Chelsea and Westminster Healthcare NHS

NHS Trust

Minutes of the Public Meeting of the Trust Board held on 1st December 2005.

Present:

Non-Executive Directors

Juggy Pandit (Chair), Marilyn Frampton, Andrew Havery, Karin Norman, Charles Wilson

Executive Directors

Mike Anderson, Medical Director
Lorraine Bewes, Director of Finance and Information
Edward Donald, Director of Operations
Maxine Foster, 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
Sue Perrin, Head of Corporate Affairs
Robert Atkinson, Campaign Company (item 3.1 Membership Strategy only)

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1. GENERAL MATTERS

1.1 WELCOME AND REMARKS BY THE CHAIRMAN

The Chairman welcomed members of the public.

1.2 APOLOGIES FOR ABSENCE

There were no apologies.

The Chairman said that Professor Ara Darzi had resigned from the Board, but would continue to be involved with the Trust through the Centre for Innovation. The Trust was grateful for his contribution.

Heather Lawrence said that discussions about his successor were taking place with Imperial College.

1.3 CONFLICT OF INTEREST

No conflicts of interest were declared.

1.4 MINUTES OF THE MEETING HELD ON 06th OCTOBER 2005

The minutes of the meeting held on 06th October 2005 were agreed as a correct record and signed, subject to the following:

1.4.1 PICTURE ARCHIVING COMMUNICATIONS SYSTEM (PACS) BUSINESS CASE

The Trust Board had approved the recommendations of the PACS Project Board to purchase the Connecting for Health PACS, *subject to confirmation of interface with Connecting for Health.*

1.4.2 FINANCIAL REPORT – AUGUST 2005

First paragraph, fifth sentence onwards to read: 'The final accounts deficit had been £1.8 million. However, Treasury Rules required that the full £5.2 million had to be repaid in 2004/2005 and the difference of £3.4 million had been reversed back to the Trust in 2005/2006. The forecast outturn for the year end was £0.9 million deficit.'

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1.4.3 MANANGEMENT LETTER
Agenda for Change – 80% of staff had been *matched* (not assimilated).

1.5 MATTERS ARISING FROM PREVIOUS MINUTES
The Trust Board noted the update on matters arising and discussed the following:

1.5.1 FINANCIAL REPORT
The report on the Private Patients Recovery Plan had been withdrawn.

1.5.2 CHILD PROTECTION QUARTERLY REPORT
Mike Anderson said that he had not spoken to Paul Hargreaves regarding the draft letter, on behalf of the Trust Board, setting out concerns regarding Capio Nightingale House, and would do so urgently. MA

1.5.3 PERFORMANCE REPORT
Lorraine Bewes said that figures backdated to April were being re-worked and the figures inclusive of patients without an NHS number would be incorporated in the following month. LB

1.5.4 CHARITABLE FUNDS ANNUAL ACCOUNTS
Lorraine Bewes said that Deloitte had advised that the change of status to Section 11 did not have to be shown as a post balance sheet event, as there was no financial impact. Section 11 had been noted in the chairman's and the trustee's reports.

1.5.5 ANNUAL HEALTH CHECKS/STANDARDS FOR BETTER HEALTH
The declaration had been signed by the Chairman and four executive directors, and submitted.

1.5.6 ANNUAL COMPLAINT AND PALS REPORTS
Andrew MacCallum said that the suggested amendments had been discussed with the Complaints and PALS team.

1.5.7 CORPORATE PLAN
Amanda Pritchard said that a list of specialist services would be incorporated in the March update.

1.6 CHIEF EXECUTIVE'S REPORT
The Trust Board noted the Chief Executive's report and discussed the following:

1.6.1 STANDARDS FOR BETTER HEALTH
Heather Lawrence referred to the internal auditors' report, which had recommended that the Trust Board should agree a definition for 'significant' in terms of risk. The proposed definition was 'A significant risk is where there is a high probability that a serious hazard could or has resulted in severe negative effects that cannot be or was not prevented or avoided and in the Trust's Risk Matrix score 20 or above'.
The Trust Executive would review the Risk Register and consider the scoring. In future, an Executive Director would score all risks.

The Trust Board approved the definition.

1.6.2 FINANCE
The Trust was on schedule to achieve a £2.1million surplus as requested by the North West London SHA. This exceeded the statutory duty to break even.

