Chelsea and Westminster Healthcare NHS
NHS Trust

Minutes of the Public Meeting of the Trust Board held on 6th October 2005.

Present: Non-Executive Directors

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

Executive Directors
Mike Anderson, Medical Director
Lorraine Bewes, Director of Finance and Information
Edward Donald, Director of Operations
Maxine Foster, Director of Human Resources
Alex Geddes, Director of Information Communications and Technology
Andrew MacCallum, Director of Nursing

In Attendance: Susan Burnett, Acting Director of Governance and Corporate Affairs
Amanda Pritchard, Acting Director of Strategy and Service Development
Sue Perrin, Head of Corporate Affairs
Darwin Kaluba, Financial Controller (item 3.1 only)
Vivia Richards, Head of Clinical Governance (items 4.1 and 4.2 only)
Berge Azadian, Consultant Microbiologist (item 5.1.1 only)
Roz Wallis, Senior Infection Control Nurse (item 5.1.1. only)

Note: Item 3.1 was taken after 1.4 and Andrew Havery was not present.

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1. GENERAL MATTERS

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

1.2 APOLOGIES FOR ABSENCE
Apologies were received from Heather Lawrence, Chief Executive and Professor Ara Darzi, Non-executive director.

1.3 CONFLICT OF INTEREST
No conflicts of interest were declared.

1.4 MINUTES OF THE MEETINGS HELD ON 04th AUGUST 2005 AND 01st SEPTEMBER 2005
The minutes of the meetings held on 04th August 2005 and 01st September 2005 were agreed as a correct record and signed.

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

1.5.1 FINANCIAL REPORT
Lorraine Bewes said that the Recovery Plan for private patients had not been completed, due to the absence of a General Manager. Acting arrangements had now been put in place and the plan would be brought to the next Trust Board. LB

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The forecast deficit for the Private Patients Unit had been reduced from £1 million to £0.5 million, and after implementation of the Recovery Plan, the Unit was targeted to break even.

1.5.2 CHILD PROTECTION QUARTERLY REPORT

Mike Anderson said that Paul Hargreaves had drafted a letter on behalf of the Trust Board setting out concerns regarding Capio Nightingale House, but there needed to be further discussion outside the meeting. It was agreed that Mike Anderson would discuss the letter with Heather Lawrence and that, if appropriate, Chairman's action would be taken to approve the sending of the letter. MA

1.5.3 PICTURE ARCHIVING COMMUNICATIONS SYSTEM (PACS) BUSINESS CASE

The Chairman noted that the Trust Board, in the confidential part of the previous meeting, had approved the recommendation of the PACS Project Board to purchase the Connecting for Health PACS.

1.6 CHAIRMAN'S REPORT

1.6.1 VICE CHAIR

The Chairman said that he had appointed Marilyn Frampton as Vice Chair.

1.6.2 TRUST CHARITY

The Chairman said that he had agreed to the request of the Charity to the name change for the Charity and its subsidiaries to the one name of 'Chelsea and Westminster Health Charity'. The transfer had taken place on 1st October.

1.7 CHIEF EXECUTIVE'S REPORT

The Trust Board noted the Chief Executive's report.

1.7.1 NORTH WEST LONDON STRATEGIC HEALTH AUTHORITY (SHA)

Mike Anderson drew attention to the stringent letter from the SHA. A response had been sent in line with the range of actions, which had been implemented by the Chief Executive. The actions had been set out in her report.

1.7.2 SENIOR STAFF

The Chairman said that the secondment of Susan Burnett to the Trust had ended, but she had returned to attend the Board meeting. He thanked her for the considerable help, which she had given the Trust.

The Chairman said he was sorry to report that Amanda Pritchard would be leaving the Trust in December to take up an appointment in the Prime Minister's office.

1.8 FOUNDATION TRUST APPLICATION

Mike Anderson said that the Clarification Meeting had taken place, and had been attended by Lorraine Bewes and Amanda Pritchard.

Lorraine Bewes said that the Trust had met the deadlines, but work on the detailed financial model was currently one week behind. The Trust was receiving help from McKinsey and Monitor with the Foundation Trust Diagnostic, which was driving the timeline. Robson Rhodes and Ernst and Young were assisting with the second wave application.

