Chelsea and Westminster Healthcare NHS
NHS Trust

Minutes of the Public Meeting of the Trust Board held on 7th April 2005.

Present: Non-Executive Directors
Juggy Pandit (Chair) Marilyn Frampton Andrew Havery
Charles Wilson

Executive Directors
Heather Lawrence, Chief Executive
Mike Anderson, Medical Director
Lorraine Bewes, Director of Finance and Information
Maxine Foster, Acting Director of Human Resources
Alex Geddes, Director of Information Communications and Technology
Andrew MacCallum, Director of Nursing

In Attendance: Amanda Pritchard. Acting Director of Strategy and Service Development
Pippa Roberts, Acting Director of Governance and Corporate Affairs
Sue Perrin, Head of Corporate Affairs
Patricia Rubin, Interim Manager, Cheyne Centre (item 1.5.7 only)
Mary Sampson, Agenda for Change Project Manager (item 3.3 only)
Helen Elkington, General Manager, Facilities (item 5.1 only)

Note: Item 2.3 was taken before 2.2; and item 5.1 before 4.1

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1. GENERAL MATTERS

1.1 WELCOME AND REMARKS BY THE CHAIRMAN
The Chairman welcomed the members of the public.

1.2 APOLOGIES FOR ABSENCE
Apologies were received from Professor Ara Darzi, Non-executive director, and Edward Donald, Director of Operations.

1.3 MINUTES OF THE MEETING HELD ON 3rd MARCH 2005
The minutes of 3rd March 2005 were agreed as a correct record and signed, subject to:
1.4.2, 2nd sentence should read 'There was public demand for the Centre, but funding was forthcoming only from Kensington and Chelsea PCT ……'
2.1 3rd paragraph, should read 'Equipment lives' not 'Equipment leases'.
4.3 2nd paragraph should be deleted.

1.4 MATTERS ARISING FROM PREVIOUS MEETING
The Trust Board was updated on the following:

1.4.1 CHEYNE DAY CENTRE
This item was covered in the Chief Executive's report.

1.4.2 CONVERGENCE WITH THE NATIONAL CARE RECORDS SERVICE
Alex Geddes asked that the extension of the IDX contract be covered in the

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confidential part of the meeting, as the report contained commercial information. The Trust Board agreed.
The update on NpfIT was covered in the Chief Executive's report.

1.4.3 AUDIT COMMITTEE
It was noted that Alex Geddes would attend the Audit Committee on a regular basis.

1.4.4 BOARD GOVERNANCE
This item was covered in the Chief Executive's report.

1.4.5 CHILD PROTECTION REPORT
Alex Geddes said that the use of a 'flag' in EPR had been implemented.

1.4.6 INFORMATION GOVERNANCE POLICIES
Alex Geddes said that there had been no significant amendments.
It was noted that the work of the Information Management and Technology Committee would be assured by the Audit Committee. Reporting lines would be discussed at the May seminar, ratified by the Trust Board and the changes reflected in the Trust's Standing Orders. SP

1.4.7 ANNUAL GENERAL MEETING, 29th September 2005
The time and venue would be discussed at the June meeting. HL

1.5 CHIEF EXECUTIVE'S REPORT

1.5.1 PERFORMANCE
Heather Lawrence said that the Trust was on track to be within £500,000 of breakeven, and had the potential to meet seven of the eight key targets. The Trust would underachieve on the inpatient waits target. The Trust had met the 98% Accident & Emergency target.
The Chairman, on behalf of the Trust Board, thanked the staff working in both adult and children's Accident and Emergency.
Performance in the balanced scorecard had been varied and the Trust was likely to be in the bottom band for the Capacity and Capability focus area because of the disappointing Staff Opinion Survey. The number of MRSA cases could also impact negatively on the scorecard.
The Trust had scored 76% on the Information Governance Toolkit, and was likely to be ranked 4/5 compared with 1 in the previous year.
It was believed that the Trust would be awarded two stars.

1.5.2 KENSINGTON & CHELSEA PCT FINANCIAL POSITION
Heather Lawrence said that Kensington and Chelsea PCT had a significant deficit. The Trust had written to the PCT setting out concerns that there was a lack of consultation in respect of the Recovery Plan, it would not deliver the savings envisaged, and would compromise the ability to treat patients in a timely manner. Heather Lawrence was a member of the Recovery Board, which had held its first meeting that week.

1.5.3 DIRECTOR OF HUMAN RESOURCES
It was noted that the post had been advertised and interviews would take place on 11th May.

