Board of Directors Meeting 31 March 2011
Extract of approved minutes

Present

Non-Executive Directors	Prof. Sir Christopher Edwards	CE	Chairman
	Andrew Havery	AHa	
	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
In attendance	Axel Heitmueller (for items 3.5 and 3.6)	AHe	Director Strategy and Business Development
	Fleur Hansen	FH	

1 GENERAL BUSINESS

1.1 Apologies for Absence — CE

Apologies were received from Catherine Mooney, Therese Davis and Liz Revell.

1.2 Declaration of Interests — CE

There were no declarations of interest.

1.3 Minutes of the Meeting of The Board of Directors held on 3 March 2011 — CE

- Minutes of the previous meeting were approved as a true and accurate record.
- AH said that point 1.7 p4 wasn't commenting about the previous year.

1.4 Matters Arising — CE

1.5/Jan/11 LB said the update on invoice discounting would be ready for May Board meeting.
2.1/Mar 3/11 The MRSA screening target will be discussed at the April Board meeting.
3.3/Mar 3/11 The Integrated Care Organisation is for discussion at today's meeting (item 3.5).
3.4/Mar 3/11 Serious Untoward Incidents; there is no date for the inquest as yet. CM will confirm the details of the inquest
It was noted that there is no potential for income generation for plant.
HL said that the safeguarding of children paper and other children's' issues will be presented at the 21 April Board meeting.

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

CE informed the Board that the HIV Select Committee had recently visited the Trust and had been impressed by our HIV service. GM said he recently toured Dean Street with Alan McOwan and said it provided a very patient-focused service in the right environment and the right location. GM thought this service could be provided at additional sites; HL confirmed that Vauxhall was being considered.

CE said the Royal Brompton Hospital (RBH) had approached the Trust for its views in relation to the reconfiguration of children's cardiac services and his view was that we should clearly support them. CE said he has written a letter which was published in the Evening Standard and had received a letter of thanks in response from the Chair of RBH.

CE has also written to Professor Dame Sally Davies to congratulate her on her new appointment as Chief Medical Officer.

CE and AHe met with Tom Kibasi in light of the last Board discussion on the Integrated Care Organisation (ICO). This will be discussed further under item 3.5.

Re the changing healthcare environment, HL said the Trust is in the minority of London Trusts in terms of agreeing the contract for next year with commissioners. HL said the steer from the centre is that cluster PCTs are the interim solution to allow for a smooth transition to GP commissioning. However, it is not ideal for C&W as NHS London's intentions do not align with ours.

The are some key issues and risks which will effect the Trust:

- Cancer network reconfiguration; HL said the Royal Marsden has suggested a crescent shaped network. HL noted that whilst only 14% of our patients come from South West London significant numbers of cancer patients go to Royal Marsden and that there could be knock-on effects for specialties such as colorectal.

- Cardiothoracic care for children (currently at RBH but if this changes it will impact on this Trust with possible further respiratory and cystic fibrosis work as well as PICU).

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

CE informed the Board that the governors have been invited to join the judging panel of the Local Clinical Excellence Awards which takes place in April/May (date to be confirmed).

The Board noted there here has been no significant change in membership numbers. JL asked how membership correlates with the demographic profile. CE said it is a complex issue; whilst there is a push to increase numbers, the key is to ensure there is sufficient active membership with good community engagement. It was noted that, although currently neither the age distribution nor ethnicity of members is sufficiently diverse, this may improve over time and that the Trust could not justify spending considerable sums on trying to recruit under-represented groups. CE said that communications with the local community are key i.e. a local hospital responding to local needs. JL requested to see a breakdown of the ethnicity information and how membership compares on a percentage basis to the population as a whole. JL suggested different cultural approaches to participation may contribute to the ethnicity distribution.
Breakdown of ethnicity information and how membership collates on a percentage basis against the population as a whole to be provided for the April meeting (TD)

JB said he thought the key to membership engagement was ensuring people feel more

involved. HL said that the distribution of different nationalities in this part of London is not clearly as defined as in some other areas and is also relatively transient. KN said harnessing membership from North Kensington is more challenging because C&W is not seen as their local hospital. AH said the Bangladeshi Trust is active in Borough activities and may be useful to speak with.

