Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting 25 November 2010
Extract of approved minutes

Present

Non-Executive Directors	Prof. Sir Christopher Edwards	CE	*Chairman*
	Andrew Havery	AH	
	Prof Richard Kitney	RK	
	Karin Norman	KN	
	Charlie Wilson	CW	
Executive Directors	Heather Lawrence	HL	*Chief Executive*
	Mike Anderson	MA	*Medical Director*
	Lorraine Bewes	LB	*Director of Finance*
	Therese Davis	TD	*Interim Director of Nursing*
	Amanda Pritchard	AP	*Deputy Chief Executive*
In attendance	Catherine Mooney	CM	*Director of Governance and Corporate Affairs*
	Berge Azadian (in part)	AB	*Director of Prevention and Infection Control*

1 GENERAL BUSINESS

1.1 Apologies for Absence **CE**

There were none.

1.2 Declaration of Interests **CE**

None.

1.4 Matters Arising **CE**

2.2/Sep/10 Performance Report commentary – August 2010
PPI audit
The paper is on the agenda.

3.10/Sep/10 X-Ray film – Storage vs. Destruction
MA proposed that we keep paediatric films which will be stored off site at a cost of £11k and destroy all adult films.
The Board agreed.

1.7/Oct/10 Chief Executive's Report
Transparency of expenditure over £25,000
HL reported that after discussion and noting other Trusts were publishing, it was decided we would publish. LB said that the format for publication was not a very user friendly format as it is simply a transactions listing. She noted that Guy's and St Thomas' Trust had disclosed everything

which she considered is potentially 'commercial in confidence'.

AH welcomed the fact we are publishing but said that we needed clarity on what we are publishing. LB confirmed that we were following the rules. CE said the point is that we must not look as if we were concealing anything.

3.11/Oct/10 UCC

HL suggested that this was deferred to January because more data is required as the impact of the UCC is not clear yet. She was able to report that it is now taking the receptionists 4 minutes per patient to book in instead of 8 minutes at the beginning of the project. A key issue to be resolved is what the residual staffing from A&E should be.

3.1/Oct/10 Infection Control Annual Report 2009/10
Advice from Department of Health on reporting on *C. difficile*.

TD confirmed that she had written to the DoH regarding this and had included the difference in reporting between us and Imperial and consequential impact of our delivering within target.

1.4.1/Nov/10 Possibility of putting stops on PPI's

MA confirmed that this was covered in the paper which was on the agenda.

3.2/Oct/10 Screening Emergency Admissions for MRSA

This is on the agenda.

3.6/Oct/10 Proposed Draft Corporate Objectives for 2010/11 to be circulated to Governors

It was confirmed that this will be part of the agenda for the Board of Governors.

3.9/Oct/10 Working Capital Facility

The update was noted. LB said we will be revisiting the Treasury Policy in January.

3.10/Oct/10 Proton Pump Inhibitor (PPIs) Audit and stopping PPI's

MA explained that there was a known association with proton pump inhibitors and patients with *C.difficile*. An audit identified that 55% of patients with *C.difficile* were on PPI's. This audit looked at the indications for starting PPI's. In many patients PPI's could be stopped for a period of time and they could receive H2 antagonists instead. In medicine pharmacists have been successful in driving down the prescribing of PPI's by 25% in the hospital this year. We are now trying to agree with primary care how to decrease prescribing in primary care. One option is to challenge the use of PPI's at the pre-assessment stage and consider patients changing to H2 antagonists for the duration of their hospital stay. MA noted that prescriptions have to indicate why a patient is on a PPI and the pharmacists challenge daily. He thinks this is more effective than an automatic 5 day block as suggested at the last Board.

