Royal Brompton & Harefield NHS
NHS Trust

Minutes of a Meeting of the Trust Board
held on 17 December 2008
in the Concert Hall, Harefield Hospital

Present:	Mrs J Hill, Non-Executive Director (in the Chair) Mr N Coleman, Non-Executive Director Mrs C Croft, Non-Executive Director Prof Sir A Newman Taylor, Non-Executive Director Mr R Bell, Chief Executive Professor T Evans, Medical Director Mr R Craig, Director of Operations Mr M Lambert, Director of Finance & Performance Dr C Shuldham, Director of Nursing, Governance & Informatics
By Invitation:	Ms M Cabrelli, Director of Estates & Facilities Mr R Connett, Head of Performance Mr N Hunt, Director of Service Development Ms C Johnson, Director of Human Resources Mr D Shrimpton, Private Patients Managing Director Ms J Thomas, Director of Communications Ms J Walton, Director of Fundraising
In Attendance:	Ms E Mainoo, Executive Assistant Mrs R Paton (minutes) Mrs E Schutte, Executive Assistant
Apologies:	Lord Newton of Braintree, Chairman Mr R Hunting, Non-Executive Director

Mrs Jenny Hill, Non-Executive Director, welcomed everyone to the meeting; Mrs Hill was chairing the meeting as Lord Newton was not able to attend due to a long-standing appointment. She explained that the layout of the Board table and hall had been reconfigured to facilitate better debate between Board members.

2008/122 MINUTES OF THE MEETING HELD ON 26 NOVEMBER 2008

The minutes of the November meeting were agreed as a correct record with the following amendments:
Page 5, paragraph 3, line 1 to read "Mr Coleman confirmed the Audit and Risk Committee would forward to the Board….."
Page 7, paragraph 1, line 7 to read "…..as the Trust's cohort of well-characterised patients….."

2008/123 REPORT FROM THE CHIEF EXECUTIVE

Academic Health Science Centres (AHSCs)

Mr Robert Bell, Chief Executive, updated the Board on the DH designation process. Sir Ian Kennedy had now been appointed Chair of the Independent Selection Panel. Applications, together with provision of evidence, had been requested by 16 January 2009. Applications were then to be short-listed by the Selection Panel, assessed in early March and designated by mid-March. As far as the Joint Working Group to explore collaboration models with

Imperial College (IC) was concerned, the Trust's three nominees had been notified to Sir Roy Anderson, Rector of IC.

Mr Bell stressed that it was contingent on him to inform the Board of the implications of AHSC developments on the Trust's strategic position and future as an institution. If the Trust did not participate in the current process, and sought to continue with an academic role, the Board needed to understand the possible consequences. Mr Bell asked the Board to consider the principles of an academic strategy (as distinct from the newly-approved R&D strategy) and said the position of the new Chairman would be central to this. He stressed that he believed that this would be an area of interest to Monitor's assessors, and not addressing the question was not an option. Mr Bell reminded the Board that the Trust's historic academic relationship had been almost exclusively with IC. Given the changes in the NHS R&D landscape and the 'merger-model' requirement of IC Healthcare NHS Trust and AHSC, the Board had to determine its comfort with this for the future. Other options involving other partners should also be considered.

Mrs Hill, in the Chair, said that any principles debated must align with the strategy of our organisation (i.e. to be an autonomous, specialist Trust based on two sites).

Professor Tim Evans, Medical & Research Director, felt that academic partnerships were crucial, that the Trust should be looking pro-actively at what was emerging and indicating enthusiasm where appropriate. The Trust should remain independent: it was clinically-led but research, development and education were extremely important parts of its mission. Professor Evans felt that the Trust should, if possible, be included in the first 'tranche' of AHSC designations. To this end, the Trust should be approaching potential partners to gauge their interest and see if their models would permit our inclusion.

