Chelsea and Westminster Healthcare NHS
NHS Trust

Minutes of the Public Meeting of the Trust Board held on 3rd February 2005.

Present: Non-Executive Directors

Juggy Pandit (Chair) Professor Ara Darzi Marilyn Frampton
Andrew Havery Jenny Hill

Executive Directors
Heather Lawrence, Chief Executive
Mike Anderson, Medical Director
Lorraine Bewes, Director of Finance and Information
Edward Donald, Director of Operations
Maxine Foster, Acting Director of Human Resources
Alex Geddes, Director of Information, Computing 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
Jane Clegg, Director of Nursing, Kensington and Chelsea PCT (item 1.5.1 only)
Roz Wallis, Senior Infection Control Nurse (item 5.1 only)

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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 non-executive director Charles Wilson.

1.3 MINUTES OF THE MEETING HELD ON 6th JANUARY 2005
The minutes of 6th January 2005 were agreed as a correct record and signed.

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

1.4.1 INFORMATION GOVERNANCE PLAN
Alex Geddes said that the Chelsea and Westminster internet site was on target for the end of February. AG

1.4.2 TSUNAMI DISASTER
Heather Lawrence said that no staff had families directly involved in the disaster. One member of staff had been released under the Trust's career break scheme to go to the area.

1.4.3 CONVERGENCE WITH THE NATIONAL CARE RECORDS SERVICE
Alex Geddes said that he was looking at the extension of the existing two licences to provide cover for more of the hospital. The contract with IDX had been extended, as there had been a financial advantage. Heather Lawrence and Lorraine Bewes would HL/LB/AG

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meet with Alex Geddes to determine if any Board action was required.

1.4.4 COMPLAINTS AND PALS ANNUAL REPORTS 2003/2004

Andrew MacCallum said that there had been a total of five referrals and contacts with the arbitration service since the change in the complaints procedure in August 2004 - one was under investigation, two had been referred and were awaiting decisions on the investigations and one was with the Health Service Ombudsman. This compared with six in a similar period previously.

1.5 CHIEF EXECUTIVE'S REPORT

1.5.1 FINANCE

Heather Lawrence said that the month 9 finance report continued to predict a deficit position of £1 million. The North West London Sector was predicting the largest financial deficit of all SHAs. The Trust had been instructed to achieve financial balance. However, January had been a difficult month due to sickness, infection and two sewage floods, resulting in increased expenditure and a decrease in income from private patients due to excessive utilisation of the single rooms in the Chelsea Wing. The executive team had recommended that, in future, the Trust should have a maximum of two beds allocated to NHS patients in the Chelsea Wing. The Director of Operations was aiming to reclaim single rooms being used as office space to mitigate the risks involved. The Trust would aim to maximise private patient income for the remaining two months of the financial year.

The Trust Board resolved that, in the future, the Trust would have a maximum of two beds in the Chelsea Wing allocated to NHS patients.

Dates for the arbitration with Hammersmith Hospitals Trust (pathology) and Kensington and Chelsea (Cheyne Centre) remained outstanding.

Tight controls on Bank and Agency spending continued although there had been higher than usual activity particularly in Accident and Emergency attendance and high Intensive Care utilisation, together with a higher than normal level of staff sickness. The Accident and Emergency target of 98% of patients having been assessed, treated, admitted or discharged within four hours was being met with difficulty.

1.5.2 PAYMENTS BY RESULTS

Lorraine Bewes said that the implementation of national tariffs had been delayed and elective care only would be included in 2005/2006. On the original table for staged implementation, the Trust's Service Level Agreement income had been expected to increase by £4.5 million at the end of the four year transitional period.

Central clarification on the impact of the revised timetable on transitional funding for 2005/2006 and future years was still awaited.

1.5.3 FOURTH BURNS CONSULTANT

Heather Lawrence said that a six month locum consultant in plastic surgery with an interest in burns had been approved by the executive team earlier in the financial year. The post had been funded from an increase in the burns tariff and was provided in the budget recurrently. However, the additional funding was variable with activity performance and was therefore not guaranteed. Additionally, under Payments by Results there was a potential for a loss in burns income.

