

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

Present: Non-Executive Directors
Juggy Pandit (Chair) 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 Communications and Technology
Andrew MacCallum, Director of Nursing

In Attendance: Amanda Pritchard, Acting Director of Service Development
Pippa Roberts, Acting Director of Governance and Corporate Affairs
Sue Perrin, Head of Corporate Affairs
Caroline Rhys Williams, Chairman, Charitable Funds Committee (item 5.6 only)
Kirsty Semple, Project Leader, Section 11 Status (item 5.6 only)

Note: Item 5.6 was taken before 2.1

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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 non-executive directors Professor Ara Darzi and Charles Wilson.

1.3 MINUTES OF THE MEETING HELD ON 3rd FEBRUARY 2005

The minutes of 3rd February 2005 were agreed as a correct record and signed, subject to:

2.4 4th paragraph, 2nd sentence should read '.....the public did not differentiate between MRSA and general hospital acquired infections'; and

4.1 4th paragraph, 1st sentence should read 'commercial' not 'contractual'.

1.4 MATTERS ARISING FROM PREVIOUS MEETING

The Trust Board was updated on the following:

1.4.1 CONVERGENCE WITH THE NATIONAL CARE RECORDS SERVICE

Lorraine Bewes said that extension of the contract with IDX would have to be ratified by the Trust Board.

Alex Geddes said that NPfIT, Phase 1 Release 2 had been delayed by eighteen months and was scheduled for mid 2006. The impact on Phase 2 Release 1, which the Trust had expected to adopt in the second quarter of 2006, was not known.

AG/
Apr TB

Action

Heather Lawrence said that the impact on PACS and how to proceed would be reviewed. She stressed the importance of document imaging in communication both internally and externally. However, the cost would be in the region of £1 million per annum and therefore the benefits would need to be clearly established, for example release of space. Andrew Havery said that the delay could result in Phase 2 Release 1 no longer being the same product as originally envisaged.

AG/
Apr TB

It was agreed that the Trust Board should receive an update at its April meeting.

1.4.2 CHEYNE DAY CENTRE

The Chairman said that he and Heather Lawrence had met with the PCT and it was clear that a decision had to be made by June. There did not appear to be demand for the Centre, although the Trust was pursuing the possibility of specialist commissioning.

1.4.3 WESTMINSTER HEALTH AND CARE NETWORK

Amanda Pritchard confirmed that she had drafted the response on behalf of the Trust Board.

1.5 CHIEF EXECUTIVE'S REPORT

Heather Lawrence gave an oral report and said that a paper would be circulated with the minutes.

1.5.1 DEVELOPING A STRATEGY FOR THE DELIVERY OF HEALTHCARE IN NORTH WEST LONDON

Heather Lawrence said this would set the strategic direction for the next ten years and would include plans for the development of primary and community health services as well as acute provision. Phase 1 would start in April/May, concluding with consultation on the strategy from January 2006.

1.5.2 PADDINGTON CAMPUS

The Department of Health had not reached a decision on the Outline Business Case. A Paediatric Steering Group was being established to agree a service model for Paddington Health Campus and Chelsea and Westminster. Heather Lawrence would attend with Dr Ed Abrahamson.

1.5.3 UROLOGY

Heather Lawrence said that the transfer from St. Mary's was progressing well. Activity of 1200 finished consultant episodes had been agreed and this would produce around £1.2 million income for the Trust.

1.5.4 DECONTAMINATION

Edward Donald said that North West London Trusts had agreed to carry out a joint evaluation of the options for meeting long-term service needs. This had been brought about by the advent of new standards and the fact that sterilisation services at a number of hospitals fell short of the target standards. The Department of Health's suggested approach was a centralised super-centre, which was expected to provide a compliant service, benefit from economies of scale and not require capital investments from Trusts. Chelsea and Westminster had invested in delivering a compliant Theatre Sterile Supply service, but the risks associated with life-cycle replacement costs and an increasingly stringent regulatory regime were likely to be too high for the Trust to bear on its own. Therefore the Trust had agreed to be a full partner in the project collaboration.