1.5.4 BOARD SEMINAR
Heather Lawrence said that the purpose of the Board Seminar would be to look at the steps, which the Trust Board needed to take to function as an NHS Foundation Trust.

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This positioning day would be facilitated by Giles Peel, the Director of Policy at the Institute of Chartered Administrators and Secretaries.

Pippa Roberts said that the seminar would cover corporate governance in its wider sense, and that The Combined Code would be circulated as background reading. SP

1.5.5 NPfIT (CONNECTING FOR HEALTH)

Heather Lawrence said that the delay in implementing NpfIT in London posed real risks to the Trust, both financially and in terms of a poor return on investment if there was no further progress in LastWord and Care Cast could not be adopted until 2007/2008. The Trust urgently needed to adopt PICIS, the theatre scheduling system, and to progress PACS and Document Management.

As a result of the London NpfIT programme, the Trust had a shortfall of staff in its IT and EPR teams. Heather Lawrence proposed an external review of the IM&T staff arrangements. **The Trust Board supported the external review.**

1.5.6 TREATMENT CENTRE

Heather Lawrence said that the Treatment Centre would be fully open in May. The urological surgery transfer from St. Mary's had been progressed as planned.

The Centre had been subject to a Gateway Review, a formal review of capital projects, and had been viewed as being risk category red. Heather Lawrence said that, whilst she accepted some of the criticisms, she did not agree with their assessment but did acknowledge the need for the Trust to have a full time Estates Team.

1.5.7 CHEYNE CENTRE

Heather Lawrence said that she and the Chairman had met with Mr and Mrs Cameron (parents of a child at the Centre) and Mr Gerrard (parent of a child previously at the Centre). They had agreed to derive a timeline in relation to the possibility of setting up a specialist commissioning scenario for children with severe neurological disorder disabilities, whilst waiting for the outstanding response from the PCT.

A report on the current status, indicated demand for the service, but lack of support from both the surrounding PCTs and Local Authorities. There were three children in attendance, all from Kensington and Chelsea PCT. There would be two from the summer. There were two additional children who had been assessed as potential admissions. Whilst the Kensington and Chelsea block contract was for 4 places in 2005-2006, this fell short in real terms, only commissioning for 2.5 children.

If the Centre was to be closed at the end of the Summer, it was essential for parents to be informed by June.

Two children from Hammersmith and Fulham PCT had been offered places at Cheyne, but had been placed in alternative schools. Their parents had not found these arrangements suitable and had withdrawn them from the service offered. They were currently receiving Care at Home packages, well in excess of the cost of Cheyne.

Westminster PCT had indicated its intention to use services provided within their own borough, such as Rainbow Children's Centre. Parents of children refused admission to Cheyne by Westminster PCT were appealing against the decision.

The Interim Manager's view that a maximum of seven children could be accommodated at the Centre was noted.

2. PERFORMANCE

2.1 FINANCE REPORT

Lorraine Bewes presented the report, which showed the overall financial position at the end of Month 11. The Trust was forecasting a year end deficit of £0.55 million. The improvement was due to an improvement in the SaFF income forecast following a review of the risk around elective over performance and an anticipated increase in

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activity during March in line with previous years. This had largely been offset by increased Pathology Service Level Agreement costs.
There was ongoing work in directorates to identify all billable activity together with negotiations on the Pathology contract. Taken together and provided that directorate forecasts remained on track, it was not inconceivable that the Trust could break even.
The Chairman said that the Finance and General Purposes Committee considered the forecast outturn of between £500,000 deficit and breakeven to be sound.

The Trust Board noted the financial position at Month 11.

2.2 PERFORMANCE

Lorraine Bewes said that key issues had been highlighted in the Chief Executive's report. She confirmed that the outpatients target had been achieved. The Child Protection survey had been published and was with the clinicians for completion.

The Trust Board noted the report and conclusions.

