail elderly is more variable. There is also an issue about IT connectivity

CE said that this is the direction of travel regardless of whether the Trust remains involved or not. It would be risky not to be involved as the Trust cannot be totally independent in the current economic climate and it would be risky to do something alternative with no financial support. He and HL will meet with Tom Kibasi of McKinseys, and Professor Elisabeth Paice (Chair of the Management Board) to discuss this further.

CE said that this will only work if there is clinician buy-in and he is happy to be a catalyst for this. The final point is evaluation and it seems weak and there may be a role for CLARHC.

AH expressed concern that if there were no savings what would the plan be then. HL said that restrictions on follow-up for diabetes will happen anyway so we may as well be part of it through this pilot. JL queried how this saved money and HL replied that we will not be paid for follow up appointments which will happen in the community which they believe to be cheaper.

JB said that this is a new thing in community health care, is inevitable and that good people should be involved. The pilot was only intended to run for a year, which seemed a very short time and he wondered what would be learnt. Being part of the post-pilot phase is fundamental and we should have a strong voice in the evaluation. If we are outside the pilot then our opinions will not count. He felt a year would be insufficient. HL said that one of the challenges is that Imperial Healthcare is three times bigger and well resourced. Our clinicians will need support, at least initially.

CW said he agreed with the analysis and queried what the alternative might be. RK asked who was making the £1m investment in IT and HL confirmed that it was NHS London. JL asked if we are able to go in with an idea of how success will be measured. HL said that it was not clear at this stage.

The Board agreed with the proposal that we seek to join a second wave pilot starting in the summer.

Action: An update to be provided to the next Board on how to take this forward and get clinicians involved

3.4 NHS Operating Framework * HL

This item was starred.

QUALITY HL

3.6 Maternity Services Review AP

AP noted that this item was deferred from January so the data appears a bit old.

Two years ago maternity was a red risk, and the issues were about leadership, and multi-disciplinary working, different work cultures (i.e. that of midwives & consultants), the attitude and behaviour of staff and the high numbers of agency staff. There was a lack of integrated governance and structure. A very detailed analysis of complaints was carried out and it was noted that a disproportionate number were 'white other' and 'black other' backgrounds. This suggested that there are different expectations from this group of service users who may be used to a model where patients are looked after by doctors rather than midwives.

AP said that there is a range of things happening but more could be done. CE asked to what extent midwives think things have improved and whether they are happy. HL said that the whole culture has improved. Staffing and understanding of roles is much better. AP said that she had done a spot check in February and there was only one agency staff. CE asked if there was still a residual core of people who do not want to change? AP said that many staff had left and many enthusiastic new staff had been recruited.

Maternity had developed a uniform policy for easy identification of staff and obstetricians, midwives and junior doctors now wore different coloured scrubs, which included their name.

JB said that the quality of front line people is crucial and good technical skills are not enough and asked whether our system of evaluation takes account of this? HL said we do need to get better at assessing skills; e.g. different skills are needed in A&E than Maternity; however co-ordinating the staff requires the same set of skills.

TD confirmed that the midwife consultant is a joint appointment, between us and Kings and is the first midwife consultant.

GM asked if patient experience is tested externally. AP said that according to the Picker Maternity Survey the Trust is the 3rd best in London.

CW asked about activity and AP said we undertook 5000 deliveries last year and the physical capacity limits us. The Netherton Grove extension will free up space and we will consider a midwifery facility.

3.7 Assurance Committee Report from meeting January 2011 * CW

This item was starred

3.8 Inpatient Survey 2010 TD

TD explained that this survey had been carried out across the NHS during August 2010. The results were very disappointing. The Trust has worsened in ten areas, in particular, discharge, communication and attitude and it was agreed that we would focus on these in the Quality Account.

CE said that there were some things that could be done straight away e.g. lockers to be provided in which to keep belongings. However, others are more problematical and will take longer e.g. attitude problems. HL said that the survey took place in August when the AAU had just opened and there were significant teething problems. CE said that the experience in AAU was crucial. LB noted that there was an increase

in people sharing sleeping areas. TD said she thought this referred to AAU and there are now single sex bays in AAU.

KN said that the same issues arose every year: availability of hand gels and single sex accommodation. JL said that the tone of a hospital stay is set by admissions and the flow through of good information. CW said the results of this survey are totally at odds with the results from the Patient Experience Tracker and asked whether the PETS are worth it?

HL said that the numbers are small but we need to focus on AAU. Working there is very challenging and we are now beginning to get the staffing right.

GM said it was important to identify the two or three things that will make the most difference.

CE summarised by saying that there are some things that we can do rapidly and some things that are already being addressed and we need to identify some 'quick wins'. The survey is a very key area for us to take note of and we need to be careful regarding the use of the PET and what it tells us.

3.9 Quality Account **CM**

CM outlined the key parts of the Quality Account and the importance of stakeholder engagement. This paper outlined the progress to date and the 'long list' of objectives and indicators that are being considered.

CE commented that this was work in progress and the Quality Account is still a relatively new idea. In order for the Trust's improvements to be measured proper data is required. CM said that she felt that in this case the process is more important than the outcome as preparing the Quality Account had led to improved engagement and focus on quality.
The Board noted the progress

3.10 Quality Award **CM**

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CM presented the paper which highlights the winners of the first Quality Awards. The purpose of the paper is for the Board to be aware of and recognise initiatives relating to quality undertaken within the Trust. It demonstrates how safety, effectiveness and patient experience is achieved in practice. CM outlined the winners and the main features of the work which led to the award. JB commented that it was very impressive.

Action: the Board to pass on its congratulations to the winners. **CM**

GOVERNANCE

3.11 Assurance Framework Report and Review of Corporate Objectives Report Q3 **CM**

CM presented this paper which contains the highlights from the Assurance Framework for 2010/11, and review of the Trust's corporate objectives for Q3 including risks. She said the majority of objectives were quality objectives and these had been discussed in detail by the Assurance Committee at its last meeting.
The Board noted the progress

3.12 Remuneration Committee Report **CE**

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CE explained that the key issue is that many of the staff re on Agenda for Change which has a built in pay increase. This is not the case for directors and there has been two years with little increase. The Remuneration Committee had therefore agreed to increase to increase the pay of the directors from 1st September

3.13	**Register of Interests Review**	
	The Register of Interests of the Chairman and Karin Norman to be amended. **Action: Register to be updated.**	**CM** **CM**
3.17	**Proposed amendment to Standing Orders re opening tenders ***	**CM**
	This item was starred	
4	**ITEMS FOR INFORMATION**	
4.1	**Assurance Committee Minutes – November 2010**	**KN**
	This item was taken as read.	
4.2	**Audit Committee Minutes – October 2010**	**AH**
	This item was taken as read.	
4.3	**Audit Committee Minutes – January 2011**	**AH**
	This item was taken as read.	
4.4	**Finance & Investment Committee Minutes – January 2011**	**CE**
	This item was taken as read.	
4.5	**Finance & Investment Committee Minutes – January 2011**	**CE**
	. This item was taken as read	
4.6	**Supply of Phaco Emulsification Machine & Consumables Contract**	**LB**
	This item was taken as read	
5	**ANY OTHER BUSINESS**	
	There was none	
6	**DATE OF NEXT MEETING – 31 March 2011**	

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