The Trust had been recommended as a Burns Centre and a fourth consultant would be required if designation was awarded. In addition, a fourth consultant was required to enable the on-call rota to continue. The cost to replace the locum post on a permanent basis was £130,000 per annum, inclusive of secretarial support. Although this was not

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a cost pressure for 2005/2006, given the uncertainty of income streams, this development could lead to a cost pressure of £130,000 in future years. Heather Lawrence advised that this cost pressure was highlighted because of the need for transparency with the Trust Board in terms of financial governance.

The Trust Board resolved that the fourth burns consultant post should be established and noted the potential cost pressure.

1.5.4 PERFORMANCE INDICATORS

Heather Lawrence said that every effort was being made to achieve the key performance targets and to improve the Trust's position with regard to secondary targets, but a number of risks remained.

The patient survey had been received and would be reported to the Board at the April meeting. The results of the staff survey had not been received. AMacC/ Apr TB

MRSA infection was a concern and the Board would receive regular updates.

The Trust was performing slightly ahead of plan for day case activity, elective inpatient activity and emergency activity. As reported previously, one patient who had waited 13 months for admission would be counted as four breaches.

The Trust was also ahead of plan for new and follow-up outpatient activity. However, there were performance pressures on the 17 week wait target in Dermatology and the Paediatric Dental Department.

There had been an overall reduction in the vacancy rate, but the qualified nurse vacancy rate was disappointingly high. This would be considered in the context of the skill mix review/recommendations, which would be discussed later on the agenda. Good progress continued to be made with midwifery recruitment.

1.5.5 GENERAL MANAGERS

Heather Lawrence said Kate Hall, currently Project Manager for the Treatment Centre, had been appointed as General Manager for Surgery, Anaesthics and Imaging. Sherryn Elsworth had been appointed as General Manager for Women and Children's.

1.5.6 PADDINGTON BASIN

Heather Lawrence said that the decision on Paddington Basin was still awaited and, as a consequence, it was not possible to take forward the business case for Paediatric Ambulatory Care.

1.5.7 BUSINESS PLANNING

Heather Lawrence said that the following Business Planning workshops had been held and had been well attended: Matron's Charter, Essence of Care, User Involvement and Complaints and Financial Issues including Payment by Results, Human Resource Issues including Agenda for Change, Integrated Governance and Standards for Better Health, and the current Information Technology Agenda.

1.5.8 CHEYNE DAY CENTRE

Heather Lawrence said that, following the Kensington and Chelsea PCT Board meeting in December, it had been agreed that the PCTs responsible for the five children assessed as being suitable for the Centre, would be contacted to enquire whether placements would be taken forward. Kensington and Chelsea was the only PCT to formally support the Centre, together with the Royal Borough of Kensington and Chelsea (which had agreed to fund a teacher from 2005/2006). Westminster had one suitable child but had confirmed that it did not intend to pursue a placement.

Heather Lawrence did not consider the Pan London PICU interest in exploring whether the Centre could have a role in providing care for a range of children with

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technical dependencies as a viable option. The children assessed as suitable for the Centre had extremely complex needs.

A Children's Commissioner's Group, a new group set up by the SHA, would discuss the Centre and how it might extend the range of choice of provision for families of children with complex disabilities in North West London.

Heather Lawrence had met with the London Lead for Specialist Commissioning to discuss the possibility of a case for special funding and had also approached the Chief Executive of the SHA for support in top slicing resources across a number of PCTs for the next financial year.

The financial risk remained. The Trust had incurred a total deficit of £850,000. A strategic plan and suggested approach for the next year was required from Kensington and Chelsea PCT. The Chairman and Heather Lawrence would be meeting with parent representatives to discuss the way forward. Chair/HL

The Trust Board was still not in a position to take a decision on the future of the Centre, but this would have to be taken by the April Trust Board, at the latest. HL/April Trust Board

2. PERFORMANCE

2.1 FINANCE REPORT

Lorraine Bewes presented the report, which showed that the overall financial position of the Trust at Month 9 had been an over spend of £3.518 million, an adverse movement of £0.69 million on the previous month's position. An in-month improvement in non-pay, reserves and income had offset pay deterioration. However, this deterioration was below trend reflecting the reduced use of bank and agency staff.