The Trust Board would receive both an outline and a full business case.

1.5.5 FINANCE

Heather Lawrence said that the North West London Sector was predicting a financial deficit of over £50 million, one of the most significant in the country. The Trust had been instructed to achieve financial balance. During the month, the predicted year end deficit had been reduced to £650,000. This was impacting on front line staff,

particularly nurses because of the strict controls on agency staff. Kensington and Chelsea PCT was predicting a £5.1 million deficit and a £9.1 million deficit for 2005/2006. A Recovery Plan had been circulated without consultation. An analysis of the Trust's position would be considered later on the agenda. Wandsworth PCT was also facing significant financial difficulties.

1.5.6 IMPROVING WORKING LIVES

Maxine Foster said that the self assessment had been completed in conjunction with the staff side. The Validation Team would visit the Trust on 16 March for an Orientation Day, with the full assessment taking place in April.

MF/
Apr TB

The staff survey work had been completed and the results would be reported to the April Trust Board.

1.5.7 CLEANING STANDARDS

Edward Donald said that, whilst the overall PEAT assessment was good, the Trust considered that there were areas, not at the level required by the contract. February had been the first month for Key Performance Indicators and the abatement schedule. A joint audit would be undertaken to agree standards and establish a baseline. There would be trust wide involvement. ISS Mediclean had introduced questionnaires for feedback on catering and would be introducing them for cleaning. The Cleaning Awareness Day had been successful.

1.5.8 IMPACT

Amanda Pritchard said that the IMPACT programme would take forward the Modernisation Agency Changes in relation to day case rates, length of stay, diagnostics and new follow-up ratios. A launch event was being held on 10th March.

2. PERFORMANCE

2.1 FINANCE REPORT

Lorraine Bewes presented the report, which showed an in month slight under spend, which included an under spend on pay. The Trust was forecasting a year end deficit of £0.65 million. The main improvement was due to Agenda for Change funding. High Cost Area Supplement funding had been confirmed at a higher amount than estimated and £0.12 million project costs had been re-phased to the next financial year.

The month 10 position included a number of key assumptions. The Trust was disputing the Pathology Service Level Agreement (SLA) proposal from Hammersmith Hospital for a real increase in costs of 12%, and had assumed that £0.4 million of this could be resolved.

Equipment leases were being reviewed to see if any could be re-profiled over a longer useful life.

It had been assumed that the additional funding for the Cheyne Centre would be forthcoming from both the Royal Borough of Kensington and Chelsea and the PCTs, and invoices were being raised.

The Trust continued to work on central initiatives. The Chairman said that the report needed to be seen in the context of the Trust having repaid £5.2 million and an in year £7.8 million savings plan, and therefore reflected good progress.

The Trust Board noted the financial position at Month 10 and the significant risks in the forecast.

2.2 SERVICE LEVEL AGREEMENTS (SLAs)

Lorraine Bewes presented the update, which outlined the approach being used to

negotiate SLAs for 2005/2006. The final arrangements for the implementation of Payment by Results had been set out in a letter from the Director of Finance and Information at the Department of Health. The introduction of Payment by Results (PbR) had been delayed and would apply only to elective care in 2005/2006. However, there was no planned change to the transition path for full adoption of PbR in 2007/2008. For activity covered by PbR, the published monthly tariff and market forces factor (MFF) would apply. Local prices would continue to apply for activity not subject to PbR.

The North West sector allocation for 2005/2006 represented only the national floor level of growth of 8.1%, as all PCTs were over capitation target. The allocation of funding to cover generic cost pressures amounted to 5.3%, inclusive of a 1.7% efficiency saving. The remaining 2.8% of additional funding should be available for investment. However, this was likely to be absorbed by the sector's financial deficit. North West London SHA had adopted a host PCT approach to commissioning services for 2005/2006.