AH asked if the link was established and whether it was causative or because patients are more likely to need PPI's and get *C.difficile*. MA said that *C.difficile* occurred mainly in the elderly. KN asked that if H2 antagonists are used instead are we sure that patients will not still get

C.difficile? MA said that PPIs have an impact on *C.difficile* because they are so effective in reducing acid secretion in the stomach and are much stronger than H2 antagonists, and it is the reduction in acid in the stomach which makes it more likely to acquire *C.difficile*.

CE said the issue is about us doing something. The national guidance referred to in the paper was not set up in this context, i.e. the risk of *C.difficile* was not taken into account. He believes there needs to be a very good reason why a patient stays on a PPI and suggested that these patients need to be treated in a different way. We need to move on from this point and he would like to see a dramatic reduction in *C.difficile* rates. RK noted that the balance of risks has changed between preventing ulcers and getting *C.difficile* and it is important to balance these risks.

CE said the question is where should these patients be located? We can identify patients who are susceptible and we are then keeping them in an environment where there is *C.difficile*. HL said that the answer is single rooms and we need to revisit this in our capital plan. CW asked what the cost was of a patient who acquired *C.difficile*? HL said that an extra 30 days costs about £6000. CW commented that PPI's are very effective and from his personal experience the impact is felt after one day.

KN asked what the risk was of telling doctors not to follow national guidance? CE emphasised that guidance is guidance. He further said that the incidence of *C.difficile* is dose related and perhaps some patients could be put on low dose PPIs plus an H2 antagonist.

CW asked about the remainder of the 50% of patients with *C.difficile* and whether we know if there are other common factors? MA said the other common factors are frail elderly patients on antibiotics.

HL noted that we spend a disproportionate time discussing MRSA and *C.difficile* but we should be discussing other infections and have a strategy for how to deal with them. It is important to get a picture of infection in this hospital and what we are doing to deal with it, and she will be asking BA to take this forward.

MA, CE, TD and HL to discuss further and agree a plan re C. difficile. **MA**

A strategy for other infections to be produced. **TD**

1.5 Chairman's Report (oral) **CE**

The Chairman reported that he and HL had lunch with the Chief Executive and the new Chairman of the West Middlesex Hospital recently.

He noted the appointment of a new Chairman of the Royal Marsden Hospital, Ian Molson, and that he would seek a meeting.

He would like to recognise the appointment of Professor Masao Takata to the McGill Chair, Anaesthetics to replace Mervyn Maze. He will write to congratulate him.

CE referred to a press release from Imperial highlighting that Steve Smith was no longer the Principal of Imperial College but was now the pro-Rector of Medicine and Chief Executive of Imperial Healthcare.

1.6 Council of Governors Report including Membership Report **CE**

CE noted that progress on the members email database which now had over 3000 emails registered was good. However, he felt that overall the membership was a bit of a worry as it seemed difficult to maintain the numbers. He said he was unclear where this whole movement was going with all Trusts becoming an FT.

He questioned how much money we should be investing in increasing the number of members rather than engagement. CW said he thought the problem was that there were no clear benefits to being a member. KN asked what we think the benefits are. LB said she thought it made us more outward looking. CW said that the membership gives us the Council of Governors. CM noted that Monitor and the FTN had recently launched a survey amongst all Foundation Trusts to identify the benefits of membership and extent of engagement.

RK said he thought the problem was that the Council of Governors was too large and unwieldy. HL noted that PCTs will go and with GP consortia being set up, the influence of governors will change. She noted that 50% of our business is in dealing with patients under 50 and these people are not represented as members. CE said we need to think of new ways to get to our constituents. RK agreed the benefit of the Council of Governors in general but a few of the governors appear unhelpful. CW said he agreed with LB's view that the Council of Governors made the Board more patient conscious. AH noted that we seem to be having endless elections and a relatively low turnout. CM said that it has previously been agreed that we would only undertake two elections a year because of the cost. CM noted that we are committed to review the constitution so now is the time to be having these discussions. HL suggested that this was thought about further and be discussed in the new year.

