Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting 21 April 2011
Extract of approved minutes

Present

Non-Executive Directors	Prof. Sir Christopher Edwards	CE	Chairman
	Charlie Wilson	CW	
	Andrew Havery	AHa	
	Prof Richard Kitney	RK	
	Sir Geoffrey Mulcahy	GM	
	Sir John Baker	JB	
	Jeremy Loyd	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	Axel Heitmueller (for items 3.5 and 3.6)	AHe	Director of Strategy and Business Development
	Mrs Zoe Penn	ZP	Divisional Medical Director
	Mr Simon Eccles	SE	Clinical Director, paediatrics
	Dr Saji Alexander	SA	Consultant Paediatrician
	Dr Jo Hacking	JH	Consultant Paediatrician
	Dr Nicola Bridges	NB	Service Director, paediatrics
	Lyn Ronnie	LRo	Clinical nurse lead, children's and neonatal services
	Jennifer Allan	JA	General Manager, Children's and Neonatal services
	Liz Revell	LRe	Interim Foundation Trust Secretary

1 GENERAL BUSINESS

1.1 Welcome and Apologies for Absence — CE

The Chairman welcomed the Board to the Board Meeting. Apologies were received from Karin Norman, Non-Executive Director. He noted that this meeting would focus on paediatric and neo-natal issues and he and HL had visited the new building that morning.

1.2 Declaration of Interests — CE

There were no declarations of interest.

1.3 Minutes of the Meeting of The Board of Directors held on 31 March 2011 **CE**

Minutes of the previous meeting were approved as a true and accurate record with the following exceptions:

- Page 3 action is TD not CM
- Page 4 4th para should read “assured” not “ensured”.

Page 8 There is a repeat of a sentence and the action should be TD and not CE

- Page 8 should read ‘Board is a target-*dominated* culture’ rather than ‘based’.

LB noted that there had been further changes to the minutes previously circulated and that these were highlighted in the subsequent minutes available to the Board.

1.4 Matters Arising **CE**

1.5/Jan/11 Invoice Discounting
LB noted that she would report further in May 2011

1.6/Mar 31/11Breakdown of ethnicity information and how membership collates on a percentage basis against the population as a whole to be provided for the next meeting
To be presented to the May Board.

2.1/Mar 3/11 MRSA Screening Target
This is on the Board Agenda.

2.2/Mar 3/11 Annual Budget 2011/2012
Discussions on issues re impairment to be arranged.

3.3/Mar 3/11 Integrated Care Organisation
This is on the agenda.

3.4/Mar 3/11 Incident DR
CM confirmed that the date of the inquest is 13 July.

3.4/Mar 31 /11 Update on Staff Survey
This was noted as in the matter arising paper.

3.14/Mar 3/11 Infrastructure Project. Mechanical Cooling Infrastructure Package
It was noted that there is no potential for income generation.

1.5 Chairman’s Report (oral) **CE**

The Chairman outlined some of the issues with Imperial Healthcare Trust and described a partnership board model. He also raised the issue of paediatric cardiology at Royal Brompton Hospital and commented that one option would be that paediatric cardiology would move to this site. Solutions for Imperial Healthcare need to be wide-ranging and go beyond the boundaries of their own trust.

1.6 Safeguarding Children Trust-Wide Training Report Update and Action Plan **ZP**

The Chairman introduced the focus on children. He said that the Board would be aware that we are spending a lot of money on Netherton Grove and paediatric theatres and this would be an opportunity to see what we do. He also noted that a re-tendering of

paediatric specialist services in London may occur. Zoë Penn introduced the team and said they were proposing to talk through the major issues. Patient safety is at the core of the service and is taken for granted by our patients but the patient experience is becoming increasingly important.

TD introduced the safeguarding training report. This highlighted the requirement for training, how it was different from previously and how we proposed to deal with the challenges of a significant increase in training. She said she would be happy to answer questions.

CE asked what the statutory basis was for the requirement and what the consequences would be if we were not to provide the level of training recommended. TD said the statutory position is set out by the Care Quality Commission but is states 'appropriate training'. HL said that the risk would be if an incident occurred and we had not done the training, we would be culpable. GM asked how much the training cost. TD said that the figures that were not to hand but she will provide.

