Chelsea and Westminster Healthcare NHS
NHS Trust

Minutes of the Public Meeting of the Trust Board held on 2nd June 2005.

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

Executive Directors
Heather Lawrence, Chief Executive
Mike Anderson, Medical Director
Edward Donald, Director of Operations
Maxine Foster, Director of Human Resources
Alex Geddes, Director of Information Communications and Technology
Andrew MacCallum, Director of Nursing
Jon Bell, Deputy Director of Finance

In Attendance: Amanda Pritchard. Acting Director of Strategy and Service Development
Pippa Roberts, Acting Director of Governance and Corporate Affairs (items 1-1.4 and 4.1/4.2 only)
Sue Perrin, Head of Corporate Affairs
Patricia Rubin, Interim Manager, Cheyne Centre (item 1.5.7 only)
Amanda Harrington, Patient Affairs Manager (item 4.3 only)
Jane Tippett, Consultant Nurse Emergency Department (item 4.4 only)
Debbie Ensor-Dean, Head of Booking and Outpatient Services (item 4.4 only)

Note: Items 4.1 and 4.2 were taken before 1.5; item 1.5 before 1.4.2 and item 2.6 before 2.5.

Action

1. GENERAL MATTERS

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

1.2 APOLOGIES FOR ABSENCE
Apologies were received from Professor Ara Darzi, Non-executive director, and Lorraine Bewes, Director of Finance and Information.

1.3 MINUTES OF THE MEETING HELD ON 7th APRIL 2005
The minutes of 3rd March 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 ANNUAL GENERAL MEETING, 29th SEPTEMBER 2005
Heather Lawrence said that the dining room has been a good venue on the previous occasion, and she had asked Edward Donald to check if it would be available for the current AGM. It was possible that the formal opening of the Treatment Centre would take place on the same date. The AGM would be held at 5.30pm. Directors were asked to provisionally allocate time from 3pm. ED

Action

Andrew MacCallum said that the Engagement and Partnership Group planned to link a membership day with the AGM.

All other matters arising were covered elsewhere on the agenda.

1.4.2 ENGAGEMENT AND PARTNERSHIP ACTION PLAN

Andrew MacCallum said that, at the March meeting of the Board, a 'Strategy for Engagement and Partnership with Patients and the Public' had been adopted. Key to the achievement of this strategy was the creation of a Trust Engagement and Partnership Group to champion and oversee the delivery of the Trust's strategy and its twenty five key actions. An action plan detailing how the strategy would be delivered had been agreed, and as requested, had been brought back to the Board.

The action plan would be reviewed, added to and updated at each meeting of the Group, which would report to the Board through the Clinical Governance Assurance Board.

Marilyn Frampton asked if the facilitator's post had been filled. Andrew MacCallum replied that the job description had been completed and the post was being graded.

The Chairman recommended to Andrew MacCallum a video of patients' stories, produced by the Mental Health Trust.

The Trust Board noted the Action Plan.

1.5 CHIEF EXECUTIVE'S REPORT

1.5.1 PERFORMANCE

Heather Lawrence said that the Trust had achieved breakeven at the end of 2004/2005 and met seven of the eight Key Targets. Good progress had been made on the secondary targets. The award of star ratings was scheduled for 27th July. The Trust was confident of achieving two stars and it was possible that three could be achieved.

The Healthcare Commission had not released the format of the Performance Ratings for 2005/2006.

The bookings target was at risk because of the information systems, which would be covered later on the agenda.

Significant progress had been made with MRSA rates through screening and ring fencing beds.

Agenda for Change was achievable by September for staff on Whitley scales.

There had been a 97.6% achievement of the Accident & Emergency indicator – 98% had been confirmed as the target. Chelsea and Westminster was one of only two hospitals in West London not to achieve the target.

There had been one breach of the 12 hour trolley wait target. The person had been a mental health patient, for whom a placement had been withdrawn at the eleventh hour. Ring fencing of beds for MRSA and the lack of an admissions ward could impact on the achievement of the Accident & Emergency target. Achievement required a different approach to nurse staffing, policies and medical take, and an action plan was being drawn up.

