ROYAL BROMPTON & HAREFIELD NHS TRUST

Minutes of a Meeting of the Trust Board held on 19 December 2007 in the Concert Hall, Harefield Hospital

Present:	Lord Newton of Braintree, Chairman Mr R Bell, Chief Executive Prof T Evans, Medical Director Mrs J Hill, Non-Executive Director Mr R Hunting, Non-Executive Director Mr M Lambert, Director of Finance & Performance Mr P Mitchell, Director of Operations Prof A Newman-Taylor, Non-Executive Director Dr C Shuldham, Director of Nursing & Governance
By Invitation:	Mr R Connett, Head of Performance (Acting) Mr R Craig, Director of Planning & Strategy Mr N Hunt, Director of Service Development Ms J Thomas, Director of Communications Ms J Walton, Director of Fundraising
In Attendance:	Ms E Mainoo, Executive Assistant Mrs R Paton (minutes)
Apologies:	Mrs C Croft, Non-Executive Director Ms J Ocloo – she had not received her papers in time to prepare for the meeting.

Lord Newton, Chairman, reported that the Shaw Trust had written to inform the Board that the World Health Organisation had awarded Ms Josephine Ocloo the title of 'Patients for Patient Safety Champion' for her work and research relating to Patient Safety issues. On behalf of the Board, the Chairman congratulated Ms Ocloo on achieving this award.

2007/136 MINUTES OF THE PREVIOUS MEETING HELD ON 28 NOVEMBER 2007

The minutes of the previous meeting were agreed as a correct record with the following amendments:
Mrs J Hill had attended the meeting but had not been added to the attendance list.

Mrs Jean Brett, Chair of Heart of Harefield, requested that her comments on the retirement of Charles Perrin be reported in full as made available for the Trust.

"Mr Perrin having been a non-executive director for over 14 years was a remarkable public service achievement. The Trust had been most fortunate for Charles Perrin's background was at the most senior levels possible, in a prestigious bank of "the old school". That financial expertise had served the Trust well in his position of Vice-Chairman and by his chairing of various Trust committees - such as that overseeing the charitable funds of the Trust. It was rare even in London Trusts for a Trust to gain a non-executive director with such talents. Therefore those working with Charles Perrin, in whatever capacity, will have learned much almost by osmosis. Mrs Brett commented that he has been so generous of his time to the Trust while working *pro bono*, that she had wondered how he had time for anything else. While much more could

be said, her attendance and comments had been to make it clear that from both sides of the fence, Charles Perrin's commitment to the public service ethos is widely admired.'

2007/137 REPORT FROM THE CHIEF EXECUTIVE

Mr Robert Bell, Chief Executive, said he was pleased the Trust had been short-listed for two Biomedical Research Unit applications, the significance of which was important in terms of future possible FT status and R&D reputation. On-going discussions were being held with Imperial College (IC) and Imperial College Healthcare NHS Trust (ICHT) towards joint collaboration for the formation of an IC health system/network. A meeting had recently been held with IC in which the Trust elaborated on the creation of such a system with a view to developing an outline 'charter'. The development of principles towards a charter should be quick, probably in the first quarter of 2008. Mr Bell also reported that a joint clinical and research appointment in cardiac surgery was being undertaken.

The Chief Executive confirmed that the Trust had recently received full details of the NHS Operating Framework for 2008/9; he felt the document made interesting reading; it would be reviewed at the next Management Committee and also submitted to the Board. A form of financial penalty had been included this year for trusts which failed in the area of health-acquired infection and their identity would be publicised. Mr Bell said this was the first time a financial penalty had been considered for failing a target and felt that the Trust's patient population could lead to high risk in this area.

The Chairman questioned whether the measurement regarding infection was a sensible one. He said that the Trust had one of the lowest rates of MRSA in the country but could still fail if the year-end total was marginally higher than that in the previous year. The Chief Executive confirmed that if the Trust has one more case this year it would be in danger of failure. The Chairman felt the SHA was applying an even more rigorous approach than before. Prof Newman-Taylor, Non-Executive Director, suggested discussing with the Healthcare Commission a more sensible approach taking into account inevitable fluctuations, especially in regard to a tertiary hospital. He continued that year-on-year numbers cannot always continue to improve and confirmed the Trust currently had one of the best infection rates in London. Professor Evans, Medical Director, confirmed that the Trust infection rates had not increased in any other organism, e.g. clostridium difficile. The Chief Executive confirmed that the Healthcare Commission threshold for MRSA was 12 cases and that the actions of the SHA were not solely about patient safety, but also about the public and political perception of the issue.