MA said that this was discussed at the Quality Committee and concern was expressed by clinicians about the significant time commitment and they queried whether this was appropriate. TD noted that there was a proposal to combine this with other training. ZP said it is wider than just children; it is about spotting areas where care is less than ideal. HL said it was about clinicians identifying parents who are carers who may be presenting a risk to their family. TD noted that Level 1 training was good but there is a problem with Level 2 and 3 training. CE said that we are in a difficult position, we can increase training in all sorts of areas and this is an emotive area. We need to know the cost and the impact. MG said we had cut back on training in other areas and there would be more investment in this area than in others. HL said this was about focus. Staff in paediatrics should be trained to the level they need to be as a priority. TD agreed. SE agreed that it was essential for some people. Level 1 training takes 90 minutes. Levels 2 and 3 can be combined and we can look at doing this at the Clinical Governance half-days. CE asked what the Monitor requirements were. CM confirmed that there had been no changes to the Monitor requirements which were about publishing a statement which included training performance at level 1. JB said there was no alternative but to go down this route and to seek to achieve the gold standard. He said that somewhere there must be a diminishing return. People do the training but does it make a difference and how does it fit in with other training? MG said we are aware of the whole picture and are putting packages in place to provide training in a single day to make better use of staff time; this could also include consultants.

The Board accepted and approved the training plan.

Action: TD to report on cost of training.

1.7 Paediatric Inpatient Survey **TD**

TD reported that there had been a low percentage response of 23% but there had been a good outcome. Lyn Ronnie presented the report further. She said that 93% respondents said Chelsea and Westminster was good or excellent and that we were better than other trusts in London. She outlined the areas which required improvement and the areas where we were best in class. She noted some challenges about partnership care, time to wait and facilities. As part of the action plan we want to improve the response rates and use publicity to encourage people to fill in the questionnaires. The survey was being done again currently. There are actions around additional information being provided, including medicines. We have increased the number of parents' overnight stay rooms from four to six and increased the tea and coffee facilities.

CE commented that the response rate had been disappointing and asked what options others are exploring to increase the response rate. LRo said that we have discussed this with Picker who undertook the survey on our behalf. They feel that pre publicity and marketing would help which has not been done before. Also, we can increase the number of times we send the survey out. JM asked if we can influence the questions in the survey. HL replied that there is no choice in this instance as it is a national survey. TD said, however, that we can do our own survey internally if we wish.

RK asked why parents' satisfaction re overnight stays had reduced from 14% to 10% in 2010. LRo said that parents of children under 11 have foldaway beds. Children older than that were in adolescent wards where parents could not stay. Also, we do not allow parents to stay in the paediatric HDU.

JL noted that we are in grave danger of extrapolating results from small numbers. JM also commented that there is a bias with low response rates. ZP commented that this is the value of the patient experience trackers because it allows us to track quality and we have a high response rate in inpatients. JL asked what we are doing to ensure patients who respond are representative and he would like to understand this a bit more. HL said it is a league table and therefore is important for our reputation. CW commented that Great Ormond Street Hospital does not take part and whether there was any significance to this. LRo said they did take part in the 2008 survey but she did not know why they had not participated this time. JL asked whether the results resonated with her own experience and JB noted some significant overlap with the survey in August last year. LRo said that the results do reinforce our own experience. CE commented that the new facilities were very well designed.

1.8 Childrens' and Young Peoples Services Board update **SE**

Simon Eccles gave a presentation covering how we see ourselves in the future and noted there are several paediatric units in NW London. The London strategy is about a decrease in fragmentation. He described the process undertaken for the previous bid.

LB said that there was an opportunity to consolidate specialist work and get a specialist tariff for NICU. SE reported that the intention was to tender all paediatric medicine and surgery. CE said that this is a very important decision. HL said that in London there are two London paediatric networks including cardiothoracic paediatrics. Currently, there are three cardiothoracic paediatric surgical centres in London and the recommendation is for two. In a recent national evaluation, the Evelina service at Guys and St Thomas's came first and Royal Brompton Hospital (RBH) and GOS came equal fourth. The specialist commissioners are consulting on where these two centres should be in London and their preferred option is the Evelina and Great Ormond Street (GOS). RBH are disputing this and intend to take NHS London to Judicial Review. SE said that we are in the top five which do a wide range of services but ICU and renal are an issue. St Mary's has a PICU and is renowned for infectious diseases in children and they also look after bone marrow transplant children. However, due to their research and success in treating children with infectious diseases, particularly meningitis, this has resulted in a reduced need for PICU and makes their unit potentially unviable. If RBH lose paediatric work there is a concern re the number of paediatric intensive care beds in NW London. We will have a 12-beded HDU so could develop a PICU if required. However, there is a national shortfall of intensive care trained paediatric nurses.

