Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 12 July 2012
Minutes

Prof. Sir Christopher	Edwards	Chairman		CE
Chris	Birch	Patient		CBir
Christine	Blewett	Public	Hammersmith and Fulham 2	CBle
Anthony	Cadman	Patient		ACad
Cass. J	Cass-Horne	Patient		CC-H
Edward	Coolen	Patient		EC
Samantha	Culhane	Public	Hammersmith and Fulham 1	SC
Carol	Dale	Staff	Management	CD
Brian	Gazzard	Staff	Medical and Dental	BG
Anna	Hodson-Pressinger		Patient	AH-P
Melvyn	Jeremiah	Public	Westminster 2	MJ
Martin	Lewis	Public	Westminster 1	ML
Kathryn	Mangold	Staff	Nursing and Midwifery	KM
William	Marrash	Patient		WM
Susan	Maxwell	Patient		SM
Wendie	McWatters	Patient		WMW
Henry	Morgan	Public	Wandsworth 1	HM
Cyril	Nemeth	Appointed	Westminster City Council	CN
Sandra	Smith-Gordon	Public	Kensington and Chelsea 2	SS-G
Frances	Taylor	Appointed	Royal Borough of Kensington and Chelsea	FT
Maddy	Than	Staff	Support, Admin & Clerical	MT
Alison	While	Appointed	King's College	AW

IN ATTENDANCE:

Sir John Baker	Non-executive Director	JB
Richard Kitney	Non-executive Director	RK
Jeremy Loyd	Non-executive Director	JL
Sir Geoffrey Mulcahy	Non-executive Director	GM
Dr Mike Anderson	Medical Director	MA
Lorraine Bewes	Director of Finance	LB
David Radbourne	Interim Chief Operating Officer	DR
Mark Gammage	Director of Human Resources	MG
Catherine Mooney	Director of Governance and Corporate Affairs	CM
Matt Akid	Head of Communications	MAk
Axel Heitmueller	Director of Strategy and Business Development	AH
Anthony Pritchard	Deputy Chief Nurse	AP
Vida Djelic	Foundation Trust Secretary	VD
Patricia Gani	LINk representative	PG
Ben Sheriff	Deloitte LLP	BS
Helen Elkington	Head of Estates and Facilities	HE

1 GENERAL BUSINESS

1.1 Welcome & Apologies — CE

CE welcomed Ben Sheriff of Deloitte LLP to the meeting who will be presenting the papers from the auditors on behalf of Heather Bygrave.

Apologies were received from Nicky Brown, Alan Cleary, Fergus Cass, Rosie Glazebrook and Jenny Higham.

Apologies were also received from Karin Norman, Non-executive Director and Therese Davis, Chief Nurse.

CE informed the Council of Governors of the reason for FC's absence which was due to a potential conflict of interest.

1.2 Declaration of Interests — CE

None.

1.3 Minutes of Previous Meeting held on 3 May 2012 — CE

Minutes of the previous meeting were accepted as a true and accurate record of the meeting with the following amendment:

- P5 EU patients should read 'non-EU patients'

SS-G sought clarification of the last para on p.2, ref the Board Governance Assurance Framework.

1.4 Matters Arising — CE

Re 2.6 the Chairman wrote to the Health Secretary regarding the timeline for implementation of the private patient income cap provision of the Health and Social Care Act 2012. The Foundation Trust Network also lobbied. There was a subsequent positive response that it would take effect as of October 2012.

Re remote access to hospital email: VD said that Greg Hewitt, Acting Assistant Director of IT had provided information to CBir, ML and MJ who are currently testing the new solution. Once they are happy all governors will be issued the chelwest email account and addresses will be published on the website. VD reassured governors that she tested the new solution and it is user friendly. CBir said he agreed with this assessment.

It was noted that MAk would address the survey under the Open Day item.

1.5 Chairman's Report (oral) — CE

CE said he was delighted that CBir was present considering the fall he suffered recently. CBir said he had received a brilliant service in A&E.

CE said it was very important that the implications of the Health and Social Care

Act are discussed and that the Board and Council worked together and he proposed that this was addressed in a joint Away Day in the autumn. This was agreed.

