Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 21 July 2010

AGENDA ITEM NO.	1.4/Jul/10
PAPER	Final minutes of the meeting of the Council of Governors meeting held on 21 April 2010
AUTHOR	Vida Djelic, Interim Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper outlines a record of proceedings at the previous meeting.
DECISION/ ACTION	1. To agree the minutes as a correct record. 2. The Chairman to sign the minutes.

Council of Governors Meeting Minutes, 21 April 2010

Prof. Sir Christopher	Edwards	Chairman		CE
Lucy	Ball	Staff	Allied Health Professionals, Scientific and Technical	LB
Walter	Balmford	Patient		WB
Christine	Blewett	Public	Hammersmith and Fulham 2	CBle
Nicky	Browne	Appointed	The Royal Marsden NHS Foundation Trust	NB
Alan	Cleary	Patient		AC
Edward	Coolen	Patient		EC
Carol	Dale	Staff	Management	CD
David	Finch	Appointed	NHS Wandsworth	DF
Brian	Gazzard	Staff	Medical and Dental	BG
Jacinto	Jesus	Staff	Contracted	JJ
Martin	Lewis	Public	Westminster 2	
Catherine	Longworth	Appointed	Westminster PCT	CL
Susan	Maxwell	Patient		SM
Ann	Mills-Duggan	Public	Westminster 1	AMD
Jim	Smith	Patient		JS
Sue	Smith	Staff	Nursing and Midwifery	SS
Sandra	Smith Gordon	Public	Kensington and Chelsea 2	SSG
Frances	Taylor	Appointed	Royal Borough of Ken & Chelsea	FT
Alison	While	Major Education Provider	King's College	AW
Taryn	Youngstein	Patient		TY

IN ATTENDANCE:

Heather Lawrence	Chief Executive	HL
Catherine Mooney	Director of Governance and Corporate Affairs	CM
Mike Anderson	Medical Director	MA
Vida Djelic	Interim FT Secretary	VD
Amit Khutti	Director of Strategy & Service Planning	AK
Richard Kitney	Non-Executive Director	RK

Greg Hewitt attended for item 2.8

1 GENERAL BUSINESS

1.1 Welcome & Apologies — CE

CE noted the apologies tendered: Andrew MacCallum, Sian Nelson, Chris Birch, Cass Cass-Horne, Cyril Nemeth and Wendie McWatters.

CE informed the Council that AMC was leaving to join Thames Valley University for a prominent academic position, that of pro vice chancellor. He wanted to publicly thank AMC for his contributions to the Trust and wished him well for the future.

CE also congratulated Amit Khutti on his new job in the private sector and thanked him for his contribution, in particular with the HIEC (Health Innovation and Education Cluster) and wished him well for the future.

1.2 Declaration of Interests — CE

CE invited declarations of interest. None were tendered.

1.3 Minutes of Previous Meeting held on 3 February 2010 — CE

The minutes of the previous meeting held on 3 February 2010 were agreed as a correct record of proceedings with the following change:

- p.4, item 1.5, 3rd para should read 'Lady Rhys Williams, the Chairman of the Chelsea and Westminster Charity Trust'

VD to amend minutes in line with comments received. — **VD**

1.4 Matters Arising — CE

2.5.2/Feb/10 Membership Report
This was included in the membership report.

2.7/Feb/10 Funding Report
VD said that the project for the Directory of Adult Services is at the information collection stage. No money has been spent yet and it is planned that it will be used for design and printing, which will commence once the information collection stage is complete.

1.5 Chairman's Report (oral) — CE

The Chairman said that the governors were aware that we are undertaking a big capital programme, that of the paediatric expansion.

We had held interviews to recruit a consultant for the paediatric High Dependency Unit but did not make an appointment. We have had to make arrangements for temporary cover. This is a challenging area in which to attract staff.

HL said that NHS London is currently reviewing how many paediatric intensive care units there should be. There will probably be two working in partnership. Our temporary HDU is up and running.