Amanda Pritchard noted the tight schedule. Draft documents for the Service Development Strategy, Risk Analysis and Governance Self Assessment had been submitted, and she would share these documents with the Trust Board outside the meeting. There were two opportunities to submit updates. The deadline for second AP

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wave applications was 9th December. There would be a formal briefing at the next meeting.

Lorraine Bewes said that the Financial Model was due to be completed within the next few days and would be circulated when complete. LB

Marilyn Frampton noted the importance of the corporate role of directors and the need for a session on Board dynamics. Andrew MacCallum suggested that there should be an external facilitator. Lorraine Bewes and Amanda Pritchard agreed to discuss whether this could be part of the November meeting or if there should be more than one meeting. LB/AP

Andrew Havery asked for assurance that as much of the previous application as possible had been used, and that management consultancy and communication costs had been kept as low as possible. The Chairman noted that public consultation would not be repeated.

Lorraine Bewes said that the previous application had been the starting point and this work had been restructured, taking account of the lessons from the Diagnostic. The financial modelling support was free. There was an added benefit in that the work built up in house skills.

Charles Wilson asked about the use of external communications support. Andrew MacCallum said that, since the departure of the PR and Communications Manager, communications had become a minimum function in the hospital. To progress the application, the Trust needed to demonstrate to Monitor that it had a lively and engaged membership. The AGM had demonstrated that the Trust had a good membership. However, short term help was needed to revitalise this membership and help the Trust work with the membership in an effective way. This would complement the work already done, and bring about a membership fully equipped to take part in the elections.

2. PERFORMANCE

2.1 FINANCIAL REPORT – AUGUST 2005

Lorraine Bewes presented the report, which showed an overall financial position of £0.554 million deficit, which represented a significant improvement from the previous month. Further recovery plans had been identified since the report. Pay costs were within the overall budget and Agency costs were being reduced. However, the key reason for the in-month improvement in the position was the impact of the £3.4 million 2003-2004 deficit payback benefit. This related to the month 12 forecast of £5.2 million deficit. The actual deficit had been £1.8 million. However, regulations meant that the amount available to the Trust to spend had not been adjusted to reflect this, and £5.2 million had been repaid. This had now been corrected and hence the Trust would receive a total of £3.4 million. The forecast outturn for the year end was £0.9 million deficit.

SaFF income was projected to be under target by £1.6 million. There were specific pressures within the Medical Directorate and Private Patients.

Agenda for Change presented a significant risk, and a prudent provision had been made. Recent discussion with ISS had highlighted that discussions were progressing at a national level regarding recognition of Agenda for Change terms and conditions for outsourced staff. Guidance was expected on an NHS wide approach to this cost and where the liability for any increase would fall.

The Trust had been asked to contribute a surplus of £1.9 million towards reducing the sector-wide deficit. In order to recover the deficit and contribute to the sector deficit reduction, the Chief Executive had proposed the actions outlined in her report.

The Chairman noted that the Trust faced a deficit, even after the £3.4 million. Lorraine Bewes said that this would have to be resolved before the Foundation Trust application was submitted. The bank and agency spend had been reduced

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significantly and on going savings were anticipated in procurement. Some £6/7 million benefit had been realised by the reduction in the valuation of the hospital on the basis of size and price. The Trust would continue to challenge on the life of the building.

The Chairman referred to the discussion at the Finance and General Purposes Committee regarding performance statistics. The current focus was on service delivery, as opposed to efficiency and productivity. Lorraine Bewes said that work was in hand to supplement the Performance Report and to benchmark. Useful indictors could be length of stay and staff costs per patient day. Lorraine Bewes said that she would circulate the draft report for comment. LB

Karin Norman noted the importance of coding to ensure income. Lorraine Bewes said that significant improvements had been made in the completeness of coding. In the previous year, 2% had not been coded. In the current year, 99.7% had been achieved. In respect of the depth of coding, work was in hand to ensure that directorates understood the procedure and their contribution to what could be brought in as income.

