Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting 29 September 2011
Extract of approved minutes

Present

Non-Executive Directors	Prof. Sir Christopher Edwards	CE	*Chairman*
	Sir John Baker	JB	
	Jeremy Loyd	JL	
	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	*Chief Nurse and Director of Patient Experience and Flow*
	Amanda Pritchard	AP	*Deputy Chief Executive*
In attendance	Mark Gammage		*Director of Human Resources*
	Catherine Mooney	CM	*Director of Governance and Corporate Affairs*
	Dr Berge Azadian (in part)	BA	*Director of Infection Prevention and Control*
	Nick Cooley (in part)	NC	*Antimicrobial Pharmacist*
	Rosalind Wallis (in part)	RW	*Infection Control Consultant Nurse*
	Dr Nick Hale (in part)	NH	*Nurse Consultant for Vulnerable People*
	Jonathan Harris (in part)	JH	*GP Relationship Manager*
	Helen Elkington (in part)	HE	*Head of Estates and Facilities*

1 GENERAL BUSINESS

1.1 Apologies for Absence — CE

The Chairman welcomed everyone to the meeting.

Apologies were received from Andrew Havery and Richard Kitney.

1.2 Declaration of Interests — CE

None.

1.3 Minutes of the Meeting of the Board of Directors held on 28 July 2011 — CE

Minutes of the previous meeting were approved as a true and accurate record with the following changes:
- P8 section 3.3, 3rd para the last sentence ‘CE’ should be replaced with ‘CW’.

LB had some minor amendments which she would supply.
Action: To amend minutes in line with comments received. **VD**

1.4 Matters Arising **CE**

2.2/Jul/11 Performance Report Commentary
MA reported on the data for deaths. He clarified that that this refers to patients who are admitted at the weekend and subsequently die rather than patients who die at the weekend. We have heard that we are one of the best in London but the data is not available.

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

HL described the Cancer Crescent to cover SW, SE and NW London. Commissioners had failed over time to get the changes required to improve clinical outcomes for cancer. Ruth Carnall has prioritised 'saving 1000 lives from cancer' and setting up a cancer network. Providers have recommended there should be two London Cancer Networks. There are five strands of work within each of these networks including end of life care and acute oncology. Governance arrangements and who would sit on the Cancer Board are being developed. Two of the meetings have been hosted here.

MA said that in order to save 1000 lives there should be more early diagnosis, not a focus on treatment. KN asked how much cancer we do and MA said not much compared to the cancer centres, but we do HIV related haematological cancers, skin, lung and colorectal, however, we play a key role in the diagnostic aspects of cancer.

1.6 Council of Governors Report **CE**

CE noted in particular the Away Day on 24 November 2011. He said that Ruth Carnall was coming in the morning for the Board only. He proposed that that there will be discussions in the afternoon with the Council of Governors around open Board meetings. If we were going to have open Board meetings he would like to be creative about how to do this. One example might be that every other meeting was a strategy meeting and not a Board meeting. It will be important to consider the balance of time with the governors to ensure there is time to focus on strategy.

He emphasised the need for separate thinking. JL supported the opportunity to discuss the strategy and look at some issue in more detail. A suggestion was that there were 5 to 6 public Board meetings with the strategy meetings in between. Another option was to have a formal Board meeting every quarter.

CE said it was very important to note what had to be done and when and how from a governance and legal perspective. JB felt that more could be handled below Board level.

GM suggested that the finance and performance report should come every month and be much shorter.

1.7 Chief Executive's Report **HL**

Finance Update
HL highlighted that we have met the financial targets but not the cost improvement programme. She said that £3m had been held in reserves for incremental drift. This appeared overly cautious and she had agreed to release £1m.

Medicine are struggling with their CIPs e.g. with the new to follow up ratio and discharge. She had agreed a loan with them from reserves for demand management for £450k on the condition they deliver a number of financial objectives. Her rationale was that the reaction to the need to deliver on CIPs would be to reduce the number of nurses and this would have an effect on the quality of front line services.

We need to focus on additional income and the rate determining step is the speed with which we can relocate paediatrics to the 1st floor.