Significant changes related to a reduction in private patient income, due to a combination of the closure of the piloted second theatre list, an unusually low level of overseas visitors' income and correction of miscoded invoice from a prior month.

The position in the Medicine and Accident and Emergency Directorate remained one of higher than planned activity resulting in significant pressure on pay and non-pay, especially drug costs. Bank and agency costs had been significantly reduced in December.

The Trust was forecasting a year end deficit of £1 million. The SHA's target for the Trust was breakeven.

Lorraine Bewes drew attention to the main risks in the financial position, which were set out in the report. Work was underway on a number of central initiatives to identify further potential savings, to mitigate the risks and/or reduce the year-end deficit.

A capital report had been given on Form 10 and this would form part of future reports. An under spend of £950,000 was forecast. Brokerage of £2 million had been offered and futher brokerage was available. This would be discussed with members of the Capital Review Group to consider whether this opportunity should be taken up. Lorraine Bewes confirmed that this money was guaranteed to be returned in 2005/2006. The surplus had arisen because of slippage in projects and brokerage would ensure that the capital was not lost.

The Trust Board noted the financial position at Month 9 and the significant risks in the forecast.

2.2 SAVINGS PLAN

Lorraine Bewes presented an update on progress with realising the Savings Plan for 2004/05 as at month 9. The Trust target for 2004/2005 was £7.8 million plus a carry forward target of £1.9 million from 2003/2004, making a total of £9.7 million.

The Trust had met its entire target via a combination of recurrent (£5.1 million) and non-recurrent (£4.6 million) schemes. The priority for directorates would be to

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continue to identify recurrent schemes to achieve the recurrent balance from April 2005.

The Trust Board noted the progress with delivering the Trust Savings Target for 2004/2005.

2.3 BUDGET SETTING 2005-2006

Lorraine Bewes presented the report, which outlined the process, which would be adopted in setting a balanced budget for 2005-2006. This would be brought to the Board in April for approval. LB/April TB

The paper outlined the significant financial and service risks facing the NHS. The application of Payment by Results to elective activity only in 2005-2006 appeared to favour the Trust but there remained considerable uncertainty around exactly how it would operate. It had been assumed that the gain in 2005-2006 would be capped at 2% of elective income, namely £400,000. The requirement to make a cash releasing saving of 1.7% in 2005-2006 had been removed from the National Tariff and was therefore non-negotiable.

Significant underlying deficits in both Acute Trusts and PCTs in the North West London Sector could result in the Trust having to make a contribution to a sector risk pool.

PCTs had stated their purchasing intention to manage referrals rather than buy additional activity in order to meet national access targets. Mike Anderson explained that this meant vetting and possibly refusing GP referrals. Agreed protocols were being developed whereby certain conditions could be managed and minor surgery undertaken within the primary care sector.

The full benefit of the savings generated from the asset revaluation exercise would be available in 2005-2006. Additionally, there would be a non-recurrent benefit of £3.4 million arising from the fact that the Trust had paid back £5.2 million in 2004-2005, based on the deficit reported in April. The final reported deficit had been only £1.8 million.

The paper set out the underlying recurrent position for 2005-2006 before SaFF negotiations.

The efficiency target had been based on the assumption that 33% of the 1.7% saving would be delivered through procurement savings and 64% through 'productive time' savings to be released through changes in working practices following the implementation of the consultant contract and Agenda for Change.