Professor Newman Taylor, Non-Executive Director, agreed with Professor Evan's thinking, in that the Trust was a specialist organisation which wished to be involved in innovative treatments and for this it needed academic and industrial partnerships. The best partnerships were those with clear common goals between the hospital and a university, e.g. the LVAD programme and Heart Science Centre work at Harefield. He felt this was the model the Trust should be developing. On the education front, he reminded the Board that the Trust was engaged in undergraduate and post-graduate education for IC degrees in medicine, nursing and physiotherapy. Dr Caroline Shuldham, Director of Nursing, Governance & Informatics, felt that the academic strategy should be comprehensive across all disciplines, i.e. all clinical and scientific professions.

Mrs Hill summarised five emerging themes from the discussion, viz. (1) the academic relationships should be aligned with the Trust's strategy; (2) multiple academic partnerships should be sought; (3) they should be inclusive (rather than exclusive); (4) they should be comprehensive in nature; and (5) they should reflect the Trust's specialist focus on heart and lung disease.

Mr Bell said that the Trust did not deliver services to a defined geographical area. AHSCs seemed to be developing on a geographical basis, and this might be a challenge to the Trust considering that the Trust does not have a

natural local health economy. He asked if the emerging principles reflected the Trust's national/international outlook, and would ensure alignment with like-minded institutions. The 'constitutional' difference of the Trust was that it was truly international, e.g. with staff and patients continuing to come from all around the world; it needed to be allied to partners with a similar focus. Professor Newman Taylor agreed there was a real importance for the Trust to align with partners that were internationally credible, which he felt (for the university sector) meant IC, Oxford or Cambridge.

Mr Bell expected the debate to be informed by the output of the working party with IC, and hoped this would help better establish the Trust's explicit identity, which would be important in the Monitor assessment. He expected the Board to return to this discussion at successive meetings.

Mrs Hill confirmed that the five identified principles would be taken forward.

2009/10 NHS Operating Framework

Mr Bell confirmed that the 2009/10 Operating Framework (OF) had just been issued, and this would set the NHS agenda for at least the next year. With reference to PCT revenue allocations for the next two fiscal years, PCTs could expect to receive around 10% cumulative growth which, in terms of the current economic situation, was considered a good outcome. 2009/10 growth would be 5-6% for most PCTs, but expectations of efficiency savings meant that the resulting net increase for Trusts would be more like 2%. Further, structural changes were to be introduced to the national tariff and this would have implications for our FT application. Changes to Market Forces Factor (MFF) and academic education, as well as the introduction of 'CQUIN' payments (commissioning for quality and innovation) would all have an impact, which was yet to be quantified.

Mr Mark Lambert, Director of Finance & Performance, confirmed that 'sense-checking' was currently being undertaken on the new tariff; the definitive version was expected to be issued in January.

Mr Bell confirmed that these were areas of concern which would be central to Monitor's agenda on our FT application. He had asked Mr Nick Hunt, Director of Service Development, to analyse the OF and report to the January Board meeting on relevant issues pertaining to our business plan and operating plan for the next year.

2008/124 <u>FOUNDATION TRUST APPLICATION</u>

Mr Robert Craig, Director of Operations, updated the Board on progress towards the reassessment of the Trust's FT application.

1. **Historic Due Diligence**

   PricewaterhouseCoopers (PwC) had completed the main elements of the exercise; their draft report had been received, which incorporated 14 areas of review, with 6 green and 8 amber gradings. The Trust was confident that the amber items could be addressed in short order. PwC's assessment had been based on an historical analysis of the Trust's performance, financial reporting, control, governance, management and audit arrangements. They planned to return in January to complete a forward-look based on the integrated business plan and long-term financial model.

Mr Bell stressed the need for tight assurance on all items. Mr Nick Coleman, Non-Executive Director, felt the amber grades might be considered in a positive light by the Trust in that they served as an early warning. Mr Bell assured the Board that the consequent challenges would be addressed in time for Monitor's assessment.

2. FT Private Patient (PP) income 'cap'

There had been a recent development in Monitor's interpretation. Monitor had undertaken a consultation exercise in 2008 in response to a legal challenge from UNISON, and had recently issued a decision. The scope of the PP income cap had been broadened to include earnings from joint ventures, associates or other subsidiaries with which FTs were involved in the delivery of PP services. Mr Craig did not think the immediate implications for this Trust would be significant. Monitor's decision would apply to all FTs from April 2009.

