Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting 26 April 2012
Extract of approved minutes

Time: 2pm
Location: Chelsea and Westminster Hospital NHS Foundation Trust - Boardroom

Present

Non-Executive Directors	Prof. Sir Christopher Edwards	CE	Chairman
	Sir John Baker	JB	
	Jeremy Loyd	JL	
	Prof Richard Kitney	RK	
	Sir Geoffrey Mulcahy	GM	
	Karin Norman	KN	
Executive Directors	Heather Lawrence	HL	Chief Executive
	Mike Anderson	MA	Medical Director
	Lorraine Bewes	LB	Director of Finance
	Therese Davis	TD	Director of Nursing
	David Radbourne	DR	Interim Chief Operating Officer
In attendance	Catherine Mooney	CM	Director of Governance and Corporate Affairs
	Mark Gammage	MG	Director of Human Resources

The Chairman noted with sadness the death of Baroness Ritchie of Brompton.

The Chairman to write to the Mayor. **CE**

1 GENERAL BUSINESS

1.1 Welcome and Apologies for Absence **CE**

There were no apologies received.

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 29 March 2012 **CE**

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

1.4 Matters Arising **CE**

These were noted.

Regarding Doughty House, Helen Elkington, Head of Estates & Facilities has had two positive conversations with Catalyst Housing and is having a further meeting next week.

1.5 Chairman's Report **CE**

The Chairman noted that he had received an email from Mark Davis regarding the visit of some consultant paediatricians and had confirmed the purpose of the meeting.

1.6 Chief Executive's Report **HL**

The main points in the paper were outlined.

It was noted that the Health and Social Care Act 2012 now has Royal Assent. The relationship with the Clinical Commissioning Groups will be important and the development of links with Health and Wellbeing Boards.

It was noted that the regular clippings service by the Head of Communications was welcome and should continue.

2.1 Finance Report – March 2012 **LB**

The main points in the paper were outlined.

It was noted that we have a surplus of £13.6 million which is above the plan by over £5 million.

A correction for HIV drugs stock was highlighted which was due to correction of a transposition error in pharmacy. The supervisory arrangements have been checked – an inconsistency was identified at the time but not escalated so the correction was made a month later. It was noted that whilst manual process support the stock validation this will always be a risk and will be mitigated when interface between the JAC and finance system is complete.

There should be an agreed value for the 12/13 contract in the next 2-3 weeks. It was noted that it was not appropriate to go to mediation with the commissioners yet as the next step was to discuss issues at CEO level and this has not yet occurred.

It was noted that the commissioners had agreed in principle to take off the table their backdated credit requests for anticoagulation pricing error of £4.9 million. It was also noted that the need for anticoagulation clinics should diminish because of new drugs such as dabigatran which does not require close monitoring like warfarin.

LB was congratulated for this performance which was a remarkable achievement on both the CIP and surplus. The role of the front line divisions who deliver the majority of the CIP was highlighted and acknowledged.

2.2 Performance Report – March 2012 **DR**

The main points in the paper were outlined.

The Department of Health target for *C.Difficile* is 31 and Monitor's target is 12. There is a considerable risk that we will not achieve 12.

Cellulitis performance is getting worse – it is expected that this is treated in the

community. It is seen more in the frail elderly and the directorates are working on care pathways including more use of the Medical Day Unit. We currently have 18 patients in the community via MediHome and some will have cellulitis. It was confirmed that patients with cellulitis are reviewed every day, with a view to discharge.

It was strongly recommended that the outpatient letter turnaround time is addressed. It was noted that an element of this was the Executive's responsibility as secretarial cover was decreased. BigHand is now in place but there are still some problems with it which are being addressed.

It was confirmed that the RTT is still 18 weeks and the commissioners will not fund any reduction in this target. This could be an area to explore with the Clinical Commissioning Groups. A&E unplanned re-attendance is a national target and there is a group in the Trust looking at re-attenders – it is possibly about the seniority of the clinician who sees them the first time. The Board noted that the A&E performance had been strong.

3.1 Assurance Committee Report – March 2012 **KN**

Regarding doctors failing to comply with hand hygiene, the Medical Director met with the Chief Nurse and Director of Patient Experience and Flow and reviewed the data in great detail. Further information was provided to the Assurance Committee which confirmed that there is not a problem with doctors in particular.

It was noted that a great deal of work has been undertaken around the CQC standards. A system will be put in place for an audit style of reporting on actions and exceptions.

3.1.1 Report on the Inpatient Survey 2011 **TD**

This was discussed at the Assurance Committee and it was noted that the results are disappointing given our CQC results and PEAT results and that re-opened complaints have decreased by 50%.