Edward Donald said that, in order to request the Emergency Bed Service to divert patients, agreement had to first be reached with a neighbouring Trust. Hospitals no longer had the capacity to help. The re-directing by staff of patients to Walk-in centres, where they could be treated quicker, was discussed.

1.5.2 KENSINGTON & CHELSEA PCT FINANCIAL POSITION

Heather Lawrence reported that Kensington and Chelsea PCT had a year end deficit of £14.5 million. The Chairman and Chief Executive had resigned. The Chairman would stay in post until an interim appointment could be made. Dr Lise Llewellyn, Chief Executive Brent PCT, would provide interim Chief Executive support.

Action

The Board noted the severity of the problem, and the real problems with regard to the Service Level negotiations. The PCT was buying minimum services, which represented a risk for the Trust in meeting its targets.

1.5.3 DIRECTOR OF HUMAN RESOURCES

Heather Lawrence congratulated Maxine Foster on her appointment as Director of Human Resources. Under her leadership as Acting Director, the Trust had achieved Improving Working Lives Practise Plus status, and was one of only eight trusts in the country to have achieved this.

1.5.4 FINANCE DIRECTOR, NORTH WEST LONDON SHA

Heather Lawrence noted the appointment of Peter Donnelly, with effect from 4th July.

1.5.5 TEACHING EXCELLENCE AWARDS 2005

The Trust Board congratulated Dr Mark Bower on winning one of these prestigious awards. Heather Lawrence said that she would write to him on behalf of the Board. HL

1.5.6 CONNECTING FOR HEALTH (NPfIT)

Heather Lawrence said that the National Programme would fund PICIS, the theatre management system, but the funding did not include the infrastructure or implementation costs.

A business case for PACS would be brought to the next meeting. AG

Heather Lawrence outlined changes to providers' partnerships in the national programme and referred to Guys and Thomas's Hospital, which had contracted with different providers and University College Hospital, which had not gone live with IDX/Carecast.

Chelsea and Westminster had made a considerable investment in Lastword and IDX was keen for the Trust to adopt Carecast. Heather Lawrence was concerned that pioneering the system, could result in the Trust being the only user, but, without it Spine Compliance was not possible. Booking could not be achieved without moving forward. There was significant risk.

Alex Geddes agreed to report on the impact of the change in partnerships and options for the Trust. AG

1.5.7 CHEYNE CENTRE

Heather Lawrence said that good progress continued to be made with this service. Re-modelling to reflect a more realistic service for commissioners, whilst retaining the quality of service, which parents appreciated for their children, was being led by the Interim Manager, Patricia Rubin. Provision of services for children of age 2-5 only was being proposed.

There would be four children at the Centre in September. Arbitration had been successful in respect of funding from Kensington and Chelsea PCT.

Westminster PCT would not fund places but clinicians would still refer children if they considered the Centre appropriate. Heather Lawrence commented that his put all those involved in the process in a difficult position.

The parents of the two children from Hammersmith, who had been assessed as suitable, were appealing against the decision not to fund the places. Patricia Rubin informed the Board that a meeting had been held but not attended by all decision makers. A further date had been set and the Director of Education would be present.

One model of care under consideration was the provision of short term assessment with outreach. The right number of children for the Centre was considered to be six.

The current shortfall in revenue was £165,000. This would be mitigated if funding was provided for two more children. Expenditure such as the ambulance contract was

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being reviewed.
The proposed model of care would be brought to the Trust Board. ED
The Chairman invited Hugo Gerrard, representative of the two families at the discussions with Hammersmith and Fulham, who had attended the meeting as a member of the public, to comment. Mr Gerrard said that he was greatly encouraged by the work undertaken by Patricia Rubin and specifically her work on communicating and selling the model and budget. He did however have concerns about a reduced age group. He felt there could potentially be a greater demand problem as well as the issue of provision for five/six year olds.
He hoped that a strong case would be put forward to Hammersmith and Fulham and noted that their decision had not been challenged at an education tribunal.

1.5.8 HEALTH MINISTERIAL TEAM
The Trust Board received details of the new Health Ministerial Team headed by Secretary of State, Patricia Hewitt.