2 ITEMS FOR DISCUSSION/DECISION/APPROVAL

2.1 Chief Executive Update

2.1.1 Contracting implications 2010/11 linking to strategy

HL said that a search is underway to replace the Director of Strategy and someone will start next week to cover some aspects of the job. She said that she is changing the post. AK worked closely with HL but reported to the Director of Finance. The new post will report to the CEO.

There are three divisions now and responsibility is being devolved. Performance will now be covered by the Deputy Chief Executive.

She added that a search for a Director of Nursing also underway and she is looking for an interim solution.

She said we have to make 10% efficiencies. We are looking at using technology e.g. electronic document management, which will have a number of benefits including reducing the number of missing notes. We are also looking at transcription voice recognition, carbon savings and sustainability.

There are challenging strategic issues. The NW sector PCTs have been asked to re-do their strategy and we need to engage with that work. We know that we need to grow but also make 10% efficiencies this year and 10% next year.

She said that when we had discussed acquisitions some of the governors were unsure about community services; this needs to be kept under review.

The Trust was approached by Richmond and Hounslow PCT provider arm re provision of outpatient services and we will take this to the Board to consider bidding. NHS London and the PCTs want 55-60% outpatient services to move into the community.

West Middlesex Hospital will look for a partner in September and we may bid for this in partnership with others, in particular the Royal Marsden Hospital. Cally Palmer, the Chief Executive of The Royal Marsden NHS Foundation Trust, was supportive of the idea and the strategy needs to be developed.

Kensington and Chelsea are tendering dermatology services which accounts for about 30% of our outpatients. We have to bid in a way that is attractive in terms of the clinical model offered to PCTs. If we do not win this bid, we will have to reduce services. She noted that PCTs are tendering different services at different times.

We are progressing with the Netherton Grove extension. We won the bid on the facilities that we had and the extension is not related but is being done to improve services. The building is changing internally and we have had to move some services. We need to make sure we are administratively smart and we need to use our facilities effectively.

AK circulated a paper 'Contract Summary' and presented the main points. He said that we needed to agree the contract by 15th March and lots of organisations did not meet their deadlines.

The main four areas where we will need to improve our ability to operationally deliver agreed contractual terms were:

- How many new patients versus follow up appointments. Ratios were set in the past to decrease follow up appointments. The rationale is that it is better not to bring patients back e.g. do not bring patients in simply to give them information. We can look at other ways of doing this e.g. texting information. This is more convenient for patients and more efficient for the NHS.
- Ensuring that we are not undertaking low priority procedures unless these procedures meet specific clinical criteria.
- Being able to take cost out of certain services e.g. dermatology. If PCTs' ambitious plans to shift care out of hospitals are delivered, we do not bring patients back.
- Working with PCTs to control emergency admissions to the hospital so that we minimise the impact of the new national marginal rate of 30% payment for emergency admissions above 2008/09 activity levels.

CE expressed concern that adherence to ratios would translate into poor long term care. CL asked for clarification on follow up appointments. HL responded that if we exceed the ratio the PCT will not pay. AK said that specialities are being asked to come up with exceptions and we argued for some clinical exclusions. AK said on p.3 there is a list of clinical exclusions we put forward such as bariatrics. There has been a discussion on a care pathway and the reasonable ratio of follow-up appointments

WB said that he felt that this was a counter to patient care. However, SM said that she had come in recently simply to be told that her last result was alright. AC said he was dubious about performance indicators and their validity.

CE said that skilled negotiations were necessary. In response to CBlew's question about the status of the contract, HL responded that we have agreed the contract and the PCTs are under a mandate from NHS London. She said that MA and clinical leads have met with the PCTs and our negotiating team is very good.

BG said he can help with plans to mitigate risks. In the HIV directorate they are doing texts already and it is very popular with patients. There are ways to reduce visits and it needs to be thought through how we could improve communication with patients.

AK said that with respect to low priority procedures it was described as 'interventions not normally funded'. It is an initiative put forward by all PCTs and has not been monitored or enforced up until now. An example is varicose veins where the PCT will only pay 50%. It is rather arbitrary and so it has been agreed that clinicians will review in year and undertake audit.

