Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting 30 June 2011
Extract of approved minutes

Present

Non-Executive Directors	Prof. Sir Christopher Edwards	CE	Chairman
	Sir John Baker	JB	
	Andrew Havery	AH	
	Prof Richard Kitney	RK	
	Sir Geoffrey Mulcahy	GM	
	Karin Norman	KN	
	Jeremy Loyd	JL	
	Charlie Wilson	CW	
Executive Directors	Heather Lawrence	HL	Chief Executive
	Amanda Pritchard	AP	Deputy Chief Executive
	Lorraine Bewes	LB	Director of Finance
	Therese Davis	TD	Director of Nursing
	Mike Anderson	MA	Medical Director
	Catherine Mooney	CM	Director of Governance and Corporate Affairs
	Mark Gammage	MG	Director of Human Resources
In attendance	Bill Gordon	BG	Acting Director of IT
	Roger Chinn	RC	Consultant Radiologist; Clinical Lead for IT
	Helen Elkington	HE	Head of Facilities
	Liz Revell	LR	Interim Foundation Trust Secretary

1 GENERAL BUSINESS

1.1 Welcome and Apologies for Absence — CE

The Chairman welcomed everyone to the meeting. There were no apologies.

He reiterated the importance of IT security and the necessity to change pass codes on iPads from the default pass code on a regular basis in order to reduce the risk of a security breach in the event of loss or theft of the iPads.

He noted with delight that Professor Brian Gazzard had been awarded a CBE.

1.2 Declaration of Interests — CE

There were none.

1.3 Minutes of the Meeting of The Board of Directors held on 26 May 2011 — CE

The following amendments were agreed:
Page 4, item 1.7 the sector Chairman is Jeff Zitron.
Page 6, item 2.2 regarding *C-Difficile* the Chairman clarified the discussion which was

that if a patient is on a proton pump inhibitor they are more likely to get *C.Difficile* infection. If there is a situation with a patient who has *C.Difficile* next to a patient who is on a proton pump inhibitor this increases the chance of the patient on the proton pump inhibitor getting *C.Difficile*. He had asked whether if this was the case, the patient could be moved. The minutes to be amended accordingly.

He noted that he had discussed this with MA who had sought the views of Dr Azadian. He noted that there is an initiative to try to ensure people are not left on inappropriate acid reduction agents. A study at the Royal Free showed that 50% inpatients with *C.Difficile* were on proton pump inhibitors. Patient on proton pump inhibitors should be put on to H2 receptor antagonists especially if they are on a ward with *C.Difficile*. He did note that it was a balance of risks.

MG noted on page 11, second paragraph that this needed some clarification. He also said he would provide some rewording to item 3.10.

Page 12, "materially" should read "materiality". CM noted that LB had provided some typographical changes. Section 3.13, second paragraph, LB clarified that there was no exception report and asked that this be added to the minutes.

Action: To amend minutes as above. **LR**

1.4 Matters Arising **CE**

CE said as previously highlighted that he had discussed this with MA and Dr Berge Azadian regarding a way forward.

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

CE said that he and HL had been to the Children's' Charity launch of the Pluto Appeal. He also noted that it was an important time for the Chelsea & Westminster Healthcare Charity who are looking for a new CEO. A number of new trustees had been recruited to the charity.

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

CE asked for questions. LB asked whether we had met the target for recruitment at Westfield shopping centre. HL said we did not meet the target and were off by a considerable amount; however, it was probably an unrealistic target. TD said that Matt Akid (MAk) will be reviewing this in the membership group meeting.

KN noted that we treat more black ethnic patients than are representative of our population. She suggested that there should be an initiative to try and encourage such patients to join so that they are represented. TD agreed to explore this.

KN also noted that we should align how we use our membership with our strategy. JB said that this report is very similar to previous reports so we tend to overlook it and suggested that it should come to the Board six-monthly. This was agreed.