1.6.3 PERFORMANCE
Heather Lawrence noted that management action had been taken with regard to the targets for thrombolysis and patients in hospital over 20 days.

1.6.4 AGENDA FOR CHANGE
Heather Lawrence said that 98% of posts had been matched and these were being assimilated. Original estimates of the financial implications appeared to be correct. Assurance of this would be given to the Trust Board the following month. HL

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1.6.5 NATIONAL INSTITUTE FOR INNOVATION AND IMPROVEMENT

Heather Lawrence said that she was pleased to report that, as a result of a tripartite initiative involving the Institute, Imperial College and the Trust, a designated hub would be established at the hospital.

1.6.6 SENIOR STAFF

Catherine Mooney, currently Head of Clinical Governance at Hammersmith Hospitals NHS Trust had been appointed to the post of Director of Governance and Corporate Affairs.

Matthew Akid, currently Media Relations Manager at the NHS Confederation had been appointed as Head of Communications.

Heather Lawrence noted that Amanda Pritchard would be leaving the Trust that month and thanked her for her excellent contribution. Several options were being considered in respect of a replacement.

2. PERFORMANCE

2.1 FINANCIAL REPORT – OCTOBER 2005

Lorraine Bewes presented the report, which showed the forecast position for the year-end of a surplus of £2.1 million. She outlined the four significant risks:

- Possible shortfalls on the over performance income to offset HIV drug increase;
- Provision for doubtful debt, in particular, over performance relating to 2004/2005;
- Demand management initiatives and caps on the level of follow-up outpatient appointments that the PCT would fund;
- Delivery of savings plans, both in the current year and recurrently in the following year.

The Hammersmith & Fulham PCT Service Level Agreement (SLA) had been agreed in principle. The Wandsworth SLA could not be agreed until the outcome of the arbitration was known; this was anticipated to be end of December. The HIV contract would not be signed until the issues regarding risk share were resolved; confirmation was expected in approximately a week.

Working capital was planned to improve by £16.3 million in order to repay the £8.5 million brokerage, Trust Debt Remuneration of £4.4 million and recover the £3.5 million cash shortfall.

Lorraine Bewes said that the Saving Plans were challenging.

The Trust Board noted the financial position at month 7.

2.2. PERFORMANCE

Lorraine Bewes said that, as noted in the Chief Executive's report, the Trust was at risk of not achieving the standard for delayed discharges and thrombolysis targets. Other key risks were performance against the 62 Day Cancer Wait target, total time in Accident & Emergency and the Booking and Elective and Outpatient access indicators.

Edward Donald referred to the elective patients and outpatients waiting targets. He said that the national deadline for the elective patients waiting target of 6 months was end December 2005, but the Trust would be treating all patients who would have been waiting 6 months at this date by 4th December. The outpatients target of 13 weeks also had to be achieved by end December. The Trust would be delivering this target by 18th December; there were eleven patients without a date at this stage, who would be brought forward, ensuring delivery of this target ahead of the end of the December deadline.

Current performance against the Accident & Emergency Department target of 4 hours

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was 98%, and 98.3% if the walk in centre numbers were included It was noted that the PCT had deferred the primary care GP scheme and that the Accident & Emergency Department was still treating a significant number of patients who would not register with a GP. It was further noted that the bed closures achieved through efficiency improvements in the summer months would make delivery of the 4 hour wait more challenging through the winter months, when an increase in emergency activity could be predicted. At, this stage the Trust remained on track to deliver this key target.

The Trust Board noted the report.

2.3 WORKFORCE REPORT

Maxine Foster presented the report. She noted that the increase in qualified nurse and midwifery vacancies was due to an increase in the budget. The Trust had also recognised that, as demand for services fluctuates, some flexibility in staffing costs through vacancies is desirable.

Sickness absence had been within anticipated trends.

The control measures introduced in respect of Bank and Agency staff had been successful and costs were within budget.

There had been a change in the ethnicity of Trust Staff, and this was now in line with the population mix. Maxine Foster noted the comment that it would be useful to include the ethnicity mix of the population.

The Trust Board noted the report.

3. ITEMS FOR DECISION/APPROVAL

3.1 NHS FOUNDATION TRUST STATUS

The Chairman said that, at the end of the discussion, the Board would be asked to take a decision on whether the Trust should submit an application for Wave 2. The deadline for submission was 9th December 2005. At a seminar that morning, the Board had considered the Service Development Strategy and the Membership Strategy would be considered at this meeting. The Trust's financial position was crucial to the decision.