CE said that it is a question of degree, some patients have severe conditions. MA said the challenge is to deal with individuals and their concerns e.g. there are some ways of treating veins problems rather than having a surgery.

AC asked if there was any benefit in early intervention? CE said that there was benefit in prevention and this principle would be fine if we had a good general practice but in London there were still a lot of single handed GPs. It was very important how this hospital got involved in polysystems.

CBlew asked how much we work in partnership with GPs and whether it is a joint decision with GPs. MA responded that GPs initially make the referral. There

would be an assessment by the hospital then a joint decision with the GP. He noted that GPs may be under pressure to refer.

AK said the point about shifting care out of hospitals had already been discussed but to note that it was more ambitious this year. With respect to controlling admissions to A and E there were schemes nationally to try and stop the rise in attendances year on year. To ensure Trusts are fully engaged the tariff has been changed so that above a certain ceiling Trusts will only get a third of the tariff.

HL noted that we have been communicating strategic direction and contract requirements widely through 'Fit for the Future' briefings with staff. **It was agreed that the Council of Governors would discuss the strategy further.**

2.1.2 Lower Ground Floor Outpatient Plans

HL introduced Hannah Coffey who is the Operations Director for Medicine and Surgery and she is leading on the outpatient project.

HC said that we are relocating the current outpatients 1 area on the second floor which is diabetes, pain, general surgery and urology. This will move to the lower ground floor between lift bank C and D.

The new outpatients is due to open in February 2011 so the deadline is quite tight. This is a good opportunity to re-design as the hospital was designed 20 years ago and we need to make it more accommodating to the current needs e.g. there is more diagnostic testing now. She said that we have reflected the feedback from patients e.g. communication, waiting time and the facilities. We have been focusing on patient flow as the current arrangements are quite confusing. There is not enough space for comfortable waiting. We are planning to provide phlebotomy and diagnostics downstairs.

We are looking at booking on line and at patient letters e.g. the content of letters. We are due to sign off the plans in 2 weeks time.

FT asked if the waiting rooms would have windows. HC said that we were looking at the atrium as the waiting area and the coffee area. Most of the consulting rooms will have natural light.

SS-G said she had a concern about how patients would get down to the lower ground floor. HL said we plan to have escalators but she did not like the plans so far. Escalators are very expensive. HL agreed with the comments about the lifts and said she had met with the contractors on this issue. SM commented that it had got worse since the stairs had been closed. CE explained the reasoning behind the closed stairwells. He said that there had been three people who had jumped since the hospital had opened and we cannot have another one. He explained that the handrails on the upper floors had also been taken away.

NB said that these plans would have a huge impact and there had been little time to absorb the information. She said papers were needed in advance so that issues can be considered in advance. CE agreed.

To AMD's question HC confirmed that the plans will be ready for the Open Day on 8 May 2010.

CE said it was important to understand clinicians and patient concerns. HL confirmed that there were defined areas but a common waiting area. BG said

that the presentation was superb and he believed the patient journey will improve.

HL said the administrative arrangements needed to improve and IT was a very important part of making this work. She had a vision that the hospital will run similar to an airport, where patients will book in early themselves and know where to go. The clinicians would be like pilots working to their own brand but following governance rules like pilots do with the airport security.

FT asked about plans for the Netherton Grove Extension Project. HL responded that they would be available on the open day and we were meeting with the neighbours tonight. The main focus is on the staff who are being displaced and finding suitable offsite accommodation. The long term strategy is to buy Doughty House to accommodate 200 staff who would need to be onsite.

Regarding communication, the governors said that they were not getting the newsletter that goes to staff.
CM to follow up. **CM**

2.2 Quality **CM**

2.2.1 Quality Accounts Update

CM gave an update on the Quality Account. She said that the final draft would go to the Board next week. She said an important element is what our stakeholders want and she outlined the process that had been undertaken and how the issues were prioritised.

In order to get feedback we initiated a staff survey and CM thanked CD for leading on this on behalf of the staff governors. She pointed out that although not many responses were received, the comments were very useful and included issues that we were aware of and some new issues. She hoped that staff feedback using the survey approach would be an ongoing process.

