

CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

Minutes of the meeting of the **BOARD OF GOVERNORS OF CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST** held on Thursday 3 July 2008 at 17.30 in the Hexagon, Frank Lee Centre, Addenbrooke's Hospital.

PRESENT

Dr M Archer (Chairman)
Mr D Adlam (Staff Governor)
Mr M Bright (Patient Governor)
Mr R Burgin (Advisor)
Dr N Burrows (Staff Governor)
Mr C Carr (Staff Governor)
Mrs M Chaloner (Patient Governor)
Brig R Cockman (Public Governor)
Dr P Dansie (Public Governor)
Dr M Davies (Partnership Governor)
Mrs A Donnelly (Staff Governor)
Ms M Donnelly (Partnership Governor)
Mrs J Ewer (Public Governor)
Mrs G Francis (Public Governor)
Ms M Hart (Patient Governor)
Prof D Humber (University Governor)
Prof B Michell (Patient Governor)
Dr J Nicholls (University Governor)
Mr T Orgee (Advisor)
Mr J O'Sullivan (Staff Governor)
Ms G Pharaoh (Patient Governor)
Mr R Quince (Advisor)
Mr E Revell (Public Governor)
Mr T Roberts (Patient Governor)
Mrs S Smith (Advisor)
Mr L Williamson (Public Governor)
Ms C Young (Partnership Governor)

IN ATTENDANCE

Dr G Goodier (Chief Executive)
Mr C Greenhalgh (Vice-Chairman)
Mr C Black (Director of Commissioning)
Mr J Ghosh (Head of Performance Intelligence)
Mr S Graves (Executive Director of Corporate Development)
Mrs H McGhee (Acting Trust Secretary)
Mrs B Hennessy (Director of Patient Experience and Public Engagement)
Mrs M Last (Governor Services Administrator)
Mrs S Rees (Member Services Administrator)
Mr F Rogers (Foundation Membership Manager)
Ms E Taylor (Board Secretary)
Mrs A Thompson (Assistant Director of Nursing)
Ms J Timpson (Senior Communications Officer)

APOLOGIES

Mr T Benson (Advisor)
Dr S Bullivant (Patient Governor)
Mr A Dasgupta (Partnership Governor)
Mr B Gerbaldi (Public Governor)
Mrs N Goddard (Public Governor)

Prof A Lever (Partnership Governor))
Dr V Muir (Patient Governor)
Miss M Nathan (Advisor)
Mr M Perry (Patient Governor)
Cllr S Stewart (Local Authority Governor)

20/08 CHANGES TO THE BOARD OF GOVERNORS

Noted

- (i) The Chairman reported the outcome of the elections. Lorne Williamson was welcomed as a new Public Governor and Maureen Hart was welcomed back for a further term of office. David Adlam was welcomed as the new Staff Governor to succeed Nigel Burrows. The following Governors were congratulated on their re-election to office: Brian Gerbaldi; Michael Bright and Malcolm Perry.
- (ii) The retiring Governors Nicky Goddard and Nigel Burrows were both thanked for their substantial contribution to the Board's activities during their time in office.
- (iii) The Chairman confirmed that Valerie Muir had unfortunately had to resign as a Patient Governor due to continued health problems. As a result, the Board of Governors had the option to appoint Susan Bullivant who had received the next most votes in the recent election. Governors confirmed the appointment of Susan Bullivant for the remainder of the term of office (until June 2009).
- (iv) A welcome was extended to Councillor Tony Orgee, representing the County Council.

21/08 THE NHS AT 60: NYE BEVAN; BBC BREAKFAST NEWS

Noted

- (i) The NHS had been announced by Nye Bevan 60 years ago on 4 July 1948. Eric Revell shared his personal reminiscences of Nye with fellow governors.
- (ii) The Chairman was pleased to inform Governors that CUH had been chosen by BBC Breakfast News as the flagship hospital from which to celebrate the 60th Anniversary of the NHS throughout the week. Four short film packages which had so far been broadcast were shown to Governors. On Monday filming had taken place in the Rosie Hospital; on Tuesday there had been coverage of infection control initiatives on the wards; on Wednesday the crew had been based in the Emergency Assessment Unit and on Thursday filming had taken place in Sterile Services, where there had been an interesting feature on how much the services cost in real terms. Friday's broadcast would return to the Rosie.
- (iii) Governors would receive a DVD of the footage.