JL noted that he had been born at the Middlesex Hospital and had been called a "Middlesex Mouse". It gave him a great feeling of belonging to the hospital. HL said that this is an idea that we are considering here i.e. people born here have some kind of passport or link to the hospital

Action: Membership Report to be presented six-monthly rather than monthly. **CM**

1.7 Chief Executives Report **HL**

HL noted that she and the Chairman had been to a meeting of the Foundation Trusts Network (FTN) and outlined the priorities identified by the FTN. She said it was possible that the Health & Social Care Bill would be passed this financial year and she outlined the key aspects. One of these was that Board meetings would be held in public. The ratio at the moment nationally is 50:50 private/public. This needed to be considered in the context that Monitor will exist as the independent regulator until 2016 and the role of the governors will not develop as expected at this time. CE said we need to think about how we would manage that e.g. double our numbers of meetings or alternatively have joint meetings with the Council of Governors in which case another room would be required. He was concerned that we would need to have a two part agenda. However, CW noted that this was the situation prior to becoming a Foundation Trust. HL said that we did not have Freedom of Information then or the complex demands that we are having now. JB said that we will need to debate strategy and commercial aspects in private and we would need to change to cabinet style minutes i.e. no names are used.

JB said that he was interested in an overview from HL and whether after the listening exercise there was anything of substance left. HL said that GPs will continue to commission but the process to introduce this will be slower. The Secretary of State retains the overall responsibility for the NHS which is a big change i.e. his responsibility is not devolved. What it means to patients is unclear. CE said that around 230 commissioning groups will remain. It is difficult to understand how this will be effective. They will still be GP-led but will require input from secondary care and a nurse. Clinical senates will be set up with a wide range of membership and it is expected that commissioning groups will take into account what the clinical senates say. HL said sector PCTs will be retained for longer.

HL outlined the BBC3 documentary initiative. She said that clinical staff have been consulted and there have been discussions with Newcastle Hospital where the last filming was done. She did note that there is an element of risk. However, Communications will liaise with the Deanery and HL and MAk will review the contract. CE said that the programme will be very focused on the individual rather the hospital but there is a concern that inadvertently there will be a reputational risk. HL said she was initially concerned about clinical supervision but the feedback from the Deanery visits regarding training in paediatrics and A & E demonstrated good clinical supervision.

2.1 Finance Report Commentary **LB**

LB outlined the key points. Regarding outpatient new to follow up ratios she was asked to what extent these were clinically valid ratios. LB said that it had been agreed by clinical leads. MA said there are average figures by speciality; some will be seen once and some will never be discharged. He commented that targets have gone up as people have challenged and the ratios have reduced.

LB said that regarding contracts we have mitigated most of the risks. There are two principles we cannot agree on; unlimited penalty per item clauses and marginal rates for non PbR activity. Non-pay is on plan. Pay was overspent driven by unachieved cost improvement programmes and we need to focus on them. They have increased from 50% identified to 80% by end of May. We have now identified 91% and 98%

recurrently. We have now moved to amber from red and are within £5m of the forecast.

2.2 Performance Report Commentary **AP**

AP reported that we are still meeting Monitor's requirements. The new A&E targets will be monitored from 1 July. We are currently achieving three out of the five new indicators and are hopeful that we will achieve four out of five; however, this requires us to change our systems. An area of concern is the re-attendance rate and a great deal of audit has been undertaken. 2% of these are "frequent flyers" which equates to about thirty patients per week. Genuine re-attenders are a concern i.e. patients are admitted, discharged and re-present at A&E. They are not necessarily admitted on re-attendance but it does indicate that patients are concerned. An alternative model would be to advise patients to go straight to the ward.

AP said a particular challenge was paediatrics. It is good practice not to admit but to advise patients that if they are concerned to come back. There is a 10% readmission rate but all paediatric hospitals will be the same. She noted that there was an article in HSJ which named us as having a high re-admission rate; however this refers to a high number occurring within seven days. 22% of this is data errors, 10% is planned pathways e.g. plastic surgery and day care. We need to ensure that these are recorded accurately. If we calculate to exclude these, the admission rate is 3.6% which is about 1600 patients per year. There will be a certain group of patients admitted for palliative care. It was noted that some Trusts have "hot clinics" set up by some specialities e.g. a daily clinic for the elderly. HL queried how many quick discharges come back. JL said it would be helpful to confirm the contractual target.

