Chelsea and Westminster Hospital NHS
NHS Foundation Trust

**Board of Directors Meeting 30 September 2010**
**Extract of approved minutes**

**Present**

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| **Non-Executive Directors** | Prof. Sir Christopher Edwards | CE | *Chairman* |
| | Andrew Havery | AH | |
| | Colin Glass | CG | |
| | Prof Richard Kitney | RK | |
| | Karin Norman | KN | |
| | Charlie Wilson | CW | |
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| **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* |
| | Mark Gammage | MG | *Interim Deputy Chief Executive/HR Director* |
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| **In attendance** | Catherine Mooney | CM | *Director of Governance and Corporate Affairs* |
| | Lucy Hadfield | LH | *Interim Director of Strategy* |
| | Prof. Derek Bell (in part) | DB | *Chairman, Research Strategy Board* |
| | Mary Tourette (in part) | MT | *Head of Research and Development* |

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| **1** | **GENERAL BUSINESS** | |
| **1.1** | **Apologies for Absence** | **CE** |
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| | None. | |
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| **1.2** | **Declaration of Interests** | **CE** |
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| | None. | |
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| **1.3** | **Minutes of the Meeting of the Board of Directors held on 29 July 2010** | **CE** |
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| | Minutes of the previous meeting were approved as a true and accurate record. | |
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| **1.4** | **Matters Arising** | **CE** |
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| | CE noted that the Board had undertaken a training session with the iPad and while it was clear that some work needs to be done it looks like it will be successful. | |

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| | MG confirmed that the main reason for sickness absence is sickness and diarrhoea but there are many different reasons, each with a small percentage. However, we are one of the lowest Trusts for sickness and he does not feel it is a significant problem. | |
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| | Otherwise the matters arising were as in the paper. | |
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| **1.5** | **Chairman's Report (oral)** | **CE** |
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| | The Chairman, Professor Richard Kitney, and Heather Lawrence have an appointment to see the Rector of Imperial College soon.<br><br>Heather Lawrence and the Chairman met Professor Gazzard regarding Frances Gosh replacement.<br><br>RK said that he feels there is a change in views regarding the importance of Academic Health Science Centres in relation to other Trusts e.g. best support reported by medical students was at the Chelsea and Westminster.<br><br>CE said he is interested in the extent of the rationalisation of services by Imperial Healthcare and their vision.<br><br>MA reported that he went to North West London sector discussion this week. He suggested at the discussion that cardiovascular services should be run by the Royal Brompton Hospital and cancer by the Royal Marsden Hospital. | |
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| **1.6** | **Council of Governors Report including Membership Report** | **CE** |
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| | In relation to the Annual Members Meeting day, CE said that the opening of the school went very well and the Head Teacher is remarkable.<br><br>In relation to the Council of Governors CE said he was keen to ensure that contributions made by any individual governor do not adversely affect other governors.<br><br>The Board noted the information on elections and the Away Day on 2 December.<br><br>CE said he was delighted to report on the re-appointments of three of the Non –Executive Directors (NED)s. CW's and AH's terms of office were extended for one year, and RK's term of office for two years.<br><br>With respect to the appointment of a new NED, he said that will miss Colin Glass but we have some potentially good candidates. We hope to make one appointment on 20 October and two proleptic appointments in preparation for the vacant NED positions next October.<br><br>The Board noted the membership report and that we are working on developing a representative membership. He emphasised the importance of active involvement rather than just an increase in numbers.<br><br>LB pointed out that the paper states that there is a lower membership in | |