3. Integrated Business Plan (IBP)

Mr Craig turned to the IBP and acknowledged that the document was not as complete at this stage as he had hoped. The financial model still had a number of crude assumptions which needed to be replaced by firmer numbers as they arrived, and much remained work in progress. The Board looked at the following IBP chapters in detail:

Chapter 3: Strategy

Mr Craig did not think this yet adequately described the Trust's strategy and business model. Mr Coleman felt it needed to be 'sharper' and with clearer, consistent threads through the IBP to later chapters describing specific market segments and the products offered. Mrs Hill also felt there was a need to sharpen up the chapter, to be crisper and to better reflect where and what the Trust would be. She thought the strategy chapter should be quite short, and should more succinctly describe the business the Trust was in.

Professor Evans agreed the style should be crisper. He referred to para 3.2: Developing the Trust's Vision & Strategy, and felt there should be more emphasis on the reorganisation of the clinical structure – more information on the changes undertaken. Dr Shuldham added that it would be important to demonstrate how the structure would help us in the future.

In general, Mrs Christina Croft, Non-Executive Director, felt it was still difficult to see how the chapters referred to each other. The document seemed too long and turgid – a shorter read would be better – with too much duplication.

Mr Coleman asked about the audiences. Mr Craig explained that traditionally an IBP for FT status was a prescribed format aimed at various audiences: SHA, Dept of Health and Monitor. Given the Trust's place in the process, the old format was not quite right. Mr Bell confirmed the document would be seen by commissioners, PCTs, Monitor and auditors and these bodies would have certain requirements on content.

Mrs Hill agreed that repeated information could be cut. She said the Trust's strategy was to aim to be specialist hospitals operating on two distinct sites – our whole business plan was predicated on this and should be clear. Dr Shuldham challenged this as she felt the Trust's purpose was delivery of excellence in patient care, research and education and that the two distinct sites, while important, were secondary. After further discussion, it was

agreed that the Trust's position in adapting and adopting clinical innovations, in achieving scale in sub-specialties, and in delivering them through two distinct sites, should be clearly and succinctly delivered in chapter 3. Mr Bell confirmed the importance of the Trust's scale in its services. Not only was it (by turnover) the biggest specialist Trust in the country, it was larger than many DGHs, and larger by several factors than cardio-respiratory services elsewhere in the country. Monitor would ask the NEDs their understanding of the strategy; all members needed to be able to understand and articulate this succinctly.

Chapter 4: Market Assessment
Mr Craig asked if members felt the chapter adequately defined the markets in which the Trust operated, and its competitors.

Mrs Hill felt there was an insufficiently clear definition of the markets – this needed to be very coherent – and the PEST analysis was not clear enough.
Mr Coleman felt the Trust's markets were: NHS heart, NHS lung, PP heart & lung, R&D. Mrs Hill pointed out the importance of this analysis in driving development of both services and markets, and showing how we managed our business slightly differently.

In terms of London's relevance, Mr Bell pointed out that we perform under 2% of London's total patient care activities, and that only 25% of the Trust's patients came from London. Mr Coleman felt this was a powerful argument for becoming an FT: the Trust was big as a specialist, national provider, but was not a big London player – there was a misalignment in relation to the commissioners, as the Trust was trying to serve the nation, not just London. Mr Bell reiterated the point in relation to research: the Trust delivered outstanding results in our disease areas, but the scale was small compared to London as a whole: e.g. the threat of losing transitional R&D funding had been a total of £28m to the Trust over 2-3 years, but over £400m to London as a whole.

Chapter 5: Service Development
Mr Coleman felt the developments needed to flow logically from the markets and market segments described in the previous chapter. In general, he wanted to see more facts and proof-points to support the assertions. Mr Craig confirmed that the proposed developments would elaborate better what was described in the previous chapters, and relative to competitors. The chapter would also seek to show services according to both 'Boston-grid' and 'product life-cycle' analyses.

The Board agreed that the chapter should indicate both how service developments fitted with the Trust's specialist nature and strategy, and took account of commissioner intentions (e.g. managing the proposed transition of some services to other centres; examples of 'shared care'), while emphasising the fact that the Trust had the skills and capacity to treat many patients that no other centre could (a further reference to scale and sub-specialisation).