CE queried why all emergency admissions are currently not being screened for MRSA. TD replied that we are screening but not achieving the target i.e. the process is not working. She noted that it was not a Monitor target any more but CW confirmed that it is still a Trust target.

3.1 Assurance Committee Report May 2011 **CM**

This item was starred.

3.3 Risk Policy and Strategy **HL**

CM outlined the main areas for consideration, noting that the full strategy and policy was in the supplementary papers. She noted that the comments of the Audit Committee had been taken into account e.g. clarifying strategy and policy. She had received comments prior to the Board and this included querying the definition of non-clinical risks. A suggestion was 'health and safety risks include risks that affect the environment of care and risks that could cause injury or ill health to any person in connection with the Trust's activities' and this was agreed. She drew attention to the classification of acceptable, tolerable and significant risk, noting that these were new definitions. It was agreed that 'action must be implemented urgently' should be added to the definition of a red risk. Residual risk to include 'or mitigation'.

The Board asked for further information on the objective to increase the rate of incident reporting.

The Risk Strategy and Policy was approved subject to clarification on the

incident target.

3.4 Complaints Annual Report **TD**

TD introduced the complaints summary report. She highlighted the 34% reduction in Type 1 complaints suggests that these are being dealt with well. There was an 11.4% increase in Type 2 which was primarily clinical care and attitude. Twelve complaints had gone to the Ombudsman but all 12 were found in our favour.

JB asked if these numbers of complaints were meaningful. TD said this reflects the complaints we receive but does not necessarily reflect all poor aspects of our service as some patients will not complain. KN asked whether we could see the numbers over time and complaint against activity. This was agreed.

TD noted that the highest complaints as illustrated in section 7 are about attitude and clinical care and this is similar to other trusts. Divisions have done good work and there has been a 33% decrease in complaints regarding attitude of nursing staff.

CE commented that it seems counter-intuitive that the low level complaints get dealt with quicker and the highest, more serious complaints take longer. TD said that this was due to the fact that serious complaints take longer to investigate, and sometimes they relate to an incident review. In these cases the complainant will be invited in to discuss it. CE said that it is important that people are treated as individuals and not part of an administrative process. He commented on an initiative in Scotland where the most serious problems were very rapidly dealt with and a senior consultant saw the patient immediately. This was shown to decrease litigation costs. It is about what the patient perceives as the level of rigour.

TD said that table 14 in the full report sets out the number of complainants contacted. HL said it is the aim that complainants are contacted but it can take a long time to do an investigation. CE said that it is important that there is an initial response and we need to demonstrate this in the future. CW commented that the character of the first contact must be an apology. KN asked when do we offer to meet and TD said this varies. CE suggested we might want to change the report and not target response time but note the initial response time. TD commented that these are internal targets that we have set; there is no national target any more; we can change what we report. AH said as a general comment it would be helpful if we could show benchmark data more if possible.

Action: To incorporate suggestions re numbers of complaints over time and against activity, and the inclusion of benchmark data into the next annual complaints report. **TD**

3.5 Strategy Update **HL**

HL outlined the position with the Royal Brompton Hospital which was that they are still pursuing a Judicial Review re Children's Cardiac Surgery and a relocation site in Hammersmith.

There is to be a London-wide review of specialist paediatric services and Simon Eccles is leading the review for paediatric surgery and we have put forward a nomination for a paediatric medical representative.

Regarding the NHS London review of adult emergency surgery, Jeremy Thompson

(job title) is our representative for Emergency Surgery and Derek Bell (job title) is chairing the group for Emergency Medicine. The Board should note that with regards to surgery the PCT commissioners do not want Chelsea and Westminster Hospital to undertake emergency surgery. MA said that a major issue for emergency surgery is the requirement for 24/7 interventional radiology.