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| | Black and Asian but it is the Black population which is a problem, not Black and Asian. | |
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| **1.7** | **Chief Executive's Report** | **HL** |
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| | CE said a good deal is going on regarding education and training. Medical Education England has a key national role in the White Paper. This will lead to possibly a more integrated structure with more of a role for Health Innovation Education Clusters (HIEC).<br><br>The Medical Education Board will possibly commission local education and training and this will needs local delivery so there is an opportunity for the Deanery and University to work more closely together.<br><br>HL said regarding the Annual Members' Meeting that she thinks we should end the presentations with the DVD i.e. on a more upbeat note, and to address more specifically care of the elderly.<br><br>AH said he felt the mood was over apologetic, and there was too long for questions. LB said she had feed back from someone who attended the Royal Marsden Hospital Annual Meeting and there were no questions. HL said we should congratulate ourselves on a good turn out.<br><br>HL reported that Amanda Pritchard, Deputy Chief Executive, will be coming back from maternity leave shortly. She would like to take this opportunity to thank Mark Gammage for covering the post of Deputy Chief Executive so ably.<br><br>Regarding the Director of Strategy post, HL said we have appointed a very able candidate and are in the process of finalising details including the start date. She thanked Lucy Hadfield for covering the post.<br><br>HL said the Director of Patient Flow was discussed at the previous Remuneration Committee meeting and the Board would discuss this again at a later meeting.<br><br>The Board agreed that the CQUIN (Commissioning for Quality and Innovation) oversight would be delegated to the Monday Executive meeting.<br><br>HL reported that North West London will have three commissioning partnerships; Hounslow and Ealing and Hillingdon will be one and Brent and Harrow another, and finally Kensington and Chelsea and Hammersmith and Fulham.<br><br>AH noted plans to reduce PCT staff from 600 to 120 staff.<br><br>The Board noted the position with CIPs and an improvement in the financial position with 93% of non-recurrent CIPs and 89% of recurrent savings achieved. LB noted that Imperial Healthcare are aware of the possibility of some of pathology services being tendered as part of the shared services initiative in the Fulham Road.<br><br>HL reported that the building works on the Urgent Care Centre (UCC) are | |

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| | beginning to cause some problems. We achieved only 90% patients being seen within 4 hours one day last week. We must be careful we do not blame the building work but must recognise how stressful it is for staff working in this environment.<br><br>HL noted that the lower ground floor work for the outpatient services development had started.<br><br>She noted the Royal visit. The awards shortlist was noted, and HL said she was particularly delighted with the shortlist achievement by 56 Dean Street.<br><br>Regarding shared services. RBH and RMH are more likely to make savings than us on most schemes.<br><br>MG reported that he had had a very useful meeting with CG's contact regarding telephony and will be looking at how we might manage things differently. He thanked CG for the contact. | |
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| | Lucy Hadfield let the meeting. | |
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| **2** | **PERFORMANCE** | |
| **2.1** | **Finance Report Commentary – August 2010** | **LB** |
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| | LB presented the finance report. She said that the run rate for the surplus is key and the actual surplus achieved was £6.2m at month 5. The forecast for underachieved surplus moved from £3m to £1.7m. 93% of the CIP has been identified with 89% recurrent.<br><br>At the Finance and Investment Committee key issues discussed included non-pay controls and a report will be presented to the next committee meeting. HL reported that we are seen as being advanced with Service Line Reporting (SLR) and although we still had a long way to go we are seen as good compared with others.<br><br>HL gave an example of a control which is to have a maximum price for a hip prosthesis. KN asked what the difference in quality is that comes with a difference in price. MA said we should be able to negotiate on this and HL said we do not want to stop innovation and excellence so it is a balance.<br><br>LB said much improvement is due to the pathology contract as £550k has been offered off the baseline. This still has to be approved by Imperial Healthcare but we are close to an agreement. Another issue was the aged debt situation. There is £5m pre 10/11 of which £3m is NHS. She has instigated a review with a target to clear by the end of November.<br><br>We triggered a capital reforecast for Monitor because our Q1 position was 25% greater than plan. There was an error in phasing in Netherton Grove. We now have detailed costs and LB will be reporting this explanation to Monitor. She said however that we do expect slippage this year because of three to four major projects where there has been change. | |
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| | CG asked if we could use invoice discounting. LB responded that we do use it in a limited sense for overseas private debt. She is not sure if the NHS debt is eligible. She will explore. | |
| | **LB to explore using invoice discounting for the NHS part of the debt.** | **LB** |
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| | CG requested a review of capital, project by project. He said that he had asked for this several times. He said this had not been reviewed in the three years he has been here.<br><br>CG asked if LB wanted approval to sign off the forecast of £32m rather than £52m and if so there was not very much detail. LB confirmed that it does need to be agreed today but she was highlighting it for information rather than approval as it had been approved by the Board already as part of the overall plan. | |
| | **Review major capital projects once a year. The first review to be in October.** | **LB** |
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| | KN said that community pilots in Cumbria was an initiative from commissioners which forced acute Trusts to improve coding. LB responded that we have a very explicit process and assured the Board that the high level of challenge is not new. An example is that £10m worth of challenges led to £250k credit.<br><br>HL said that challenges arose because some organisations are 'gaming' so everyone takes the pain of the challenge. | |
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| **2.2** | **Performance Report Commentary – August 2010** | **MG** |
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| | MG introduced the paper and listed the areas to be addressed.<br><br>CE noted the *C. Difficile* position on p.4 and said that a recent audit indicated that 50% patients with *C.Dfficile* were on a proton pump inhibitor (PPI). He asked if they should be on them? MA said it is unclear at the moment. He said he was unhappy regarding infection control and the role of doctors and will be writing to colleagues.<br><br>CE said we must look at PPIs as getting *C. Difficile* is not by chance and PPIs should be looked at and stopped.<br><br>TD noted that we now had a fourth MRSA case which was an elective and a root cause analysis will be completed on Monday. It looks at the moment as if we failed to screen and therefore it was preventable.<br><br>MA noted that VTE assessments are higher than 57% as pre-assessment completion was not being counted. It will be mandatory from 4 October.<br><br>CE said that the overall figures are good. He noted that we had been very busy in A&E and had several breaches. MG said he looked into what happened on Tuesday and has asked for a review to see by hour who was attending. It is important to learn from this as more than 20 people were waiting for more than 4 hours. | |
| | **MG to report back on review of A&E and breaches.** | **MG** |