New Generator Installation
HL noted the significant risk of power failure this weekend due to the need to replace the generators. She had been through the plan in detail and was confident that it was comprehensive.

She wanted to share with the Board how impressive the Trust is when clinicians and managers have to work together.

Treatment for Injured Libyans
Regarding the treatment for injured Libyans, it is highly unlikely we will get them but we are registered and able. She noted that Mr Nott was the only surgeon in the country who had been to Libya and was aware of the situation and potential needs.

The newspapers had reported on a fire recently in London which stated that two surviving patients with burns were at St Mary's. In fact, two patients are being treated at Chelsea and Westminster Hospital, and one child is severely ill.

Update on Paediatric Burns
She reminded the Board how important it was to resolve this because of the need to free up wards.

HL reported that our bid had been turned down. Burns consultants have been asked to discuss again with commissioners alternative sources of funding. She noted the change of the internal lead for burns.

JL said that the private patient cap removal raised a number of strategic challenges and he felt that this strategy should be driven by the overall strategic objectives. HL said this was taken into account. She noted that private maternity was built for 90 deliveries/month in 15 rooms and we deliver 70 per month.

JL said he assumed we would talk about this at the strategy day and CE confirmed this was the case. There would be the opportunity for scenario planning especially if the private patient cap is lifted.

CE noted that we have used the private patient facilities when we had an infection outbreak and we need to take this into account.

HL reminded the Board that we want the Burns Unit because it gives us specialist status. Ruth Carnall made it clear during a meetings of Foundation Trusts in London that she perceives us to be a district general hospital.

Trust shortlisted for Health Service Journal Award
We have been shortlisted in two categories of the Health Service Journal Awards 2011 for 'Research Culture' and for 'Clinical Service Redesign'.

Trust shortlisted for HR awards
We were shortlisted in the 'Best for Mothers' and 'Best for Carers' categories of the Top Employers for Working Families Awards 2011. HL noted that the competitors were all private sector.

HL noted that we have had an unexpected elective surgical death which is being investigated.

She also drew attention to a 'Never Event' which has been reported in the performance report. This was due to a retained vaginal swab. She understood that there were complex arrangements in theatres regarding swabs in these particular circumstances.

2 PERFORMANCE

2.1 Finance Report Commentary – August 2011 LB

LB noted that overall we were broadly on plan and outlined the key issues in the summary section of the paper.

She noted that the Doughty House loan is unlikely to be significantly utilised in year.

In relation to the London Specialist Commissioning Group contract, the outstanding point regarding the agreement of the HIV contract had been settled 50/50. It was felt to be more important to have discussions regarding future commissioning.

The aged debt has increased and this is due to unpaid SIFT bills (£1.7m outstanding, £1.2m relates to 2010/11 and £0.5m is current year) from Imperial College Healthcare Trust. She has informed the Finance Director of Imperial College Healthcare Trust that we are holding back an equivalent amount on the pathology contract. She noted that there is some uncertainty at Imperial Healthcare as the Finance Director has left and a new director is not in post yet.

She confirmed that we have no deposits outstanding on government accounts.

GM said he noted that we were behind the plan in some areas and asked if we were running under capacity. LB said it was hard to say but there are decreased referrals in some areas. HL said it could be the capacity plan or demand management beginning to work.

AP said that there was lower level of activity this year compared to the same time the last year, but there was not a decrease in referrals except in

diabetes. There could be a simple answer such as consultants being away in August. This needed to be built in to planning in future. Most areas think they can catch up simply by consultants returning to work, others need to do more to catch up.

KN asked if there is a policy on new to follow up ratios. MA confirmed that there was but said that some patients are difficult to discharge for example they may require drugs that can only be prescribed by hospital doctors. Other appointments will only need one visit. He said this area is still relatively new and not sophisticated at the moment.

2.2 Performance Report Commentary – August 2011 **AP**

AP outlined the new performance monitoring approach and said that it was work in progress.

She noted that there were some gaps e.g. workforce and there needed to be sufficient profile on the Quality Account priorities. She noted the intention to align the indicators to the pathways eventually.

AP confirmed that Monitor compliance of zero was good.