1.7 Chief Executive's Report **HL**

In addition to the areas highlighted in her report, HL said she had reflected on the previous paper regarding the West Middlesex University Hospital. She thinks we should consider acquiring the Trust utilising a partnership approach with the Royal Marsden Hospital and other partners.

She outlined the issues associated with the National Sentinel Stroke Audit and incorrect data being submitted. AH noted that this had happened before. HL agreed and said we must have a system that is more robust. Submissions that are received centrally are well monitored through the governance system but the problem is when these are devolved to the Divisions and the centre is unaware of what has been requested.

Regarding volunteering, the Chairman agreed that we should have a

report and greater recognition of the work that the volunteers undertake.

To produce a report on the work of volunteers at a future meeting. **TD**

HL reported that she went to Liverpool with the HIV/ GUM team for the Health and Social Care Awards. They had received the London award for partnership working but unfortunately did not win the national award. She noted the good publicity from David Cameron in the magazine *Boyz*.

2 PERFORMANCE

2.1 Finance Report Commentary – October 2010 HL

LB reported that the month 7 position was on plan. We are forecasting an improvement and expect to be within £0.5 million of our planned surplus. The main slippage is the cost improvement programme, where just over 98% has been identified.

CE noted that community dermatology would lead to a potential downsize in the hospital.

CE has asked for more information on the profitability of 56 Dean Street as we need to understand the capital input and the income generated and whether this is a model we could roll out elsewhere. It was agreed that this analysis would be presented to the Finance and Investment Committee.

LB continued to say that pay is broadly on plan and the focus needs to be on non-pay. She said that HL had asked for a review of procurement and utilisation of prosthetics. As the Board had asked for a further analysis of debt, this was outlined in the report. All of the debt has not been recovered yet but we have collected £1.5m against a debt of £12.7m so progress is still quite slow. She noted the summary on page 5 and that the private debt recovery had done better. She noted that the Finance Director in North West London had written to all PCTs requesting payment without quibble on 80% of invoice value. Currently the whole invoice is held back if there is one query. Recovery of debt needs a continued focus and she has put in extra resources, however she said there is nothing to suggest that it is not collectable, it just takes time.

CE asked for further information on the reference to £0.2m for one patient. LB explained that we are required to notify the commissioners when we have a long stay patient. Our central team usually send this report through but in this case this did not happen. She has not written it off because discussions are still going on and it is unlikely the commissioners will say that they did not know about it. HL emphasised it is important to ensure that our team speak to the right staff at the commissioners as there is so much change in personnel. The Chairman congratulated the Executive regarding achieving the target on the cost improvement programme.

LB to provide further information on the reference to £0.2m for one patient **LB**

2.2 Performance Report Commentary – October 2010 **AP**

AP highlighted the percentage of women smoking at the time of delivery. She said that the data quality problems had been sorted and this now reflects an accurate position. She also wanted to emphasise the massive increase in VTE risk assessment which was now at 88.9%. She noted if we included dermatology as low risk we would be over 90%. MA confirmed that he had had discussions with the Information team and the lack of inclusion of dermatology initially was an oversight.

The position with MRSA was noted.

AP said she wanted to highlight single sex accommodation. She said the final information was only published this week and the implications are potentially very serious because of the financial penalties. For non-Foundation Trusts this is being introduced in December but for Foundation Trusts this will be from April because it is not in the current contracts. She and TD have identified risk areas as the Emergency Observation Unit in A&E, the trolley area in the Acute Assessment Unit (AAU), and the level one area in AAU. Five other areas have an element of risk but these can be mitigated. Children require further clarification but the guidance at the moment is that children are asked the question as to what they would prefer. The highest risk with children is in Burns. TD noted that 16 -18 year olds have the right to choose to be on an adult ward. AP said she will come back to the Board next month with more information and noted that the problem is solvable but difficult.