2.3 BUDGET 2005-2006

Lorraine Bewes presented the paper, which set out the proposed budget for 2005-2006. The Trust was not in a position to set a balanced budget. The proposals by Kensington and Chelsea PCT to impose an additional savings requirement on the Trust as a contribution to its recovery plan meant that the Trust's budget would produce a deficit of £1.7 million.
The opening budget showed £4.8 million of non-recurrent savings, which would have to be delivered recurrently. The asset revaluation would result in savings of £5.2 million. Other recurrent pressures were £1.7 million SaFF shortfall, £1.5 million SLA underlying deficit and £400,000 facilities contract. Uncommitted reserves brought forward from 2004/2005 totalled £2.1 million. An underlying deficit of £1.1 million would be brought forward to 2005/2006 compared with £9 million in the previous year. However, there was the additional contribution of £1.658 million to the PCT's Recovery Plan.
There were a number of new cost pressures. There would be SIFT income losses as a result of local re-basing – the transfer of income to hospitals not traditionally funded for teaching. Gains from Payment by Results were now assumed to be zero. There were a significant number of generic cost pressures, not fully covered by the generic uplift. These included a 24% increase in drug costs, 30/40% increase in utility costs, 18% increase in rates and an increase in CNST contributions of £500,000.
The total savings target required in 2005/2006 in order to produce a balanced budget and before the SaFF reductions from PCT Recovery Plans would be £5 million. A draft savings plan had been proposed and this would be worked up into a detailed plan.
Lorraine Bewes confirmed that Agenda for Change had been factored in.
Andrew Havery asked for confirmation of the rates increase – he understood that any increase was pegged to inflation. — LB

The Trust Board noted that:

- **the proposed draft budget together with the key assumptions, which showed a deficit of £1.7 million due to the expected requirement to contribute to the PCT's recovery plan;**
- **the Trust was working with the PCT through the SLA negotiation process to ensure that there was an agreed realistic income baseline; and the risks were with the organisation best able to control them and were consistent with Payment and Pricing rules; and** — LB/June
- **a balanced budget would be brought to the June meeting.** — Trust Board

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2.4 SERVICE LEVEL AGREEMENT (SLA) PROGRESS REPORT

Lorriane Bewes presented the report and explained that the timetable for concluding negotiations by 31st March had slipped, predominantly because the process for agreeing Pricing and Payment Rules within North West London, had not been concluded until 5th April. The revised deadline for concluding negotiations would be 6th May 2005.

The SHA Acting Director of Finance had produced a Financial Framework for 2005/2008, in consultation with Chief Executives and Directors of Finance within the sector, which set out guidelines for principles underpinning the SHA approach to delivering financial balance across the sector.

The negotiation process had involved two parallel work streams, one involving the agreement of principles and technical rules governing all SLAs within North West London, and the other involving the production of Chelsea and Westminster specific information, including detailed activity and financial proposals. It was intended to finalise the paper setting out baseline activity and initial responses by the end of the week.

Lorraine Bewes outlined some of the key changes in the Pricing and Payment Rules since the draft rules were reported to the Trust Board in March. The final proposals provided a more balanced share of risk.

The national tariff would be applicable for elective activity. Community type services such as regular day attendances were not included in Payment by Results. Accident and Emergency Services were subject to local host commissioner arrangements. It was expected that there would be a clear relationship between changes in activity and price paid. This would be an improvement in risk for the Trust, which had seen a 10% increase in Accident and Emergency attendances in 2004/2005.

The proposals required fines for not achieving 100% ethnic coding. The consequences of not recording ethnic coding would be communicated through training and publicity. Lorraine Bewes confirmed that refusal to give the information was a valid exclusion, but this had to be coded correctly.

The Trust Board noted:

- **the timetable and approach being taken to the negotiation of SLAs for 2005/2006; and**
- **that the Trust was proceeding at risk pending agreement of its SLAs**

2.5 STAFF SURVEY 2004

Maxine Foster presented the report, which summarised the Trust's results in the October 2004 second national NHS staff survey. Areas of positive and negative responses had been highlighted as well as significant changes since 2003. There would be further analysis of key areas of concern with the JMTUC and detailed action plans linked to key strands of work would be developed.

The Trust's final response rate had been 56% (1296 staff out of 2341). The Healthcare Commission would base their analysis of the Trust on a random sample of 782 staff of whom 426 responded, representing a response rate of 54%. Maxine Foster agreed to ask for evidence of the 'randomness' of this sample.

Andrew MacCallum suggested that a comparison with similar hospitals would be more useful than comparison with acute trusts nationally. Maxine Foster would look into this. — MF

Maxine Foster replied to a specific question that an action plan had not been produced after the previous survey – it had been used to inform Improving Working Lives. The action plan resulting from this survey would be brought to the June Trust Board, and thereafter Maxine Foster would report to the Trust Board on a quarterly basis. — MF

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The Trust Board noted the report and conclusions.

