Chelsea and Westminster Healthcare NHS
NHS Trust

Trust Board Meeting, 6th April 2006
Minutes

Present:

Non-Executive Directors:	Juggy Pandit (JG) (chairman) Marilyn Frampton (MFr) Andrew Havery (AH) Karin Norman (KN) Charles Wilson (CW)
Executive Directors:	Heather Lawrence (HL), Chief Executive Mike Anderson (MA), Medical Director Lorraine Bewes (LB), Director of Finance and Information Edward Donald (ED), Director of Operations Maxine Foster (MFo), Director of Human Resources Alex Geddes (AG), Director of IM&T Elliot Howard-Jones, (EHJ), Interim Director of Strategy and Service Development Andrew MacCallum (AMC), Director of Nursing Cathy Mooney (CM), Director of Governance and Corporate Affairs
In Attendance:	Fleur Hansen (FH), Foundation Trust Lead Deirdre Linnard (DL), Deputy Chief Pharmacist (for item 5.1)

1. GENERAL BUSINESS

1.2 Apologies for Absence

Apologies were recorded from Edward Donald.

1.3 Declarations of Interest

No conflicts of interest were declared.

1.4 Minutes of the Previous Meeting held on 2nd March 2006

KN commented that a number of points she made at the previous meeting were not included in the minutes. An example of this being that under Connecting for Health in item 1.6, there was no mention of the September deadline for connectivity to the National Spine. In addition KN said that there was no mention of the discussion on debtor/creditor days or PCT performance. AH suggested that the minutes should reflect decisions, strong views and actions only to which CW added important facts should be included as well. HL commented that the Board should be focusing on corporate risks, strategies and objectives and that looking at other Foundation Trust Boards, their minutes are considerably shorter.

MFr also challenged the minutes as they did not include a matter arising regarding the risk management minutes which she had raised with FH (It was determined outside the meeting that this was actually an issue from a previous Board that had been dealt with.) She also asked the Board to note that action 5.1.2 (circulation of the proposed Core Standards Declaration) had not been done. HL pointed out that the Standards would be tabled later in the meeting.

CW enquired as to the process of formulating the minutes. HL informed him that FH writes them, JP, HL and LB then edit them before being distributed to be Board for

comments. HL clarified that the final minutes were the province of the chairman. KN had an amendment – on page three under the NHS Foundation Trust Application – Cash Risk Update could the final sentence be amended to the following:

> The Board agreed that it was confident that the cash issue could be resolved and that the Trust should proceed with its Foundation Trust application.'

KN also said that the discussion around the readmissions rate needed to be reflected in the minutes.

LB clarified a point that KN had raised at the previous meeting regarding the arbitration for Foundation Trusts. The Foundation Trust model contract provides for a dispute resolution process which includes four stages – settlement by negotiation, mediation service agreeable to both parties, independent panel and legal action.

The minutes were agreed as a correct record of the meeting subject to the changes listed above.

1.5 Matters Arising

5.1.1/Mar/06 Assurance Framework
CM informed the Board that as decided at the previous Board meeting the Assurance Framework had been amended and signed off by the Audit Committee on behalf of the Board.

5.1.2/Mar/06 Standards for Better Health Declaration
CM told the Board that the Declaration was submitted to the Overview and Scrutiny Committee (OSC) for comment and their response, which was received on April 5th, was attached. The OSC highlighted some key issues including CRB checks and MRSA. The Trust is not allowed to amend its Declaration after submission but has until May 4th to attach comments to address these issues. JP asked that the Board feed back any comments to him and he will take chairman's action if necessary to resolve.

DL joins meeting.

5.1/Aug/05 Child Protection Quarterly Report
MA informed the Board that there had be no response yet from the Healthcare Commission but that Paul Hargreaves, clinical lead for child protection, was negotiating with them. The issue would be carried over to the May 4th Board meeting.

3.3/Dec/05 Sub-Committee Terms of Reference
MFr informed the group that this was discussed at the recent Clinical Governance Assurance Committee and that it would be useful for CM to go through the Terms of Reference. MFr said it had been decided that the main issues raised at the Clinical Governance Assurance Committee would be raised at the Facilities Assurance Committee and vice versa.

1.6/Mar/06 Connecting for Health
AG updated the group on the progress with IDX/GE. AG and HL had both met with IDX/GE and they were expecting a reply from them stating their position by the end of the week. There are also meetings been held with Connecting for Health and AG and HL would bring a paper to the next Board meeting.

5.1/Jan/06 Influenza Pandemic Contingency Planning
This will be discussed in the Chief Executive's Report.