1.5.9 PADDINGTON BASIN DEVELOPMENT
Marilyn Frampton referred to the press item, which said that the development had been stopped. Heather Lawrence said that a formal decision would be taken by the SHA on 21st June.

The Trust Board noted the report.

2. PERFORMANCE

2.1.1 PROVISIONAL FINANCE REPORT – MARCH 2005
Andrew Havery referred to the £5million shortfall in cash, of which the Board had been made aware in March. Jon Bell said that Lorraine Bewes had commenced an external review of the Treasury Function. Money had been borrowed from the SHA and a cash issue avoided.
Andrew Havery said that there had been a predicted significant overspend throughout the year, and a year end small surplus, as a result of the release of reserves. He said that the Board should be kept fully informed of the reserves and their release should be the right balance. Jon Bell noted his comments.

The Trust Board noted the provisional achievement of the Financial Management Key Target for 2004/2005 and statutory financial duties.

2.1.2 FINANCE REPORT – APRI L 2005
Jon Bell presented the report, which included only pay variances as non-pay and income could not be accurately determined so early in the year.
The overall financial position after one month was a deficit of £0.154million, including a pay savings target for Month 1 of £0.218million. There had been a significant overspend on Nursing and Midwifery staff. Bank and Agency staff expenditure had increased in March and April, and would be a focus for the Executive Directors.
On the balance sheet, debtors had increased significantly, relating primarily to current debtors. The Hammersmith Hospitals NHS Trust debt of £1.864million, over 90 days old, was noted. Jon Bell said that Lorraine Bewes would be meeting with the SHA to resolve the outstanding issues.
Andrew Havery asked for confirmation that all the cash flow anomalies had been reversed out. Jon Bell believed so, but would check. LB

Action

The Trust Board noted the financial position at Month 1.

2.2.1 PERFORMANCE REPORT TO 31st MARCH 2005
2.2.2 PERFORMANCE REPORT TO 30TH APRIL 2005

The Trust Board noted the report and conclusions. (Discussion had taken place under the Chief Executive's Report).

2.3 BUDGET 2005-2006

Jon Bell presented the paper, which updated the Board on the budget for 2005-2006. The Trust had submitted a balanced budget to the Department of Health, but there was a further unidentified savings target of £2.9million arising from the intention of most PCTs to purchase activity at less than 2004/2005 out-turn.

There had been a requirement to contribute £1.7million to the PCT's recovery plan. The SLA had subsequently agreed in principle with Kensington and Chelsea PCT that there would most likely be a reduction of circa £800,000 on the 2004/2005 out-turn position, due to specific demand management initiatives.

The opening recurrent position 2005/2006 of £4.9million meant that it was possible to break even, but if all PCTs followed Kensington and Chelsea with demand management initiatives, there would be further £2.5million deficit.

The HIV consortium had proposed a contract for 2005/2006 that imposed an unrealistic savings requirement of £0.4million, which was being disputed.

It was noted that all surrounding PCTs faced financial difficulties. £7.9million savings would be required to balance if the demand management reduction on Service Level Agreements and the HIV Consortium SLA reduction materialised.

The report included a draft savings plan. Jon Bell said that the schemes were all new items. A total of £246,000 savings remained to be met.

Andrew Havery asked if the non-recurrent savings plans from 2004/20005 had been made recurrent. Jon Bell said that these had been made good by the asset revaluation from which the Trust would benefit in 2005/2006.

Jon Bell referred to the question at the previous meeting regarding the rates increase. He said that there had been an assessment of the rateable value, leading to an increase of 18%. The Trust was appealing.

Heather Lawrence said that the additional savings of £2.9million meant that the Trust would struggle to meet its other targets. She noted that the overall sector wide deficit was £56million.

The Trust Board approved the balance budget and noted the significant risk within the plan.