HL highlighted the short videos of the Trust being shown at Westfield Shopping Centre, with one of the goals being to increase membership.

Surgeries

The governors' have been asked to sign up for Chelwest IT accounts which offer more privacy and professionalism for governors when communicating with the public.

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1.7 Chief Executive's Report **HL**

Re the Inner North West London Community Trust (INWLCT) HL noted that this had occured without a formal competition process; but when components come up for tender, C&W will bid where appropriate. HL met with James Riley, INWLCT's newly appointed CEO (who used to work at Hammersmith & Fulham Social Services) and was assured of the direction of travel under his leadership. HL highlighted the three areas for collaboration included in her paper.

In relation to pathways for the elderly (as mentioned in HL's report at the previous meeting), a recent incident in the Trust highlighted the vital role of effective communications and ensuring patients and their carers feel informed and assured. JB welcomed the focus on making the patient journey right and noted that this is not necessarily achieved through measurable factors. KN said this topic was discussed at the recent Assurance Committee meeting. HL said whilst this is an endemic issue for the health service, we need to ensure that the absolute importance of effective communications is instilled in staff from the point of recruitment, through induction and at every point possible. CE said that patients respond to empathy and a connection.

HL congratulated the ICU on their customer service excellence award, and said she hoped other areas of the Trust would also apply and follow their lead. HL said ICU led the way in ensuring every step of the patient pathway. AP said the ICU department is overspent with an EBITDA of -17%. KN asked if you look at the total cost per patient over time, does it show that better early care impacts on cost; HL said no.

The Board were reminded of the Open Day on 7 May at which the Trust will focus on people taking responsibility for their own health. The Trust has asked the charity for additional funding for placing adverts on the tube in order to reach a wider audience. The new lower ground floor outpatients centre will be formally opened on the day at approximately 12 noon. CE said it was important to focus on health and fitness for children for whom there is a high level of obesity.

HL detailed her recent trip to the US (with AHe) which included an international benchmarking conference convened by Dr Foster in Boston. HL said this also involved visiting a number of hospitals in and around Boston which all appear to face similar pressures as Trusts do in the UK. HL and AHe visited the simulation centre at Beth Israel Hospital which undertakes 600 simulation sessions annually (although HL said she hadn't been impressed with their evaluation systems). There was also a visit to the Children's Hospital Boston which has appointed a Chief Innovation Officer to lead on innovation and which has a joint quality programme with Great Ormond Street. HL said, in relation to IT, she was interested to see that they use both EPIC and Cerner systems for different functions and that they are happy to share their experience. The IHI (Institute for Healthcare Improvement) are focusing on integrating secondary and primary care and HL said they met two British fellows there who suggested encouraging staff to apply for US

programmes.

HL said she was impressed by an innovative start-up they visited called PatientsLikeMe, which provides an online platform for patients to share information on their medical history and experiences. HL said as a result they have built an impressive database of information which can show disease and treatment trends. Their funding comes in part from selling some of this information to pharmaceutical companies. HL said they are interested in setting up in the UK and she will meet with them when they next travel to the UK to discuss opportunities.

JL said he had looked at the website and concluded that it was very interesting by allowing people to form a community from those who have had similar health experiences e.g. HIV, maternity, and cancer. CE said it may not raise our particular profile as patients may not necessarily be treated by the Trust. AH asked whether there may be data protection issues; HL said anyone who signs up has agreed to share their information but recognised that this would need to be looked at in further detail. HL said it could be a possible workstream for the CLAHRC or, alternatively, the Trust may be able to take an equity stake. CW said it could be a great marketing tool with KN suggesting that NEDs could help bring some charities on board.

HL said the final hospital visited was Massachusetts General who focus on quality and safety and have a strong voluntary focus on transparency of information. HL said since returning from the US, Dr Foster have carried out on-site training for our staff on their benchmarking systems.