2 ITEMS FOR DISCUSSION/DECISION/APPROVAL

2.1 Presentation of Annual Accounts & Annual Report 2011/12 LB/CE

LB presented the highlights of the annual accounts which are from page 123 onwards in the annual report. She described the key points outlined in the executive summary.

BG said that there must be a point when the surplus is excessive compared with the Cost Improvement Programme (CIP) and reducing costs is very painful for staff. It is a difficult situation to manage with staff when they are required to make savings of 10% and then be advised that there is a surplus of £13m.

LB acknowledged this and confirmed that an appropriate level of surplus was agreed by the Board.

CE said that to be able to have funds to invest is key to our future success. He assured the Council of Governors that patient care has not been affected. He referred to the recent visit of the Health and Social Care Scrutiny Committee and said that they were very impressed by the visit to the pediatric ward but not so by the visit to A&E. It highlights the fact that to have a world class facility we have to invest in the services.

LB commented that 9% is an overall figure and relates to approx 5% income and is within Monitor's guidelines. The scale of the Trust development would reduce if we cut back on CIPs.

BG suggested that this should be explained to staff and the benefits of the surplus emphasised.

CE said that an example might be that we have invested £9 million in modernising the infrastructure and this will lead to savings of £600k per year and will decrease our carbon production.

CE congratulated LB and said that the CIP is at a level that is impossible to be achieved at other Trusts and that we are more viable compared with our competitors. This is valuable for patients and for staff.

SM asked about the significant development in IT and whether this was just patient records? She had been told that LastWord is out of date.

LB replied that the LastWord is the patient administration system and is a legacy system, although was more advanced than the national IT programme.

CE commented that we were very much ahead of the time when it was put in to the Trust but we now recognise that this system needs to be replaced.

DK who is the Non-executive Director lead on IT, commented that the Trust has a

strong IT department and we are still advanced. As a part of the IT Strategy we are going to replace the system over the next few years and we are implementing the first phase of Electronic Document Management at the moment and the second phase will be completed in spring 2013.

CN referred to a recent incident where a hospital had lost records and there was potential adverse clinical consequences and he asked for assurance about the situation at Chelsea and Westminster Hospital. DR replied that this had been checked and he assured CN that it was unlikely to happen here.

In response to a question re savings, LB said that the Trust is working collaboratively with the Royal Brompton and Royal Marsden Hospitals as part of the Fulham Road Collaboration. She said that by having a joint contract with the three Trusts with ISS there were savings of £38 million over 3 years. We are also looking at pooling resources for IT.

ML queried if there is a system in place to charge foreign nationals who are outside of the EU. LB replied that we are exploring options to take credit card swipes for private patients. Non-EU patients who use A&E services do not get charged.

LB referred to a recent development involving the UK Border Agency which is allowed to hold details of people who have outstanding bills with the NHS and refuse them admission to the country. This was successful for the Trust recently as an American visitor was refused entry, and as a result paid his bill.

CE congratulated Matt Akid, Head of Communications and others who had worked extensively on the Annual Report.

CBir said that it is a magnificent report with a beautiful photograph on the front page cover and congratulated MAk for producing it. He commented that 'Terrence Higgins Trust' was misspelt and that some governors' terms of office are stated when they originally joined, and some when they were re-elected. He noted that on page 103 of the Annual Report, where the criteria for membership of the Trust are listed, the criterion of being a volunteer had been omitted.

ML said that he would like to record thanks to CM and Melanie Van Limborgh for the Quality Report.

2.2 External Auditors' Report on the Annual Accounts 2011/12 BS

BS presented the external auditors report on the annual accounts. He said that Deloitte had issued a clean opinion and there were no items they required to be reported by exception. He described the principal risks that Deloitte had covered.

ML queried if there were two systems for Payment by Results and BS clarified that there was one process but two types of checks.

LB confirmed that the figures disclosed do not show VAT.

2.3 Report on the external assurance audit of the Quality Report year ended 31.03.2012 BS

BS said that it is a legal requirement to produce an annual report about the quality of services delivered as an NHS service provider.

The audit includes a review of the content of the Quality Report and testing three performance indicators, two mandated by Monitor and one agreed locally. Deliotte had provided a private opinion last year and this year it has provided a public opinion on *C.difficile* and 62 day cancer wait. The limited assurance refers to the scope of the review rather than an opinion.