Marilyn Frampton noted that the PCT was a relatively inexperienced body. Lorraine Bewes cautioned that the experience of host commissioning arrangements was that they were likely to be very difficult and virtually impossible to achieve a standard approach across the sector.

Lorraine Bewes noted the Kensington and Chelsea PCT recovery plan, which had assumed £1.6 million recovery from Chelsea and Westminster, and potentially double counted the savings needed to deliver the 1.7% national tariff efficiency requirement. It was noted that the Trust had not been consulted. The Trust would be detailing its concerns to the PCT about the lack of consultation and realism of the targeted savings.

A framework for the negotiation of SLAs had been set out by the North West London SHA and the PCTs. Pricing and Payment rules were being negotiated – the draft rules carried significant financial risk for hospital providers. There were also a number of absolute key standards in 2005/2006, some of which would require additional investment.

Andrew Havery said that the Finance Committee had discussed both finance papers and there needed to be a mechanism for assuring the Board. The timing of the meetings (the Monday prior to the Board) precluded the circulation of minutes in a timely fashion. It was agreed that either the Chairman or Andrew Havery would report on issues raised and clarification received.

Chair/AH

The Trust Board noted the approach being taken in negotiation of Service Level Agreements for 2005/2006.

2.3 PERFORMANCE

Lorraine Bewes presented the report and noted that the Trust was forecast to under achieve on the financial management target, rather than significantly underachieve. The Healthcare Commission was reviewing the financial management indicator. The Trust had underachieved on the elective admissions target. There were a number of areas on which to focus improvement on the balanced scorecard. The key area for raising performance was the Information Governance Toolkit, which was covered later on the agenda.

There had been nine breaches of the outpatient standard. If the Healthcare Commissioner decided that all nine should be included for 2004/2005, the Trust would need to see approximately 350 additional attendances in order to achieve this target.

The MRSA cases had increased and this would be a significant percentage because of the small numbers involved. The conclusion of the report was that the most likely result would be two stars, but there was still the possibility of 1 or 3 stars.

The Trust Board noted the report and conclusions.

3. STRATEGY/DEVELOPMENT

3.1 A STRATEGY FOR ENGAGEMENT AND PARTNERSHIP WITH PATIENTS AND THE PUBLIC

Andrew MacCallum presented the strategy, which had been discussed by the Trust Executive Meeting. It built on the Trust's existing strategy (User Involvement) produced in 2002. The strategy reflected the NHS Plan and the Health and Social Care Act (2001).

The paper described four areas of activity:

- Working with Patient and Public Involvement Forums (PPIF)
- Seeking the views of patients, the public and stakeholders
- Developing a Shadow Membership (NHS Foundation Hospital)
- Supporting engagement and partnership work within the hospital.

The Chairman noted that the PPIF members did not attend the Trust Board meetings. Andrew MacCallum said that engagement had included participation in PEAT assessments, meetings and orientation. Regular meetings with Heather Lawrence were being established. However, the PPIF preferred to conduct their own business and choose how they worked with the Trust. The Forum was independent and had complete control over its own programme of work, which was not shared with the Trust. They had chosen not to use PALs as a co-ordinator and preferred to make their own direct contacts.

Jenny Hill considered that this was an important group and there should be direct feedback to the Trust Board. It was noted that the consultation document on Healthcare Standards required the PPIF and the auditors to sign the declaration.

Andrew MacCallum agreed to draft detailed terms of reference and bring an action plan to include a process for the declaration to Trust Executive and then to the next Trust Board meeting.

Mike Anderson noted that there had been no growth in the membership. Andrew MacCallum agreed that this needed to be developed, including funding of a membership co-ordinator, a post originally funded from Foundation Trust funds.

AMacC/
April TB

The Trust Board approved the strategy and appointed the Chairman as the non-executive director to chair the Engagement and Partnership Steering Group.

