Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting 28 May 2012
Extract of approved minutes

Time: 1pm
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 (attended in part)	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
	Dr Rachael Jones (for item 3.12)	RJ	Consultant Physician/Service Lead – GUM
	Dr Zoe Penn (for item 3.12)	ZP	Divisional Medical Director Division of Womens, Childrens and Young People, HIV/GUM and Dermatology Services
	Dr Simon Barton (for item 3.12)	SB	Consultant Physician/Clinical Director – HIV, GUM & Dermatology

1 GENERAL BUSINESS

1.1 Welcome and Apologies for Absence — CE

Jeremy Loyd gave his apologies for the early part of the meeting.

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 26 April 2012 — CE

Minutes of the previous meeting were approved as a true and accurate record with the following amendments:

- Section 2.1 the last sentence should read ‘it was noted that whilst manual processes support the stock validation this will always be a risk until the interface between JAC and the finance system is complete’.

- Sec 2.2 the Department of Health target for C.*difficile* is 31 not 32.
- there were other minor typographical errors

1.4 Matters Arising **CE**

It was noted that the Academic Health Sciences Partnership (AHSP) did not appoint a Managing Director. It was also noted that AHSPs may be superseded by Academic Health Science Networks (AHSN). The Board agreed there might be an opportunity to proceed straight to an AHSN. This might require a different leadership. **It was agreed that this would be raised with Lord Darzi.** **CE**

1.5 Chairman's Report **CE**

CE confirmed that Mike Anderson would be the acting Chief Executive Officer in the interim until Tony Bell starts.

1.6 Chief Executive's Report **HL**

The performance issue was specifically highlighted and it was noted that we have three cases of *C. difficile* to date.

Regarding GP letters it was agreed that these would be sent unsigned in order to shorten the timescale.

There is a particular concern about never events and it was confirmed that there has been very detailed discussions regarding the latest never event which was a retained vaginal swab. It was confirmed that there had been three retained vaginal swabs, one surgical swab and one wrong side surgery. The number of events defined as 'never events' has been extended from 5 to 25. It is a very high focus for the Executive and the Divisions.

The concern regarding a drop in referral data was noted, however, it was confirmed this was down in a similar way this time last year.

Jeremy Loyd arrived.

Private Patients
It was noted that the cap has not yet been lifted and will not be until April next year. It is thought Monitor will include it in the guidance on provider licence and it is a scheduling issue.

It was agreed this will be considered outside of the Board.

2.1 Finance Report – April 2012 **LB**

The key points were outlined. Elective surgery and trauma and orthopaedics is behind the plan which is having an impact on adult critical care. We have been assured this is a timing issue due to surgeons being on leave and there are plans to recoup this loss. There was a slow start last year also.

It was confirmed that the paediatric HDU variance is real and has a value of £700k.The plan set is artificially high.

We have agreed the contract to a value of just under £134 million which is broadly the same as last year but we are planning an over performance to £140million. A

side letter will be prepared to remind the commissioner that we do not accept that some of the penalties are legally enforceable.

It was confirmed that commissioners will not pay over- performance that decreases our waiting list but only for specialities which are over the 18 week target.

It was suggested we should focus on our outpatient slot availability and free up slots to increase outpatient booking as a course of action, rather than reducing waiting time.

2.2 Performance Report – April 2012 **DR**

The key issues were outlined as described in the report. There is a correction to the A&E performance. The Urgent Care Centre and A&E systems are now interfacing and this has highlighted more breaches. The figure for breaches is 98.7% not 98.9%. The team are using the updated breach analysis to understand root cause and focus improvement work.

The Board noted the CQUINs for 2012/13 and plans are in place to ensure achievement.

It was noted that the performance for rapid access chest pain was 'red' i.e. failing the target and getting worse. It was confirmed that the Trust was focusing on this as a priority to ensure ongoing achievement.

The Trust is identifying pathways where consultant to consultant referral is appropriate and those where consultants should be referring back to GPs. There are plans to undertake an audit with the commissioners. Despite pathways it may be a case of judgement for individual patients.

The important element is that the decision must be clinically appropriate and the audit would be key to understand whether the pathways are being followed in a safe way.

The Board sought assurance on continuity of training regarding blood cultures. It was confirmed that this was the case.

It was suggested that clips from the junior doctors' programme might be used to demonstrate good and bad practice. There is a 4 day mandatory programme starting in August and this programme could be used as training material.

Performance on *C.difficile* and MRSA was discussed and the question was asked whether there are other infections we should be monitoring ourselves.

It was confirmed that other infections are monitored and the view of the Director of Prevention and Infection Control (DIPC) will be sought as to which ones we should be including in the report.

Confirm the view of the DIPC as to which other organisms we should be monitoring. **TD**

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

There were no particular points to highlight although the Board was disappointed

with the care of dying audit given the impressive presentation to the Council of Governors.

It was confirmed that the lead for care of dying is not a palliative care doctor as care of the dying includes all patients. The Board was reassured that this is area of focus.