BS said that their opinion was that the Quality Report is user friendly and consistent. There were some issues in the data relating to the 62 day wait but this did not affect the breaches. There were more issues with the emergency surgery indicator but this was a less well established indicator. The overall conclusion was 'required improvement'.

2.4 Audit Committee Annual Report 2011/12 **JB**

Sir John said that this report notes the work of the Audit Committee for the last year and its important assurance that the committee gives to the Board. The assurance is in three areas: governance, control, and process improvement.

In relation to process improvement, KPMG look across a wide range of activities. The Audit Committee decides the priorities. KPMG provide audit services to a large number of trusts and so we gain from the experience of others. There was only one high risk recommendation re Freedom of Information requests and the speed of responses. KPMG were content to sign off their report and were also content with the improvements we are making.

There are few cases of fraud that come to the attention of the Audit Committee, either because we cannot find it or because we have good deterrents in place. The value of money saved is not very large but the deterrent value is unquantifiable.

Pages 6 and 7 report on a coding issue identified by KPMG which the Trust will address.

Overall there is reasonable assurance on the systems of control in place.

2.5 Shaping a Healthier Future – consultation update **MA**
& **&**
2.6 Shaping a Healthier Future – communication and engagement plan **MAk**

MA noted that the details have been published of the NWL 'Shaping a Healthier Future' consultation which proposes major changes to hospitals in the area including closing some A&E units. The consultation will run for 14 weeks from 2 July 2012 to October 8. The Response Form has 35 questions which may cause some difficulties and we will need to develop a plan to help people. Meetings are being organised with various parties including local MPs.

WM referred to a question asked of the Prime Minister by a Labour MP regarding 4 hospitals out of 9 closing their A&E units and the impact it will have on other

hospitals. There is also a risk of unemployment. MA responded that the consequences will be different in each Trust but no hospital closure is intended. An important point in the case of Charing Cross Hospital is that 70% of the people who attend A&E there now would still get care locally through the Urgent Care Centre there.

CBir said that A&E is an important local resource and asked if we are successful could not Charing Cross Hospital retain its A&E for its 'walking wounded'? MA replied that Charing Cross Hospital would keep the Urgent Care Centre 24/7 and 365 days a year.

WMW said some politicians have asked if the Trust would be able to cope with the additional number of patients. MA replied that we have to fully separate the UCC from A&E which would need to be bigger. We would have to deal with additional adult admissions and need extra bed capacity. We would achieve this by reducing length of stay and admissions.

CBle queried how the Trust would manage without the UCC. MA replied that the Trust would keep an UCC but at present it is integrated within the A&E and we would have to separate it to increase the space for A&E. Part of the overall proposal is to improve primary care so that the call on A&E services reduces. The risk is that primary care improvements do not occur and we need to take this into account when planning.

MA highlighted that the Trust will have to consider its capacity and potential to develop. Some research indicates that treating patients in hospital is very expensive and that the care could be delivered in the community.

CN queried if we have sufficient number of consultants. MA replied that the Trust has an appropriate establishment and that it could employ more consultants if there is demand. We also have an appropriate number of surgeons to deal with capacity.

ML suggested we involve the Westminster MP.

MA invited governors' views on how to help people answer questions in the consultation. Some model answers will be prepared.

EC said he doubted whether the consultation would achieve anything and referred to the closure of his local GP surgery and added that unless there is a powerful lobby group it will go ahead regardless of the consultation outcome results.

MA suggested providing help with submitting responses which could be via volunteers and governors and if not this is not workable we could pay for assistance.

CE noted that the communications department produced a communication and engagement plan offering a variety of proposals on how to do this.

MJ said he had looked at the electronic form and it is more extensive than simple options. MA responded that Ipsos Mori conducted the consultation and they had followed the brief they were given.

SM queried if we can present comparable quality data such as MRSA rates. MA said that Imperial cannot give separate data for each hospital and the assumption is made that quality is the same in the different Trusts although we have the best patient experience results and that is part of the reason we are preferred option.

MAk said they are encouraging people to provide responses electronically and he circulated a paper which outlined ways in which governors can contribute. The key messages we would wish to get across are described in the paper.

MA will find out whether it is possible to e mail and simply say what option is preferred.

CBle commented that it is important to deal with people's emotional attachments.