3.2 EQUALITY AND DIVERSITY

Maxine Foster presented the paper, which reported on the approach being taken towards Equality and Diversity. The structure and status of the Equality and Diversity Steering Group, which was chaired by Edward Donald, was under review. As a result of the recent raft of equalities legislation the focus had mainly been on internal and employment issues. A specialist equality and diversity worker was required to comply with the Trust's legal responsibilities and this had been identified as a cost pressure for the following year.

A training event on 22nd March would inform the Board about policy and legislation as well as decide on the Trust's priorities for action.

Maxine Foster said that a very helpful relationship had been developed with the PCT and there was potential for shared management arrangements.

Marilyn Frampton noted the provisions of the 2004 Amendment Act, which strengthened the provisions for the disabled. She asked about the relationship with the Facilities Assurance Group. Edward Donald said that the provision for people with disabilities should be a key mainstream action in everything the Trust did.

Jenny Hill suggested that rather than being a strategy in its own right, it should inform all other strategies.

4. GOVERNANCE

4.1 AUDIT COMMITTEE

The unconfirmed minutes of the meeting held on 10th February were received.

Andrew Havery drew attention to the new Statement of Internal Control and the fact that there was no longer scope for partial compliance. He referred to the Acute Hospital Portfolio Phase 4 and drew attention to Pathology. This work was outsourced to Hammersmith Hospital and therefore no work had been undertaken at the Trust. However, the Audit Committee had been concerned that work could not be carried out at Hammersmith Hospital because of poor information. This represented a significant risk.

Both Internal Audit and Counter Fraud Services had been put out to tender for the Trust, the SHA and Kensington and Chelsea PCT. A shortlist of five for Internal Audit and three for Counter Fraud had been drawn up for interview.

There was a potential problem in achieving a quorum for the July meeting. The Chairman agreed to attend if necessary.

Alex Geddes said that, since the report, the Information and Records expenditure had substantially decreased. Andrew Havery said that the score was based on 'low' expenditure as a percentage of total revenue, and this meant that the Trust would remain in the upper quartile. He said that input from Alex Geddes to the Committee would be very helpful and he would arrange to discuss this further.

AH/AG

The Trust Board noted the minutes.

4.2 RISK MANAGEMENT COMMITTEE

Pippa Roberts said that the Trust Board was required to receive the minutes of the Risk Management Committee. It would also receive quarterly risk management updates.

The Committee comprised the risk leads from all departments. The key agenda items included the risk register and two incident reviews – one relating to a stairwell incident and one to a mental health patient. It was noted that the stairwell incident did not involve a 'current' patient, although the person was known to the Trust.

Jenny Hill noted the Pathology incident on the risk register. Lorraine Bewes said that the Pathology issues were being taken up with the trust and particularly the clinical risk aspects and the lack of assurance. The contract with Hammersmith had been taken up a number of years previously and there was no known alternative.

The Trust Board noted the minutes.

4.3 BOARD GOVERNANCE

The Board received the discussion paper, which proposed ways to provide effective assurance on the governance of the Trust. It suggested ways in which the sub committees could be effectively aligned and ways in which the Trust Board could assure a complex agenda of cross cutting activity. It proposed that a Board Assurance Portfolio be provided to each member.

It was agreed that this should be discussed in an April seminar.

PR

Jenny Hill said that there had been a change in the accountability of the non-executive Chair and the responsibility of non-executives for Board Assurance. The Board Assurance Products (BAPs) did not mirror the Healthcare Standards, but provided a checklist.

The Portfolio would be a useful induction pack for new directors and a review tool

for existing directors.

The Trust Board thanked Jenny for her contribution in ensuring that the Trust was advanced in its work on Board Governance.

The Trust Board adopted the proposal as a working document.

Pippa Roberts would lead on the development of the Board Assurance Portfolio and Comments should be referred to her. Andrew Havery agreed to e-mail his amendments to the terms of reference of the Audit Committee. Marilyn Frampton reminded the Board that the terms of reference had been established in line with the model terms in the Audit Committee handbook.