2.4 SERVICE LEVEL AGREEMENT PROGRESS REPORT

Amanda Pritchard presented the paper, which updated the Board on the Service Level Agreement (SLA) negotiation process for 2005/2006. Heads of agreement had been reached with Kensington and Chelsea PCT (the host commissioner for Chelsea and Westminster). However, the SHA had indicated that there might need to be changes to the SLA during the financial year as a result of the unexpectedly high deficit posted by the PCT at year end. The original assumption in the PCT's Recovery Plan was that Chelsea and Westminster would make a £1.7million contribution during 2005/2006, but it was subsequently agreed that SLA negotiations would confirm the level and detail of the Trust's contribution. This represented a £600,000/800,000 reduction to the baseline on the PCT SLA, with a clear risk share arrangement linked to the delivery of demand management initiatives.

Hammersmith and Fulham had proposed to commission on outturn but with specific

reductions to the elective plan based on their expectation that average waits could be lengthened and still meet the six month maximum wait by December 2005, and a specific initiative to divert referrals for minor surgery (dermatology) to a GP with special interest. This would represent £300,000/400,000 reduction to the SLA baseline. In addition, Hammersmith and Fulham was seeking an overall cap on follow up attendances.
Amanda Pritchard said that practice based commissioning was not being introduced during the current year by any of the Trust's main commissioners. A significant impact was not anticipated, but it did add another level of uncertainty.

The Trust Board noted the progress with SLA negotiations for 2005/2006 and considered the risks set out within the paper.

2.5 WORKFORCE REPORT

Maxine Foster presented the report. She said that there had been a slight increase in Trust vacancies over the quarter. Midwifery vacancies showed a substantial decrease, as a result of an increase in the average number of midwives rather than changes in the budget.
Overall wastage was slightly lower than in the same quarter in the previous year. Maxine Foster confirmed that all staff were offered a termination interview. It was not known if the uptake was higher or lower than other Trusts.
Average sickness over the quarter was almost identical to the average in the same quarter in the previous year. Training for managers in the management of sickness had begun as part of an initiative to reduce long term sickness.
Bank and Agency usage had increased over the quarter. This was disappointing and could lead to a re-introduction of the rigorous controls, which had been introduced at the end of 2004/2005.
Preparation for the implementation of Agenda for Change continued, with staff due to be assimilated on to the new system by September 2005.

The Trust Board noted the report and asked to be updated on Bank and Agency usage at the next meeting. MF

2.6 CAPITAL PROGRAMME 2005/2006

Jon Bell presented the paper, which sought Board approval for capital expenditure equalling £12,571,000, representing 0.3% over programming, which would be managed through in year slippage.
Budget costs for PACs in 2005/2006 and 2006/2007 had been given. A Business Case would be brought to the July Trust Board. AG/Jul Trust Board
£1.1million had been allocated for cooling permanent solution. Edward Donald explained that a temporary solution had been necessary because of timing. A permanent solution could be implemented only during the winter months. The project would take on board noise reduction at roof top level.

The Trust Board approved the Capital Programme for 2005/2006.

3. STRATEGY/DEVELOPMENT

3.1 There were no items under this heading.

4. GOVERNANCE

4.1 CLINICAL GOVERNANCE ASSURANCE COMMITTEE - REPORT

Pippa Roberts presented the first report from the Clinical Governance Assurance

Action

Committee, and re-circulated copies of the Governance Structures and the Risk Management Process, for ease of reference. She reminded the Board of the re-alignment of Trust Governance structures in the previous twelve months. The initiative had originated with Clinical Governance structures and had been extended to Trust Governance structures as a whole. The new Governance Structures was illustrated in a wheel format and placed the patient at the centre of the wheel. The directorates formed the next layer, which was concerned with the delivery of the agenda and they were supported by the Trust Executive Meetings where corporate decision making occurred. The Trust Executive meetings were colour coded to show the relationship with supporting meetings. The outer circle of the wheel had been created as an assurance layer with the sub committees of the Trust Board in place to provide assurance to the Trust Board by tracking progress with the work streams within their remit and escalating to the Board key points of note or areas of concern for further discussion. These committees look in detail at the appropriate areas of work and act as a filter for the Board, escalating key issues only. It was intended that this should release time for strategic discussions.