22/08 MINUTES OF THE PREVIOUS MEETING HELD ON THURSDAY 3 APRIL 2008

The minutes of the previous meeting were agreed as a correct record.

23/08 MATTERS ARISING FROM THE MINUTES

(A) Joint Meeting with Board of Governors of Papworth (minute 09/09)

Mr Robert Burgin, Chairman, Papworth Hospital, reported.

Noted

- (i) Mr Burgin had been invited to respond to the Governors' invitation which the Board of Governors conveyed to the Papworth Governors to hold a Joint Meeting. A joint venue had been found at the Cambridge Belfry in Cambourne and a meeting was planned for the beginning of December 2008. The Deputy Chairmen of Governors would construct a mutually convenient agenda.

Secretary's Note: This is now confirmed as Tuesday 2 December 2008.

- (ii) Mr Burgin updated the Board on the Papworth project. The complete Business Plan had been finalised and submitted to Monitor. The Trust's current Financial Rating was above 4. The plan would be formally considered by the Strategic Health Authority towards the end of the month. Papworth was confident that 'Papworth in Cambridge' would be supported. The Section 106 agreement would be finalised in July. There would also be a formal meeting with the Chief Executive and Chairman of Monitor the following week. The plan was the culmination of five years' work and it was hoped that the outcome would be a positive one. It was anticipated that the Board of Governors would be able to discuss forward planning at the Joint Meeting in December.
- (iii) Dr Goodier highlighted the joint working between cardiologists from both Trusts which was under way to establish an interventional cardiology laboratory on the Addenbrooke's campus, to establish a comprehensive service.

(B) FTN Governors' Association (minute 15/08)

Noted

Georgina Pharaoh would replace Judy Ewer on the FTGA after the October AGM.

(C) Laundry Outsourcing (minute 08/08)

Noted

Staff had accepted the decision to outsource laundry services. Arrangements had been made to guarantee affected staff a position.

(D) Children's Hospital Project Board (minute 05/08)

Noted

The Children's Hospital Project Board had held its first meeting on 27 May. The issues regarding the development had been outlined and Deloitte would be looking at the Strategic Outline Case. The draft Terms of

Reference were presented and the Board would meet again later in the year when more background information would be available.

24/08 FINANCIAL AND PERFORMANCE REPORTS

(A) Financial Report

Received a report from Mr Craig Black, Director of Commissioning.

Noted

- (i) The Trust was on plan in terms of delivery of the surplus and was forecast to achieve the target by the year-end. However, the Financial Risk Rating (FRR) was currently at 3.6 and a small change in income or expenditure could reduce this figure.
- (ii) There had been significant investment in infection control and in increasing nursing levels on the wards. There had been a deliberate and sustained intention to invest, which would deliver benefits, but had an adverse effect on finances which would require careful management during the year.
- (iii) At this stage, there were no concerns over the overall financial position. In order to secure the capital plans however, the surplus needed to be delivered this year, as well as in future years.

Agreed

Governors thanked Mr Black for the comprehensive report.

(B) Performance Report

Received a report from Mr Joe Ghosh, Head of Performance Intelligence, as copy attached to the minute book.

Mr Ghosh reported.