1.7/Jan/06 Foundation Trust Application
The timetable has been updated and circulated with the Foundation Trust Update

Report.

2.1/Mar/06 Capital Report
This is to be tabled later in the meeting.

2.2/Feb/06 Delayed Discharges
Information on this is available and will be included in the April Performance Report.

2.2/Mar/06 Readmissions
These had been included in the March Performance Report.

3.1/Mar/06 Corporate Plan
This is to be tabled later in the meeting.

1.6 Chief Executive's Report

Payment by Results
HL told the Board that the tariff had been published and that it would imply an increase in the CIP requirement for 2006/07.

Finance and Performance
HL informed the Board that the Trust was still on schedule for a £2.2m surplus and that the Trust had won the HIV arbitration. HL also told the Board that the Trust had achieved all its core performance targets and it was noted that the Board extended its congratulations to staff in meeting these goals.

Standards for Better Health and Assurance Framework
This was updated under Matters Arising.

Connecting for Health
AG updated the Board on this under Matters Arising. HL added that there is an issue around partial spine compliance in that IDX/GE is dependent on BT for testing. If this was not secured the Trust would be at risk under the choice agenda.

Changes at NICE
HL asked the Board to note these.

Influenza Pandemic Planning
HL informed the group that the influenza plan would be brought to the next Board meeting and that the PCT plans had been circulated.

Staff Pay Awards
HL mentioned that these had been delayed because of discussions between the Department for Health and the Treasury. HL highlighted the most significant issue was around the 1% change in consultant pay which would rise to 2.2% in November. It was noted that these changes had been factored into the financial plan.

Senior Staff
HL informed the Board that a shortlist had been made for the Deputy Chief Executive position and it would interviews would commence shortly. HL reminded the Board that the need for this role had arisen out of the requirement to strengthen the Board which was highlighted by Monitor and McKinsey at the Board to Board. Shortlisting has not yet taken place for the Director of Service Development and Strategy position.

1.7 NHS Foundation Trust Application

HL informed the Board of the recent presentation by Marianne Loynes, the Trust's senior assessment manager and Tania Sang our allocated analyst had outlined the timetable and what to expect at the Board to Board.

HL asked the Board to note the potential dates we had been given by Monitor for the Board to Board and the general consensus of the group was that the June 26 day would present problems and that the preference was for July 5. HL also informed the Board that they next key date for submissions was on May 22 when the financial model and self-certification on governance would need to be submitted. To this end it was noted that extra seminars and an extraordinary Board would need to be arranged and the Board was asked to inform FH of dates that would work for them.

The pre-Board seminar had looked at the reassessment of risks listed in the Service Development Strategy (SDS) and it was noted that two or three new risks had been identified with two being removed. A sub-committee would be formed to clarify these and to look at the current scoring system and layout and amend as appropriate.

AMC updated the Board that membership currently stands at 10,418 and JP asked the Board to note what an impressive figure this was. HL also mentioned the successful event that had taken place to thank the candidates and that a number of members had been involved Hand Hygiene Week. HL enquired as to the induction programme for the Members' Council – AMC said a plan would be drawn up for this.

Action: Plan for Members' Council induction to be drawn up. **AMC**

AMC informed the Board that there had been a small number of comments had been made relating to the election process and that one regarding various issues of the election process was been addressed through the Trust's Complaints system. AMC also mentioned that the PPI Forum had met with the DoH's Foundation Trust team and they informed the team that they were satisfied with the way the election had been run.

2. PERFORMANCE

2.1 Finance Report, February 2006

The Board extended their congratulations to LB and the organisation on the projected year end surplus of £2.2m.

LB highlighted the two significant risks. The HIV issue has now been resolved and the Consortium will reimburse the Trust for the over-performance. Provision for outstanding debt whilst still a risk, was in line with last year's audited provision and was considered to be satisfactory.

LB also highlighted that the Trust was now ahead of its cash plan as a result of strengthened credit control arrangements and had met the cash targets for year end.

LB informed the Board that the interim audit had been completed and no issues had been raised that the Trust was not already aware of. The draft accounts submission deadline is May 8th.

It was noted that the Finance Report had been discussed in detail by HL, JP, KN, AH and LB at the Finance and General Purposes Committee meeting on April 3rd.

2.3.1 Capital Programme (brought forward in the meeting)

LB asked the Board to approve the proposed Capital Programme for 2006/07. LB informed the Board that it would be the last year the Trust would be given devolved Public Dividend Capital (PDC) to finance capital. In the future, the Trust Board would also need to approve the capital financing strategy if the application to be a Foundation Trust is successful. If we remained an NHS Trust, all future capital is anticipated to be funded from interest bearing debt not PDC.