Karin Norman said that measurement of re-infection and re-admission rates was important. Edward Donald noted that any indictor would have to be assessed against the norm for the group. He commented on 'revolving door patients' – patients with chronic and long term conditions and the development of models of care with the Community Sector.

Andrew Havery suggested that savings might be made on debt collection agency fees by linking with other trusts. He referred to the significant variances on Form 2B(1) and said that budgets should be realistic and not just targets. Lorraine Bewes noted that the budgets had made separate provision for the income loss, but actual SaFF income loss had exceeded the provision by £1.6 million.

There remained a few significant Service Level Agreements by value that had not been agreed, notably Hammersmith & Fulham PCT, Wandsworth PCT and the HIV Consortium. There had been no further progress on the Wandsworth arbitration.

The cash forecast showed a £6.2 million variance from plan as at month 5. Of this, the £1.5 million of invoices disputed by PCTs were the focus of attention. The balance related to issues that had since been resolved and the phasing of the cash plan, which would be re-phased for month 6.

The Chairman noted that £1.5 million was of immediate concern, not £6.2 million. However the underlying cash position would need to be resolved before becoming a Foundation Trust.

The Trust Board noted the financial position at month 5.

2.2. PERFORMANCE

Lorraine Bewes presented the report, and highlighted the areas of concern – Accident & Emergency, Cancer Indicators and Elective and Outpatient access indicators.

In respect of the Accident & Emergency Indicator, the Trust had recovered from poor performance in the first three months and had achieved 98.3% from June to August. If the Trust maintained this level between September and March, it would achieve the 98% target for the whole year. This was an intensive and challenging target. Mike Anderson said that the Trust would be shutting beds and, on the basis of past experience, this meant that it would be harder to meet the Accident & Emergency target.

Edward Donald said that Kensington and Chelsea PCT planned support of GP cover, Monday to Friday, in the Accident & Emergency Department had been deferred to the following year. The Trust would be looking at the number of patients brought to the hospital by the London Ambulance Service, to ensure that it was not getting patients from outside its agreed catchment area.

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Lorraine Bewes said that performance against the Cancer Indicators was improving, and plans had been put in place to achieve the target. It was also anticipated that, as a result of the action being taken in respect of the Elective and Outpatient Access Indicators, the Trust would achieve these targets.

Edward Donald referred to the Cancer Indicator for patients waiting 62 days from GP referral to first treatment. On the formal return to the Department of Health, twenty patients had been excluded because of lack of a NHS number. Hammersmith and St. Mary's hospitals had the same problem. Charles Wilson asked that the two figures be given in the next report. LB

MRSA cases were lower than in the previous year, even though clostridium difficile toxin had been included in the calculation.

With reference to the cancelled operations indicator, Mike Anderson said that the Trust was being prudent and counting operations cancelled as a result of the London bombings until confirmation had been received from the Healthcare Commission.

Edward Donald said that twelve medical beds had been closed and six surgical beds would be closed by the end of October, as a result of reduced length of stay. A further six surgical beds would be closed if the Trust did not secure additional work to earn a contribution from Guys and St. Thomas Hospital in the financial year.

Marilyn Frampton asked Maxine Foster to explain the action plans which had been put in place to ensure that feedback from the staff survey improved. Maxine Foster gave the following examples: the improvement of feedback to staff on action which had taken place in response to suggestions; and building on the work undertaken to achieve Improving Working Lives Practice Plus by keeping the momentum going through staff focus groups. Additionally, the questionnaire had been substantially reduced in size. Basic skills training was being offered to staff and one person from the Learning Resource Centre had been licensed to help staff fill in the form. Surveys on a directorate basis had been organised by the Trust.

The Trust Board noted the report.

2.3 MANAGEMENT LETTER

Andrew Havery, Chair of the Audit Committee, said that he did not wish to comment – the report was self explanatory. He noted that the Trust was still providing some shared services.

Charles Wilson asked about progress with Agenda for Change. Maxine Foster said that the target of 100% of staff on Whitley contracts being assimilated by the end of September had been met. 80% of staff on Trust contracts had been assimilated.

The Trust Board noted the Management Letter.