2 PERFORMANCE

2.1 Finance Report Commentary – February 2011 LB

LB said that overall this was a positive report with the key headlines being that we are over achieving the financial plan for the year by £1.3m and total debt has reduced since last month from £19.8m to £10.5m.

LB said that income is forecast to be ahead of plan by £7m with this change being mostly activity driven. The EBITDA forecast is on plan with the Trust holding back some reserves until the data challenges are resolved; however, there is still the outstanding issue related to HIV deferred expense which LB is seeking the auditor's advice on.

LB highlighted that in the month the Trust has overspent on pay by £0.2m which is against trend; HL said that Medicine is the main concern and is in part due to the need to reopen St Mary Abbot's (SMA) ward. AP said staff are being drawn from wards to staff SMA and that she had asked the Divisions to focus on pay.

CE congratulated everyone on achieving 100% CIPs which, given the challenging environment, is an impressive achievement.

JB queried the Trust's approach to capital. HL said it had been a difficult year for capital, in part due to the Netherton Grove project, and it was appropriate to align the capital from these loans with business planning. HL recognised that there will be more challenges to come (given the need to invest c£12-15m in IT) to facilitate the strategy but that this investment was crucial. HL said it was unclear at this stage whether the Trust would proceed with the burns redevelopment but that we need to push forward with the move to have 50% single rooms. LB said that the Trust was taking a prudent position and as such is planning for projects that may not materialise, but that given the DoH loan specifications, it was appropriate to extend them at this time. CE said that this was the correct approach given the current economic environment.

At this point, HL highlighted there is a possible procurement issue in relation to the

redevelopment of the paediatric wards and that she had asked LB to look at a way of resolving this.

KN cautioned against locking into higher interest rates given the current environment. LB said they would be monitoring this closely over the next 2/3 months but did not anticipate needing to draw down any more funds at this stage and that, even if we had to replace the legacy loan, the prevailing interest rates are lower than the legacy loan. Any changes will need to be made when the Monitor plan is signed off in May.

RK asked for an explanation of the risk rating table. LB explained that Monitor use five measures of financial efficiency and performance to measure risk with an FRR of 5 being the best, i.e. reflecting the lowest level of risk. CE said the Trust plan was for 4 for the full year but LB confirmed that we are currently achieving a 5.

AHa asked if there was any update on the data challenges; LB said not as yet. AHa asked how long PCTs can wait before challenging; LB said she was not anticipating an additional challenge.

Regarding the private patient cap (PPC), LB said that Monitor had agreed to rebase the Trust's PPC to 3.7%. GM asked about the penalty for exceeding the cap; LB said it would be viewed as a governance risk and in breach of its terms of authorisation. HL said there are different vehicles (such as social enterprises and partnerships) that can be set up and asked if this will be part of Monitor's role in the future. CE said these had been considered in the past but were quite expensive to set up (hence not proceeding) but that they could be considered again. GM asked what income we are sacrificing by being capped. JB said it would seem logical that the more private work undertaken, the more funds are available for the NHS. JL asked if the Charity can take the lead on setting up vehicles. CE said that we had discussed this with them. The Trust is on track to stay within target.

2.2 Annual Budget 2011/2012 **LB**

LB explained this is the first cut of the three year plan which will be presented in its finality at the May meeting. In terms of, income, LB said the Trust is planning for £328m which coincidentally is also the current year forecast. LB said in relation to the contract, the Trust has had a very successful outcome which has resulted in more alignment in the internal income plan with Commissioners. There is still not agreement on the full range of KPIs so some assumptions have had to be made around these (e.g. assuming 75% for CQUIN), in addition low priority procedures are subject to audit. Non-clinical income, which includes teaching and education, includes SIFT income which is expected to halve over the next few years. **-**

LB said expenditure is budgeted at £298m but that this was a prudent position as this includes £5m discretionary cost pressures from Divisions, which are being challenged by the Executive. Re the CIP target HL said the initial assessment is c8% of which 4% is the Gershon saving (cash releasing). LB said she thought it would not be necessary to plan at 10%.

