Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting 27 January 2011
Extract of approved minutes

Present

Non-Executive Directors	Prof. Sir Christopher Edwards	CE	*Chairman*
	Andrew Havery	AH	
	Prof Richard Kitney	RK	
	Sir Geoffrey Mulcahy	GM	
	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	*Director of Nursing*
	Mark Gammage	MG	*Director of Human Resources*
	Amanda Pritchard	AP	*Deputy Chief Executive*
In attendance	Catherine Mooney	CM	*Director of Governance and Corporate Affairs*
	Bill Gordon (in part)	BG	Director of IT
	Fleur Hansen (in part		
	Dr Paul Hargreaves (in part)	PH	Consultant Paediatrician and Designated Doctor for H&F and K&C
	Monica King (in part)	MK	Staff Nurse
	Kingi Aminu		Named doctor for safeguarding children

1 GENERAL BUSINESS

1.1 Welcome to Sir Geoffrey Mulcahy — CE

CE welcomed Sir Geoffrey Mulcahy to his first meeting and congratulated Therese Davis on her appointment as the substantive Director of Nursing. He also congratulated Mark Gammage on his definitive position as Director of Human Resources.

He said that there had been some problems with iPads and expressed his gratitude to IT for all their hard work in achieving the first paper free Board meeting

Bill Gordon said that he would now be looking at virtual Board apps and will liaise with Apple representatives over the problems we have experienced.

1.2 Apologies for Absence — CE

There were none.

1.3 Declaration of Interests **CE**

There were no declarations of interest

1.4 Minutes of the Meeting of the Board of Directors held on 25 November 2010 **CE**

Minutes of the previous meeting were approved as a true and accurate record with the following changes: CE noted under item 1.5 that the McGill Chair appointment is Professor Masao Takata.

1.5 Matters Arising **CE**

1.4./Nov/10 Matters Arising
1.4.1 Proton Pump Inhibitor (PPIs) Audit and stopping PPI's
CE outlined the background and a link between proton pump inhibitors and *C. difficile.* MA said that changes to the prescribing of proton pump inhibitors for patients on admission (i.e. stopping them where possible) had now been agreed with Medicine and will be agreed with the other directorates.

CE said the cost of an extra 30 days in hospital should be noted to be at least £6K.

TD confirmed that a strategy for other infections was being considered and had been discussed at by the Infection Control Group committee earlier this month. A smaller group will be set up to take this further.

Action: to report back on strategy for other infections at April Board **TD**

1.7/Nov/10 Chief Executive's Report
A report on the work of the volunteers will be scheduled for the April meeting **TD**

2.2 Performance Report commentary - October 2010
An update on progress with single sex accommodation was covered in the performance report.

Follow up on reporting of false positive results
CE confirmed that this matter arising was regarding having to report MRSA contaminants i.e. when the patient did not have MRSA bacteraemia. TD confirmed that this does have to be reported and she said that all bacteraemias are now being treated as serious untoward incidents.

HL confirmed that the 7th MRSA which was noted in the performance report was community acquired and therefore we remain at 6 cases.

With respect to the *C.Difficile* tests we are using being more sensitive, TD reported that she had written to the Department of Health (DoH) and the DoH had agreed that we could report clinical cases of *C. Difficile* and not all cases in which *C.Difficile* was detected.

5/Nov/10 Any other business - MRI scanner
5/November/10
CE confirmed that this had been discussed in some detail at the Finance and Investment Committee and the decision was reflected in the matters

arising paper.

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

CE said that a consultation on education and training came out on 20th Dec with a response required by 31st March and he said we should think about how to coordinate a response. HL said that HIEC will respond and NWL are setting up a group. MG has been put forward to join the group along with HL. CE noted that he had some conflict as chair of Medical Education England.

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

CE said that many of the Board will have met the new governors and he and HL had met them individually this morning. He said the report will be taken as read as we have been through the issues before. A key area is how we can improve the ability of the governors to liaise with their constituents.
AH attended at 2.15pm.

1.8 Chief Executive's Report **HL**

HL reported that there had been unprecedented numbers of patients attending A&E in December to January (430 instead of a maximum 330). The problem was with seriously ill patients presenting not specifically about 'flu'. 'Flu' had affected young men under 30 and pregnant women. The hospital would normally ventilate 6/7 patients in ITU whereas we had been ventilating 10 patients in ITU with another 1/2 patient in Recovery and 8 level 1 patients (normally 2-4) in AAU with more in down stream wards.