3.1.1 Membership Strategy

The Chairman welcomed Robert Atkinson.

Andrew MacCallum said that the Membership Strategy, although broadly the same as the one drawn up for the first application, which had been consulted upon, had been updated by solicitors. There would be a standard constitution for trusts obtaining Foundation Trust Status from October 2006 onwards.

The constituency of the membership had changed to one category, and this was believed to be more workable.

Robert Atkinson's team would be responsible for refreshing the membership database and recruiting new members. Methods would include face to face interviews and the use of activities within the hospital. There would be a breakdown of existing membership, and recruitment to un-represented areas, such as ethnicity and location. There would be staff seminars and meetings with external bodies, for example Mencap, and local organisations. Areas outside Kensington & Chelsea would be targeted, as well as commuters who lived in the area but worked outside. The target was to recruit 10,000 additional members (currently 4,000) by the end of April 2006, and a minimum of 600 staff.

Heather Lawrence noted that the application form was in English only. There would need to be support for other languages.

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3.1.2 Governance Tables

The meeting discussed the Governance Tables and the terms of appointment for the non-executive directors. Current non-executive directors would remain either until the end of their current term or for one year, whichever was longer. The Members Council would make subsequent appointments. The non-executive director would be a member but did not have to be on the Members' Council. It was suggested that periods of appointment should be staggered so that one third of non-executive directors stood down each year. It was agreed that duration of appointment should be a minimum of 2 years and a maximum of 4 years, with an overall maximum of 8 years.

The Trust's sponsors had initially been the Royal Marsden and the SHA, but the SHA had subsequently been replaced by the Royal Brompton.

Andrew MacCallum was asked to incorporate the terms and conditions for non-executive directors and advise on indemnity. CNST/RPST requirements would still have to be met, and this should be made explicit. AMacC

Lorraine Bewes was asked to advise on insurance requirements. LB

Alex Geddes was asked to advise on the business continuity risk around IT. AG

3.1.3 Business Case

The Chairman outlined the advantages of NHS Foundation Trust status, and noted that by April 2008, all hospitals would need to apply for this status. The Trust believed that its business plans and strategy were robust, and Monitor, McKinsey and the SHA had tested these. There were obvious advantages in maintaining the momentum by applying for Wave 2. Delay would result in work being redone. Should the Trust not achieve Foundation Trust Status, there was a risk that it would continue to be adversely affected by the SHA's financial position.

The Trust had been advised that the error in the property valuation, which was part corrected in 2003/2004, had resulted in a cumulative cash pressure, which had significantly contributed to its cash brokerage position of £20.5 million. While the Service Development Strategy projected cash to remain within limits set by the Foundation Trust working capital facility and borrowing limits, this required stretching targets for working capital control to be met and ran the risk of having to divert funds from capital expenditure in the future. If a majority of the Board believed that it would not be prudent to proceed unless the cash consequence of this anomaly was corrected, the above wording should be added as a proviso.

It would be possible to submit an application with the proviso that the Secretary of State made available this shortfall on a permanent basis. Amanda Pritchard explained that should this condition not be met, the Trust would effectively have not submitted an application.

It was agreed that the application should emphasise the Board Development Programme and Process for both executive and non-executive directors.

The Chairman asked the Trust Board to vote on the following questions:

1. **Should the Trust become an NHS Foundation Trust?**

   Agreed unanimously.

2. **Should the Trust submit an unconditional application?**

   Rejected by a majority.

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3. **Should the Trust submit an application, with the proviso, that the Trust wishes to go forward to Monitor if the Secretary of State resolves the cash deficit?**

Agreed by a majority.

3.2 MEMORANDUM OF UNDERSTANDING WITH THE ROYAL BROMPTON

Heather Lawrence said that the Memorandum was an initial step in building an alliance with the Royal Brompton, and the arrangement would possibly be extended to the Royal Marsden. There were specific areas of partnership, liaison, co-operation and collaboration in areas of mutual interest, which would be explored. It was noted that the Royal Brompton would not be becoming an NHS Foundation Trust at this stage.