WMW suggested leaflets be issued which explains the issues simply and which could be handed out by volunteers.

EC said that following the consultation he attended he had heard that there could be 20% redundancies. MA confirmed this was not correct and if there were less beds, less staff would be employed in hospitals but more would be employed in the community.

JB said that the crucial element is care and MA cited how care had been improved in trauma, stroke and cardiac services through centralisation of services.

SC commented that naturally people are inclined to save their own local hospital.

CE summarised the following points:

The Council is supportive of the idea of using volunteers to help people complete the responses to the consultation. There may be a cost element to this and we may ask the governors to fund this.

The consultation is not just about A&E but will impact on other services e.g. we would lose pediatrics, emergency 24/7 anesthetic cover and maternity, obstetrics.

MAk suggested leaflets be available in A&E as most people will not know that this consultation is going on and we need to access the people who live locally.

AH-P suggested that an important point was that this was about saving money and we have the money to expand A&E which Charing Cross Hospital does not. CE said that part of the response should include what we will do if we succeed.

GM suggested that we announce that we are making an investment in A&E. There is a group looking at how we can improve the facilities currently.

BG suggested that as part of the consultation we advertise our new pediatric A&E and the Children's Hospital.

JL agreed with GM and that we should make a firm commitment to having a world

class A&E and if we are to win this argument we need to make quick changes which will involve both estates and level of services we provide.

SS-G suggested that MAk's department was too small and suggested that there was a temporary increase in staff especially as Renae McBride had left. CE said this will be considered.

WMW said we must be very careful not to have a negative campaign against Charing Cross Hospital.

ML asked that governors should be invited to join any MP visits.

CE concluded that the Council of Governors fully supports the Preferred Option A to retain the A&E within the Chelsea and Westminster Hospital.

2.7 Health and Social Care Act 2012 – briefing and review of constitution **CE/CM**

The Council of Governors noted the paper.

CE said that we will organise a joint Away Day with the Board to address the issues. The working groups will be put in place and will report back to the away day.

The Council of Governors agreed with the proposed approach.

2.8 Membership Recruitment, Engagement and Communications Strategy 2012/13 **MAk/TP**

MAk outlined the Membership Recruitment, Engagement and Communications Strategy and the main points. He noted that this was considered in detail by the Membership Sub-Committee at its meeting on 1 June.

ML highlighted the need to target black minority and ethnic groups and that Priti Bhatt, Equality and Diversity Manager will be the key to help with this.

MJ said that the membership sub-committee will discuss the option of an opt-out Membership system for the patient constituency as presently applies to the staff constituency.

CE highlighted the value of 15,000 members and the support they can give us in relation to the NWL consultation.

2.9 Council of Governors Quality Sub-Committee Terms of Reference* **CM**

This item was starred and therefore approved as read.

2.10 Annual Members' Meeting Proposal **MAk**

MA outlined the proposal and highlighted that the new Chief Executive will attend.

The first part of the meeting will consist of a presentation by a governor and will focus on the role of members and governors in supporting the Trust during the

consultation on ‘shaping a healthier future’.

The second part will consist of a presentation by clinicians and a couple of topics were suggested e.g. dementia

BG highlighted the important work of the volunteers and how they help on the wards. This might also attract more volunteers.

CBir commented on ‘Medicine for Members’ seminars and the proposal to repeat the recent Dementia seminar led by Dr Morgan. MAk said that the communications department could provide help with any slides.

MAk invited governors to express interest in presenting at the Annual Members’ Meeting.

Governors interested in presenting at the Annual Members’ Meeting to let MAk know. **All**

2.11 Governors’ Questions

In response to a question from ML if the Trust plans to redecorate some of the clinics and corridors MA responded that any big refurbishment is usually done during the summer season.

Helen Elkington, Head of Estates and Facilities said that over £1m of capital has been allocated for refurbishment of some clinical areas and noted that replacing of some floors, patient bathrooms and general repair of the hospital building has recently been done. She recognised that the Medical Day Unit and transport area need refurbishing.

ML commented that the transport area needs redecorating and a reception desk in the area needs to be of proportionate size (very high currently).

SM suggested that the transport waiting area should be extended to something like the Macmillan departure lounge. She felt the area needed developing and suggested some refreshments to be available and a desk where pharmacy could hand out prescribed medication instead of patients waiting for it on the ward. HE responded that this will be considered.