She noted that the discharge summary CQUIN was 85% within 24 hours but we set our own target of 100%. A Discharge target of 82% was achieved for August and 85% for September so we are gradually improving.

MA said that paediatrics is the biggest challenge and has the least engagement. This is the area of biggest staff vacancy and there are number of small sub specialities, for example neurology where there is only one consultant and she is on maternity leave.

AP said there had been a significant improvement in timeliness of outpatient letters in some areas but there are some with significant backlog. She confirmed that following the suggestion at the Board last month extra resources had been put. This has been helpful. There are some teething problems with the system.

She said that there had been an alert from the CQC regarding our 35% caesarean section rate. She said that we are always higher than average overall but it was a marked increase in elective Caesarean sections which triggered the alert.

She noted that if women have had an emergency caesarean section with their first child they are more likely to have an elective caesarean section subsequently so we focused our attention on emergency caesarean sections.

Epidurals are linked to caesarean sections and we have a very high rate of epidurals. This is possibly due to having 24 hours anaesthetic cover and this is what attracts patients.

CW asked if we wanted to decrease the epidural rate. AP said not as it is part of choice which we do not want to restrict. However, we do need to explain the impact of epidurals for example the increase risk of complications. She also noted that the caesarean section is about culture.

We have a medical model of care and therefore a clinician is likely to intervene. We need to firm up guidance for medical intervention.

We also routinely scan big babies which inadvertently suggests a possibility of caesarean section and we have decided to stop doing this. MA noted that the clinical assessment of whether the child is large is poor.

AP said that new NICE draft guidance allows women to opt to have caesarean section.

LB noted that there was a profit and loss implication to decreasing caesarean section rate.

CE asked for more on this at the next Board to include the issues that have been discussed with more data. He said it would be helpful to bring an obstetrician.

Action: Provide more data on increased caesarean section rates and invite an obstetrician. **AP**

3 ITEMS FOR DECISION/APPROVAL

3.1 Infection Control Annual Report 2010/11 TD

Dr Berge Azadian, Director of Infection Prevention and Control, Nick Coolley, Antimicrobial Pharmacist and Rosalind Wallis, Infection Control Consultant Nurse attended for this item.

BA said that it was a statutory requirement that the Infection Prevention and Control Director presented a report to the Board. The report was structured according to the DH guidelines.

He noted that we were doing well with MRSA and the target for this year was the same as for last year (the Department of Health target was 3 hospital acquired cases and Monitor tolerance was 6).

BA reminded the Board that previously there was a concern regarding whether blood was correctly taken. BA said that the progress against targets on this was outlined p. 20-21 of the full report. Initially MRSA bacteraemias was measured by lab isolates, since then clinical elements have being introduced and also whether MRSA is hospital or community acquired.

He noted that in 2004-05 there were 47 MRSA cases and last year there were only 6 cases. We are working hard to ensure this reflects clinical disease. A very strict blood collection kit was introduced to reduce the level of contamination. He described the impact of introducing a blood collection pack. Initially 9.1% of MRSA was due to contaminates at the Chelsea and Westminster Hospital and 9.3% at the Charing Cross Hospital. The blood collection pack was introduced at the Chelsea and Westminster Hospital and the rate of contaminates fell to 3% whereas it remains 9.3% at Charing Cross Hospital.

Every MRSA has a ‘root cause analysis’ undertaken, however, it is difficult to identify trends when there are only 6 in a year.

A further statutory requirement is to report on *Clostridium difficile* rates.

Last year there were 111 hospital acquired *Clostridium difficile* of which 73 were hospital acquired and 55 were clinically significant. It is very important to identify the presence of the organism and the actual disease.

Multidisciplinary groups go through every *Clostridium difficile* case to identify if it is the *Clostridium difficile* toxin gene or *Clostridium difficile* infection

It is also a statutory requirement to report on Orthopaedic surgical site infections. Only one area needs to be reported and we report on total hip replacements. To date 136 hip replacements have been carried and only three reported superficial infections. There are strict guidelines regarding reporting.

Regarding Glycopeptide Resistant Enterococci (GRE) we did not have many at the Trust last year. It is seen mostly in departments where vancomycin is frequently used e.g. renal or haematology units.