AP to report on progress with achieving the target for single sex accommodation to the Board in January. **AP**

3 ITEMS FOR DECISION/APPROVAL

3.1 Screening Emergency admissions for MRSA **TD**

The Chairman welcomed Berge Azadian to this part of the meeting. He said he had seen a letter from Mary Archer, Chairman of Addenbrooke's Hospital to the Secretary of State regarding MRSA in which it referred to the cost of an MRSA test as £3 in a large Trust and £4 - £5 in a small Trust. In this paper we refer to tests costing £4 - £19 and he asked BA to explain the difference. BA said these were the prices we paid to Imperial last year and he would look into it.

To confirm costs of MRSA tests. **TD**

CE said he was particularly concerned with MRSA as it was an amber risk now for our organisation. He said that he saw patients as being divided into three categories, the elective patients who could undertake the conventional chromogenic agar culture test; non-elective and emergency patients such as Burns, ICU and transfer-in patients who were previously infected who would receive the PCR tests because rapid results are required; and the remaining non-elective patients for whom the chromogenic agar culture would be appropriate.

BA said what concerns him is what the Trust will do with the results. 45% of carriers in the hospital today are in bays. Once test results are known

what action will we take? HL commented that we are clearly constrained with the number of side rooms available but asked what other action we could take. BA said the alternative is to institute virtual isolation, however, this might cause problems with perception from other patients who might think they are being put at risk. BA's view is that the chromogenic agar test is fit for purpose. CE said we need to sort out which patients are the ones where results are critical to the care.

BA described circumstances in which prophylactic antibiotics are given such as Teicoplanin and a swab is used for confirmation. He said we cannot adopt the Dutch system because they have single rooms. CW asked for clarification regarding the discussion about bays. BA said that the sooner we know which patients have MRSA the sooner we initiate treatment. Patients will go into bays and have the results and once the results are known they should go into side rooms or be kept virtually isolated or be cohorted. BA said he prefers option 2 because it complies with the directive, everyone is screened and it is cost effective.

He was asked what increase in MRSA colonisation he thinks will become apparent with this. He said there was 3.5 – 6% in the general population. We are capturing the majority now because of screening for ICU patients etc. AH said, if we accept that there are the logistical challenges, are they solvable so that we can benefit from this screening? BA said winter is coming and there will be other priorities for side rooms such as patients with TB, H1N1 and they will take priority over patients who are colonised with MRSA. He said that in a sample of 400 blood cultures only 5 would be MRSA positive.

CE summarised that there is a problem and we recognise that screening of electives was successful. It is unclear if further screening will make a difference but the Board agreed to initiate full screening pro-tem with the chromatographic method. However, we need to be clear that we are getting the best price. He noted the option of prophylactic antibiotics which is not in the paper.

He said that with respect to PPIs we recognise that we have got an irreducible core of patients on PPIs and we need to consider treating them as immuno-compromised patients. He would like BA's view on this and other issues regarding infection control.

CE said he is not sure we have solved the problem with taking blood cultures and training. MA said he had written to Divisional Medical Directors outlining a proposal that blood cultures that we do not think have been taken properly will be destroyed. BA highlighted that he does not agree with this, he believes this cannot be done for medico-legal purposes. He described the process if blood cultures are received without documentation and stated that they are still given a number and processed. The information may be critical for patient management.

CE was concerned that we were publishing false positive results i.e. the blood was being taken inappropriately and was getting contaminated and if taken properly it would be negative. We are publishing them as positive MRSA bacteraemias when they are not. He would like these not to be taken into account. HL suggested that this is discussed further

outside of the meeting.

AP noted that other less controversial actions had also been agreed.

CW said that BA had referred to the 2 hours test being really 8 hours and queried whether we should be accepting that. Would there be situations where if it was known that a patient had MRSA, we would stop and not operate? MA said there were very few cases where we would stop, it is more likely that patients would be given prophylaxis. The issue is more about the recovery phase and the risk of getting infected. CE confirmed that we have invested significant amounts of money and we should come back to this in a year's time. BA noted that we will have targets for MSSA from January.