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| | **MA to report back on the Protein Pump Inhibitor (PPI) audit.** | **MA** |
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| **3** | **ITEMS FOR DECISION/APPROVAL** | |
| **3.1** | **Assurance Committee Report September 2010*** | **CW** |
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| | This item was taken as read. | |
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| **3.2** | **Claims report update** | **MA** |
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| | MA said this follows on from the previous Board meeting, and introduced the paper with a brief word on context. Approx. 10% patients nationally are harmed by healthcare interventions. Our biggest repository of knowledge of harm is through incident reporting and we have 'orange' incidents reported about once a week. A great deal of effort goes into trying to understand what goes wrong. Claims are expensive, and the value of compensation is related to continuing care which is why harm to children is expensive.<br><br>He highlighted the difference between a pre-action letter and a claim and described the internal processes.<br><br>CE said a key issue for the Board is where we are in the league table and can we do better? He asked if there was any evidence that we are employing individuals who are high risk, either because of personal skills or high risk procedures and are there trends we should recognise? MA responded that trends do occur at incident level, but we do check on these and we look to see if there has been a complaint or incident. We will make a judgement early on regarding individuals. The numbers of claims in Medicine are too small to say if there is a trend. KN said we need to look at complaints and incidents as well as claims. CM explained that this is done quarterly and reported to the Quality Committee although the process had been reviewed recently.<br><br>CW noted that there were other concerns re Medicine and HL confirmed that this was being looked at now and progress had been reported to the Board. CW asked if anything had changed recently in Medicine? It was confirmed that this was not the case and CM pointed out that the average delay between an incident and a claim was 4.5 years. HL noted that this could be even longer in obstetrics.<br><br>CE said it is important to note section 6.1 regarding consultant cover as this is relevant to a move to consultant delivered rather than consultant led services.<br><br>KN asked if there is any evidence that good complaint handling decreased claims? CE said there is clear evidence from Scotland where senior consultants from another Trust were invited to look at complaints and there was a marked decrease in litigation, as complaints were seen to be taken seriously.<br><br>CW said it is frustrating to lose control to the NHSLA for claims settlement. MA noted that the NHSLA are now giving feedback to Trusts on learning. | |
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| **3.3** | **Complaints Annual Report 2009/10** | **TD** |
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| | TD introduced the paper. A key point is that this is a new process.<br><br>There has been a 13.4% increase nationally in complaints, but a decrease at C&W which could be good or bad. We know that we need to get better at resolution time. There are three areas of concern, appointments and information to patients and attitude.<br><br>KN asked if the new appointment system came in after the annual report? TD confirmed that this was the case and we are beginning to see a drop.<br><br>TD noted that a very small number of complaints lead to claims. CW asked who decides on grading. TD responded that it is risk team and complaints team and confirmed that this was the same people so there was consistent judgement.<br><br>KN asked if attitude had got better after customer care training? TD said that this was the case where there had been targeted training in 'hot spots'. AH asked if we can we bring out issues of quality of service compared with care?<br><br>KN asked about outcomes and if we have a target for reduction. TD said she thinks 're-opens' should be a target i.e. where people are not happy with the response. | |
| | **TD to highlight issues of quality of service compared with care in future reports.** | **TD** |
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| **3.4** | **Complaints Policy 2010/11*** | **TD** |
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| | This was approved. | |
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| **3.7** | **Research Strategy** | **Prof. Bell** |
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| | CE welcomed Mary Tourette and Professor Derek Bell and emphasised the importance of research to the Trust.<br><br>DB outlined the presentation and noted the Trust Research Mapping workshop on 4 October.<br><br>CG asked which areas are likely to be world leading in research. DB responded it is likely to be neonates and HIV but this will be discussed at the workshop.<br><br>CE said that we have to recognise the reputational issue associated with research and the importance of research which aligns with our clinical expertise as it is difficult to be world class without this. The hospital must be an active partner. We have not had a dialogue with Imperial College re a complementary strategy. There are financial implications associated with research e.g. space, and potentially a slight loss leading impact e.g. the recent debate with International AIDS Vaccine Initiative (IAVI) regarding the rent for space. | |