The Board would be updated on Service Level Agreements at the March meeting. AP/March

Lorraine Bewes said that the Savings Plan 2005-2006 approach would involve conversion of the non-recurrent savings plus the additional 1.7% savings. It was intended to establish a Trust wide savings group with representatives from all directorates. A timetable and process would be agreed. A contingency reserve of 0.5% was an objective, but would depend on the level of 2005/2006 cost pressures. TB

Andrew Havery asked for clarification of the gains of £4.5 million over four years and £400,000 in 2005-2006 from Payment by Results. Lorraine Bewes said that these figures were based on comparison between the current tariff and the national tariff. Heather Lawrence said that these assumptions had been confirmed by the SHA. It was agreed that Lorraine Bewes would present the detail behind the assumptions to the Finance and General Purposes Committee. LB

Specific cash releasing savings for the efficiency reduction had not been identified, but two examples of possible savings were given. Mike Anderson said that there could be an increase in day surgery rates through the Treatment Centre. Maxine Foster said that it was hoped that the 'Hospital at Night' work would result in more practical and productive ways of working.

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2.4 PERFORMANCE

Lorraine Bewes presented the report. The Trust had underachieved on the key target of elective admissions and there was no possibility of this being mitigated. There was a significant risk of the finance target being underachieved. The star rating was also based on the balanced scorecard. The capacity and capability focus area had been shown as middle band, and could improve to top band, dependent upon the Information Governance Action Plan and the Workforce Indicator.

The clinical focus area was shown as middle band and this was difficult to influence. The Patient Focus Area was shown as middle to top band.

Jenny Hill suggested that there should be a campaign to involve the public in tackling MRSA. Edward Donald said that, following patient feedback, an information leaflet was being developed.

Pippa Roberts said that the National Patient Safety Agency (NPSA) was leading a national 'Clean Hands Campaign'. Andrew MacCallum said that the Infection Control Team had been featured in the current edition of Trust News. He referred to hospital acquired infections and the fact that the public they were all classified as MRSA by the public. There was a need to target efforts to where they would be most effective. The Trust News had also contained information for patients on MRSA.

The Trust Board noted the report and conclusions.

2.5 WORKFORCE

Maxine Foster presented the report and commented on the aspects, which had not been covered by the Chief Executive's Report. Equality and Diversity training for staff continued and the Trust Executive Team had given a commitment to attend the programme during March.

The Trust had achieved 98% compliance with junior doctor hours. Monitoring was performed every six months via diary cards completed by junior doctors. However, the return rate for the last monitoring was significantly below 50%. To improve on this, instead of diary cards, doctors would be asked to sign a roster pattern and pay band to confirm that they were able to work the rosters without significant variations and take adequate natural breaks. It was hoped that the Trust would be able to achieve 100% compliance.

Maxine Foster reported on the work being undertaken in respect of the career structure of the clinical coders, as a result of the increased importance of coding. The groups of procedures, which would come under the national tariff would increase in the fourth quarter from the 15 procedures covered in 2003-2004 to 48 of the 540 groups of procedures. Activity un-coded or not coded within three months would not be paid by the PCT.

Professor Ara Darzi asked if there was validation of the accuracy of coding. Lorraine Bewes said that there was a cycle of audits and this was being increased. The Trust also participated in a bench marking group.

3. STRATEGY/DEVELOPMENT

3.1 1000 GOOD IDEAS

Andrew MacCallum presented the update and said that the good ideas had been incorporated into the business planning process and linked with the patient surveys and PEAT.

Andrew MacCallum said that it was not intended to continue with the detailed progress reports. The Trust Board agreed that progress reports were no longer required.

Marilyn Frampton said that there needed to be assurance that action had been taken.

Professor Ara Darzi suggested that there should be information on how the actions

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had been communicated back. Andrew MacCallum said that there had been a ten point action plan demonstrating this.

The Trust Board noted the report and agreed that further progress reports were not required.

4. GOVERNANCE

4.1 ASSESSMENT FOR IMPROVEMENT: THE HEALTHCARE COMMISSSION'S (HCC) APPROACH

Pippa Roberts presented the report, which summarised what was currently known about the HCC's future approach to performance assessment. The framework would replace the current star rating system, the assessment against the twenty two controls assurance standards and the formal trust wide Commission visits. The process was currently out for discussion and the paper was intended to support discussion to enable a Trust response to be formulated. The Standards for Better Health Comprised one component of the assessment framework, and the paper described the proposed initial Trust approach to undertaking a baseline assessment of its compliance position. This would support the development of an action plan to ensure compliance by the date of Declaration, September 2005.