Noted

- (i) The Trust continued to strive to combat infection as had been reported in the Finance Report. There were some challenging performance targets for 2007/08 and onwards especially with regard to infection control.
- (ii) There had been no cases of MRSA during June and two cases in July to date. The risk status for MRSA had been red for May but green for June. The position had continued to improve. The Trust had set a stretch target together with the PCT of 36 cases to the year end. This was a challenging target given the number of cases of MRSA that were pre-existing to the patients' arrival at the hospital.
- (iii) The Trust and the PCT were working constructively together to reduce Hospital Acquired Infections (HAIs) and to implement all known effective strategies. There were plans to provide new infection control wards by December 2008, including 21 single rooms with en-suite facilities to cater specifically for patients with *C. difficile*.
- (iv) The PCT had reviewed the available facilities for continuing care. The numbers of Delayed Transfers of Care (DTOCs) had been reduced from

over 30 to around 5 cases or less, which had had a huge positive impact on ward occupancy levels and the calmness of the wards. This was now classified as a green risk area rather than red.

- (v) Governors sought clarification on the budget for nursing staff. It was confirmed that nursing staff costs came under the Operations Directorate.
- (vi) Governors requested that the question of 'Did not Attend' (DNA) rates for outpatients be discussed by Governors at the next meeting, with a review of actions taken to address the issue of non-attendance and further consideration of ways to reduce this figure.
- (vii) In answer to Governors' queries it was explained that expenditure during March was traditionally comparatively high in the effort to close a range of accounts by the financial year-end. The budget throughout the year was phased to reflect this and consequently the budget for March would typically be higher than that for April and for May.

Agreed

Governors thanked Mr Ghosh for the report.

25/08 'TOWARDS THE BEST, TOGETHER' – CLINICAL VISION FOR THE NHS EAST OF ENGLAND

Received a presentation from Dr R Winter, Medical Director, NHS East of England followed by a Question and Answer Session. The summary document was circulated and full consultation document was available.

Noted

- (i) 'Towards the Best, Together' represented the SHA's response to the Darzi challenge. This involved more than 150 clinicians from throughout the East of England, as well as patients and senior managers, including many staff from CUH including Mr Adlam, who had now joined the Board as a Staff Governor, on Elective Surgery; and End of Life Care, which had been led by Dr Traue.
- (ii) Major inequalities in health and well-being across the East of England meant that change was necessary. For example, residents of Great Yarmouth had a life expectancy which was ten years lower than residents in part of Peterborough. Around one quarter of adults still smoked, 8,500 (mainly children) would start smoking in the region, and it was known that smoking was directly linked to one in six deaths. 60% of deaths in the region were associated with stroke, heart disease and cancer and many of these were preventable. Around one quarter of adults had a long-term condition including malignant cancers and HIV. In terms of outcome, the NHS had improved a lot over the past ten years but still lagged behind a number of Western European countries.
- (iii) Consultation with the public had underlined the need for a more convenient and easily accessible service. Expectations had changed; patients were now much more informed and involved in their care.
- (iv) In the 'Improving Lives, Saving Lives' project, patients and practitioners providing the service were asked what their priorities were. This led into 'Our NHS, Our Future' and the resulting clinical vision 'Towards the Best,

Together', was a third complementary piece of work. The principles for progress were building on the case for change: more prevention, addressing health inequalities, focusing on the needs of individuals, services localised as much as possible but centralised where it saved more lives or improved outcomes. Services that were more accessible, workforce working smarter in a way that was more integrated and more flexible, partnerships with others wherever possible, and very importantly, moving on from just looking at clinical outcomes to looking at functional outcomes and patient satisfaction. The quality and effectiveness of an organisation providing healthcare could be summed up as the clinical outcome, plus the functional outcome plus patient satisfaction, divided by cost.