LB informed the Board that planned capital expenditure would be just over £9m. Since the Capital Programme Board meeting the programme had been cross-referenced with

the Risk Register and a contingency had been retained centrally to cover these requirements. The Capital Programme Board will assess these at their May meeting.

KN enquired as to the figures for previous years. LB said last year the Capital Programme was £13m of which £5m was for the Treatment Centre. Previous years had been around £7m. KN also asked whether the £500,000 contingency would be sufficient to which MA explained that the medical equipment budget was distributed in tranches to allow for unexpected risks. MA also mentioned that phasing had resulted in £900,000 being carried over from last year. KN asked for confirmation that the generator upgrade had been completed.

Action: Report to next Board on generator upgrade. **LB**

JP questioned the high spend on lifts and it was decided that the Facilities Assurance Committee should report to the Board whether this spend has been worth it.

Action: Facilities Assurance to report to Board on lift expenditure. **ED**

The Capital Programme was approved by the Board. The Board noted that following the sign off of the Corporate Plan, the Capital Programme would need to be revisited.

2.3.2 Revenue Budget 2006/07 (brought forward in the meeting)

LB informed the Board that this paper set out the overall context, the process for budget setting and identifying the savings plan and the build up of the budget and savings requirement from this year's outturn. The key issues to highlight were:

1) The Trust's outturn surplus of £2.2m was underpinned by non-recurrent income, being the repayment of the 2003/04 deficit overpayment. In addition there was non-recurrent expenditure and income in 2005/06. Therefore the underlying deficit carried forward for 2005/06 was £3.3m.
2) There were unavoidable new cost pressures of circa £12m including 2.5% cash releasing efficiency (£5m), shortfall on generic inflation (£1m) and local cost pressures of £2.8m and a £1.6m loss in HIV funding.
3) Income was expected to grow by £7m of which £4.6m would be recurrent plus carry forward surplus of £2.2m with a dividend of £150,000. This would result in a net deficit before savings for the Trust of £7.6m.

LB advised the Board that the London-wide strategic financial plan required those who had achieved breakeven on 2005/06 to plan a 1% surplus. Therefore to reach this target of £2.3m, £9.9m savings would be required for 2006/07. Page seven of the report outlined the main areas targeted for savings. The Board was asked to note that significant savings were expected in workforce costs due to increased productivity and rostering improvements.

KN queried the private patients income and contribution target. HL explained that a general manager had yet to be recruited to private patients and that the Trust would need to be clear on private patient income before this would be appropriate. MA pointed out that it was important to note that deficit in private patients is actually only an underachievement in income, not a loss as such.

JP enquired if the nurse rostering benefit had been double counted but LB explained that rostering was a Trust-wide initiative on top of directorate savings driven by IMPACT efficiencies. MFo said that the Trust needed to determine where exactly workforce savings can be made and that the Trust would need to be consistent with other organisations in order to retain staff. EHJ pointed out that the Budget would be linked with the Annual Plan.

HL highlighted that Anaesthetics & Imaging, Women's & Children's and Surgery Directorates had identified cost savings for 2006/07 and that HIV & GUM was planning

to meet its savings requirement through cost reduction for the first time. The Finance Department is working with the Medicine Directorate to secure a deliverable budget. LB informed the Board that the key area of risk highlighted in negotiations with Commissioners was GUM income. HL pointed out though that if HIV negotiations went well this would offset the GUM risk.

There was also discussion on Agenda for Change (AfC) figures – LB said the expected increase was £1.3m for this year. This was to cover pay increments and the cost of outsourced staff, which equated to an average 30% increase in hourly pay. JP pointed out that AfC is supposed to be paying for improved efficiency therefore the Trust should be demanding benefits to offset the costs involved, i.e. it needs to be self-funding. CW suggested a productivity scheme should be required to ensure efficiency and value.

MFo pointed out that the £1.3m would only be passed to ISS if reflected in staff salary and would not generate additional profit to them. Consequently if pay was increased, ISS would attract higher calibre staff and increase productivity. The Trust was also part of national negotiations with unions and thus tied to pay AfC uplifts. AMC also highlighted that staff had been informed that AfC was an evaluation of their current positions, not whether they were been paid the correct amount for it.