CE said he recognised that certain parts of the Trust need updating and various options for upgrading will be explored and this will be part of the Estates Strategy.

A further question was ‘May we please have a report explaining in simple terms and relating specifically to our Foundation Trust the system described under the heading "Accountability and Governors" in the Paper "Accountability in Action" recently circulated? (ACle)

In response to this question CM tabled information on risk management within the Trust and apologised for not circulating it to the governors in advance of the meeting which was due to a misinterpretation of the question that was being asked.

CM highlighted section 3.1 which demonstrates how the Board of Directors

manages risk and drew attention to the Risk Strategy and Policy a copy of which is available on request.

She explained the committee structure and the involvement of Non-executive Directors and governors.

She provided some examples of where the Board had intervened to deal with issues of performance. These included *C.difficile* and a special review of maternity which resulted in significant improvements.

Regarding reliability of past performance CM noted that we have not incorrectly predicted our performance since we became a Foundation Trust which indicated that our past performance was a reliable indicator of future performance.

VD to send the tabled paper to Alan Cleary. **VD**

2.12 Report on Senior Nurse/Governor Rounds **TP**

TP said the wrong paper was circulated and he tabled a copy of the correct paper reporting on the visit of ML to the Emergency Department during the evening of 5 May. ML met with the Charge Nurse and observed the work of the team.

ML commented that staff were very professional but that some areas needed upgrading.

HM visited Nell Gwynne ward and the Stroke Unit and met with the coordinator of the Stroke Unit on 29 June. He was content with the unit and the way it operates.

TP invited governors to join regular Wednesday Clinical Rounds and also if any governors are interested in individual visits to advise him so that he can arrange it.

CE thanked TP for organising governors' visits to wards.

2.13 Council of Governors Funding Report **CM**

The Council of Governors noted the funding report.

CBir commented on the proposal for additional funding for the September recruitment session was higher by £40 otherwise he supported the request.

The Council of Governors agreed the additional funding of £1,260 for recruitment sessions in September 2012.

2.14 The tenth FTGA National Development Day 23 May & 27 June 2012 – feedback* **SM/ACle**

This item was taken as read.

2.15 Quality Sub-Committee report* **CM**

This item was taken as read.

2.16 Membership Sub-Committee report* **ML**

This item was taken as read.

2.17 Membership Engagement and communication – update* **MAk**

This item was taken as read.

2.18 Membership Report* **TP**

This item was starred and therefore taken as read.

2.19 Open Day 12 May 2012 – Evaluation Report **MAk**

MAk highlighted that more than 2,100 visitors came to the May Open Day which was a new record for the event.

Question 6 of Appendix 1 presents information on how people heard about the Open Day. 10% of respondents said they received information via letter drop and 5% said via newspaper advertisement.

MAk highlighted that the Careers Event attracted a lot of interest and was well attended.

ML added that he received fantastic feedback from some people who attended.

ML expressed his thanks to MAk and Renae McBride on the successful organisation of the Open Day event.

MAk outlined a proposal for Open Day 2013 funding.

The Council agreed to support funding of the Open Day 2013 for £20,000 from the 2013/14 allocation. More information on organisation of the event to be provided at a future meeting.

3 ITEMS FOR INFORMATION

3.1 Finance Report – June 2012 **LB**

This item was taken as read.

3.2 Performance Report – June 2012 **DR**

This item was taken as read.

3.3 Monitor Code of Governance – compliance **CM**

This item was taken as read.

3.4 Wayfinding Project Update **TD**

This item was taken as read.

3.5 Director-Governor interaction in NHS Foundation Trust **CE**

This item was taken as read.

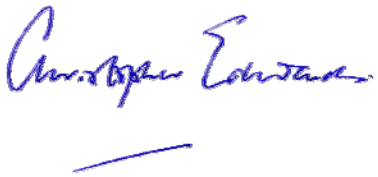
4 ANY OTHER BUSINESS **CE**

None.

5 DATE OF THE NEXT MEETING

The next meeting of the Council of Governors will be held on 13 September 2012 at 3pm and will be followed by the Annual Members meeting.

Signed by



Prof. Sir Christopher Edwards
Chairman