- (v) People wanted better and more personal services, particular in primary care and also in dentistry, for issues to be addressed around stroke, heart disease cancer, safety and the attitude to non-voluntary risk including healthcare-related infections. Other core objectives included improving health and reducing unfairness connected to work, smoking and obesity.
- (vi) Eight clinical pathways stretched through from birth to the end of life.
- (vii) **Staying healthy:** this theme addressed the importance of life-style behaviours and partnerships with schools, authorities, local employers and others.
- (viii) **Mental health:** this was an opportunity to put mental health back on the agenda, to ensure that access targets of 18 week were used and that the benefit of cognitive behavioural therapy was recognised.
- (ix) **Maternity and New-born:** this theme explored the concept and desire of women to have a more holistic experience promoting the normality of birth, with co-located mid-wife led units, and one-to-one midwife-led care throughout established labour.
- (x) **Children's services:** effectively a mini-NHS for children, a move to ambulatory care with the sort of model that has been so successful in EAU applied to Paediatrics with a senior paediatrician who would see a child and where the child would very often not need an admission to hospital. There was a need to focus on the specialisation of children's services in centres such as CUH, for example, and on child and adolescent mental health services as well as enabling a seamless transition between childhood and adult services.
- (xi) **Planned Care:** This theme identified the importance of choice and better local support for post-operative recovery; more work in the community before and after surgery, better access to diagnostics, local care as much as possible but centralisation where it improved outcomes.
- (xii) **Acute Care:** this work stream had been chaired by Dr Winter. A proposal was for urgent care centres where there could be a primary-care led centre co-located with a hospital A&E department. Services needed to be improved in terms of stroke and heart attack as well as in the management of major trauma. Although major trauma accounted for only about 0.1% of A&E attendances there were plans to establish a major regional trauma centre which was likely to be on the Addenbrooke's site. Managed clinical networks were envisaged to deliver this. The London model was inappropriate for the East of England because travelling times were a greater issue.

- (xiii) **Long-term conditions:** this theme identified the 'expert patient' and the idea of increased self-management, especially with regard to diabetes, COPD, and consideration of patient-held budgets.
- (xiv) **End of Life:** this theme had been led by Dr Dee Traue. In the UK 54% of people died in hospital compared with around 20% in Sweden. One of the objectives was to improve palliative care and services at the end of life.
- (xv) In summary, the clinical vision would help to deliver services that will focus on prevention, more choice, more care locally, accessible and better integrated real partnership, and most importantly it would produce better outcomes. Delivery of the vision would depend on continuing and developing the support of all NHS providing the services both in primary care and secondary care. There was a strong will and appetite to engage with this. It was recognised that this has never been done before and that there was a tremendous energy in getting professionals and patients together to plan, develop and deliver the services needed.
- (xvi) The vision had been launched on 12 May at the Genome Centre. The final version was due to be agreed in September taking account of feedback received during the 12-week consultation period currently underway. Dr Winter encouraged Governors to contribute to the feedback. An implementation plan would then be established. The vision was clinically led, evidence-based and patient-centred.

Questions and Answers

Noted

- (i) Governors commented on the important principle of services focused on the needs of individuals and the carer, and ensuring that patients were always considered as people. Dr Winter agreed that the litmus test of good- quality care was always whether it was what you would like a member of your family or yourself to have, and it was important to ensure that the holistic aspect of care was considered as important as good clinical care.
- (ii) In answer to governors' comments about the effect of large numbers of patients with obesity problems, Dr Winter agreed that the forward projections in terms of hypertension, heart disease and diabetes were significant. There was a need to ensure that the NHS became a wellness-promoting service.
- (iii) Governors asked to what extent the clinical vision would provide research opportunities and how these would be taken up, and the financial costs associated with these developments. Dr Winter replied that research had not been the primary focus of this piece of work. However there had been discussion about Academic Health Science Centres and opportunities for research linking bench to bedside and bedside to bench. In relation to cost, this was one of the big issues each country was currently facing with regard to the expansion of technology and new drugs. However, there were many changes that could be made that were either cost-neutral or would produce cost savings.
- (iv) Ms Maureen Donnelly spoke on behalf of the PCT. The PCT welcomed the clinical vision from the SHA and noted that the PCT would need to develop its own clinical strategy and to consolidate this by early 2009. Ms Donnelly recognised that the vision did not contain a great deal of detail about the