KN asked as a Foundation Trust, would the Trust be required to pass on this pay award. HL responded that we would not be able to move from AfC but it was possible to challenge given that the Trust would be £1m short and would need to see at least £500,000 in benefit. CW enquired as to whether pay increase arrangements had been made with contractors to which MFo replied that they were not linked to the Trust. HL said that the contract would be reviewed to determine any caveats on this. JP suggested a separate paper on this should be brought to the Board.

MFr enquired as to training for contract staff – JP pointed out that it was important to ensure that the Trust should benefit from training provided. CW asked why these costs incurred where not being centrally funded. HL explained that when AfC was initially conceived, it did not include contracted staff and that when the budget was set there was only a prudent allocation. Given that it has taken much longer to implement AfC than anticipated, the allocation is not prudent enough.

There was further discussion on whether the onus was on the Trust to cover the AfC uplift for contracted staff as technically they were not employees of the Trust. JP suggested that a number of actions be taken on this issue and that it be brought back for discussion at the May board meeting.

Action: Paper setting out the facts, options and contractual position on AfC for contracted staff be brought to the May Board meeting. **ED / MFo**

Action: Executive Directors to explore with contractors potential benefits and report back at May Board meeting. **Exec. Dir**

Action: Analysis to be undertaken of pay levels in other industries. **AH / All**

HL emphasised that it was important to remember that it was not an issue of not adhering to AfC, it is more a question of how and when to undertake the change – it should be a phased process. HL also stressed the importance of supporting the spirit of AfC and continuing on in the most beneficial but timely fashion.

LB surmised that the conversation on this paper had been useful in highlighting areas where more detailed work will need to be undertaken and then returned to the next Board meeting.

In conclusion, the Board supports the £2.3m surplus in the 2006/07 budget but needs to be reassured on the detailed savings plan to support with confidence at the May Board meeting.

At this point there was a break in the meeting.

CW, KN, AMC and MA were absent at the recommencement of the meeting.

5. ITEMS FOR NOTING (brought forward in the meeting)

5.1 Medicines Management Strategy

DL explained to the Board that the purpose of this paper was to lay out the strategy for spending, procurement, dispensing and all other factors relating to medicines and highlighted that the projected spend was £34m for the year of which £26m would be on HIV.

CW joins the meeting.

JP suggested that as HIV drugs were such a significant part of the medicines spend, it would be useful to have a breakdown of these to gain a feel for efficiency. LB explained that efficiency was harder to gain for these drugs as the HIV Consortium only reimburse for actual spend on HIV drugs thus creating a problem in retaining a procurement saving.

KN joins the meeting.

LB said there was opportunities for savings and the Trust would need to review drug spends on budgets as there was no incentive for directives to control spending. At this point DL highlighted that the Trust is working with the PCTs to maximise on the use of generic drugs wherever possible.

AMC joins the meeting.

HL enquired as to what was the Trust's position on the length of prescriptions provided to patients in Outpatients – had the Trust not decided to prescribe for one week only? CM stated that the national guidance is for two weeks. HL asked that this be audited to determine what is current practice and feed back to the General Matters meeting. If there was a reduction in the need to follow up, this would have a knock-on effect in reducing drug spend providing a cost saving initiative.

Action: Audit of length of prescribing in the Outpatients Department to be undertaken and fed back to the General Matters meeting. **ED**

MA joins the meeting.

MA told the group that packaging limitations meant that Outpatient prescriptions are generally for 28 days. CW commented on the use of robots in prescribing which had reduced errors by 70%. Was it possible to identify what the other 30% was due to? DL explained that whilst the robot reduces picking errors, there was still a chance of human error due to misreading prescriptions. There is also an issue surrounding errors that may not be picked up such as dosing errors. DL pointed out though that once full electronic prescribing was in place, transcribing errors would also be reduced.

HL suggested that in the future, this strategy should go to the Clinical Governance Assurance Committee which can approve it on behalf of the Trust Board. This was agreed by the Board.

2.2 Performance Report, January 2006

LB informed the Board that on the preliminary data available, the Trust had achieved all its key targets for January apart from access to rapid chest pain clinics. The report also highlights areas for improvement for the forthcoming year such as GUM, ethnic coding and delayed discharges. LB asked the Board to note that the readmissions rate had

been included in the report as requested at the previous Board meeting. MA commented that there were not significant numbers for readmission but it would be useful to have some insight into the trend over time.

KN enquired as to whether there had been an improvement in bank and agency costs re workforce indicators. LB said that she would update the Board on this at the May meeting.

Action Update on Bank & Agency for May Board meeting. **LB/MFo**

KN requested that the negative figures not only be highlighted in red but also by brackets in the SLA report. KN also request that the cumulative delayed transfer of care graph should specify 'below target'.