HL had set up Gold Control (as in our Flu Plan) which had met daily with Divisional Medical Directors input. TD and AP had done an excellent job in keeping the hospital operational and safe. This has resulted in some cancelled elective surgical operations. Our focus has also been on achieving the key targets – 18/52 waiting time, 98% 4hr target in A&E and financial targets. We are aiming to reinstate the cancelled elective work in order to achieve our 18/52 week target and income.

We are penalised on emergency admissions and receive only 30% of the tariff for emergency admissions beyond the 2008/9 out turn. This amount is currently being assessed by the finance team. However we will have mitigated this impact by additional ITU income and that staff who were absent were unable to be replaced by agency due to travel conditions and staff sickness.

The result is this additional activity has resulted in some slippage on Trustwide schemes, for example the Electronic Document Management Project.

AP said that of the 47 patients who had been cancelled for elective procedures, 34 had already been treated. We contracted with the Cromwell for 5 bariatric patients requiring surgery and in terms of extra costs the worst scenario was a £20k increase and the best was £10k increase.

Action: Chairman to write to the Trust on behalf of the Board thanking them for all their hard work. **CM**

AP confirmed that we are catching up now and there had been a great

deal of flexibility from surgeons and others. All patients who were postponed were told personally and new dates have been arranged.

HL outlined the position with the International AIDS Vaccine Research Initiative (IAVI) i.e. that we have agreed a collaboration with Imperial College and IAVI wherein they will remain at C&W taking over part of the vacated microbiology space. This is an excellent outcome for all three organisations. She also noted our position with respect to consultant overtime. She noted the Trust response to the FTN Network consultation.

3.35pm FH attended.

HL noted the situation with bank holiday annual leave on the day of the Royal Wedding and that other local Trusts were giving it, however it was estimated it would cost between £400 -500k. She said that we may be a bit unusual for not regarding it as a Bank Holiday. She questioned the extent to which patients would want to come in on that day. A&E could possibly be very busy as we may be a designated centre. AH suggested that we could write to people in advance asking whether they would be coming in as electives.

The Board agreed the decision regarding 26th April not being regarded as a Bank Holiday. It would be a normal working day and staff would request annual leave as normal. Those staff who work on that day would receive an additional day's leave in lieu.

HL noted the Burns Appeal and the Sunshine Appeal.

She said we now know the situation with paediatric specialism London-wide. Guys and St Thomas' and Great Ormond street will be the two hubs South and North. There are 28 providers in London of which 26 say they offer specialist paediatric services. We are the 5th largest with St George's and the Royal London also ahead of us.

She also noted the strategic need to consider our position in relation to Burns.

She noted the proposal re integrated care organisations. CW asked if patients could be referred anywhere in the country and HL confirmed that in theory this was true.

2 PERFORMANCE

2.1 Finance Report Commentary – December 2010 HL

CE noted that two tables on the paper are blank on the iPad. LB said she had noted this and paper copies were distributed.

LB reported that we are broadly on plan, pay continues to be under control and there has been an increased focus on debt in the Finance and Investment Committee. We need to focus on NHS debts and ensure we are not left with any following the changes in commissioning. Processes are being reviewed and the actual risk will not materialise for another year. There is still some outstanding debt in dispute and we are bringing it to a head by discussing it with the new head of commissioning. They claim there is £1m in dispute but which we think is significantly less.

LB confirmed that with NHS debt we do tend to recover it or strike a 50:50 deal

GM asked about the extent of non NHS debt. LB replied that it is usually overseas debt and CE noted that we are now more strict about payment for elective operations. For private work we have specific private patients' management and there are issues around the processes for recognising debt. We now have a mechanism for credit cards.

There is one category where we have not made provisions, which is road traffic accidents and the NHS Injuries scheme. The usual practice is not to provide for this but LB will attempt to find out more.

MA asked if there is a category for staff debt i.e. where we have overpaid and have no way of contacting the individual or recovering it. LB confirmed that there was. HL said the executive team need to look at this in more detail.

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

2.3 Urgent Care **MG**

MG described the process. There were three areas to focus on. 60-70% of adults had been seen in the Urgent Care Centre and table 2 demonstrates a decrease in admissions. With respect to the finances, the aim is to try to make care less expensive and an incentive payment has been agreed which is £300 for each decrease in admission.