Meticillin Sensitive *Staphylococcus aureus* (MSSA) is likely to be a new target and it is expected that reporting on *E. coli* will also be a target.

He noted that there had been 6 serious incidents in the year. The St Stephens Centre water system was colonised with Legionella bacteria and corrective action was put in place such as looking at deadlegs and providing filters on outlets. The key is to look whether there is hazard. No patients have been affected.

Regarding antibiotics he clarified that in the summary of the report it should state a 26% reduction in proton pump inhibitors (PPIs) not a 31.6% reduction in. We are working closely with the community.

CE questioned why more action was not taken if it was known that a patient over 65 years old would spend 30 days extra in hospital if they get *Clostridium difficile.* NT said that in the Acute Assessment Unit all patients are screened for the need to have PPIs and if appropriate it is suggested that they are stopped for the duration of care in the hospital. However, many have various co morbidities and it may not be appropriate.

CE explained the difference between a drug like ranitidine (an H2 antagonist) and a PPI and why taking patients off PPIs and putting them on H2 antagonists may not be effective. MA reminded the Board that from a gastroenterologist perspective PPIs can be life saving.

BA reported that the Trust had undertaken an internal assessment against the Hygiene code. He also reported on MRSA screening. The Department of Health required the number of swabs taken and the number of patients admitted. We are trying to marry every swab with a patient.

Regarding decontamination, we are one of a few centres with a centralised decontamination unit.

RW reported on Synbiotix which was very easy to use and to enter data and was proving very good for monitoring. It is possible to ‘name and shame’ by ward.

BA reported on the rest of the report with special emphasis on the Infection

Control Link Professionals (ICLP) who are a tremendous back up to the team. To date 202 ICLPs have completed the training and 136 are still active in the Trust. The remaining ICLPs have left the Trust. RW organises the courses.

CE summarised by thanking the team and congratulating them on performance on the last year.

3.2 Board Level Agreement for Infection Prevention and Control **TD**

TD said that it was requirement to have appropriate management and clinical governance systems in place to deliver effective infection prevention and control. The Board was asked to approve the Board Level Agreement.

The Board approved the Board Level Agreement for Infection Prevention and Control

3.3 Safeguarding Adults Annual Report 2010/2011 **TD**

Dr Nick Hale, Nurse Consultant for Vulnerable People attended for this paper.

TD said that she would welcome any questions.

CE asked about the definition of a vulnerable adult. NH replied that it used to be purely an individual under a safeguarding inquiry, but this has been extended now and includes learning disability, and there is potential for it to be extended further for example patients with dementia. The law defines vulnerable adults in a narrow way. Some patients are vulnerable and not included in the definition.

CE commented on the low training and TD confirmed that training is a challenge.

HL asked where mental capacity fits in. NH said that this has been integrated into level one training.

TD also noted the work that has been undertaken with patients with learning disability as highlighted at the Annual Members' Meeting.

CE thanked NH for the report.

3.4 Safeguarding Children Annual Report 2010/2011* **TD**

This item was starred and therefore taken as read.

3.6 Primary Care engagement **AH**

Jonathan Harris, GP Relationship Manager attended for the paper on the Primary Care engagement.

He introduced the paper and noted that shadow Commissioning Boards will be fully formed from April 2013.

A delegation of executives representing each of the Fulham Road Trusts led

by Heather Lawrence has met with clinical commissioning groups in North West London. Meetings have taken place with NHS Hammersmith and Fulham and NHS Westminster and recently the West London Clinical Commissioning group. The visits have been successful and Kensington and Chelsea GPs in particular hold us in high regard.

He noted the difficulty in getting quantitative feedback, although we have good qualitative feedback.

JB asked whether clinicians and consultants here really understand the importance of communication. CE asked whether when GPs ring do they speak to registrars or should it be consultants>. JH said that at GSTT an administrator answers the call who then refers the caller to a consultant. HL confirmed that rapid access should always be to a consultant.

JM asked if there are any measurable targets and JM confirmed that there were not.