The main areas of concern remain as communication and discharge and action plans are in place. To put it in context, we have 64,000 adult admissions per year and this represents less than 1% of those patients.

Although it is undertaken is September following new doctors starting in August, it is the same for all trusts. Ways of preparing patients for the survey and increasing the response rates were discussed.

It was confirmed that data is available per ward and we have requested this to assure ourselves there are no particular areas of concern. It was confirmed that nationally those with a higher response rate have better results.

The survey consists of 87 questions, which was considered to be excessive. It has been agreed that we will look at the top 8 areas of concern and survey patients more frequently on these.

Concerns about the survey should be relayed to Picker and the Department of Health.

3.2 NHS Staff Survey – Summary of Results **MG**

The main points in the paper were outlined.

It was confirmed that all staff were surveyed and this report represents a 10% sample. Although the results are good we will identify what we need to do to be in the top 10%.

It was noted that one area of concern is discrimination and the largest group within this is nurses. There was a discussion about the support we give to people and the importance of understanding issues before we can address them.

It was noted that our performance compared with other Trusts is outlined in the appendix.

3.3 Updated Strategy paper (see the Board Strategy paper) **HL**

An update on our strategic position was discussed at an earlier meeting. The action agreed was to prepare a programme of communication and engagement

3.4 Academic Health Science Partnership **HL**

The Board was asked to comment on the Memorandum of Understanding (MOU) and to approve the Trust joining the Academic Health Science Partnership (AHSP).

It was noted that the advertisement has been placed for a Managing Director and the location of the AHSP will depend to some extent on that appointment.

The MOU was discussed. Re point 2.2.3 it was agreed that this should be re-phrased as it is not up to the Boards to constitute the NW London LETB within the partnership.

Regarding 2.2.4, it was confirmed that any income generated will be shared.

There was a discussion regarding point 5.3.1. The Board agreed that as the AHSP is a limited company it must employ staff and NHS pensions should not be retained. Interim arrangements could be put in place e.g. employment through secondment initially but then moved to contracts within the AHSP.

It was confirmed that the Clinical Academic Group leads will not be employed by the AHSP and will be compensated for their time.

The importance of the new Local Education Training Boards being set up later this year was noted and their £330 million income. The AHSP needs to be positioned so that there is a link with the LETB. Health Education England will employ the Chief Executive of the LETB.

It was noted that the Royal Marsden Hospital was not a member of the AHSP and that this was regrettable.

It was agreed that the Board would make a formal note to the Royal Marsden Hospital saying that their participation would be welcome. **HL**

Trusts are required to commit for 3 years and can give notice after 2 years.

It was noted that the MOU was a mechanism to get people to sign up. A panel has been set up to appoint the Managing Director which is chaired by Ara Darzi.

The Board approved the MOU in principle with some minor changes of the text.

3.5 Monitor in Year Reporting & Monitoring Report Q4 **LB**

The report was noted.

The Board authorised the Financial and Governance combined return for quarter 4 2011/12 and commentary for submission to Monitor.

3.6 Risk Report 2011/12 **CM**

The main points in the paper were outlined. This highlighted that there needs to be more rigour about identifying the risks identified through Board papers.

The Board needs to focus on financial, reputational, clinical and operational risks and political risks, which could be considered as part of reputational risks. It was noted that the change of the Chief Executive and no permanent Chief Operating Officer was a risk that needed to be put on the risk register. Other risks include delivery of the plan and government plans.

More risk awareness would be beneficial and to encourage people to challenge assumptions. This would help avoid catastrophic risks. The risk process itself is a risk if not done properly. Risks need to be prioritised and mitigation and actions need to be identified.

This is an important way of formalising the risk process and ensures that the issues are being addressed. It was confirmed that risks would be assessed and only orange and red risks would be brought to the Board. It was agreed that it would be helpful to identify the top clinical, financial and organisational risks.

CM to identify top risks. **CM**

3.7 Register of Seals Report Q4* **CM**

This item was starred and therefore taken as read.

4 ITEMS FOR INFORMATION

4.1 Audit Committee Minutes –– 22 March 2012 will be provided at the May Board **JB**

4.2 Assurance Committee Minutes – 26 March 2012 **KN**

This item was taken as read.

4.3 Finance & Investment Committee Minutes – 27 March 2012 **CE**

This item was taken as read.

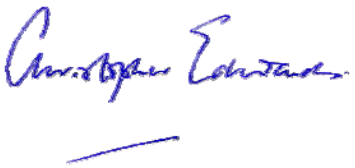
5 ANY OTHER BUSINESS

None.

6 DATE OF NEXT MEETING – 28 May 2012

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