The Facilities Assurance Committee was scheduled to hold its first meeting later in June. The Riverside Ethics Committee was not a sub-committee of the Board, but provided assurance in terms of Research and Development, as all clinical trials which were undertaken in the Trust must have ethical approval before commencement. The Clinical Governance Assurance Committee had agreed that it would provide assurance to the Board by monitoring progress made and, where appropriate, escalating issues for discussion in the following areas of work:

- Clinical Governance development plans (integrated in the Corporate Plan for 2005/2006)
- Clinical effectiveness agenda including National Service Frameworks (NSFs), guidelines work and indicators
- Risks in the risk register
- Actions agreed as part of incident reviews
- Risks identified in the risk management quarterly report
- Complaints response times and actions agreed as part of complaint reviews
- Patient Advice and Liaison Services
- Patient engagement and partnership agenda including 1000 good ideas and progress against patient survey action plans
- Claims and actions agreed as part of claim reviews
- Research and Development

It then covered three key areas:

- Highlights from the Risk Management Quarterly Report, January to March 2005 (Quarter 4)
- Progress with the Incident Review Register
- Highlights from the Risk Register Report May 2005

The Risk Register was the Trust's key risk management tool. Risks were identified through incidents, complaints and claims, gaps in compliance with the Standards for Better Health, the Assurance Framework and annual risk reviews, both annual, carried out within every department in the organisation and ad hoc reviews undertaken between the annual reviews.

Risks scoring above 12 or incidents graded orange or red using the risk management matrix were entered in the register and monitored by the Risk Management team and the Operational Risk Management Committee. Risks, which could not be dealt with, would be escalated to the Trust Executive for Clinical Governance for resolution and all risks scoring above 20 were reported to the Board.

Action

Andrew MacCallum noted that there were statutory responsibilities regarding receipt of complaints reports by the Board, but the Clinical Governance Assurance Committee would, in future, filter this information for the Board.

4.1.1 Risk Management Quarterly Report, January to March 2005 (Quarter 4)

There had been a slight rise in the total number of incidents reported in quarter 4, 2004/2005, when compared with the same quarter in 2003/2004 (2.9%), but the trend was much lower than in previous quarters during the year, where average rises of 25% had been observed compared to the previous year. The reason for the change in trend was not known. It was possible that it could relate to changes in staff, for example. Pippa Roberts said that trends were in line with other organisations.

The Clinical Governance Assurance Committee had agreed that incident reviews should take no longer than nine weeks from incident to final write up of recommendations.

The top five patient safety incidents reported in the quarter were:

- Patient falls
- Blood incidents (blood tests required for the safe blood/blood component transfusions, not routine blood tests for biochemistry)
- Medication incidents
- Phlebotomy incidents (routine blood tests for biochemistry)
- Equipment incidents.

Falls

Pippa Roberts said that falls were a problem across all acute trusts. The Clinical Governance Assurance Committee had agreed that a greater emphasis and focus was needed to support the Falls Groups to develop systems for fall prevention. The Assistant Director of Nursing would, in future, attend the Falls Group. The Committee had suggested that a medical representative should also be nominated to routinely attend the meetings. Links needed to be made, for example to PEAT monies, to support the purchase of walking aids if necessary.

Falls were reported by wards and, in future, would be reported by patient throughput. This would enable operational management and the Falls Group to focus on key trends and to look at staffing levels and time of incidents, for example at night.

Heather Lawrence noted that falls were an unavoidable part of rehabilitation.

Blood and Pathology Incidents

The Committee had recommended that the changes required to the HISS system to support the inclusion of mandatory data fields on the request forms for blood transfusion and biochemistry tests be prioritised in the Information Management and Technology programme. Pippa Roberts said that, if patient information was not completed in full, cross matching of blood should not take place. The problem also included incomplete forms being submitted by GPs.

Medication and Equipment Incidents

Medical devices and medical incident committees had been established to review these incidents in detail. A business case for an equipment library was being developed. Andrew MacCallum said that the library would provide a single point for the tracking of equipment, monitoring and repair. All staff would be trained on the equipment, which they used. Pippa Roberts said that staff training was key to the achievement of CNST assessment at level 2.