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| | CE said his view is that this is part of price you pay to be the world class but we need to ensure return on investment. We should consider if there are themes we should concentrate on e.g. immunology. CG said we are probably unique in having Dean St clinic and do we maximise this? DB said that there is a very heavy patients and public involvement in the Collaboration for Leadership in Applied Health Research and Care (CLAHRC). CE noted the opportunity to develop this further at the strategy workshop on Monday.<br><br>LB said the Board has approved investment in research and development of £2.5m factored in over 5 years and we are approaching year 3 (2011-12).<br><br>DB reiterated that we work in a very competitive environment with respect to research.<br><br>CE raised the issue of intellectual property (IP) rights and said that the NHS is relatively weak in this area. He agreed with CG that we need a robust IP policy.<br><br>CE posed the question of whether we should have a proper clinical research facility which will attract people. MA said that research is a defence against mediocrity. HL said perhaps consultants who engage in research should have to have a higher degree and perhaps we might make it mandatory in some areas and therefore we need a recruitment strategy to support the research strategy. In answer to CG's question she said it was difficult to get a PhD once an individual is a consultant because of the time commitment. CW asked if we could get commercial sponsorship for a clinical research facility? CE said that could be possible but noted that we are in the richest part of the UK and could fundraise for such a facility as part of the Charity. We may use space freed up by the paediatric development.<br><br>**The Board approved the strategy.** | |
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| **3.9** | **Pressure Surge Assurance Process** | **MG** |
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| | MG explained that this is part of planning with the local health economy. The London Ambulance Service is taking a more proactive approach, and NHS London a more strict approach. This approach ties in with our internal response.<br><br>A Capacity Management system (CMS) is being piloted and this will work with other trusts and has near real time data.<br><br>CE expressed concern about the loss of central control with the loss of the SHA. HL said she was concerned about how Trusts manage sickness, and LOS etc which contribute to problems.<br><br>LB said she was concerned that we had no business continuity plan in place. TD said that she is picking this up with Amanda Pritchard. The plan we have is out of date and we have arranged for an external consultant to help. | |