SE outlined his vision for the future. GM asked how far off we are providing world class services. SE said that data does not exist for benchmarking but we are held back because

we have no PICU. CE noted that we have a Professor of Neonatal Medicine here and host the National Neonatal Database. We need to use this to grow research and an academic base. GM asked what the timescale was to be world class. SE said we are very close in surgery as only Leeds and us have robotics. He would not like to comment on medicine. AP said that with neonatal medicine and surgery we can say we are up with the best in the world. We cannot say that with paediatrics because the data is not available. HL said we are never going to be a GOS or an Evelina and so will always need to be federated. JM asked how far behind GOS we are. SE said that we do different things e.g. they do not do routine endoscopy and have no emergency department and have electives only, but are very good at specialist work CW asked how far we can go with a federated model without a PICU. HL said we have got a neonatal Level 3 unit and have a PICU up to 6 months and provide the majority of paediatric neonatal and gastric surgery for children under two years. CE said it is a complicated question because it is more about politics than medicine. He said there is significant interaction between us and the RBH. SE agreed and said that if the RBH goes somewhere else that will be a problem for Chelsea and Westminster. RBH needs us for general paediatrics. JL commented said that being world class is not about doing it all and there is a case for volume-based excellence. He asked to what extent the volume test applies to us. SE said that we are not able to do surgery without partners. The job is less interesting if there is no complexity. The number of children requiring PICU is actually very small. CE said that the number of cases transferred to GOS is very small and asked why this was. SE said it is because we use local resources at RBH and there are other networks we need to be part of e.g. renal. JB asked whether the bidding process contained threats. SE said that having a consultant for specialist paediatrics on one site which is not here would be very expensive. JB said that the vision needs to be shared and SE agreed and said that the vision has been done in conjunction with others. HL said that facilities are very expensive and paediatric surgery is a very small part of what we do and we need to consolidate other areas such as diabetes. NB commented that we hope to participate in paediatrics and endocrinology networks and we need to have specialists that are part of a joined-up service and do not need to have them all. Centres should be seeing complex cases but should not be seeing non complex cases.

CE commented that 50% of children and young people in Birmingham are obese whereas only 4% of children in Amsterdam are obese and asked to what extent should be working with the GPs in the community on this type of problem? ZP said that we have done our internal vision and now need to look at paediatrics within the community and liaise with GPs. Our unique selling point was emergency paediatrics. JA added that they had set up a child-friendly dentistry service in partnership with community dentists which was an example of partnership working. JB asked whether there were any cultural issues around working in the community compared with the Trust. SE said that there were; clinicians are very protected in this environment e.g. they work from a referral letter which contains information and to work in the community is quite a mind shift. JM asked who the principal stakeholders were as the consortia are still in their infancy. HL said there was an opportunity for us to drive it and take the initiative. JA commented that there was a particular opportunity currently with the merge of the three boroughs.

CE congratulated ZP and her colleagues on their performance in the last year. They had demonstrated an EBITA of 15% and an 11% increase in turnover which was very positive and justified the investment. He noted that there was a threat around the potential for re-tendering. Our view is that we won the bid on every single count and to re-tender and lose would be extraordinary. The new facilities are part of that award. However, we do need to be complementary rather than competitive. We do wish to increase our research and our medical facilities and research together makes it world class. He would like to

see us be a bit more visionary with the community and links with the boroughs and move public health forward. AH said that the important issue is trying to get a model for the future but which is not necessarily complete at this stage.

GM asked whether we have a specific plan to market our service. CE said that one of the issues is that we do not have an annual general meeting for this group of patients. We have our general meeting in the early evenings which does not attract mothers and children and we need to understand what is convenient for patients and how we get our message out.

The paediatric team left the meeting.

The Board discussed the benefit of this approach of having Divisions presenting and agreed they had found it very helpful and welcomed the opportunity to praise paediatrics.

2.2 Patient Experience Strategy **TD**

TD outlined the three key areas and the campaign themes and noted that JL had agreed to chair the patient experience group. Some quick wins were suggested and these were outlined on page 6 of the report. It should be recognised that these are first steps and part of the group's remit will be to consider what is the best

CE said it was a very helpful paper and he was pleased to see we had picked up on the results of the survey. The Board agreed that it was important that we focus on three priorities. GM asked whether these three priorities were those as far as patients were concerned e.g. that we prioritise A & E rather than maternity? TD said that the two main themes across the Trust are communication and discharge but the issues will be slightly different in different areas. Everyone has signed up to the themes but will want a divisional focus. CE said that it is important to communicate across the whole organisation. JL said he would like to add the admissions process and having a clear link to discharge. RK said that in his experience discharge is what people are concerned about. JL said he was very pleased to be chairing this group.