Pippa Roberts reported that, although the document was out for consultation, it seemed unlikely that the standards or elements would be changed. However the prompts were proposed for discretionary use by a Trust. She suggested that the Trust should use the individual prompts unless a reason for not doing so was justified by the appropriate executive. There was a lack of clarity in the consultation document regarding the assessment process for other components of the framework, such as the Use of Resources, which made it difficult to make comment upon the framework in total.

She referred to the example of a proposed trust monitoring proforma and the allocation of individual responsibility for individual prompts to the executive director with managerial responsibility for that area of work. The Chairman said that the prompts referred to the process, not to whether it was actually happening and the Trust needed to ensure that the exercise did not become 'tick box' in nature. Pippa Roberts said that she felt it would be appropriate for the detailed monitoring to be delegated to the Clinical Governance Assurance Committee and a report submitted to the Board on an exception basis. The Trust would be required to submit a declaration on each standard by September 2005. This would need to be discussed with partners and assured by the internal auditors before it was submitted and therefore the Trust needed to be in a position to make a declaration by July. Pippa Roberts emphasised the importance of declaring honestly. The HCC could announce that a Trust had made a false declaration. Formal HCC visits would be undertaken for specific reviews, which might be domain, patient group or governance orientated. Governance reviews would be undertaken to assess organisational leadership.

Jenny Hill suggested that anything, which sat outside the framework, was a risk, for example contractual work. The Board needed to look outside the standards for areas not covered. Mike Anderson sited Pathology as an example of a contract with another provider, which would be outside the framework but should be considered. Jenny Hill said that she was developing a set of Board assurance prompts, arranged roughly under each domain, which she would share with the Board.

Pippa Roberts said that she had discussed with the Clinical Governance Lead at SHA, the need for the production of a separate clinical governance plan and a business plan. The Standards for Better Health were much broader in their reach than the areas traditionally covered in the remit of clinical governance and it was difficult to see how the Trust could base a clinical governance plan on these standards, without

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duplicating information that could be found in other areas of the corporate plan, for example financial plans. It seemed that the standards were standards for integrated governance, of which some fell within the clinical governance agenda. The SHA Lead had advised that he thought that it would be possible to submit a Corporate Plan as an integrated governance plan and have one section, which covered the clinical governance aspects of the healthcare standards and still comply with the need to prepare a clinical governance plan. Pippa Roberts would request this formally after the consultation had closed. She reported that the SHA Lead had suggested that the Trust was fairly advanced in thinking about the issues of integrated governance.

It was agreed that Pippa Roberts would draft the Trust response to the consultation incorporating the above comments and concerns. PR

The Trust Board endorsed the initial approach to the assessment of compliance with the standards for better health.

5 ITEMS FOR APPROVAL/INFORMATION

5.1 INFECTION CONTROL ANNUAL REPORT 2003-2004

Andrew MacCallum presented the report with Roz Wallis, Senior Infection Control Nurse. The report described the work of the infection control team over the last twelve months. Activities included infection surveillance, training, environmental initiatives, auditing and policy development.

In December 2003 'Winning Ways' had been launched by the Department of Health, a national strategy for Infection Control. As a result Dr Azadian had been appointed as the Trust's Director of Infection Prevention and Control.

Infection and Control key indicators included surveillance and monitoring of specific micro-organisms such as MRSA. The Winning Ways Action Plan encapsulated the action on MRSA. Key issues were linked to good Infection Control practice and this was being revisited with staff and patients.

Marilyn Frampton said that the public perception of MRSA was a dirty hospital. Roz Wallis said that there was daily liaison with the Trust's Support Services and representation at committee level, and the Infection Control Team had trained the Support Service trainers.

Heather Lawrence asked how the Trust could measure if it was doing better or worse. Roz Wallis said that this was through compliance with Infection Control policies and MRSA tended to be a marker of good infection control. However, it was not a good indicator because numbers were so small. There were no specific outcome measures.