MG emphasised there was still a great deal of learning and the outstanding risks are mainly around IT and no disclosure of HIV details to GPs and we have a way of managing this. The other risk is the interface between Lastword and Adastra and software called Blue Prism allows the interface and we are working on this. CE expressed concern about the reputational risk and financial risk. MG said that all GPs have been through an assessment and vetting process and had been inducted by us. He is confident that systems are in place including what to do when GPs are sick and need cover.

MA said November and December may be unusual because of the huge increase of activity and questioned what the position would be if the activity was as before. HL said it is important to understand the development in Earls Court. CW asked if the triage nurse is employed by us. MG said he was not sure and would find out. LB confirmed that there was five year a contract.

CE summarised by saying that the interface problems have been noted ad we will continue to monitor the situation, including the financial position.

Confirm employment of triage nurse **MG**

3 ITEMS FOR DECISION/APPROVAL

3.1 Safeguarding Children Annual Report 2009/10 **TD**

Dr Paul Hargreaves, Monica King, Kingi Aminu and Lyn Ronnie attended for this item and the next one.

TD introduced the paper by apologising for it being late to the Board which was due to a gap between the old and new Directors of Nursing.

PH said that the first section outlined the background and he noted in particular item 3, roles and responsibilities, and item 4.4 and local developments e.g. flagging.

He said there was a robust Did Not Attend (DNA) and midwifery services had been strengthened and child death procedures are being reviewed.

Section 9 covers arrangements with external agencies and section 10 covered Child Protection Training which was the main focus of work where more was required.

The report was noted.

3.2 Safeguarding Children Report April – December 2010 TD

TD introduced the report for April to December 2010. A mid-year report is not usually provided to the Board but she felt it was important to update the Board as the annual report was late.

PH noted that the national child database is now not happening but there would be a review of child protection arrangements in the UK by the National Safeguarding Delivery Unit and a report is expected in 2011. He drew the Board's attention to Section 5, the RBKC Safeguarding Inspection Team report. They had been very impressed by the arrangements.

PH corrected an error in the paper under Section 5.3, second bullet point, which should read "increase the frequency of *community doctors*, (*not social workers*), attending case conferences". He noted that a comprehensive risk assessment had been undertaken. It is recognised that training is the area where extra work was required.

CE thanked the team for all the work that they do and recognised this is very important area. However he highlighted a concern with training.

MK said that an inter-collegiate document had now defined levels 1, 2 and 3. She said she was new to the trust and felt that the levels of awareness were very good and there was a good coverage of well trained staff. This new document highlighted that staff were not trained and aware to the level that is expected. She noted that the figures were slightly better than in the report, for example 88% of new doctors are now trained. She explained the difference between level 2 and level 3. Level 2 is required for staff working with children and Level 3 is needed for staff involved in case reviews.

HL identified a concern expressed by Baroness Ritchie when the social workers rooms were moved, that this would affect availability of social workers for meetings. PH said this had been resolved and most happened off site usually at short notice.

LB said that we had declared to Monitor that all staff had Level 1 training, however this report was saying this is not the case. HL reminded the Board that Monitor required 80% of staff to be trained and the Board had

made the decision that this should be100%. TD confirmed that we do have 100% of training and there are recording issues. CW asked if these were self-imposed targets and TD confirmed that there were and that a year from now we hoped to be up to 100% of training for all levels. She said we needed strict processes in place and to ensure training is being recorded.

KN emphasised that the Board needed to be assured that the plan was in place. MK said it was important to look at recording. At level 1 the records say that 80% have been trained but she knows this is more. Level 2 and Level 3 training is not as high as she would like and the number of staff with Level 3 training would need to be increased according to the new guidance. CE asked where the plan was to address the gap? MK said there is a plan for online learning and a full training needs analysis is being undertaken. There is a need to be more imaginative about how training can be delivered.

CE summarised by saying that the function of this paper is to reassure the Board and for the Board to receive any concerns expressed by the team. He felt the Board should perhaps receive a summary regarding training at levels 1, 2 and 3 and the actual deadlines when the staff need the training.

He said the second point was, are there things they could be doing better? KA said there is a very small team delivering the training and levels 2-3 need to be face-to-face. Level 3 is supposed to be inter-agency training so this is not necessarily in our gift. HL said that as we expect social services to have less money will we expect to see a decrease in funding? KA said this was not within the internal social services team. MA asked about contracted out staff and how confident we were with their training? MK confirmed that the training included these staff. CE thanked the team for coming and looked forward to receiving the figures as discussed.