Mr Craig confirmed that the final draft would go to the Board seminar in January, and be reviewed again at the Board meeting in January for submission to Monitor.

Financial Model

Mr Bell expressed his concern about the timescale for review of the financial model (LTFM). Mr Lambert confirmed that the LTFM already existed, albeit with more assumptions than he would like. He tabled a current Income & Expenditure summary position, which showed a 2009-0 surplus of £0.5m. Mr Bell emphasised that this was contingent on delivery of the Financial Stability Plan (FSP – £18m+ of efficiencies and cost cuts in the Trust).

Prof Newman Taylor asked about the measures constituting the £18M, and Mrs Croft and Mr Coleman said the Board had to be comfortable with any risk arising from the recovery of the £18M, counselling caution not to endanger patients in the pursuance of financial targets. Mr Bell said there seemed to be an obsession with cutting costs, i.e. CIPs, whereas the talk should be about contribution, i.e. cutting costs but also generating additional income. He agreed that all Board members should review the current draft of the 2009/10 FSP to assess its scope, and the inherent risks and implications, bearing in mind that the plan would continue to evolve, and that the size of the I&E challenge in 2009/10 would determine how much of the plan would be implemented and at what speed.

Prof Newman Taylor recognised that Monitor would expect the Board to confirm its confidence in the FSP. Mrs Hill felt that the Board would need to review the frequency of its forthcoming seminars and meetings in order to assure itself that the risks had been identified; she felt that a working party might be needed to focus on this aspect, perhaps with independent support.

2008/125 <u>FINANCIAL PERFORMANCE REPORT FOR MONTH 8: NOVEMBER 2008</u>

Mr Lambert reported that the Month 08 position showed a surplus of £289k, giving a YTD cumulative surplus of £2,501k. The profit made was after special provision for costs for services relating to the FT application. He reminded the Board that the Trust had a NHS London 'control total' for 2008/09 of £2.4m (within a range of £1.8m to £2.5m).

Mr Lambert referred to the FSP and reminded the Board that the target was to achieve £11.5m in 2008/9 and approx £18m in 2009/10. Mr Bell pointed out that Monitor's assessors would be interested in the 3-4% extra required in 2009/10, and what was in place to deal with it. As discussed under item 2008/124 above, he referred to the FSP already developed for 2009/10 with third party assistance.

Mr Lambert went on to report on the NHS London Provider Agency Financial Performance regime:

- The Return on Assets metric was now 'amber' rather than read as it had been previously.
- The overall position at Month 08 was a financial risk rating of 4 out of a maximum of 5 (which would equate to a 'use of resources' score of 4/excellent).
- NHS clinical income was showing a £3m positive variance against budget, driven mainly by respiratory medicine and additional bed-days within Critical Care.
- Private Patient income was showing a favourable YTD variance of over £600k.
- Pay expenditure was £2.8m overspent at Month 08, with nursing pay significantly overspent as a result of additional activity undertaken and agency prices.

Mr Lambert then reviewed the current-year FSP, which was forecast to reduce to a £864k shortfall (against £11.5m, or 93% achievement) in the full year. Mr Lambert wished to credit this improvement to the Director of Operations and his team. He said there was 'third' split between pay, non-pay and income measures.

On other matters, there had been a reduction in the month in non-NHS debtors to £5.8m. The Capital Programme was progressing reasonably well with a total spend of £5.1m (slightly behind the YTD plan of £5.5m).

Mr Craig responded to a question from Mrs Hill on activity in cardiac surgery, confirming that the service remained busy on both sites, with volumes up slightly on the previous year. The initial plan for the current year had assumed some volumes of surgery to meet 18-week targets which had not proved necessary: this was why cardiac surgery was below plan for the year. Nonetheless, some NHS surgery continued to be undertaken in the private sector to ensure that access targets were met.

2008/126 OPERATIONAL PERFORMANCE REPORT FOR MONTH 8: NOVEMBER 2008

Mr Lambert commented on the following items:

- Response to Patient Complaints: slightly deterioration on the same quarter in the previous year but the target was still being met.