HL said demand management had not impacted yet (nor has the 80% move of outpatients to the community) nor has it being linked to staff job plans. LB said the impact of moving outpatient activity to the community would be in tens of millions. LB said that in 2010 £5m was taken out of our contract for demand management initiatives but these had not been delivered. This year £2.5m.demand management initiatives have been deducted from the contract. LB said, therefore, there is a need to revisit the Commissioner's intentions. LB noted that being an FT meant we can hold our line on being paid the tariff for projected activity with the Commissioners, although there may well be shifts in the tariff in future years. HL said this links with the ICO development and suggested the Lower Ground Floor Outpatients could potentially be used in the future as the poly system for K&C.

Regarding key cost changes, LB said Divisions with recurrent CIP shortfall has been written off with the majority of this being in clinical support and theatres. However, overall the recurrent CIP had been met. LB confirmed the CIP target for 2011/12 is 8.7% (£19.7m) with the corporate functions expected to contribute £13m of this. Approx 10m of total CIP has been identified at this stage.

LB informed the Board that the Trust is planning for an impairment, which relates to the fact that half of the Netherton Grove development will not add floor space, as it will be utilising current space. The Trust will therefore not be expecting to capitalise £15m and this will be accounted for as an exceptional cost and will not impact the FRR. JB expressed concern as to this change of use and believes it should be discussed in detail at the Audit Committee. AHa said we should check if there is any treasury guidance. LB agreed and suggested we seek the view of our auditors and discuss outside the meeting.
Discuss issue of impairment and raise with auditors and treasury guidance reviewed. (LB/AHa/JB)

LB asked the Board to approve the capital plan as a maximum for year 1 of the 3 years. KN said she is concerned about the allocation for IT which she read as £4.5m over 4 years. LB said the spend would also include other schemes listed including the replacement of EPR and EDM. HL confirmed that the £8m discussed is for all aspects of the IT strategy. DK said he felt this sum would only cover the replacement of LastWord. LB said she was also concerned that £8m may not be sufficient and to this end would be considering the availability of loans for this. HL requested that the IT Strategy be deferred to the June Board; this was agreed.
Presentation of IT Strategy to be deferred to June Board (LR)

CE recapped on the three issues for approval:

- The delegation of the budgets to the divisions and departments were agreed;
- The delegation of the capital scheme to the executive directors was agreed;
- The impairment issue would be discussed by LB, AHa and JB outside the meeting.

JB asked for an explanation of the PDC dividends. LB explained these are basically a tax that the Trust is required to pay to HM Treasury. JB said, in relation to the CIP target of 8.7%, that, given the competency of the Executive Team, the target should be a stretching target. HL said it was but that it is also important to create an opportunity for innovation.

CE asked for an explanation of the Gershon saving. LB explained that one indicator of efficiency is the calculated cost index for NHS providers with the Trust operating at 92 which is 8% more efficient than the national average of 100. Following the spending review, Gershon has been increased to 4% and is likely to remain at this level. GM asked how the tariff compares to private contractors; KN said it was hard to compare due to the variability of private pricing. LB said that there is limited information available on this. CE suggested checking whether data is available from when the independent treatment centres were set up. HL said that they are generally more efficient, but they are not doing the complexity of work that the Trust is. CW said that BUPA publishes its own figures. GM asked if the more straightforward work could be stripped out and treated in a separate unit; HL said we would need to grow our market share in order to do this. GM asked about Dean Street's effectiveness; HL said there was no waiting list so it is different but the Trust could look at this. GM highlighted the fact that waiting times tend to dominate discussion and asked whether some operations be done more efficiently. AP said where possible we have tried to introduce more streamlined procedures but the Trust is obliged to provide junior doctor training which inevitably means operations takes more time.

MA questioned why, in table 12, medical equipment for 2011/12 was listed as 0. It was

noted that this table only relates to schemes over £1m of which no equipment items exceeded this.