The Integrated Care Project for care of the elderly and diabetes was launched yesterday and a very heavy infrastructure has been put in place.

HL noted that Ruth Carnall's priority is for improving cancer care for the population of London and she is in the process of setting up managed cancer networks.

HL noted that the interim Chair for developing the strategy for the Academic Health Science Centres (AHSC) is Lord Darzi. CE noted that in London there are three AHSCs and two of them, UCL and Kings have partnership boards. He said that being co-managed is a very limited model and he would be interested in a partnership board being developed to include Imperial College, Imperial College Healthcare, the Royal Brompton Hospital, the Royal Marsden Hospital and Chelsea and Westminster Hospital.

HL noted that a Health Improvement Board for London is being set up chaired by the Mayor of London and agreed that we would formally invite the Mayor here in this capacity.

JB asked what our expectations are, if any, regarding industrial action in the autumn. HL said we worked closely with the Unions and the NHS pension is largely resolved. HL confirmed that if London services are affected by industrial action we have plans in place. MG said that this was being looked at across London.

Action: HL to invite the Mayor of London to visit.

3.7 IT Strategy **HL**

HL introduced Roger Chinn and Bill Gordon. The IT strategy had been developed with guidance from Richard Kitney and input from Fleur Hansen.

The purpose of it is to enable delivery of our strategy and objectives. Drivers identified include the need for shared decision making, access to information by patients, patients' choice agenda and the rating of the hospital. Our clinical systems have a high level of maturity but LastWord is essentially a clinical system and is now a legacy system.

HL outlined the five tenets of our IMT strategy demonstrated on page 21 of the paper. She noted that there had been some external assessment and we were about level 2 of maturity in the strata on page 23. The plan is to implement document management and to set up a repository and a portal so it is easy to access as and when we need to replace the clinical systems.

The cost over three years is £12.4m capital and revenue. This is in the capital programme already. DK said a lot of work had already been undertaken including looking at other comprehensive systems such as Cerner. They do not quite fit the bill. Technology has moved on and the portal approach is the right one to use. We will need a careful migration strategy. This will include keeping the current LastWord,

buying EDM and introducing the portal approach.

RC noted that people and process were very important and workflow and engagement were critical. TD suggested that we need to link to what the patient expects and CE agreed that we do need to consider the view of the patient and that it is their notes and they need to access them. This will require a change in attitude. JL said it is about having educated and informed patients and delivering information to them. You should be able to interrogate your appointment, walk the ward etc. He linked it to an online bank account. It is important to really empower patients.

RC said that the next stage is to develop the detail of how the portals work and that no patients were involved at the moment. JB asked how pioneering this approach was. HL said it would be very pioneering if we do it soon.

CW asked whether this approach was implemented anywhere. RC that it was in the USA and in Denmark. JB noted that top down thinking is very much an NHS approach and there needs to be a "demand pull" through this system. DK said it was designed to be as flexible as possible. GM was concerned that flexibility adds costs. HL said that we will have a distributed model of healthcare and we need an information system that allows for that. RC likened our approach to an iPad which was the base and Apps which bring in what you want. The patient at the centre will change the culture of the hospital. JL asked how easy it would be to access information. He had been in a hospital where it was very difficult to get access to his notes.

MA said he was very supportive of this strategy but we needed to be careful with patients who are not IT literate e.g. the frail elderly. He also noted that giving access to health records is different to allowing amendment of them. RC said that the electronic record is easier to control and audit. AH noted that in Westminster Council they had introduced One Stop Shops for transactions with the Council. However these were now shutting because people can do this on line. The Council had trained people in libraries to help visitors as advocates.

Regarding the Apps model AH said that we buy Apps; we do not write them so asked whether we can buy portals? Alternatively, if we develop them can we sell them? He supported the IT strategy but said it rests on the assumption that the data is around and we just need to access it and questioned whether this was correct. BG said that EDM work will look at paper and electronic records but mostly electronic. HL said we have a reputation of being advanced in clinical systems but poor with data. The data warehouse is where all the data is currently. LB confirmed that this is very clinically rich data and that she would want Finance feeding into the repository.