3.3 Appraisal and revalidation of medical staff **MA**

The process required and the progress to date was outlined. It was confirmed that we cannot amend the appraisal paperwork which is standard. The issue is how we could include our values.

There was a discussion over item 5, feedback from patients, and how this might be done in practice. This is unknown at the moment. It was clarified that the Responsible Officer would make a recommendation to the GMC regarding revalidation, the Trust does not revalidate. A national process is being followed.

NHS London are responsible for arranging the appraisal of our Responsible Officer. It was noted that this system will not stop accidents, it is a system to mitigate risk and this is all that can be demonstrated.

3.4 & 3.5 'Shaping a Healthier Future'– NWL Pre Consultation letter of support and Trust communication and engagement plan **HL**

The proposed letter was discussed. It was confirmed that if we were to lose A&E, paediatric A&E would be provided at Charing Cross Hospital and burns would be lost to the sector. The option to retain C&W is cheaper because of the additional cost of relocating other services such as obstetrics and paediatrics.

It was confirmed there would be £138 million of capital spent in the community which would be used to build local centres. The consultation is not about out of hospital care and it is assumed that it has three times the value compared with the cost of secondary care.

It was agreed that we should be expressing concern that the out of hospital model has no evidence or financial evaluation.

There was some discussion about the approach to a campaign – this should reinforce our reputation. It is important not to alienate the people who support us such as politicians. It was noted that the consultation is not very clear that this does not include paediatric A&E. The campaign message should acknowledge that there is a problem with over provision which needs to be addressed.

It is important to emphasise that the Urgent Care Centre will be retained at Charing Cross Hospital. The appeal to patients is that we will absorb extra A&E activity and in a great environment.

It was noted that the surplus for Chelsea and Westminster is £8m not £22m. Nevertheless the emphasis should be that we can reinvest.

The Board remains unclear of Imperial Healthcare's strategy should Charing Cross Hospital A&E close.

Letter to be rewritten and re-circulated to the Board for final approval. **HL**

3.6 Monitor Annual Plan Sign-Off – completion of governance statement **CM**

CM outlined the paper which is intended to provide assurance for the self-certification for governance by the Board. Each statement identifies assurance for that statement. We are able to confirm all statements with one exception.

This is that we achieved level 1 on one element of the Information Governance Toolkit and therefore not level 2 on all. This gives us an amber/green governance rating for Monitor.

The Board agreed completion of the governance statement as above.

3.6.1 Monitor Annual Plan Sign-Off **HL**

It was agreed that the reference to Academic Health Science Partnerships should also include 'Networks' and a reference to Higher Education Clusters (HIEC) should be added. It was noted that our biggest risk was the NWL Commissioners' consultation on the reconfiguration of NW London and this should be addressed in the plan. It was also agreed that more was needed on the risk around burns.

It was confirmed that Monitor plan is submitted to Monitor and we are bound by it.

LB to amend as above. **LB**

3.7 Health and Wellbeing Boards **AH**

This item was noted.

3.8 External Auditors Report (IAS 260) **LB**

The Chairman of the Audit Committee confirmed that there are few areas to be picked up but nothing serious. The Audit Committee had been through this in some detail. The external auditors were very complimentary about the finance department and all points were minor.

The Board's attention was drawn to appendix 4 the Management Representative Letter.

It was noted that our private patient income is near the edge of what is acceptable. Our plan has been phased to step up from July and this needs to be reviewed.

3.9 Audited Annual Accounts **LB**

The Chair of the Audit Committee recommended on behalf of the Audit Committee that these accounts were adopted. **The Board agreed.**

3.10 Annual Report including Quality Report Sign-Off **HL**

It was noted that many people have read this report during its preparation.

It was noted that for the first time reporting bodies are required to disclose the relationship between the remuneration of the highest paid Director in their organisation and the median remuneration of the organisation's workforce. We had looked across London and confirmed we were in range.

Regarding the Quality Report it was highlighted that responses from the local Borough's Scrutiny Committees and from the PCT cluster were still expected and would be inserted before the final sign off.

It was agreed that the Annual Report content would be discussed in January next year to agree content and emphasis and to be more explicit about risk. It was emphasised that the plan must follow Monitor's requirements.

The benefits of considering a patient's journey and having patients talking at the Annual Members Meeting was noted.

To schedule in the planning of the Annual Report for January next year. **HL**

3.11 Audit Committee Annual Report **JB**

The only points highlighted were that there was not a lot of fraud identified and some concern about the process of fraud investigation and the role of management.

4 ITEMS FOR INFORMATION

4.1 Audit Committee Minutes – 22 March 2012 **JB**

This item was taken as read.

4.2 Assurance Committee Minutes – 23 April 2012 **KN**

This item was taken as read.

4.3 Finance & Investment Committee Minutes – 19 April 2012 **CE**

This item was taken as read.

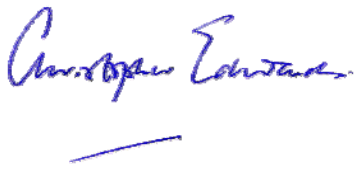
5 ANY OTHER BUSINESS

None.

6 DATE OF NEXT MEETING – 28 June 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