process for implementation and the costs associated with that. These were questions for the PCT, which had a budget of just over £700M of which about a quarter came to CUH. As part of a development strategy it would be necessary to evaluate how the pathways would deliver the clinical objectives specified within the document. The PCT was very keen to do this successfully and in partnership not just with NHS partners but with the County Council, the District Councils, with the private sector and the voluntary sector. The PCT was already working with the County Council and local schools to make improvements with regard to children's diet, sport, mobility and transport policies. It was noted that about 37% of the PCT's budget was spent on those over the age of 65. This was expected to grow to over 45% within the next ten years. This budget needed to be managed carefully and jointly with the budget for adult social care, especially with regard to long-term conditions and the care of the elderly. Within adult social care there was already a mechanism in place allowing individuals to have choice e.g. on whether to spend funds on a family social carer or a neighbourhood carer rather than on a professional carer. It was possible that there could be a rapid move into the arena of some individuals managing their own personal budget jointly across the health service budget as well as the social care budget.

- (v) Governors commented under the theme of maternity services that 'guaranteeing' women a choice of where to give birth was too strong and could produce some unexpected consequences. An alternative phrase of 'supporting' women in their choice might be more appropriate. Dr R Winter would relay this comment back to the SHA.
- (vi) A full information pack on the clinical vision was available to Governors which included the consultation document. Governors were welcome to submit an individual response as an individual or alternatively to contribute to the Trust's consolidated response by emailing their comments to the Trust Secretary, Dr Ann Alderton, who would take these into account in formulating the Trust's response to this very important document.

Agreed

Governors thanked Dr Winter for his comprehensive presentation, and for his detailed answers to their questions.

26/08 SOUTHERN CAMPUS

Received a presentation from Mr Stephen Graves, Executive Director for Corporate Development.

Noted

- (i) In the past few weeks, approval had been received for the MRC LMB facility and for additional residences on the campus. This was excellent news and it was hoped that construction would begin very soon.
- (ii) An update on New Papworth would be given to the Board of Directors at the end of the month.
- (iii) Over the last eight years there had continued to be notable physical development which much more importantly supported clinical care and research on the campus.

- (iv) The Section 106 approval bill was due to be signed soon which would release the land to be built on in the new area of the campus. This would provide the Trust with some unprecedented opportunities. As a Foundation Trust the Trust also had the ability to make some decisions. It was important to ensure that developments fitted well with the needs of Cambridge.
- (v) The challenges to be faced included the need to improve the care of the elderly. The areas highlighted in Dr Winter's presentation would need to be reflected in the campus developments. Sustainability in urban expansion were also key issues. The Cambridge Biomedical Campus would be 140 acres, much of which would be under the control of the hospital. The Hospital Estate would include both old and new areas, in particular the Southern Campus. It was evident that masterplanning would play an integral role in the overall management of the developments. All masterplanning needed to be cognisant of commercial colleagues, the University and of the clinical relationship with New Papworth. The Trust aimed to appoint contractors, subject to the approval of the Board of Directors, who would propose a number of detailed options and complete their work by the end of this financial year.
- (vi) The Southern Campus projects included the Children's Hospital, Cancer Centre, Emergency Department, Critical Care, Theatre Capacity, Neurosciences, Perinatal Services, Infectious Diseases and general wards within the hospitals, with a move towards single rooms. This would be a very complex and interrelated piece of work. Deloitte had been brought in to study the rules governing the borrowing abilities and the private finance initiative. The benefits of each individual scheme were being evaluated. Thirdly, the relationship between each scheme was being evaluated in order to produce best-fit options. The report would incorporate ongoing work in Finance and Estates and Facilities, with a large amount of clinician input. This would be available in the early autumn and was due to be presented to the Board of Directors in October.
- (vii) Mr Graves was overseeing the masterplanning with Mr Richard Howe and Mr Stephen Davies. Governors were represented on the Southern Campus programme board. It was important through the Forward Planning Group to share progress on this important piece of work.
- (viii) In answer to Governors' questions, Mr Graves outlined the flexibility available. One level of flexibility was the available land around the existing campus. As one of the oldest campuses in the region however, it was not possible for the project to replace the whole of the existing hospital. It was essential that maintaining and improving core services was at the heart of the masterplanning.
- (ix) Governors enquired as to how partners would be engaged in moving forward from masterplanning to implementation. Mr Graves explained that the Trust met regularly with the estates department of the University to discuss the programme. A key objective of the masterplanners would be to comprehensively discuss plans with all partners. It was important for Governors to continue to hold the Trust to account on this issue.