- Cancelled operations: remained 'amber', and the Board discussed the issue in some detail. Mr Craig explained that a major contributory factor was work being done to achieve the 18-week target. A higher proportion than usual of complex (and unpredictable) cases was being undertaken and putting pressure on theatre time and peri-operative capacity. Mr Craig warned that December figures were unlikely to be any better, but felt that achieving 'steadier-state' on 18 weeks, and the new clinical management structures on both sites would help address this in 2009. Prof Evans confirmed this analysis from his own experience of theatre and AICU activity in recent weeks. Mr Craig added that he was keenly aware of the Board's patient safety commitment to reduce cancellations by 50% between mid-2008 and mid-2009.

  Mr Coleman commented there seemed to be a 'tightrope to walk' between targets and patient safety and asked about the safety of the judgements where they had to be made. Professor Evans confirmed that individual decisions were made on patient safety grounds, e.g. staff fatigue determining that a case should not proceed when there might otherwise be pressure to do so. Mrs Croft asked if scheduling had become too optimistic; Professor Evans replied that scheduling was extremely difficult in relation to the types of complicated work recently being undertaken in higher than usual numbers. He and Mr Craig acknowledged that there was a fine balance to be struck, but confirmed that schedulers sought to take adequate account of the likely length and complexity of cases, rather than applying a rigid, 'formulaic' approach.

- 26-week inpatient target. There had been one breach of the target in November, due to an administrative error in paediatric respiratory medicine. This had been investigated and corrective action (a revised process) was being implemented. Although serious, one breach did not

constitute failure of the national target.

- Cancer 62-day referral to treatment: the 'repatriation' of one breach to the referring Trust had been agreed and the other breach-shares were being discussed with relevant referrers. The results were still within target.

PCT measures

- Patient admissions with complications remained higher than the threshold proposed by PCTs. Further analysis was being undertaken on this complex metric.

18-week wait

Mr Craig reported that the end-of-year target (90% for admitted patients, 95% for non-admitted) had again been achieved in November, although (as anticipated) the detailed position was slightly worse than October due to the number of longer-waiting patients treated in the month. Concerted effort had been undertaken by many staff in the preceding six months to be able to manage patients along 18-week pathways and achieve the current performance. There had been a real improvement for patients, and Mr Craig wished to congratulate all those involved in delivering this – in every division – but in particular the Project Manager, Ms Kelly Goulding, and Head of Modernisation, Mrs Lucy Davies. He was also able to report that the DH Intensive Support Team had 'signed-off' the Trust in recognition of the progress made and results being achieved. Mr Craig reminded the Board that NHS London's target was achievement by December 2008 (i.e. figures reported in January 2009 would be the definitive measure), and Healthcare Commission (HC) monitoring would begin from January.

Mr Bell added that the HC would measure the Trust on consistent achievement on a week-by-week basis from 1st January. Mr Richard Connett, Head of Performance, confirmed that January, February and March would be assessed as three separate months. Mr Bell confirmed that a huge amount of work and resources had been involved, and Mrs Hill wished to offer her thanks and congratulations for the progress made in recent months.

2008/127 RECOMMENDATIONS OF ADVISORY APPOINTMENTS COMMITTEE

The Board received the recommendations for the appointment of:
Dr Sarah Trenfield, Consultant in Adult Cardiothoracic Anaesthesia
Dr Arshad Ghori, Consultant in Adult Cardiothoracic Anaesthesia
Dr Mary Lane, Consultant in Paediatric Anaesthesia
Dr Alexandra Rice, Consultant in Cardiothoracic & Transplantation Pathology

All four appointments were approved.

2008/128 AUDIT AND RISK COMMITTEE

Mr Coleman (Chair of the Audit & Risk Committee (ARC)) presented the following reports to the Board:

(i) Minutes of the Meeting of 9 September 2008 (for information).