3. ITEMS FOR DECISION/APPROVAL

3.1 CHARITABLE FUNDS ANNUAL ACCOUNTS

Darwin Kaluba said that the Charitable Funds Committee had approved the accounts, subject to the following amendments, which the Chair, Caroline Rhys Williams and Heather Lawrence had subsequently agreed:

- A note relating to staff had been removed – the Charity did not employ staff.
- A paragraph had been inserted in 'Related Party Transactions' regarding the revenue and capital payments made on behalf of Kensington and Chelsea PCT and North West London Strategic Health Authority.
- The section relating to the investment policy had been expanded to include a breakdown of how the fund was currently invested.

Information on the phasing of grants made to the chaplain had been included and a breakdown of debtors had been given.

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The external auditors, Deloitte & Touche, had signed the amended accounts and given an unqualified Audit Opinion.

Karin Norman noted the substantial cash held as part of the investment portfolio and that no interest was shown against this. Darwin Kaluba said that the Accounts were presented in the format set by the Department of Health. The cash was circulating from the sale of shares and was held by fund managers in a bank. Interest had been included in that attributed to investments listed on the stock exchange.

Lorraine Bewes said that the Charity had transferred to Section 11 status on 1st October and that this could be considered as a substantial post balance sheet event. Darwin Kaluba would discuss with Deloitte and Touche. LB

The Trust Board endorsed the Charitable Funds Annual Accounts subject to the above amendments.

4. ITEMS FOR ASSURANCE

4.1 RISK MANAGEMENT STRATEGY AND POLICY

The Chairman said that the Trust Board had an overarching responsibility for all risks, which was not reflected in the document.

Marilyn Frampton said the three committees should be working in tandem to assure the Board.

Specific comments were made as follows:

- The Chair of Audit Committee was not included as an individual with specific responsibilities.
- A non-executive director chaired the Facilities Assurance Committee, not the Director of Operations.
- The Risk Management Map needed to be amended to show the responsibilities of sub-committees, other than Clinical Governance Assurance Committee.

The classification of risk was discussed, i.e. clinical, facilities or audit. Any risks, which did not fit into one of these categories, would be the responsibility of the Trust Board, for example strategic risk. It was agreed that there should be only one risk register and that risks should be categorised as above.

Lorraine Bewes noted that risk was measured on the basis of impact and likelihood, but controllability was missing.

Susan Burnett said that it would be helpful to show risks in terms of whether they had been mitigated, transferred to another body or accepted.

Marilyn Frampton said that the Terms of Reference of the Clinical Governance Assurance Committee were being clarified to reflect its responsibility for risk and to ensure that the membership was appropriate. She noted that the Riverside Ethics committee was shown on the Governance Wheel, but there was uncertainty about its role. Responsibility for research risks had not been covered.

Amanda Pritchard said that a risk assessment was being carried out as part of the Foundation Trust application. This would result in a good analysis of the Trust's risks and a better understanding.

Mike Anderson said that some risks had been given a surprisingly high score. Susan Burnett said that methodology for a new scoring system was being piloted on one month's data and the results would be presented to the Risk Management Committee.

Vivia Richards said that the Risk Management Procedure, which supported the strategy and procedure, would also be taken to this meeting.

Karin Norman said that the strategic intent should have a higher profile at the beginning of the document. It was important to note that the duty of care rested with both the Trust and individuals.

The Chairman asked that any further comments on language or presentation be made

outside the meeting to Vivia Richards.
Andrew MacCallum said that the Trust was refining a process, which was well established and staff were orientated to achieve.

The Trust Board approved the strategy and policy, subject to the amendments noted above.