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

There have been no more reported MRSA cases and we are hopeful that we will meet our target. Monitor is due to publish their compliance framework today. The consultation document suggests four changes: A&E indicators; median and 95th percentile waits for referral to treatment; introduction of a stroke indicator and the replacement of the MRSA screening target with self-certification.

In relation to the A&E indicators, AP is most concerned about the "time to treatment" target and work is continuing around data quality. We will struggle to achieve all these targets in the first few months. HL said we should look to interface our IT systems rather than having separate ones. JB asked if we can expect there to be any difference with the split of A&E targets. AP said that the focus on the length of time between arrival and treatment was good. JL said that the Board is in danger of creating a target-dominated culture and that more real patient experiences should be presented to the Board. CE said given the patient survey results we should be careful not to be "trapped" in systems, thereby losing the ability to address problems in relation to human experience. JL said that the survey can become part of the data culture. GM said that there are two key issues: the results of the survey and the fact that 77% people are dissatisfied with their GP. He felt it more important to have good patient and GP feedback; balance is required to work out what we can do to improve.

AP clarified that the Executives do not spend all their time managing targets but that it might be helpful if there was more transparency about what the management team do as the Board agenda tends to be target heavy. When targets were first introduced (in A&E) we did focus on targets but less so now. GM asked what steps are required to get a high rating from patients and GPs; focus on objectives and a team approach is needed. HL is disappointed with the results but as, only a small survey of people were questioned in August, the clinicians would say it was not statistically relevant. Complaints are a better guide; our response to them is getting better but further improvements are still possible. Complaints should be investigated when they occur; however, some are not representative. JB said whilst targets are important, the quality of treatment is also crucial and both elements need to be thought of together to ensure good patient care which is his most significant concern. TD said she will bring a more complete report on the patient survey (considering things that could be done differently) to a future Board meeting. We need to look at achievements as well as negatives. HL will be speaking to Sir Donald Irving, Chairman of the Picker Institution, to discuss how to take things forward.

2.3.1 Single Sex Accommodation Declaration **AP**

This issue arose from patients' need for dignity and privacy. The paper contained background information and asked the Board to make a declaration that day regarding the provision of single sex sleeping accommodation, including beds and trolleys. It is further hoped that patients should not have to walk past people of other sexes to reach the toilets. The main areas of concern in relation to access to toilets are endoscopy and dermatology; the plan is to move endoscopy and improve the situation in dermatology (but C&W is compliant on sleeping requirements). However, AAU/ITU are both potential areas of risk because in AAU different sex patients may occasionally have to share in order to provide the most appropriate clinical care when the gender mix of patients requiring admission or level one care doesn't match the beds available. There is also a risk relating to ITU-step down because there are a limited number of side rooms. AP confirmed to KN that there had been two breaches in AAU on 28 March 2011.

Arrangements for children were discussed. The Trust's main Commissioners think this Board should take a view on what age children should be asked if they would rather be

with someone of the same sex or age. Children can choose to share with children of mixed sex. Children on Jupiter ward (aged 11 upwards) are segregated but a recent group of 14 yr olds had wanted to share. JB asked how it would reflect patients' choice to be treated quicker in mixed settings. AP said we are must not put patients in this position. The onus is on the patient's preference. HL said the split should probably be around 9 years old. KN had raised the issue of breaches at Assurance Committee. HL said management should consider this. JB asked if we could decertify. AP said we would get fined £250 per person per day for each breach and failure to self certify would put the Trust in breach of its terms of authorisation as an FT. HL recommends that we accept the policy and review if there is a high level of breaches. GM asked whether the Trust will be held to account if breaches happen but we have declared compliance on the Trust's website. AP said we cannot put it on the website if not true. It cannot be said that there aren't any risks but presently the Trust is compliant and we have policies in place to avoid breaches. HL suggested leaving the split at 11 for this year, and potentially to reduce to 9 in the future. AP had involved the paediatrics team. AH said it would be best to set the age at being about six months above what you want the target to be. JB thought it should be set at 10 as there are cultural issues. CE said that children are often going through puberty by 11. The Board agreed on 10 and will monitor and review in a year's time.