AH

5 ITEMS FOR APPROVAL/INFORMATION

5.1 CANCER 31/62

Edward Donald said that the Healthcare Commission would include the 31/62 access time targets in the Key Performance Indicators in 2005/2006 – 31 day maximum wait from diagnosis to first treatment for all cancers and 62 day maximum wait from urgent GP referral to first treatment for all cancers by December 2005. This would replace Accident and Emergency waits as the top priority in 2005/2006.

Edward Donald said that, after discussion with the Cancer Team, it would be important to ensure that delivery of access targets did not compromise important features of the services at Chelsea and Westminster, such as the cancer service reputation for being patient centred, the need to meet Peer Review standards and the continuing contribution to research.

The National Cancer Services Collaborative had identified endoscopy and radiology as key bottlenecks in the cancer journey, and these departments would be supported to develop service improvement plans, aimed at reducing unnecessary waits, linked to the IMPaCT programme.

Edward Donald outlined key risks, including the clinical and managerial capacity to maintain Accident & Emergency whilst delivering 31/62. There were practical issues in relation to funding MDT co-ordinators for Urology and potentially Dermatology to enable baseline data to be collected in line with the national programme. In relation to peer review, investment was also required in Palliative Care to deliver sustainable medical cover at SpR level.

There were a number of opportunities including the use of the Treatment Centre, for diagnostics and short stay cancer surgery, where this was clinically appropriate.

Edward Donald outlined the key questions that might help to achieve Board Assurance.

Mike Anderson explained that a data co-ordinator tracked people going through the system and the consequences.

The Trust Board noted the report and the inclusion of the 31/62 target in monthly performance reports from May 2005.

5.2 CHILD PROTECTION REPORT

Andrew MacCallum tabled the report, which outlined:

- Child Protection Action Plan 2004/2005 Update, based on the self assessment, which the Trust undertook as part of the national audit of child protection. The plan addressed areas identified as requiring attention.
- Post Laming Status Discussion – areas of achievement and areas to be addressed
- New Issues, both national and local.

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	Lorraine Bewes said that a budget had been set up for the training programme.	
	Alex Geddes expressed reservations about the use of a 'flag' on EPR to alert staff to vulnerable children. It was agreed that there would have to be training and a protocol for use. Alex Geddes suggested that the matter be progressed through the EPR Reference Group.	AG
	Maxine Foster said that Criminal Records Checks were carried out only on staff working in high risk areas, because of volume. It was possible that this would be extended to all staff coming into contact with children.	
	Security on the Children's Ward was high, including security locks. However, provisions in areas, which were not dedicated children areas might not be so good. It was agreed that the Children's Board should cover all areas, not just Paediatrics.	
	Andrew MacCallum replied to a specific question that information sharing between a consultant and GP would be followed through by the child protection nurse, who might also liaise with a health visitor. The Information Sharing Agreement had been signed by GPs, the PCT, acute trusts, social services, education and the police.	AMacC
	Andrew MacCallum said that the Trust Board would receive an Annual Report showing the number of incidents and the outcomes.	

The Trust Board noted the report.

5.3 INFORMATION GOVERNANCE POLICIES

The Trust Board was asked to approve the policies as the basis of the implementation of Information Governance across the Trust, and in the development of information management and sharing with health care and related partners such as social services and education.

The Trust Board agreed to e-mail any amendments/comments to Alex Geddes.

Maxine Foster commented on the helpful format of the Information Compliance Chart.

AG

The Trust Board approved the revision of the policies that support information governance, subject to the reporting of any significant amendments to the next meeting.

Alex Geddes said that the internet site existed and direct access issues were being resolved.

5.4 HEALTHCARE COMMISSION: CONSULTATION RESPONSE

The Trust Board received the response to the Healthcare Commission consultation on the new Assessment Framework.

5.5 CHARITABLE FUNDS COMMITTEE

The Trust Board received the unconfirmed minutes of the meeting held on 9th December 2004.