JB said that he is concerned about the top-down approach when the personal behaviour of the front line staff troops is critical. CW commented that the last few hours were very important which is about drugs, transport and logistics.

2.3 Quality Account **CM**

CM outlined the key parts of the Quality Account. She emphasised that it was still draft and that the figures need to be updated and that it needs to be checked for readability and needs to be reduced. She also noted that Monitor require external audit on targets (cancer, *C.Difficile* and a local indicator).

The statement by the Chief Executive should include what we have done and our priorities for next year. Section 2 outlined last year's priorities. She noted that in some areas the data collection had been difficult and although we did not necessarily achieve all of our objectives we did achieve a lot. The priority on venous thromboembolism (VTE) was discussed. MA said we were working on a system of identifying when patients were diagnosed with VTE so we could follow them up. CE noted that a third had appropriate preventative anti-coagulant therapy but still got DVT. CM said that a third of patients will get VTE no matter what the treatment is and although the group will focus on preventable VTE they will also look at those who got VTE despite preventative treatment. MA said that

the numbers from the audit are too small to notice a difference.
CM noted that we did not do as well as we would have liked with the national inpatient survey. AH said it looked like the results from the PET are not reliable as the two bits of information are incompatible. TD agreed.

CM noted that surgery had achieved very close to the objective of 100% and that the falls reduction had been achieved.

CM outlined the new priorities. She noted the difficulty in measuring a 20% reduction due to difficulty in extracting the data and a target of zero had been agreed, although this may not be achievable in the first year. MA likened it to having a zero target for MRSA when five years ago we had fifty cases and now it is six. MA said that one third of patients will get VTE and some people have diseases which means they are at higher risk. We will aim to get zero but that will not be achievable in the short term. JL felt that this needed to be further defined. CE asked how we define preventable. MA said it is when patients are given the right preventative treatment but still get a VTE. AH said it was like antibiotic treatment which is not always successful.

Regarding the patient experience priority the governors and the Kensington & Chelsea Local Involvement Network (LINk) were happy with what had been identified. LINk would do spot checks on dignity and also would assess the impact of the strategy on discharge when we were a bit more established.

CM outlined the third priority on clinical effectiveness. JB said he understood the improved satisfaction and the waiting time but queried an improved satisfaction rate of 10% where there was not a baseline. CM said that this had been discussed in some detail with the Division and they also found determining a target very difficult. MA outlined the issue of nil-by-mouth where patients may be starved all day for several days. AP said it was about lack of communication. CM said a previous version of the objective had no target and if the Board approved this she would revert to the previous objective. This was agreed.

CM confirmed that the fourth priority from last year would not be taken forward. This was agreed.

LB commented that this is difficult data to make sense of and we should perhaps reflect and acknowledge that and though we did not manage to do all of it is the beginning of a journey. **The Board agreed.**

JL drew attention to the Statement of Income and said it was not very clear. CM agreed and explained that it was about ensuring that Trusts reflected the majority of services in assessing their data and that this was a statement that was required in that format by Monitor.

TD said that at the recent governors quality meeting one of the governors had said how important staff experience was for the patient experience and that this should be addressed. HL agreed and suggested that this would be fourth priority. This was agreed.

2.4 Risk Report. **CM**

This item was starred.

2.5 Register of seals **CM**

This was not discussed

2.6 Standing Financial Instructions. **CM**

This item was starred

2.7 Standing Orders **CM**

CM outlined the changes. **The Board agreed to the changes and approved the Standing Orders**

2.8 Reservation of Powers to the Board and Scheme of Delegation **LB**

B outlined the two key changes. **The Board agreed to the changes and approved the Reservation of Powers to the Board and Scheme of Delegation**

3.1 Audit Committee Minutes – October 2010 **AH**

This item was taken as read.

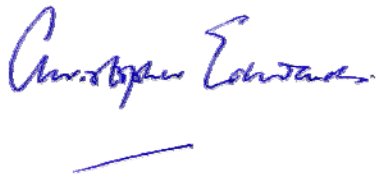
3.2 Finance & Investment Committee Minutes – January 2011 **CE**

This item was taken as read.

5 DATE OF NEXT MEETING – 26 May 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