CM said she was confident that the quality account will be of a good standard as governors had read it and she was very grateful for their time.

CM said that the next step was that PCTs would receive the draft quality account to comment on.

The Council had no further comments on the engagement process.

2.2.2 Quality Sub-Committee Report

CM said that she had covered most of this already but wanted to draw attention to the minutes of the Quality Sub-Committee, item 6 on p.5 relating to feedback from governors on patient experience. Each governor will ask five friends/contacts for feedback on their experience. She thought this would be a useful way of using individuals' experience to get feedback.

2.2.3 Patient Experience

CE introduced AMC's paper about phase I and II of the implementation of the Patient Experience Tracker (PET).

We set a target of achieving an 80% response rate and 40% response rate was

agreed with Kensington and Chelsea PCT as a CQUIN with a value of £110,000.

CE said that patients should be made aware that the PET is anonymous.

SS said she wanted to reassure governors that as an outpatient sister that the PET is completely anonymous. Sometimes when it is busy it is difficult to focus on making sure that all outpatients have given their comments. She said that patients are not put under any pressure to complete them. HL suggested using volunteers to help. JS said that he does not think there is pressure put on patients to complete the trackers and it is obvious that it is anonymous.

ML suggested that the PET is used at the Open Day on 8 May 2010. HL confirmed that it was in the plan.

ML asked how we managed if the patients did not speak English. CD said we now have overlays in the major languages. AW asked if it was possible to know the different settings and to look at this data with complaints from the same area. CE suggested a geographical correlation so that bad areas do not get 'lost' and agreed it would be good to correlate with complaints.

HL said that there has been an excellent response in the Maternity Unit. However, in some areas there are no responses at all.

CD said we should celebrate the information gathered via the PET which helps wards improve the level of service they provide.

CE referred to fig 18 of the patient experience paper regarding booking appointments. HL said that this should improve.

AC queried fig 8 and fig 10 and the way questions were worded. HL said most of questions were taken from the national survey.

To CL's question on how many people took part in the survey, CD responded that this is illustrated in point 2.4.

HL agreed with AW's point that it would be a worthwhile exercise to analyse responses by age group. However the age is not recorded but this could be done by ward.

TY joined the meeting.

2.3 MEMBERSHIP **CE**

2.3.1 Membership Sub-Committee report

JS said that he had received a copy of the main discussion points that CBir had drafted and had asked JS to present them to the Council of Governors. The main points covered the following:
- In total there were 27 items on the agenda of the Council of Governors meeting and they weighed 1 lb 13 oz.
- At the Membership Sub-Committee we usually had about 13 or 14 items, but at the April's meeting we cleared the decks so that we could have a full of membership development and engagement discussion. The membership has declined and a new approach is needed. The sub-committee discussed schools and participation in the Nothing Hill Carnival and that the community mobile health clinic bus could be taken elsewhere.
- JS also noted that there was a new membership leaflet.

FT said she did not think that the Notting Hill Carnival would be as productive as we would hope as it is very crowded. She suggested instead going to the Portobello Market. ML said that we need to ensure that the black minority community get involved. FT suggested that the Mobile Health Clinic get taken to Kensington Town Hall.

CE said that with respect to the papers at this meeting there is an agenda sub-committee so this is in our hands. It was agreed previously that we would reduce the finance and performance report.

NB felt that we still had not addressed why patients and the public should get involved. We had not used the newsletter appropriately and a section on 'what was covered at the last meeting' would be a good idea. BG suggested we could write one page on what has been achieved e.g. 'you do make a difference, the following things have been done....'

Ideas to be considered by the Executive. **CM/AMC**

2.3.2 Membership and Engagement Strategy

This will be covered in more detail at the next Council of Governors meeting.

2.3.3 Membership Report

This was noted. CE said we need to be careful as we need active members not just numbers.

2.4 Funding Report* **CE**

This item was taken as read.