Action: to come back to the next Board with more definitive figures on training **TD**

3.3 Assurance Committee Report* **CW**
This was not noted due to time constraints.

3.5 Maternity Services Review **AP**
This was not discussed due to time constraints.

3.7 NHS Operational Framework **HL**
This was not discussed due to time constraints.

3.8 NWL Sector Strategy update/corporate planning **HL**
This was not discussed due to time constraints.

3.9 IT Strategy – update **RK/HL**

RK outlined the IT Strategy. He said we rely heavily on LastWord which is very good but is coming to the end of its life. The hardware is supplied by Hewlett Packard and that needs to be replaced also at a cost of approximately £0.5million.

The first part of the paper is an outline of the strategy and the impact on

the Trust. He summarised the problems and listed the core services. He said we may need to move to a patient-centric approach and include the potential for social networking. He felt that we do want a web-based system. There were two front runners, Millennium and Lorenzo and a third one called Epic.

He proceeded to demonstrate a portal system which included a clinical portal, patient portal and research portal. He said he would like to do a detailed study on Millennium and Lorenzo systems and develop a strategy for a portal system. CE asked if we were accessing huge amounts of data is there a problem with access to the server and will we have one on site. RK confirmed that the preference is to have one on site. BG said that other work was being undertaken to rationalise the IT system and looking at cloud technology. It was important to ensure that services are cost effective. CE commented that the patient portal was very important i.e. the ability for patients to relate to their own data. It should be possible to locate patients by GPS chips i.e. to see where they are in the hospital. KN asked how if everyone has a wish list this will be reconciled. HL said that the White Paper was about care across sites and a range of providers. We need to address the old system as well as take into account the future. Whatever else we do we need a modern system. We will take the project forward with a steering group and a core group of the executive but also involve the divisional structure.

GM asked whether we will implement it in manageable chunks or a big bang approach? HL said that LastWord was implemented using a big bang approach and it worked. She suggested for the core IT system we would need a big bang approach but would phase other sections of the system.

LB said that the scope needs to help us manage the business for example, include patient costing. RK said he is unaware what is offered but will include that.

LB asked if we are considering just Millennium and Lorenzo, whether they are limiting our approach? RK said that these are the two that are widely used. HL said Imperial are putting in Millennium and RMH and RBH work on bespoke systems.

CW asked how much we should involve others. RK said this will be considered in the weighting but HL said that we cannot wait for others because otherwise we will have a defunct system.

MA said that the advantage of the portal was that it was future proof because we can replace bits at a time and it seems to have a greater functionality. AH asked how the system would handle data between different applications within the portal system. RK said it works on the HL7 international standard which allows links.

CE summarised by saying that we will come back to a more detailed discussion in May.

3.10 Proposed amendment to Standing Orders re opening tenders* CM

This was not discussed due to time constraints.

3.11 Assurance Framework Report and Review of Corporate Objectives Report Q3 CM

This was not discussed due to time constraints.

3.12 **Monitor In-Year Reporting & Monitoring Report Q3*** **LB**
This was not noted due to time constraints.

3.13 **Risk Report Q3*** **CM**
This was not noted due to time constraints.

3.14 **Register of Seals Report Q3*** **CM**
This was not noted due to time constraints.

3.15 **Register of Interests Review** **CE**
This was not discussed due to time constraints.

3.16 **Remuneration Committee Report** **CE**
This was not discussed due to time constraints.

3.19 **Open Day 2011 – proposal** **HL**
This was not discussed due to time constraints.

4 **ITEMS FOR INFORMATION**

4.1 **Assurance Committee Minutes – 29 November 2010** **CW**

This was not noted due to time constraints

4.2 **Audit Committee Minutes – 21 October 2010** **AH**

This was not noted due to time constraints

4.3 **Finance & Investment Committee Minutes – 18 November & 21 December 2010** **CE**

This was not noted due to time constraints

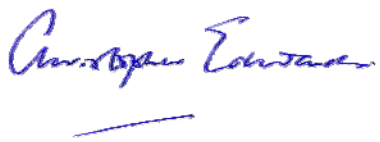
4.4 **Supply of Phaco Emulsification Machine & Consumables Contract** **LB**
This was not noted due to time constraints

5 **ANY OTHER BUSINESS**
There was none

6 **DATE OF NEXT MEETING – 31 March 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