The Board agreed option 2 which was to continue to screen elective patients and screen all non elective patients.

Follow up on reporting of MRSA false positive results **TD**

3.2 Job planning and medical staff appraisal - Revalidation for Medical Staff **MA**

MA outlined the paper. He said that when appraisals were first introduced they were seen as a supportive process which was not related to performance. He believed that here at Chelsea and Westminster there was a hybrid approach, however no-one had ever told him that there is a concern even when these were known. He continues to get boxes ticked to say that everything is fine. He wants to introduce a system of aligning appraisals with the management structure and to introduce 360 degree appraisal.

CE said that if we are going to make this process more valid people doing it need to recognise that there is a step change. Will they be held to account if they know there is a problem and they have not reported anything? MA said that everyone will need to be re-trained as appraisers.

CE queried whether it was necessary to have £24k for a spreadsheet and £7K for administration and asked whether we could be clearer about what we are buying. He would like to be reassured that this is necessary. MA said that we need to have a system that stores information electronically. CE also noted that having an associate Medical Director adds costs in an environment where we are cost constrained. MA said that these options are much cheaper than any other options put forward.

KN commented that this is the government ensuring that we are responsible for the competency of our staff. MA said the aim of the process is to allow him to make recommendations to the GMC or whoever is recommended, 'that the following doctors should be revalidated'.

TD commented that the process MA described already exists in other disciplines such as nursing. She said it is important that staff know how to appraise.

CE said that we are likely to have to come back to this and commented that this is going to be part of the onus put on the providers for ensuring staff are appropriately skilled.

The Board agreed MA as the responsible officer. The executive team to reconsider costs.

3.4 Maternity Survey **AP**

AP outlined the paper and said this was a follow up to the survey in 2007. The results were a mixed picture with some good news. 30% of the responses were noted as a significant improvement, however, the postnatal care at home was significantly better in 2 of 12 questions. We were reported as being significantly worse on 25 questions and the major negative scores were on postnatal care. She noted that the survey took place in February and a lot has improved since then. She intends to bring back the full report.

CE asked what would we be required to do in order to improve the experience for women. AP said we would need to take 6 beds down to 4. KN said she liked some of the ideas outlined in section 5.2. AP commented she had a number of friends in the unit recently and one does get a different perspective when sitting there and there is something fundamental about the environment.

TD confirmed that Guy's and St Thomas' Hospital had the best results last time and they have a Midwifery-led Unit within the hospital. AP said that possibly there would be space freed up by the Netherton Grove extension. HL asked for an update on the idea of using a hotel for women breastfeeding.

Provide fuller update on maternity services. **AP**

3.5 Assurance Committee Report – October 2010* **CW**

This item was starred.

3.6 Business Planning /Financial Assumptions **LB**

CE suggested that we talk about this at the Away Day.

3.7 Netherton Grove **HL**

No update.

3.8 Remuneration Committee Report for the period April 2009 to October 2010 **CE**

After some discussion in the absence of the Executive Directors, who left meeting at this stage, CE confirmed that this would be brought back to a future meeting.

Remuneration Report to be covered at a future meeting. **MG**

4 ITEMS FOR INFORMATION

4.1 Assurance Committee Minutes – 25 October 2010 CW

This item was taken as read.

4.2 Audit Committee Minutes – not available AH

This item was taken as read.

4.3 Finance & Investment Committee Minutes – 21 October 2010 CE

This item was taken as read.

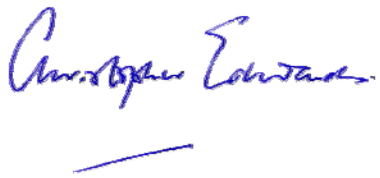
5 ANY OTHER BUSINESS

The Board agreed that a decision on the MRI scanner could be delegated to the Finance and Investment Committee.

6. DATE OF NEXT MEETING – Thursday, 27 January 2011

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