2.5 Remuneration of Non Executive Directors (NEDs) and the Chairman **CE**

CE said that the Council is required to consider the remuneration of the NEDs and the Chairman at least every three years. Considering the current financial climate he suggested that there should not be any change to the remuneration of NEDs and the Chairman. He noted that a very thorough benchmarking exercise had been taken at the time the remuneration was agreed, when the Trust became a Foundation Trust. The governors supported the Chairman's view.

2.6 FTGA/FTN Development Day 12 February & 23 March 2010 – feedback **SS-G/WB**

SS-G said that she would recommend the FTGA/FTN Development Day events to other governors having attended one on 12 February.

WB agreed that the day was worthwhile and informative.

2.7 Proposed questionnaire for Council of Governors performance evaluation **VD**

VD said the proposed questionnaire was an update on the questionnaire previously used for the evaluation of the Council of Governors performance. Changes included grouping of questions and an additional question relating to the Quality Account. The aim of the questionnaire is to evaluate and improve the performance of the Council of Governors.

Governors discussed the proposed questionnaire and the following questions were agreed to be added to the questionnaire:

- How would you rate the level of support provided by the Foundation Trust to discharge your responsibilities as a governor?
- How would you rate your communication with the Trust?
- How would you rate the idea of having a chelwest e-mail account?

VD to update the questionnaire. **VD**

VD invited the governors to agree the proposed timetable:

- Questionnaires to be distributed to Governors by e-mail on 26 April 2010;
- Questionnaires to be completed and returned to the Trust Secretary by 10 May 2010;
- Summary report, including any recommended developmental actions, to be prepared and presented by the Chair to the Council of Governors meeting on 21 July 2010.

Governors agreed the proposed timetable.

2.8 Governors chelwest e-mail account arrangements **CE/GH**

CE said some governors expressed strong views about having a chelwest e-mail account so that members of their constituency could contact them.

Gregory Hewitt of the IT Department attended the meeting and briefly outlined the arrangements for the governors to have an e-mail account with the Trust. The e-mail address would be then published on the website.

It was agreed that VD would circulate an e-mail request form and the Acceptable Use Policy to the governors. **Those governors who are willing to have the e-mail account would send back to VD completed e-mail application form and signed Acceptable Use Policy.** **All**

2.9 Council of Governors group photo

One governor proposed that a group photograph be taken for the purposes of publishing it in the next Trust News. **It was agreed that it would be a good idea to gather together at 4pm on 21 July 2010.** **All**

2.10 Open Day – 8 May 2010 – update

CE said that the arrangements are in the place for the Open Day. VD said that copies of flyers for the Open Day were available for the governors.

3 ITEMS FOR INFORMATION

3.1 Finance Report – February 2010 **LB**

This item was taken as read.

3.2 Performance Report – February 2010 **LB**

This item was taken as read.

3.3 Foundation Trust Staff Governor Study **CE**

This item was taken as read.

3.4 Appraisal of Chair and NEDs – FTGA publication

This item was taken as read.

4 ANY OTHER BUSINESS **CE**

CE said that EC wanted to raise a few points under any other business.

EC said that he objected to not having time for AOB. He also said that the governors should be allowed to make unannounced visits to hospital wards so to be able to judge everyday standards. He said that he had personal experience as an outpatient, day patient, in patient and private patient. He found excellent nurse care as an outpatient and day patient while doctors were present. However, not the same standard of care was provided when doctors were not present.

CE responded that any personal views should not be generalised.

EC said he felt that the Trust News was mainly aimed at staff and felt that money spent on circulating it to members was not essential. He thought it should have been spent on other more essential areas e.g. nurse training. He said that the amount of paper generated appears excessive and that it could be reduced and some savings made.

NB said that she had not been contacted by anyone about the agenda and the agenda sub-committee should be seeking members' views. CE said that the dates of the agenda sub-committee meetings would be circulated so everyone was aware and could forward their views.

Vida to circulate a list of agenda sub-committee meeting dates to all governors. **VD**

5 DATE OF THE NEXT MEETING

The next meeting of the Council of Governors will be held on 21 July 2010 at 4.30pm.