Agreed

Governors thanked Mr Graves for his interesting report.

27/08 PATIENT EXPERIENCE REPORT

Received a report from Mrs Brenda Hennessy, Director of Patient Experience and Public Engagement.

Noted

- (i) Governors were thanked for their continuing participation in focus groups. Governors appreciated the opportunity to participate and thanked staff for their contribution.
- (ii) There had been two focus groups on Infection Control issues which had been well attended. Governors recognised the need to educate the public with regard to hospital-acquired infections and the relatively low levels of associated risk. In particular, the risk of infection for elective patients was low.
- (iii) It was reported that a group of staff scientists within the Trust would be working with the Parkside Federation next week, looking at aspects of healthcare science as a career. At this event students would have the opportunity to see the research techniques being used to combat obesity.
- (iv) The opportunities for developments in the area of relationships between the NHS and schools were discussed, particularly in terms of encouraging the study of sciences at A-level. The Trust had been approached by Parkside and Netherhall Schools for support in their application for Trust status. Both schools were interested in the opportunities for providing education on the Southern Campus. The Trust supported all such initiatives without favouring a single provider. Such initiatives formed part of the Trust's Corporate Social Responsibilities programme. Governors would have the opportunity to contribute to a CSR statement which would be developed over the next few months.

Agreed

Governors thanked Mrs Hennessy for her report and looked forward to developing a CSR statement.

28/08 END OF LIFE STEERING GROUP

Professor Bob Michell reported.

Noted

- (i) Professor Michell represented Governors on the End of Life Steering Group. The group began its work in Autumn 2007. A patient's decision of where to end their life would be decisive in determining their quality of life remaining. A number of issues which he had raised relating to changing the ethos and providing a different patient experience did not seem to have been addressed. He was most concerned that no meetings of the Steering Group had been held since February 2008. It was not clear that progress had been made on a number of important issues, such as making sure staff had experience in a hospice setting, although progress was being made e.g. on buildings. He was very concerned that progress should be made in such an important area.

- (ii) The Executive Director of Operations, Mr Sunley, agreed that end of life care was an important issue and highlighted the collaborative work underway at a national and regional level. The Trust was implementing the Liverpool Care Pathway focusing on end of life care. The necessary training for nurses had been very successful. Bereavement counselling had been re-organised across the Trust. Mr Sunley regretted any perceived delay in progress, or lack of communication of the progress which had been made.
- (iii) The original timetable had been set to reflect that of the end-of-life review by the SHA, the timetable for which had been set back in the light of the Darzi Review. One of the key impacts on the hospital environment had been the provision of infection control wards which had served to release a number of side-rooms so that there were now more single rooms available for those in the terminal stages of their illness.
- (iv) Dr Castille commented that Dr Traue had significantly raised the profile of this work for the Trust and had helped the clinical directors to understand the priority of this work, as well as working with nurses and doctors to help implement the Liverpool Care Pathway.
- (v) It was agreed by the Executive that the situation of end of life care was not ideal. From a strategic and long-term perspective the Trust had been in discussion with Arthur Rank about the possibility of building a new hospice and about ways to improve communications with the PCT and other parties.
- (vi) Governors commented that some nurses from Addenbrooke's spent time working on the wards at Arthur Rank and therefore gained experience of working in a hospice environment.
- (vii) The Trust's 'Values Project' had been undertaken over the past 12 months and had taken account of around 5000 comments from staff and patients about priorities. The principal values which had emerged as being most important to staff, patients and the public were that the Trust should aspire to be 'Kind, Safe and Excellent'. It was intended that these principles would be reflected at every level in the Trust's activity and would be used as a yardstick for decision-making. The NHS Confederation had last week launched the new NHS values, which the Trust had also been a part of forming and which highlighted the need for compassion for patients and for caring.