3 ITEMS FOR DECISION/APPROVAL

3.1 Update on Quality Account * MA

This item was starred *

3.3 Assurance Committee Report February 2011 * CW

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This item was starred *

3.4 Update on Staff Survey MG

MG said he will bring a full report on the recent Staff Survey results to the next Board meeting but that this report highlights key results.

MG said the survey had been carried out by Capita and that the results were broadly the same as last year which is viewed as a good outcome given challenges throughout the year. MG said we are in the top 20% of acute trusts re the staff engagement score with CQC analysis and comparison with other Trusts provided in the report. CW had a query related to the number of indicators that formed part of the CQC review; MG said this may be due to the CQC collating but that he would look into this.
Check apparent discrepancy in figures reported in the supplementary papers (MG)

CW asked how this information will be utilised. MG said directorates and different staff groups will be given key actions and the result will be shared through team brief. CE said it was important to note that we have had a higher CIP programme than our competitors and, although it was better to have acted swiftly, this indicates all the more what good results these are. It was noted that our staff generally work longer hours than other Trusts but that this was often because they chose to do so. JB asked about health and safety training and how this correlated against the data the Trust collected. MG said the results in the survey are people's own perceptions which does not always match data the Trust has collected e.g. staff appraisal rates.

STRATEGY

3.5 ICO – Integrated Care Organisations HL

AH presented his paper. Imperial is going to be in wave 1 while CW is going to join later with local GPs. The urgent next step will be to look at what the financial implications

would be for us. HL sits on the ICO Board and acute trusts have a total share of 25% with Imperial. Of this 25%, Imperial want a higher percentage as they are the founding partner; but we would not want to be seen as junior partner, given that we were asked very late to join the pilot. AH confirmed that funding is not linked to votes. Imperial is proposing to use the number of patients in A&E to base the votes on; we do not agree and suggest a compromise (using the % of patients in A&E compared to the overall hospital activity) if Imperial is unwilling to accept an even split. HL said that there are other voters (community trust, GPs (50%), patients, voluntary sector, and local authorities) and that we would be able to form alliances. GM asked what they are voting on. AH said only on issues that can't be resolved by consensus.

CE said it would be challenging and expensive to start an ICO on our own. McKinsey are key to IT systems but their contract is ending soon; around £1m has been paid on IT alone and previous attempts in our sector have failed to raise the necessary money to start similar projects. JB said that the voting system is not compatible with a pilot scheme. AP said the most important thing is for us to be seen at the table. CE said hence he and HL are meeting with the Chair of the ICO at which this issue could be discussed.

AH said there is a lot of detail missing in the ICO papers and the data was often not accurate. AH said that the main purpose of the pilot was linking up existing services in a better way, rather than service re-design.

3.6 Business Planning Update **AH (HL)**

Business planning update was given for information and update on how the process works. Divisions had been asked in January to think about cost pressures, CIPS and investments and had held a number of bilaterals with them. The process had been formed by corporate objectives.

Re the figure for CIP (8.7% - for item 2.2) HL said that this is still a high CIP and includes 4% Gershon (cash releasing). MA agreed with the figure but was nervous re 15% from non-clinical as it was much higher than ever before. LB said we should try for as high as possible. CE said to realise 8.7% after 10% is a big ask but given our income has been maintained at £327m, he was happier. The Board accepted.

GOVERNANCE

3.9 Third Party Stakeholder Schedule* **CM**

.This item was starred *

4 ITEMS FOR INFORMATION

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

This item was taken as read.

4.2 Audit Committee Minutes – October 2010 **AH**

This item was taken as read.

4.3 Finance & Investment Committee Minutes – January 2011 **CE**

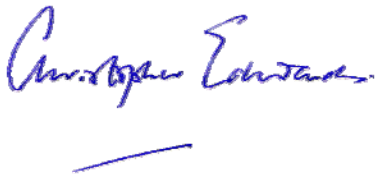
This item was taken as read.

5 ANY OTHER BUSINESS
There was none

6 DATE OF NEXT MEETING – 21 April 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