There were no national rules of screening of patients. Edward Donald said that screening had been incorporated in the pre-assessment process.

Mike Anderson confirmed the importance of good infection control and suggested that the patient's interest in MRSA could be used to re-enforce practices.

Jenny Hill suggested that Frequently Asked Questions be posted on the website.

The importance of visitors not being allowed to enter a ward without washing their hands was discussed.

The Trust Board noted and endorsed the report.

5.2 NURSING WORKFORCE REVIEW

Andrew MacCallum presented the report, which described the proposed implementation of the Nursing Workforce Review. The aims related to assuring a workforce for the future developing roles that reflected the skills escalator, better aligned to the Trust in terms of cost and numbers of staff. The Trust had a very high level of staffing and skill mix. £1 million of savings had been identified, reduced to £800,000 based on the average staff cost. This equated to a reduction of 7.67 whole

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time equivalents out of a workforce of 1207, i.e replacement of 85 registered nurses with 77 support workers. The development of the role of the support worker was in line with action taken by most hospitals over ten years ago
triggered by the introduction of the supernumerary status for student nurses.
It was recommended that the changes in skill mix at ward level be implemented with immediate effect. This process would be facilitated by the vacancy factor.
Andrew MacCallum considered the changes to be modest, but with a high impact on costs, and essential to make the Trust an employer of the future. Progress had already been made with the development of the support worker.
Midwifery remained outside the scope of the review. Andrew MacCallum confirmed that Birthrate Plus was still in the process of reporting. Operating theatres and Juniper Ward would also need to be considered separately.

The Trust Board approved the approach taken to implement the workforce review.

HL left the meeting.

5.3 WESTMINSTER HEALTH AND CARE NETWORK

Amanda Pritchard presented the paper, which outlined the vision and priorities of the Westminster Health and Social Care Network as set out in their Programme for a Healthier Westminster. It also summarised the Strategic Service Development Plan (SSDP) developed by Westminster PCT.
The SSDP proposed a model of care for the future that would involve developing a number of integrated health centres, acting as 'hubs' for the provision of primary care, intermediate care (including minor procedures and possibly diagnostic services) community and voluntary sector services. This model was intended to facilitate the transfer of activity and resources from secondary to primary care. The Trust provided services at the South Westminster Centre and the Soho Clinic, which might be affected by these plans.
Whilst there had been an extensive discussion with St. Mary's Hospital NHS Trust, as the major provider of hospital services to the population of Westminster, Chelsea and Westminster had not been involved in the development of these plans. The documents did not reference the partnership activities with Chelsea and Westminster.
It was agreed that there should be active engagement with Westminster PCT and the Westminster Health and Social Care Network to ensure that Chelsea and Westminster was involved in shaping plans for the future.

The Trust Board asked Amanda Pritchard to draft a response on its behalf. AP

6. QUESTIONS FROM THE MEMBERS OF THE PUBLIC

A member of the public said that different immune systems impacted on MRSA rates – clean hands and dirt were not the only factors. She also raised questions about her daughter's discharge from hospital, which she considered to be too soon. Mike Anderson explained that it was not possible to discuss this at a public meeting. Mechanisms were in place for addressing concerns, but this would have to be done with her daughter's consent. He noted the Trust's policy of not keeping patients longer than necessary.
A member of the public referred to the Westminster plan for integrated health centres and said that it was the third such scheme of which he'd become aware in recent months. He referred to the Epsom and St. Helier model, which had an acute hospital at the centre driving the hub. He also referred to the use of acronyms in board papers, which could be confusing.

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7. ITEMS FOR INFORMATION

7.1 There were no items under this heading.

8. ANY OTHER BUSINESS

8.1 The Chairman reminded members that Jenny Hill would be leaving in March, because she had served the maximum term of office as a non-executive director.
The Chairman, on behalf of the Trust Board, thanked Jenny and recorded the Board's enormous appreciation of her work. Her contribution would be greatly missed.

9. DATE OF THE NEXT MEETING

9.1 3rd March 2005

10. 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 a commercial development from which individuals could be identified, and to the Charitable Funds Committee.