(ii) Report from Meeting of 3 December 2008.
Mr Coleman reported that the September and December meetings had both focused on risk. At the December meeting the ARC had:

- Reviewed management's assessment of the top 20 risks facing the Trust,

endorsed the assessment and now recommended the list to the Board for adoption. This was approved;

- Reviewed the Trust's refreshed Assurance Framework to ensure linkages between strategic objectives, risk, controls, assurance and action plans;
- Taken "deep dives" into specific risk areas to establish assurance of controls around these areas. Focus had been on risks associated with certain defective medical devices when, subsequent to the items being implanted in patients, the manufacturer had reported equipment faults. ARC had achieved adequate assurance that controls were in place sufficient to manage risks down to the lowest practical level. Assessment of property-related risks had been deferred to a later date;
- Reviewed the Governance & Quality Report. Discussion focused on the suggestion that rising activity levels and constraints on capacity might lead to patient safety risks. The ARC felt the controls were not clear and management confirmed that this had not been considered a top risk, and that other indicators to provide better early warning were therefore to be identified. The ARC felt there was a need for clear action plans to maintain patient safety as activity grows;
- Reviewed Patient data-security processes. The ARC agreed with the management recommendation to consider alternative ways of achieving adequate data security rather than simply trying to comply with difficult encryption requirements;
- Reviewed Payroll and Overpayments. Controls were being continually improved and assurance monitoring could now be reduced to KPI reporting.

On Audit matters, The ARC had reviewed:

- Internal & External Audit Recommendations. There was one item which was one month overdue and this related to consultant surgeon and anaesthetist job-planning. This had been due by June 08, but (under the new clinical management arrangements) was now set for completion in January 09;
- Internal Audit work programme, Counter-Fraud programme, External Auditor's work programme, changes to the Key Lines of Enquiry for the Auditors' Local Evaluation, losses and special payments.

The ARC's regular annual review of its relationships with all Trust committees concluded that it was appropriate to continue to focus on the G&Q committee, and recommended a NED to join that committee, albeit it would remain a management committee.

The ARC had discussed the Board Assurance Framework (BAF) and executive recommendations relating to Board and management committees and their remits and concluded that these matters were for the Board to consider (see item 2008/129 below). The ARC members had also completed their required annual private session with the Internal Auditors.

(iii) Annual review of Terms of Reference

A few minor changes were proposed. Mr Lambert had identified a further change (as the PPI Forum no longer existed). With this change, the Board approved the revised Terms of Reference.

Mr Coleman confirmed that the ARC was now submitting to the Board a list of the top 20 risks facing the Trust which were embedded in the BAF. He felt

that this was a good basis for moving forward, including for the FT application. Mr Coleman wished to thank all involved in the work, particularly Dr Shuldham and her team.

2008/129 FUTURE GOVERNANCE AND RISK STRUCTURE

Dr Shuldham introduced the item and explained that KPMG had been invited to review the management structure and processes and had made some recommendations about the Board Assurance Framework. Development to meet best practice guidance was already underway, together with a review of the risk register and committee structure. The reviews encompassed such issues as Board agenda, skills and behaviour, and service line reporting. KPMG had recommended the Finance Committee be reinstated and Mr Bell confirmed that a Finance Management Committee would be convened by the Director of Finance as a management committee. The Board agreed that the existing Finance Committee should remain a committee of the Board, to meet when Board members felt it necessary.

Following the discussion under item 2008/128, the Board confirmed that G&Q remain as a management committee which a NED could attend. Mr Craig said it was important that everyone who attended the G&Q Committee should understand that this did not mean the committee was becoming committee of the Board.

Mr Bell reminded members that the Board was a combination of executive and non-executive members. He proposed that a schedule of the Trust's management committee meetings be circulated to non-executive members, who should regard themselves as at liberty to attend to improve their understanding of particular issues if they so wished.

Mrs Croft recommended that the Trust's top 20 risks should be compared with those of other Trusts as one means of ensuring that their scope was comprehensive, and Dr Shuldham agreed to pursue this.

2008/130 ANY OTHER BUSINESS

There was no other business.

2008/131 QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions.

2008/132 DATE OF NEXT MEETING

Wednesday 28 January 2009 at 2 p.m. in the Boardroom, Royal Brompton Hospital.