HL said that out of the top 5 GP criticisms of the Trust listed in section 6.3, we have discussed number 1 (missing or late discharge summaries), no. 2 (quality and presentation of clinical information contained within discharge summaries), and no. 3 (medical secretaries phones not being answered) and no.4 (difficulty accessing consultants by phone or e mail) are variable within specialities. JL asked if no. 4 was valid. HL said that it is different for different consultants e.g. in paediatrics there is only one consultant in some sub specialities.

MA said he would be interested in how other Trusts do it. JL said one idea is to have an e mail such as gynae@chelwest and this would be an acceptable solution for GPs. It was agreed that other initiatives should be looked at in more detail.

GM said we need to understand what could be done better. LB asked if we ever asked GPs what we can help with. CE said that when he participated in appraisals it was identified that GPs needed coaching and a link to the hospital would be very helpful.

CE said was interested in GP liaison committees and to what extent did GPs attend. LB said when she worked at UCLH the GP Liaison Committee was well established and well attended.

JL said he was interested in patient portals and the potential for direct communication with patients. He would like to understand the communication workload of those in direct compunction with patients. MA pointed out that there was no income attached to communication unless it is face to face.

HL pointed out that JH has a wider remit than his predecessor which now includes reviewing market share.

GM said he would like to understand why there were not referrals from some areas. JH said it was largely to do with geography. CE noted that GP study days were key way of influencing GPs and asked to what extent we had looked at these. JH said that as part of contract for community dermatology and gynaecology we are obliged to provide study days and these fad been very successful

CE thanked JH for the paper and highlighted the importance of communication and the need to anticipate what GP requirements might be.

3.7 Sexual Health and HIV performance **HL**

MA noted that there was a new clinical lead for Genitourinary Medicine which was Rachel Jones.

Action: Further paper on Sexual Health to be brought to the Board at a future date. **HL**

3.8 Carbon purchasing strategy **TD**

Helen Elkington attended for this item.

She said that the Combined Cooling, Heating and Power (CCHP) plant would lead to a 30% reduction in our carbon usage. She said if we do not achieve the cap we will have to pay the differential which will work out at £120k a year.

CE asked where we were with planning permission. HE said that the application was being considered on 11 Oct. Very onerous requirements have been set but we have agreed to all of them. HE noted that there had been a particular objector but we had dealt with all of his objections.

HE drew the attention to section 5, future procurement options and asked if the Board was happy for us to explore alternative procurement routes for utilities. JB said he was happy to participate if that would be helpful.

The Board agreed to exploring alternative procurement routes for utilities.

3.10 Vice-Chairman of the Board of Directors **CE**

JB left the room.

CE said he had sought the views of the Board regarding the election of the Vice-Chair and the Senior Independent Director (SID).

This was unanimous agreement that Sir John Baker would be the Vice-Chair.

He also said that Jeremy Loyd was chairing the Patient Experience Committee and had agreed to be on the Assurance Committee.

He needed to discuss the Audit Committee membership and the Chair of the Assurance Committee with the relevant non-executive directors.

It was noted that JB would then be the Vice-Chairman, the Chair of the Audit Committee and SID.

GM highlighted the need to confirm that this was acceptable from a governance point of view. HL thought that this would be quite advantageous. CW agreed. CE noted that the SID being the Chairman of the Audit Committee was very helpful as both require independence.

Action: Check if appropriate for roles of Vice-Chairman, Chairman of Audit Committee and SID to be held by one Non-executive Director. **CM**

4 ITEMS FOR INFORMATION

4.1 Research Strategy **CE**

This item was taken as read.

4.2 Assurance Committee Minutes – 25 July 2011 **CW**

This item was taken as read.

4.3 Audit Committee Minutes – 27 July 2011 **AH**

This item was taken as read.

4.4 Finance & Investment Committee Minutes – 18 August 2011 **CE**

This item was taken as read.

5 ANY OTHER BUSINESS

None.

6. DATE OF NEXT MEETING – Thursday, 24 November 2011

The items were discussed in the following order: 3.1, 3.2, 3.3, 3.8, 3.11, 3.5, 3.6, 3.7, 3.9 and 3.10.

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