3. STRATEGY/DEVELOPMENT

3.1 CORPORATE PLAN

Amanda Pritchard presented the Corporate Plan which:

- set out the overall vision for the organisation;
- described the vision in a set of corporate objectives;
- identified the top priorities for each of these objectives;
- translated these into service strategy at a directorate and departmental level;
- summarised the detailed directorate and department plans to explain what was going to be done to achieve the key organisational objectives and priorities in the current year.

The Plan had been developed through a process of consultation and engagement, including a series of open workshops for all staff. It was a 'live' document, designed to be able to incorporate new ideas and respond to changes within the local and national NHS. It was anticipated that the plan would be updated in approximately four months. AP

The Chairman noted the importance of linking with financial resources once the Service Level Agreements had been negotiated.

Pippa Roberts said that the Corporate Plan was all encompassing and would incorporate actions from, for example Clinical Governance and the patient survey. The SHA had agreed that there was not a need for a separate Clinical Governance Action Plan. A Clinical Governance Annual Report would suffice.

The Plan had been distributed widely internally and was on the intranet. It would also be distributed externally.

Andrew Havery said it would be helpful to show information on actions achieved/not achieved. This would be captured in the quarterly updates to the Board and through the integrated performance framework, which was being taken forward by Lorraine Bewes, Amanda Prichard and Pippa Roberts.

The Trust Board approved the Corporate Plan 2005-2006.

3.2 TERMS OF REFERENCE FOR THE ENGAGEMENT AND PARTNERSHIP COMMITTEE

Andrew MacCallum said that, further to the approval of the strategy for engagement with patients and the public at the March Trust Board, terms of reference had been drafted for the Committee. The detailed Action Plan of work would be agreed at its first meeting. AMcC

The Trust Board asked that the following comments be considered:

- the Committee should report to the Clinical Governance Assurance Committee, which would provide assurance to the Board. The Committee would oversee the delivery of the strategy and objectives rather than provide assurance directly to the Trust;
- the committee would champion rather than provide leadership;
- the key actions in the strategy should be given in an appendix to the terms of reference;
- shadow members should be included on the committee; and
- group was more appropriate than committee.

Marilyn Frampton suggested that the User Involvement Group should be formally disbanded. She also logged the need for Standing Orders to be further amended to

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reflect the new Governance structure, for example the Communications and Education Committees were no longer sub-committees of the Board. Lorraine Bewes said that Internal Audit had conducted a review of Standing Orders and would report to the Audit Committee.

3.3 AGENDA FOR CHANGE

Maxine Foster presented the paper, which outlined the progress being made in implementing Agenda for Change and identified some of the risks to the project meeting national deadlines. All NHS staff, with the exception of Executive Directors and Medical staff, had to be assimilated on to the new Agenda for Change pay scales by 30th September 2005, having had their job either matched or evaluated. A large number of Trust staff were on local contracts and they would have the option to remain on these contracts. A standard offer letter would be sent and staff would have three months to decide. It would be proposed to the JMTUC that this period be reduced to 28 days in order to speed up the process.

The North West London Sector had left it to organisations to determine whether any service outside of the NHS would be countable as reckonable service for annual leave, maternity, sickness and redundancy. Whilst this was likely to help recruitment, there was concern that this could be exploited. There needed to be a clear agreement on what was acceptable. Maxine Foster was asked to bring back a proposal to the Trust Board. MF

The suggested notice periods had been locally agreed.

The importance of communication was noted.

Mary Sampson replied to a specific question, that an individual had the right of appeal against a pay banding to another Job Matching/Evaluation Group, but there was no further right of appeal.

There had been no further progress on payments for unsociable hours.

The Trust Board noted the progress and agreed the recommendations:

- **the establishment of a sub group of the Project Implementation Group to determine clustering with reference to the establishment; and**
- **the development of an equitable mechanism to allow for discretion in recognising previous non-NHS service to the organisation.**

4. GOVERNANCE

4.1 RISK MANAGEMENT REPORT

Pippa Roberts presented the report, which provided information, trend analysis and actions taken for incidents, which had been reported at the Trust between October and December 2004. Good risk management practices required ownership of the risk management agenda at all levels of an organisation and the Clinical Negligence Scheme for Trusts (CNST) assessment required that Trust Boards discussed trends in incident reporting on a regular basis. The report had been presented in full for review on this occasion, and it was suggested that, in future, a précis should be received, containing information regarding the total number of incidents in the quarter, the severity, the detail concerning action taken for 'moderate' incidents and above, and the top five incident trends with action taken.

The full report would be considered by the Clinical Governance Assurance Committee, which would provide a commentary for the Trust Board.