Non Clinical Incidents

Pippa Roberts said that they top four non clinical incident types reported were:

- Environmental incidents relating to hospital cleanliness and temperature control.
- Sharps incidents – the Department of Health was considering the implementation of ‘safer devices’ such as retractable needles. This would have a significant impact on injuries but would have a cost implication.

Action

- ❖ Accidental injury to staff – no particular trends had been observed here.
- ❖ Verbal abuse of staff, primarily relating to abuse by patients – it was encouraging to note that the number of incidents had decreased when compared to the same quarter in the previous year.

4.1.2 Incident Review Register

Reviews were undertaken on incidents graded 'orange' or 'red' and actions agreed. They were entered on to the register, which had been developed in the previous six/eight months. The incomplete items on the register formed the basis of an exception report for the Clinical Governance Assurance Committee.

Pippa Roberts said that, although a number of actions arising from incident reviews remained outstanding, good progress had been made in establishing a system, which enabled the Committee to identify the information and monitor progress corporately. In future, items, which were significantly overdue, would be reported.

4.1.3 Risk Register Report

Risks were scored as they were mitigated but, as a minimum, every six months. In May, 2005, there were 165 risks on the register – 49 high, 60 moderate, 28 low and 28 very low. Overall a pattern of risk reduction was seen in the last quarter.

The Trust's risk management process required that all risks which scored 20 and over were escalated to the Board. There had been five risks scored at 20 since the previous report. Of these one involved essential colposcopy reports needed for the Department of Health, which had been resolved in the quarter. The others involved:

- ❖ Capacity issues and cover arrangements relating to the medical directorate and, in particular the SPR rota (two separate but linked issues).

The risk was being addressed through a review of the hospital at night work within the critical care group. In the interim, two SHOs had been funded in medicine to provide additional support.

Mike Anderson said that there were pressures because of the hours trainee medical staff could work. He emphasised the importance of the registrar to medical care and the difficulty in replacing staff. Often an experienced registrar would be promoted to a consultant post, and would have to be replaced by a more junior registrar. Working practices and staffing levels were being addressed.

- ❖ An issue with the placement of the sprinklers for the Treatment Centre, which could, in the event of a fire, lead to a mains collapse resulting in the loss of the sprinkler system to significant parts of the hospital.

A solution had subsequently been identified and capital funding approved.

- ❖ Litigation risks resulting from pharmacy on call staff not meeting European Working Time Directives.

This was a cost pressure, which the Chief Pharmacist was discussing with the Director of Operations.

Heather Lawrence commented on the 34 risks in the register, which had passed their review date. She requested that future Performance Reports included a table of risks, which had missed their re-scoring date, and showing the person responsible. Pippa Roberts agreed that this would become normal practise.

The report included a list of risk issues and actions of note since the last Clinical Governance Assurance Committee. Pippa Roberts said that this was more detailed than future reports, when only issues of concern would be raised. She had felt that it was important for the first report to give the Board a stock take of the key issues of note, which needed to be monitored.

Marilyn Frampton commended the report, which she had found very helpful. There had been a major culture change to individual ownership of risk.

Pippa Roberts noted the importance of the discussion of risks at the Clinical Governance Assurance Committee, which was attended by all executive directors.

Action

Heather Lawrence referred to Medical Gases as an issue, which crossed boundaries. One of three directors, Information, Communications and Technology, Operations or Nursing, could take executive leadership. She would appoint the Lead at the next Trust Executive meeting. HL

Andrew Havery said that the Audit Committee would consider producing a similar paper, supplementary to the minutes. He noted that the Audit Committee considered risks over a long period.

The Chairman said that Charles Wilson would chair the Facilities Assurance Committee, which would also need to consider how to report to the Board.

Heather Lawrence noted that any reports referring to commercially sensitive issues

would not include detail of the discussion.

The Trust Board noted the report and agreed that it was in a suitable format.

4.2 RISK MANAGEMENT COMMITTEE

The Trust Board received minutes of the meetings held on 17th February, 15th March and 22nd April 2005. These would be received monthly in future.

The Trust Board noted the minutes.