Heather Lawrence asked that comments be taken outside the meeting, and the document be brought back to the next meeting. All

3.3 CONSULTANT APPOINTMENTS

The Trust Board ratified the following appointments:

Mr Simon Clarke, Consultant Paediatric Surgeon

Dr John Janssen, Consultant Neurologist

4. ITEMS FOR ASSURANCE

4.1 AUDIT COMMITTEE HANDBOOK

Andrew Havery said that the handbook had been considered by the Audit Committee. In his view, the handbook was more onerous. The Chairman considered that the handbook gave responsibility to the Audit Committee for things, which should be the responsibility of the Trust Board.

Marilyn Frampton noted the Audit Committee's role in respect of systems and processes being in place. She suggested that the Chairs of the three assurance committees (Audit, Clinical Governance and Facilities) meet to look at the recommended terms of reference and bring back any issues to the next Trust Board. This was agreed. MF/AH/ CW

It was noted that the handbook was not binding on an NHS Foundation Trust.

Andrew Havery said that he had asked the members of the Audit Committee to complete the self assessment checklist.

The Trust Board agreed that there would be further discussion at the next meeting if appropriate.

5. ITEMS FOR NOTING

5.1 CANCER WAITS UPDATE

Edward Donald said that the paper set out the background to the cancer waits targets, criteria for achievement and the monitoring period. Achievement of the target required the following level of performance to be achieved in the last quarter and then maintained:

- 80% data completeness for the Trust's incidence benchmark, currently 600 patients per year.
- 95% compliance with the 2 month (62 day) target

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- 98% compliance with the 1 month (31 day) target.

It was highlighted that if the benchmark was wrong, it would not be possible to achieve the target. The Trust had achieved 92% compliance with the 62-day target and 97% with the 31-day target.

Primary Target Lists (PTLs) were the approach being adopted nationally to prospectively track patients through their care journey, to ensure that the maximum wait times were achieved. PTL data was reported on a weekly basis and the Trust had achieved 50% completeness, compared to its benchmark of 12 patients per week.

The report set out the reasons why it was likely that the benchmark had been set too high. Early estimates suggested that a realistic return would be 312 to 416 patients first treated at Chelsea and Westminster for cancer, compared with the current benchmark of 600 per annum. A case would be made to the North West London SHA to revise the current benchmark against incidence figures from the Thames Cancer registry, current and future referral patterns and past data quality.

It was noted that the impact of patients without an NHS number not being recorded was high, because of the small numbers involved, particularly in respect of the 62-day target. This issue had been logged with the SHA and National Cancer Waits Team, and a resolution was awaited.

The Trust Board noted the report and the action being taken in December to achieve the cancer waits target in the last quarter of 2005/2006.

5.2 RAISING CONCERNS (WHISTLEBLOWING) POLICY

Maxine Foster said that the Trust's policy, which had been in place for some time, had been updated. The scope for raising a concern externally had been increased and the greater involvement of the Local Counter Fraud Services reflected. The Trust Joint Management and Trade Union Committee had formally ratified the policy.

The Trust Board noted the policy.

5.3 PROPOSED CLOSURE OF PRINCESS LOUISE (KENSINGTON) HOSPITAL

Edward Donald said that the paper summarised the impact for the Trust of the Kensington & Chelsea PCT proposals to close Princess Louise (Kensington) Hospital. Before responding formally, it was recommended that the Trust required clarification in respect of the following points:

- Current intermediate care capacity, quantified in terms of activity and funding by service;
- Replacement of intermediate care capacity from Princess Louise Hospital; and
- Plans for increasing intermediate care in the south of the borough.

The Trust Board approved the recommendations.

6. ITEMS FOR INFORMATION

6.1 RISK MANAGEMENT COMMITTEE – MINUTES

The Trust Board received the minutes of 15th September 2005 and 20th October 2005.

Lorraine Bewes suggested that it would be appropriate for representatives of the Finance and Procurement Departments to attend these meetings.

Marilyn Frampton said that she and Mike Anderson had arranged to meet to discuss the relationship between the Clinical Governance Assurance Committee and the Trust Executive Clinical Governance.

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7. QUESTIONS FROM THE MEMBERS OF THE PUBLIC

7.1 Questions had been taken earlier. These related to the NHS Foundation Trust Application and the Members Council in particular.

8. ANY OTHER BUSINESS

8.1 There was no other business.

9 DATE OF THE NEXT MEETING

9.1 5th January 2006

10. CONFIDENTIAL BUSINESS

10.1 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 item to be discussed related to commercial matters and to individual patients.