29/08 INFECTION CONTROL

Received a report from Mrs Angela Thompson, Assistant Director of Nursing, as copy attached to the minute book.

Noted

- (i) The Trust was grateful to the patients who had taken time to participate in the Take Five evaluation summarised in the report. About 500 questionnaires had been issued to patients and there had been a 40% response rate, which was quite high. The 18-page full evaluation report was also available on request.
- (ii) The Trust continued to 'horizon scan' with regard to new documents about infection control. The Department of Health (DH) recently published a 'Going Further, Faster, II' on reducing healthcare-associated infections. The Trust

was following the recommendations within the document, which was available on the DH website.

30/08 CHAIRMAN'S REPORT

Received the report of the Chairman.

Noted

Mr Rogers, Membership Manager, was seeking one Patient and one Public Governor to join the new Patient Safety Council.

31/08 CONSTITUTIONAL ITEMS

Received the minutes of the Governors' Constitution Committee meeting held on 24 June 2008.

Dr Megan Davies, Chairman of the GCC, reported.

(A) Deputy Chairman

Received a proposal for a Deputy Chairman of Governors.

Noted

The Committee strongly recommended that the role of the Deputy Chairman of the Board of Governors be introduced. The Committee also proposed a method for election. It was proposed that the Deputy Chairman should be drawn from the Public and Patient Governors as both Staff Governors and Partnership Governors would be seen as potentially conflicted in holding that role, although all Governors would have the opportunity to vote.

Agreed

The Board of Governors approved the proposal. The election process would start very soon.

(B) Senior Independent Director – Proposal for Extension of Term of Office

Received a proposal from the Board of Directors to extend the Term of Office for Mr Colin Greenhalgh.

Noted

The Board were reminded that the extension of Mr C Greenhalgh's Term of Office as a Non-Executive Director had been approved at the previous meeting. The above proposal was intended to bring his two roles into line with one another.

Agreed

The Board of Governors approved the extension of Mr C Greenhalgh's Term of Office as Senior Independent Director, for the remainder of his term of office as a NED, i.e. until 31 October 2010.

(C) Recommendation for a revised expenses policy

Received a recommendation from the Governors' Constitution Committee.

Noted

The recommendation was to align the allowance for travel expenses with those widely used elsewhere in the public sector and those allowed by HM Revenue and Customs, which also applied to Non-Executive Directors.

Agreed

The Board of Governors agreed the revised policy.

32/08 GOVERNOR/DIRECTOR WORKING GROUPS

Reports from the meetings of Governor/Director Working Groups

(A) Forward Planning held on 25 June 2008

Mr Michael Bright, Chairman of the Forward Planning Working Group, reported.

Noted

The Group had proposed that it would be helpful and more efficient were different aspects of the Annual Plan to be considered separately by different working groups. Mr Graves, Executive Director of Corporate Development, had updated the Group concerning Papworth and Hinchingsbrooke. An overview of business development and marketing had been presented by the Head of Marketing, indicating the importance of targeting General Practitioners as well as the wider public. A representative of Deloitte attended to brief Governors on the evaluation of eight services related to the Southern Campus development, in particular identifying the issue of future balance between the specialist and district general services provided by the Trust.

(B) Governance and Assurance held on 17 June 2008

Received the minutes of the Governance and Assurance Working Group.

Mr Jim O'Sullivan, Chairman of the Governance and Assurance Working Group, reported.

Noted

- (i) The Board Assurance Framework highlighting the main risks over the coming year had been presented. As this was a living document it was agreed the group would review this on a regular basis. A presentation of the Safety First initiative had also been received.
- (ii) The Group had discussed its future in the context of how it could better integrate with the Board of Governors' meetings and the seminars held throughout the year. It was suggested that some standing agenda items could be 'pre-screened' as in the Board's pre-meeting, allowing sufficient debate and discussion of items but keeping the Board of Governors' meetings to a reasonable length, identifying items that could be appropriately dealt with in that way.