JB noted that the system would be as good as the frontline people using it not as good as the IT people developing it. It is important to watch what people do not what they say they do. AP said it was important to see this as a change management programme and it was important to really import learning from LastWord. For example the PAS functionality was difficult but it was clinically good. It is important to understand the needs of different groups e.g. clinical and administrative. JB said that as we will do this in-house it could be useful to have outsiders challenging to make sure that we remain vigilant. LB noted that LastWord does have a costing facility but it was not being used. BG said that this was removed as part of the Anglicisation.

In summary, CE thanked DK, BG and RC others for the strategy. He said that the Board were very supportive of the strategy and moving ahead with it. This was an

opportunity to use IT to transform the hospital and something that can distinguish us. It is an opportunity to build new partnerships with patients. It is a flexible approach which could move us into the new world and develop pathways, working with commissioning GPs and in non-clinical areas such as social services. He said it was important to think about how we could get some critical input. He noted the concern that technology is changing very fast.

RC and BG left. CW asked whether we have quality people within the hospital to handle this strategy. RK agreed that we do. AP said she agreed but we have a capacity problem and will need to put some resources in. IT are hugely busy but the perception is that IT does not respond to requests so it is important to manage that.

3.8 Assurance Framework 2011/2012 **CM**

CM introduced the paper and explained that this year the focus for the Assurance Framework is on the four corporate objectives rather than the deliverables. The paper outlined the risks that the executive team had highlighted and she asked the Board to comment and agree on the risks. She emphasised that these were potential risks and the next stage would be to grade them and the Board will then focus on orange and red risks.

JB said that we spend too much time on Monitor risks and we should consider what we are really worrying about. HL suggested we should have only three to four risks to be concerned about.

CE said that the biggest risk is the government. GM said in lots of areas the main risk is not identified, which is management.

CE suggested a broader discussion about risks at an away day.

RK identified the need to look at *C. Difficille*. However, HL said that it would be a major mistake if we did not focus on cost improvement programmes and if we do not keep and grow paediatrics the rest is peripheral. TD said we must ensure that we do not miss the focus on patients.

GM emphasised the important of reputation, which can overcome the risks of what the government might do. However, LB pointed out that if the tariff is not set appropriately it will affect services e.g. GOS. GM said that the point is that reputation is hugely important. JL however said we needed to be clear about whose risk we are referring to and it is the risk to the patient that must be considered primarily.

KN said that this was more helpful than previous approaches and she finds it helpful to know what the Executives think.

Action: To consider discussing risks in more detail at an away day. **CM.**

3.9 Information Governance Training Report*

This item was starred.

3.10 Assurance Committee Terms of Reference*

This item was starred.

The Chelsea & Westminster Foundation Trust Annual Report was presented.

3.11 Annual Members Meeting **HL**

HL introduced the paper and noted that this was the governors' day. It was suggested that this could be used to test out our values. CW suggested that it would be interesting to have some DVDs to look at and perhaps the ones that were generated as part of the Westfield project. It was also noted that paediatric events would be running in September.

4.1 Assurance Committee Minutes – 23 May 2011 **CW**

This item was taken as read.

4.2 Audit Committee Minutes – 19 May 2011 **AH**

This item was taken as read.

4.3 Finance & Investment Committee Minutes – 19 May 2011 **CE**

This item was taken as read.

5 ANY OTHER BUSINESS **CE**

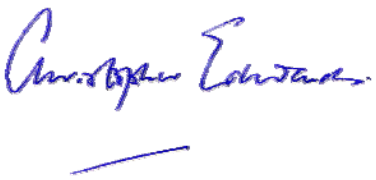
CW asked about the role of the GP Liaison Officer and noted that we had not seen a paper relating to this recently. He would welcome a review of progress.
Action: To schedule in a report on GP liaison. **CM**

6 DATE OF THE NEXT MEETING **CE**

Thursday, 28 July 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