4.2 ANNUAL HEALTH CHECKS/STANDARDS FOR BETTER HEALTH DECLARATION

Susan Burnett said that, by the end of October 2005, the Trust Board was required to complete a draft declaration assessing its performance against the government's twenty four core standards, signed by all Board members for the period 1st April to 30 September 2005.This would form the basis of the final declaration in April 2006. Assurance reports for each of the standards had been prepared by the Executive Directors. Evidence had been compiled against the prompts, which had subsequently not been included in the published standards. Compliance was required with the spirit of what was required by each standard, for example standard 22 related to Public Health and an acute hospital would not be expected to comply with all the prompts.
The Trust was required to give its local partners the opportunity to comment on its performance against core standards. These comments would be produced verbatim in the relevant sections of the declaration template. The partners were the Strategic Health Authority, the Patient and Public Forum and the relevant Overview and Scrutiny Committees, represented by Kensington and Chelsea.
The SHA's commentary would be an overview and there would be an internal audit report on the robustness of the process.
Susan Burnett recommended that the declaration was not signed until the commentaries from the SHA, the PPF and the Overview and Scrutiny Committee had been seen. The Chairman was responsible for the final sign off, and would need to e-mail non-executive directors to obtain explicit feedback on whether or not they agreed with the declaration. Chair
Edward Donald agreed to forward to Andrew Havery an ISS Mediclean monthly report. ED
Karin Norman said that there was not one single area where the Trust was not compliant. Susan Burnett said that compliance was required with the spirit of what is required by each standard. Compliance against the prompts had been undertaken before trusts were told not to use the prompts.
Marilyn Frampton noted that compliance against the thirteen developmental standards would be required for the following year.

The Trust Board noted the report.

5 ITEMS FOR NOTING

5.1 ANNUAL REPORTS

5.1.1 CONTROL OF INFECTION

Andrew MacCallum said that the activities of the Infection Control Team, as presented in the report, included surveillance, training of all staff, environmental issues including new building works, policy development including antibiotic guidelines, decontamination and audit. He noted the outstanding work of the department, and that both Berge Azadian and Roz Wallis undertook advisory roles nationally.
The Chairman asked for clarification of the 48 MRSA bacteraemias reported. Berge Azadian said that 25% of the 48 cases had been acquired in the community or other

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hospitals.

The Chairman noted that 36 MRSA cases were orthopaedic patients. Roz Wallis explained that these were not bacteraemias – they were either patients colonised with MRSA (ie MRSA was detected on their intact skin but was doing no harm) or wound infections. A dedicated orthopaedic ward had been established together with enhanced pre-operative MRSA screening and surveillance. These actions had significantly reduced the incidence, and there had been no cases for the previous 4/5 months.

Marilyn Frampton said that her local hospital had established a dedicated ward in 2001 and asked why it had taken so long to establish at the Chelsea and Westminster. Andrew MacCallum said that it had been difficult to set up a dedicated ward and the timescale was on a par with most other hospitals. Mike Anderson noted the pressures in the sector, and specifically the transfer of Orthopaedic cases to Ravenscourt Park.

It was noted that the hospital had a very active Burns Units and that MRSA tended to be endemic in burns patients. Mike Anderson said that the Government did not differentiate on the basis of case mix. However, most hospitals would have a similar specialty, with associated high MRSA rates.

Charles Wilson asked if finance had been made available for the macerators. Mike Anderson said that they had been included in the business plan for sterile areas for the following year.

It was noted that the Trust could not comply with Department of Health guidelines regarding taking precautions with reusable surgical instruments on patients at risk of CJD. The Trust routinely assessed patients on admission.

Roz Wallis said that Kingston Hospital had successfully screened all pre-op elective surgical patients for the last four years. The assessment consisted of four questions. Pre-assessment had agreed to do the same following the production of a patient information leaflet and education for the pre-op assessment nurses.

Susan Burnett referred to Needlestick Injuries and asked if the purchase of retractable needles had been considered. She considered that the cost would be offset by the benefits realised from a reduced number of staff injuries. Edward Donald said that the Health and Safety Committee would identify a pilot area in the Trust. He noted the importance of education and training, as all sharps injuries were preventable.

The rise in clostridium difficile toxin rates was noted. An audit had shown that this had occurred mostly due to antibiotic use, rather than cross infection. Prudent antibiotic prescribing was being promoted.

The Trust Board noted the report.

5.1.2 ANNUAL COMPLAINT REPORT

The Trust Board noted that the number of complaints received had been the same as in the previous year. There had been a downward trend between 2002/2003 and 2003/2004, and this was believed to be the result of PALS, which had been established in April 2002.