4.3 COMPLAINTS REPORT, OCTOBER – DECEMBER 2004

Andrew MacCallum presented the report, which showed that the Trust had received 107 formal complaints, a drop of 6 compared with the same period for 2003. A response was provided to 84% of complaints within 20 working days, an increase of 16% for the same period in 2003. This represented a tremendous effort in the directorates and from Amanda Harrington and her team.

The top three issues had been:

- Attitude/behaviour of staff
- Clinical Treatment
- Appointments' issues

The Appointments' issues had been taken up by the Patients' Forum. The Trust had put in place work to improve and streamline the system.

Under the new system, 15 complaints had been referred to the Healthcare Commission – 6 had been closed, 4 rejected and 2 referred back for local resolution. 4 complaints were pending with one scheduled to report in the near future.

There was a processing delay with the new system. It was believed that this was attributable to an overwhelming amount of work. This highlighted the importance of record keeping and also the need to send the right information, so that complaints did not get referred back.

Marilyn Frampton noted the percentage of complaints relating to attitude/behaviour of staff and the intention to introduce a Customer Care Programme. Maxine Foster said that training was on-going for individuals and groups but a bespoke package was required.

The Trust Board noted the report.

4.3.1 PALS REPORT, OCTOBER – DECEMBER 2004

Andrew MacCallum presented the report, which showed 706 contacts from the public and patients during the quarter, an increase of 7% on the same period for 2003. The report described contacts by issues raised with PALs, and whether the issues were raised as general queries, concern, comment/suggestion or complaint. There had been an increase in contacts during the summer months, but there was not a known reason for this.

Action

Amanda Harrington said that the team was not currently undertaking speaking engagements in the community because of staff shortages. Publicity via the internet was on-going.
Andrew MacCallum confirmed that suggestions were added to 1000 Good Ideas.

The Trust Board noted the report.

4.4 NATIONAL PATIENTS SURVEYS, EMERGECNY AND OUTPATIENTS DEPARTMENTS

Andrew MacCallum presented the report, which described and summarised the method and results from the National Patient Surveys for 2003/2004 carried out in Emergency and Outpatient Departments. The surveys had been developed by the Healthcare Commission and were part of a rolling programme to obtain feedback about standards of care that trusts provide. Both surveys had been undertaken by Picker UK, and the results, which would contribute to star ratings, had been presented to a cross-section of staff from all areas of the Trust. The paper outlined the approach in disseminating the results of the surveys and in fostering ownership within the departments and clinical teams in the Hospital.
The surveys comprised 850 adult patients (aged 16 and over) who had attended the Emergency Department in June 2004 and a further 850 adult patients who had attended the Outpatients Departments in August 2004.
In the Emergency Department, there had been a response rate of 34% - the average response for 88 trusts was 42%. The Trust had scored significantly better on 12 questions and significantly worse on 2 questions. This compared with 7 and 0 respectively in the previous year.
Andrew MacCallum noted that the Trust had achieved a high score in respect of patients being given the right amount of pain medication, and this was an area of good practice, which would be shared. The cleanliness of the toilets and the ability to make telephone calls were areas where the Trust performed badly, and this was replicated in the Outpatients survey. Debbie Ensor-Dean said that the installation of Patientline in Outpatients was being considered.

The Trust Board noted the report.

5 ITEMS FOR APPROVAL/INFORMATION

5.1 STAFF SURVEY ACTION PLAN

Maxine Foster said that the Action Plan had been developed after extensive consultation with both formal and informal groups of staff. The actions identified focused on the Top 10 indicators, where the Trust compared badly to other trusts across England.
Maxine Foster was meeting with lead people to agree definite action and a target date, and any funding implications.
The survey would impact on star ratings.
Charles Wilson suggested that the induction process be reviewed.

The Trust Board approved the Action Plan.

5.2 SECURITY POLICY

Edward Donald said that Helen Elkington, General Manager – Facilities, had presented the policy at the April Trust Board, at which members had asked for a number of comments to be considered. Copies of all Security-related policies and procedures were available from Helen Elkington and copies would also be placed on the intranet.