Pippa Roberts said that historically risks had been 'owned' by the Risk Management Department, which was not appropriate. Ownership should be with directorates/departments, and staff needed to be accountable for their actions with escalation to the Trust Board if action was not taken.

Pippa Roberts explained the NPSA requirement for a multi-disciplinary review, with

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root cause analysis for serious incidents to ascertain root causes and contributory factors and put in place plans to prevent recurrence. A wider role out of training was planned. The Risk strategy, policy and procedures, were being reviewed.
Charles Wilson noted the high number of incidents in the Women and Children's Directorate and of drug errors. Pippa Roberts advised that a safe risk culture was one where incidents were reported and actions were taken to mitigate incidents. Reporting should be encouraged. She said that, in reality, what was reported was probably a small proportion of the total actual incidents. Pharmacists were key staff into preventing medication errors. On average over 400 prescribing interventions would be made in a week. There was no difference with any other Trust and pharmacists were employed for this purpose. Prescribing and administrative errors were not uncommon.
Marilyn Frampton noted the lack of movement on the Training Database and the Induction Programme. She said that these had been issues of concern as long as she had been on the Board. Maxine Foster responded that the Database would shortly be discussed at the Executive Team meeting and that Induction would be discussed with the Staff side on 14th April.

The Trust Board discussed the information and agreed that, in future, a précis, should be received.

4.2 RISK REGISTER REPORT

Pippa Roberts presented the report, which described how the Trust used the risk register as a tool to monitor progress made to mitigate risks in the Trust. All risks scoring 12+ were recorded in the register and would be re-scored, either when mitigation occurred or by default every six months. The Clinical Governance Assurance Committee had reviewed the register in full and the summary report gave an overview of the Trust's progress to mitigate key risks.
Maxine Foster said that, although the training database was still shown as high risk, significant progress had been made. She outlined the work that was being taken in conjunction with IT and the progress made in respect of mandatory training.

The Trust Board agreed that this level of filtered information was appropriate.

4.3 THE BOARD ASSURANCE FRAMEWORK

The Trust Board had received the current version of the Board Assurance Framework, which had been considered by the Executive Directors and key managers and clinicians, who had identified risks, which might prevent the Trust meeting its objectives in the new corporate plan. The corporate objectives, as discussed earlier, had been developed over the previous three months with directorates, and the assurance framework had been developed in line with the new plan. PR advised that the information from the previous Assurance Framework had migrated into the new document.
The Assurance Framework supported the Statement of Internal Control. The Trust Board confirmed that, at this point in time, there were no potential risks known to be missing.

The Trust Board:

- **noted the process for the development of the Assurance Framework;**
- **endorsed the Assurance Framework; and**
- **confirmed that the gaps in controls assurance would constitute key areas for action in 2005/2006.**

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5 ITEMS FOR APPROVAL/INFORMATION

5.1 SECURITY POLICY

Helen Elkington presented the policy, which had been produced as an initial step towards developing a pro-security culture within the Trust. It would act as an overarching document across a range of related procedures.

The Trust Board asked that the following comments be considered: HE

- the public should have the 'appropriate' level of access, not the 'right of access';
- more publicity in respect of cctv monitoring;
- the meaning of 'verbal assault';
- the yellow and red cards should be seen as a way of avoiding abusive behaviour;
- there should be an indication of areas which could be entered freely, those for which a swipe card was required and those for which an escort was required;
- IT Security Policy and Child Protection should be referenced;
- incident reporting should include visitors;
- the Trust would not guarantee to honour a patient's wishes in not reporting an incident to the police;
- weapons should not be brought on to the premises; and
- there should be a reference to patients' behaviour, which might be inappropriate because of their condition – Helen Elkington would consider the Mental Health Unit's policy.

5.2 REGISTER OF SEALING

The Trust Board noted the report.

5.3 CONSULTANT APPOINTMENTS

The Trust Board ratified the appointment of:
Dr Karen Agnew, Consultant Dermatologist;
Dr Sabita Uthaya, Consultant Neonatology; and
Dr Shu-Ling Chuang, Consultant Neonatology

6. QUESTIONS FROM THE MEMBERS OF THE PUBLIC

There were no questions.

7. ANY OTHER BUSINESS

7.1 There was no other business.

8. DATE OF THE NEXT MEETING

8.1 2nd June 2005

9. CONFIDENTIAL BUSINESS

The Chairman proposed and the Trust Board resolved that the public be now excluded from the meeting because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be concluded in the second part of the agenda. The items to be discussed related to commercial matters and the Paddington Health Campus.