Action: The above changes to be made to the Performance Report. **LB/NC**

3. ITEMS FOR DECISION/APPROVAL

3.1 Consultant Appointments

The Board approved the following consultant appointments:

Consultant in Acute Paediatrics: Dr Saji Alexander
Consultant in Neonatal Medicine: Dr Mark Thomas

4. ITEMS FOR ASSURANCE

4.1 Draft Corporate Plan

EHJ explained to the Board that the Corporate Plan was still a work in progress and that the Annual Plan format that had been used was a requirement by Monitor for Foundation Trusts. EHJ explained that it was not complete partly due to the delay in the tariff which meant the costing figures still needed to be inputted.

EHJ went on to point out that the strategic objectives listed on page four utilised the same headings as last year's corporate plan but there was no reason why these could not change and the Board's feedback would be appreciated. Appendix one lays out the directorate summaries and EHJ is currently working with directorates determining whether they meet the corporate objectives. The directorate plans are broadly consistent with the SDS.

MA commented that on review, it appeared that departments have had a strong influence on their sections reflected by the fact that they were not entirely consistent with the corporate objectives. An example of this was that the Medicine Directorate made no mention of acute medicine, a significant corporate issue. HL suggested that the corporate objectives should not be listed in the appendices – they should be in the main body of the Annual Plan.

KN commented that there had been differing amounts of work done across the directorates but that overall it was a solid Plan. HL said that it was important that directorates reflect the main corporate objectives which for 2006/07 would mean a focus on customer service training, teaching and the workforce plan. HL went on to emphasise that it was important that the Board identifies the key factors which will allow the Trust to achieve its corporate objectives.

AH also emphasised the importance of tying in with the corporate objectives and that if plans did not then these should be reviewed. MFo pointed out though that some may be national targets but not necessarily corporate objectives. AH also challenged the following statement under objective two in appendix one, 2.3:

> 'The Trust should have an effective plan to deal with any influenza pandemic.'

This should not just be an effective plan, but it should be the best plan the Trust is capable of enabling.

CM suggested that the SMART method should be applied to the Plan which would certainly assist in straightening up the Annual Plan. HL emphasised the Plan was a work in progress and that discussions were very much still underway with directorates. EHJ said there is a grid which reflects work being undertaken and what needs to be achieved. KN suggested that a marketing strategy should be mentioned in the Annual Plan to which HL responded that this is being worked on by the Modernisation team in conjunction with GPs.

EHJ pointed out that unfunded developments were not being included in the Plan and also that work was being done around the new to follow up ratio. LB suggested checking whether appendix one is the Trust's corporate objectives and then focusing on ten key aims which are then risk-assessed against the Assurance Framework. KN suggested taking out section 2.2, the key elements of the Trust's corporate objectives which may cause confusion with the Trust's actual objectives. CW had an amendment to page nine under radiology – maximum wait should be 13 weeks not 133.

HL noted that as highlighted by McKinsey, it is important to reflect financial impact and that figures should be included in the plan. EHJ responded that this information would be included in section 1.2 and the end of section 2.3. EHJ then explained that the plan would not be required by Monitor for the authorisation process but that it was expected to be submitted on May 31 annually once Foundation Trust status is achieved. HL at this point highlighted the importance of communicating the plan and ensuring that it is fully and sufficiently implemented. HL also highlighted the importance of linking with the risks outlined in the SDS such as research and choice.

KN suggested that Trust wide objectives should be separated from directorate objectives and that on page five, the Council of Governors should be changed to the Members' Council. KN also enquired as to benefits available as a Foundation Trust such as PCT contracts. EHJ responded that contracts would be for three years as a Foundation Trust and these would allow greater financial flexibility. HL pointed out that paediatrics/maternity do not include reducing length of stay as an objective. It was also suggested by HL that the plan could be distributed with the Annual Plan.

HL summarised that the section 2.3 should be merged with appendix one and that the focus should be on the corporate objectives with more work to be done by the executive team with EHJ. JP commented on the very productive discussion and looked forward to seeing the revised plan at the next Board meeting.

Action: Annual Plan to be amended and then presented to the May Board meeting. **EHJ**

6. ITEMS FOR INFORMATION

6.1 Minutes of the Audit Committee meeting March 22nd, 2006

The Board was asked for any amendments to be forwarded to FH.

7. QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions from the public.

8. ANY OTHER BUSINESS

There was no other business.

9. DATE OF THE NEXT MEETING

The next meeting is scheduled for May 4th, 2006.

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 concluded in the second part of the agenda.