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| | MA said if we are going to exceed our cap regarding admissions because of taking other patients we should be compensated. | |
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| **3.10** | **X-Ray Film – Storage vs. Destruction** | **MA** |
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| | MA outlined the situation. He confirmed that there is no medical value to the X-rays.<br><br>CE said an option that was not included was to ask patients if they wish to have their X-rays. MA said that this would cost a lot to implement as most of the patients were a long time ago and we will not have their contact details.<br><br>HL asked if since 1999 all reports are on LastWord? MA confirmed that this was the case.<br><br>CW asked if there is any research value. MA responded that there is not but there is silver value.<br><br>CE said that adults are not a problem.<br><br>CW asked why we would keep them and MA responded that they would be needed in case of claims, a medical need would be rare and the likelihood decreases as time goes on.<br><br>CE asked if we were clear on the legal requirements. MA responded that the legal requirement is the report which is on the LastWord.<br><br>RK said that research shows that 30% of films are lost in the first 6 months.<br><br>LB said she was struck by the current retrieval rate being so low which suggests that this is not a risk.<br><br>MA confirmed that his recommendation is to destroy all records.<br><br>HL asked how difficult it would be to pull out children and MA responded that we would need to look at each one i.e. children are not marked.<br><br>HL asked what happened at Birmingham when the new hospital was built and MA agreed to follow up on this.<br><br>CE said it was important to note that this had been discussed should we need to defend any decision in the future.<br><br>MA said we need to vacate the space soon.<br><br>**It was agreed that subject to the further work contacting Birmingham, that the Chairman would agree on action outside the Board.** | |
| | **MA to follow up on actions taken with respect to records at Birmingham when new hospital was built.** | **MA** |
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| **3.11** | **UCC Single Tender Waiver** | **HL** |

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| | HL outlined the single tender waiver requirement.<br><br>**The Board approved the single tender waiver.** | |
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| **4** | **ITEMS FOR INFORMATION** | |
| **4.1** | **Assurance Committee Minutes – 13 September 2010** | **CW** |
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| | This item was taken as read. | |
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| **4.2** | **Audit Committee Minutes – no meeting** | **AH** |
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| **4.3** | **Finance & Investment Committee Minutes – July & August 2010** | **CE** |
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| | This item was taken as read. | |
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| **5** | **ANY OTHER BUSINESS** | |
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| | LB said she was made aware of an issue the day before regarding pharmacy education and training which we host. A paper was tabled at the meeting.<br><br>LB explained that the lease for their offices runs out at the end of March 2011 and extension of the lease requires Board approval. She highlighted that the current lease has no break clause.<br><br>AH asked why that location? LB responded that it is difficult to move them and access to the main line station is required due to the area they cover.<br><br>HL said pharmacists will have increasing role in healthcare.<br><br>CE was concerned about SHA and successor and in which direction things are going and it is sensible for both sides to have a break clause.<br><br>LB said she feels that the landlord will not change his opinion.<br><br>CE suggested that LB talks to NHS London, as we do not want to take on a 5 year liability without some assurance and/or a break clause in the contract.<br><br>KN said she was concerned that there is other space we should be looking at and we should know what Department of Health space is becoming available. HL suggested checking Hammersmith Broadway for available space and AH noted there was space available at the Westminster Council. | |
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| | **Approach NHS London regarding concerns about the 5 year lease because their existence is limited or extend the lease to the end of the SHA life which is 2 years. Include a break clause.** | **LB** |
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| **6.** | **DATE OF NEXT MEETING – Thursday, 28 October 2010** | |
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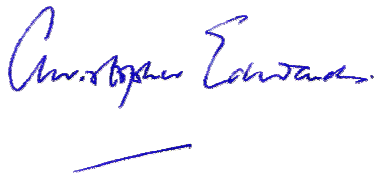
NB: These minutes are extracts from the full minutes and do not represent the full text of the minutes of the meeting. For information on the criteria for exclusion of information please contact the Foundation Trust Secretary.

**Signed by**



**Prof. Sir Christopher Edwards**
**Chairman**