- (iii) The Trust Secretary would arrange a meeting for the Chairmen of the Working Groups together with Non-Executive Directors chairing senior Board Committees. A meeting had been proposed for November.

Agreed

There was scope to align the business of the Working Groups with that of the main Board. The issue would be discussed at the Governors' Constitution Committee.

(C) Membership and PPI held on 3 June.

Received the minutes of the Membership and PPI Working Group.

Mrs Mary Chaloner, Chairman of the Membership and PPI Working Group, reported.

Noted

Governors were requested to direct any questions to Mrs Chaloner.

33/08 CONSULTATION ON PRIVATE PATIENT CAP

Received Monitor's consultation on the Private Patient Cap.

The Chairman reported.

Noted

- (i) The Trust Secretary would co-ordinate the Trust response to the consultation. Governors were welcome to respond as individuals or to forward their comments to Dr Alderton by the end of August for inclusion in the Trust response.
- (ii) The Chairman explained that Option 1 was regarded by the Executive as the preferred option. In contrast, Option 2 and Option 3 would both seriously inhibit the amount and value of private patient care that the Trust could provide. Option 3 would require a recalculation of the Trust's private income baseline for 2002/03.
- (iii) It was suggested that should co-payments come into effect, this would affect the private income baseline which presumably would then need to be re-addressed. The Chief Executive confirmed that the Trust's current cap was set at 2% and that the Trust's private patient income was currently at 1.65%. There was a real opportunity to raise revenue from private patients, particularly through a private hospital on campus and through clinics off campus. If the Trust received only NHS funding it would be limited in the improvements to services which it could fund. To be able to provide patients with the best equipment and the latest drugs and to facilitate the Trust's role as pioneers at the boundary of excellence the Trust required revenue streams from a range of different sources. In effect, revenue from other sources would be used to subsidise the care for NHS patients.

34/08 REPORT FROM THE NHS FOUNDATION TRUST GOVERNORS' ASSOCIATION

Mrs Ewer reported in Mr Gerbaldi's absence.

Noted

- (i) Since the last meeting of the Board there had been an Executive meeting, the minutes to which were available on the website. Some new Foundation Trusts had joined the Association. Mr Gerbaldi continued to visit FTs including Hertfordshire Partnership and Colchester FT.
- (ii) The Chairman and Mr Gerbaldi had together presented a talk on 'What Makes a Good Governor' at the FTN Session of the NHS Confederation Annual meeting held in Manchester in June, which had been well received.

35/08 ARRANGEMENTS FOR THE ANNUAL GENERAL MEETING 18 SEPTEMBER

Received the arrangements for the Annual General Meeting on 18 September.

Noted

The Chairman noted that in addition to the standard presentations there would be a presentation from the new Deputy Chairman of Governors.

36/08 BOARD ASSURANCE FRAMEWORK

Received the Board Assurance Framework.

Noted

The BAF had been discussed at the Governance and Assurance Working Group and was available for information. The Chairman reminded the Board that the BAF was a living document and that as the guardian of the BAF the Trust Secretary was always happy to receive comments on it.

37/08 UPDATE OF REGISTER OF GOVERNORS' INTERESTS

Noted

The Register of Governors' Interests had been updated and copies were available from the Secretary.

38/08 FUTURE EVENTS

Noted

A list of future events was tabled. The Chairman added that on 21 July a talk would be given by former US Senator Bill Bradley (also a former Olympic Basketball player) on the subject: 'Obama versus McCain: the Watershed Election'. The talk would begin at 17.30 and would be held in the CRUK Lecture Theatre at part of the Leadership Forum lecture series.

39/08 DATE OF NEXT MEETING

Tuesday 16 September 2008 at 17.30 in the Hexagon, Frank Lee Centre, to be continued at the AGM in the Atrium at 18.00 on Thursday 18 September 2008.