Action

Heather Lawrence noted the change of emphasis from escalation to de-escalation of incidents.
Edward Donald responded to comments on responsibility for ICT Security. Responsibility for policies remained with the Director, but all staff had individual responsibility.

The Trust Board approved the Security Policy for implementation.

5.3 PAY 2005 FOR TRUST CONTRACT HOLDERS

Maxine Foster presented the paper, which provided a summary of the

2005/2006 national pay agreements for Pay and Non-pay Review Body Staff on written terms and conditions. The proposed pay recommendation was the same Whitley percentage increase of 3.225% for every point of the Trust pay scales.

The Trust Board agreed the pay offer of 3.225%.

5.4 CONSULTANT APPOINTMENTS

The Trust Board ratified the appointment of:

Dr Francesca Garnham, Consultant in Emergency Medicine; and
Dr Charlotte Cohen, Consultant in Sexual Health.

5.5 REGISTER OF SEALING

The Trust Board noted the report.

5.6 CHARITABLE FUNDS COMMITTEE

The Chairman said that Jenny Hill, who had represented the Trust Board on the Committee, had been appointed a trustee of the new committee, which would be set up in September. He proposed that she remain as the representative and be appointed as an Associate Director until the formation of the new committee.

The Trust Board endorsed the appointment of Jenny Hill as an Associate Director, until the uptake of her appointment as a trustee.

6. ANY OTHER BUSINESS

6.1 REFURBISHMENT OF THE SEXUAL HEALTH SERVICES AND SUPPORT FACILITIES AT THE ST. STEPHEN'S CENTRE

The Chairman gave permission for the above paper to be tabled.
Heather Lawrence outlined the background to the Business Case, which set out the options for capital development of the St. Stephen's Centre and the establishment of a Diagnostic and Treatment Centre (DTC) for Sexual Health and HIV services.
A related capital project, completed in February 2005, had refurbished and extended the laboratory facilities on the fifth floor of the Centre, including the extension of the existing sample tube system of the Kobler and John Hunter Clinics and the expansion of the existing Sample Reception Centre. This had been entirely funded by the International AIDS Vaccine Initiative (IAVI), which leased laboratory facilities within the Centre. The Business Case formed the final part of the modernisation of the Directorate's infrastructure and implementation of a DTC for the clinical networks of Sexual Health and HIV across the North West London Sector.

Action

The Business Case presented two options. Options 1 was to 'do nothing'. Options 2 was to undertake the capital redevelopment of the Centre, at a cost of £837,000 as set out in the Capital Programme for 2005/2006.
The service had remained 'Open Access' self referral. Mike Anderson confirmed that the target of 600 new positive patients by 2009 was achievable.
Andrew Havery asked if the cost of £837,000 was accurate and if there was a risk.
Heather Lawrence said that if there was a deviation of more than 10%, the business case would be brought back to the Trust Board.
The Chairman did not consider that the non-executive directors had had enough time to consider the case. It was decided that the non-executive directors would give their decisions to the Chairman the following day.

The Trust Board agreed that Chairman's action should be taken in respect of the Final Business Case for the capital development of St. Stephens. Chairman

7. QUESTIONS FROM THE MEMBERS OF THE PUBLIC

7.1 A member of the public asked why four hours had been chosen as the Accident & Emergency target, as this seemed a long time to patients.
Mike Anderson explained that this had been a central directive, and that only a short time ago, patients could be waiting days in an Accident & Emergency Department.
The four hour target represented a big effort and achievement from the whole hospital. The 98% achievement was based on the fact that occasionally patients did need to spend more than four hours in the department, for example to wait for test results.
As a result of these targets, there had been an increase in the number of patients, as Accident and Emergency was often providing a faster service that primary care.
Mike Anderson explained the department had changed over the years from its origin as a Casualty Department.

8. DATE OF THE NEXT MEETING

8.1 4th August 2005

9. ANY OTHER BUSINESS

NON-EXECUTIVE DIRECTOR

The Chairman reported that Karin Norman had been appointed as a non-executive director and would be taking up post in July.

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 commercial matters and the Paddington Health Campus.