5.6 CHARITABLE FUNDS COMMITTEE – TRANSFER TO SECTION 11 STATUS

The Chairman introduced the item and briefly covered the background to the transfer to Section 11 Status. Kirsty Semple confirmed that the transfer would have no impact on the powers and governing procedures of the charity. Only the trustees would change - from the Trust to independent trustees appointed by the Appointments Commission.

Caroline Rhys Williams said that the Charitable Funds Committee had asked that the Trust Board supported the application and asked the Department of Health to proceed with the Order, which had been prepared in draft.

Lorraine Bewes referred to Hospital Arts and asked if the transfer would be subject to

any restrictions as per the original donations. Kirsty Semple said that such a clause was already in the general objectives of the Charity. However, much of the art was held in the subsidiary charities, which had even more specific objectives.

Caroline Rhys Williams said that art donations accepted by the Charity would be placed/hung in liaison with the Trust.

The Chairman asked about the future administration of the Charity. Caroline Rhys Williams said that it was proposed to have seven trustees and the Order could be in place by the beginning of May 2005. This would enable the establishment of a shadow board in advance of the transfer date. Trust staff currently managed the charitable funds and this could continue with an appropriate service level agreement. In the longer term, it was likely that the Charity would have its own Chief Executive and staffing structure.

Andrew Havery asked for clarification of which assets would transfer. Caroline Rhys Williams said that the assets currently held by the charities would transfer. These were distinct from the Trust's own assets and could be used only for charitable purposes. Anything, which had been bought for the Trust from charitable funds, was regarded as the Trust's asset. The Charity's assets were bound by Charity law and by the aims and objectives of the Charity.

It was agreed that protocols would need to be put in place to manage the relationship between the Trust and the Charity and ensure full communication and liaison, and these should be developed by the Shadow Board. They would cover mechanisms for regular communication, process for policy and co-ordination and administrative arrangements.

Andrew MacCallum asked about the benefit to patients and staff. The Chairman said that the transfer had been brought about partly by the Trust's potential change to an NHS Foundation Trust. It would only be possible to remain as corporate trustee if the committee was managed directly by Board members. The separation of the Charity would enable fundraising opportunities on behalf of the Trust to be more fully utilised, and would resolve the conflict of non-executives sitting on the committee.

Marilyn Frampton noted the importance of communication with Trust staff about the proposed transfer.

The Trust Board unanimously confirmed the decision to transfer to section 11 status.

5.7 RECOVERY PLAN, KENSINGTON AND CHELSEA PCT

Edward Donald tabled a paper showing the impact of the PCT's Recovery Plan on the Trust. The Plan assumed an income reduction of £1,656,000 in 2005/2006 and a total reduction of £2,368,000 in 2006/2007.

Heather Lawrence said that the reduction in length of stay represented double counting. Trusts had assumed that savings in this area would be a first call in delivering the 1.7% cash releasing efficiency saving, required under Payment by Results. Additionally, the higher than average length of stay was a result of a lack of community based rehabilitation.

The 1% reduction in emergency bed days was set against an increase in admissions in 2004/2005 and the PCT capacity plan assumption of an increase in 2005/2006. The risk of reducing the activity plan would need to be managed in line with the 'Pricing Rules' agreed across North West London SHA.

The Trust Board resolved that it would not support the PCT Recovery Plan.

Heather Lawrence would write to the Overview and Scrutiny Committee to the effect that the Trust did not support the Recovery Plan and considered that the desired

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outcomes had not been costed.

6. QUESTIONS FROM THE MEMBERS OF THE PUBLIC

There were no questions.

HL

7. ANY OTHER BUSINESS

- 7.1 It was agreed that the AGM would be held on 29th September 2005 – time and venue to be agreed.

8. DATE OF THE NEXT MEETING

- 8.1 7th April 2005

9. CONFIDENTIAL BUSINESS

- 9.1 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 items to be discussed related to individuals.