Marilyn Frampton asked for clarification of the 'Investigation' stage of the complaints process. Andrew MacCallum said that the Healthcare Commission might require further information before making a decision and therefore this was still part of the local resolution stage.

The Trust Board agreed that the percentage of complainants compared with total patients would be more informative than actual numbers. AMacC

Mike Anderson said that the General Medical Council was receiving an increased number of complaints and was referring a greater number back to hospitals.

Karin Norman noted the number of complaints about staff attitude and behaviour. Andrew MacCallum said that this was in line with other trusts, and should be balanced with the number of thank you letters received, as shown in the PALS report.

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The Trust Board noted that no complaints had been received in respect of discrimination.

The Trust Board noted the report.

5.1.3 PALS ANNUAL REPORT

It was noted that the number of contacts with the PALS office was lower in 2004/2005. Andrew MacCallum said that there had been a change in reporting. He had been concerned that the PALS team was spending too much time on data entry and therefore contacts, such as request for directions were no longer logged.

Lorraine Bewes said that a correlation of PALS contacts to complaints would be useful. AMacC

The Trust Board noted the report.

5.2 MINUTES OF SUB-COMMITTEES

The Trust Board received the following minutes:

5.2.1 Audit Committee, 08th September 2005 (draft)
5.2.2 Charitable Funds Committee, 23rd June 2005
5.2.3 Clinical Governance Assurance Committee, 15th September 2005 (unconfirmed)
5.2.4 Remuneration Committee, 04th August 2005 (unconfirmed)

6. ITEMS FOR INFORMATION

6.1 RISK MANAGEMENT COMMITTEE – MINUTES

The Trust Board received the minutes of 25th August 2005.

6.2 CORPORATE PLAN

Amanda Pritchard said that the Corporate Plan, which had been signed off by the Trust Board in April, had been updated and additions had been clearly identified. There had been no changes to the weighty appendices and these had not been circulated.

The update was intended to:

- keep the Trust Executive Team and Trust Board fully informed of progress towards delivering the Plan and identify areas where positive action was required to meet delivery;
- reflect changing priorities and new initiatives resulting from external drivers for change and internal Trust developments;
- maintain a live link between the Corporate Plan and the Trust's Assurance Framework, and support the Foundation Trust Application; and
- allow the Board to reflect on the strategic vision for the Trust at regular intervals and offer an opportunity to develop the Trust's long term strategy in response to changing circumstances and priorities.

Considerable progress had been made and, if the Trust had decided not to do something, the rationale had been clearly defined.

The Chairman asked if the list of specialist services was complete. Mike Anderson said that those listed were the ones for which the Trust was paid. However, there were services such as high risk maternity, which could be regarded as a specialist service, for which the Trust was paid on a local rate. The Chairman asked that the list be made more explicit. AP

Charles Wilson noted that the plan had been written before the letter from the SHA (discussed earlier). It was not known if any of the objectives were compromised.

It was noted that PCT help in providing a GP service in Accident & Emergency was still included in the plan. **Action**

The Chairman noted that the cover page referred to 2005-2006, and asked that the date be dropped as much of the document involved forward planning – the steps the Trust was taking towards the strategy for the future.

Maxine Foster confirmed that objectives of the executive directors had been linked to the Corporate Plan.

The Trust Board agreed that the Corporate Plan was an extremely useful document.

6.3 INTEGRATED SERVICE PLAN

Amanda Pritchard said that the Integrated Service Improvement Plan linked different strategic policies to support delivery of the Trust's priority objectives (Proforma D). It focused specifically on key objectives and desired outcomes.

Proforma A gave the key drivers, challenges and enablers. Proforma B summarised progress in delivering the Trust's priority objectives and Proforma C highlighted the evidence used to assess this.

The Trust Board considered that Proforma D was particularly useful.

7. QUESTIONS FROM THE MEMBERS OF THE PUBLIC

7.1 There were no questions.

8. ANY OTHER BUSINESS

8.1 There was no other business.

9 DATE OF THE NEXT MEETING

9.1 1st December 2005

10. CONFIDENTIAL BUSINESS

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