2007/138 HAREFIELD REFURBISHMENT & REDEVELOPMENT

Mr Patrick Mitchell, Director of Operations, reported that building works continued at Harefield (HH) with two floors having been completed and work now moving onto the F floor. Timescales were still on target. An approach was to be made to several companies to compile a Strategic Outline Case (SOC) for the redevelopment of HH. Care Consulting will be undertaking 'scoping' work for the exercise, taking into account any national or regional developments. It was hoped the scoping work would be completed by early January, but the outcomes from consultation on "Healthcare for London" would not be known until March, and London mayoral elections might also contribute to delay. Northwick Park Hospital (NW London NHS Trust) had now stated it would like to be included in any SOC consideration. Mr Richard Hunting, Non-

Executive Director, asked at what stage other organisations' declarations of interest in involvement in the strategic option appraisal might cease. Mr Mitchell felt that Northwick Park had had other problems at the time of the original exercise, and had not been able to declare a reasonable interest. At this juncture, the scheme and consideration needed to be comprehensive.

Mr Mitchell also reported that more referrals than ever were being received from other DGHs, e.g. from Buckinghamshire for surgical work, and a further two centres had also requested help.

2007/139 RESEARCH & DEVELOPMENT UPDATE

Mr Robert Craig, Director of Planning & Strategy, presented a paper for the Board's information. The Trust had been notified by the National Institute for Health Research (NIHR) that both applications for Biomedical Research Unit status (cardiovascular and respiratory) had been short-listed for further consideration.

NIHR had indicated that 19 applications across the six specified disease areas were to be taken forward and the Board discussed the likelihood of all these applications being funded.

The Chairman said it was encouraging that the Trust's applications had been short-listed. Mr John Ross, Heart of Harefield, asked about the costs involved in making these submissions. Mr Mark Lambert, Director of Finance & Performance, said the incremental costs were minimal, although the time commitment was significant. The Chief Executive confirmed that the process was part of the new NHS application and bidding process. Professor Newman-Taylor confirmed that Imperial College was also engaged in the process. The Chairman felt that the reputational issue could not be measured in terms of finance.

2007/140 PERFORMANCE REPORT FOR MONTH 8: NOVEMBER 2007

Mr Lambert reported that the Trust for Month 8 had made a profit of £1,686k, giving a year-to-date cumulative surplus of £2,958k. The year-to-date EBITDA position was £10,339k.

In addition, Mr Lambert noted that the financial stability plan was showing some minor slippage but was assured that this would turn around. The cash balance as at 30th November 2007 stood at £12.4m.

Mr Mitchell reported there had been a burst of activity in the month to clear waiting lists in working towards 18-week-wait targets. In the month of November four catheter laboratories had been in operation (three in previous months) but the number would soon return to three as one was to be converted to Stereotaxis use.

The Board discussed the fact that although results for both October and November had improved, Mr Lambert explained the previous financial year had also presented this trend. Historically the Trust's year-to-date financial performance peaks in November and then declines in December and January due to the impact of the Christmas/New Year break. The final few months of the year are neutral and impacted if Easter falls in March (as in 2007/08). Mr Mitchell stressed that some elective activity had been planned between Christmas and New Year for this year.

Mr Lambert reported he, the Chief Executive and the Director of Operations had attended the usual monthly meeting with NHS London's Provider Agency. A paper had been produced showing monthly profitability for the previous years and Mr Lambert agreed to forward this to Board members.

Mr Lambert confirmed capital expenditure of £4.9m had been incurred in the first 8 months of the year. The Strategic Health Authority expected the Trust to spend its capital allocation otherwise the unspent portion would be withdrawn, so the emphasis was on ensuring delivery of the capital programme. The Chairman remarked that it seemed strange to be penalised for not spending money at the end of the year. Mr Mitchell confirmed that next year's medical equipment programme had already been planned and could be brought forward if necessary.

Operational Performance

Mr Lambert then moved on to the operational report for Month 8. He went through the "traffic light" report and commented on those that were not green.

The Private Patients cumulative spell activity was not within 3% of the internal target and this was explained further in the financial performance papers.

The reportable cancellations target is showing 'underachieved' and it would not be possible to improve on this target in the balance of the year due to the number of cancellations already reported. The Board discussed this situation and Mr Mitchell reported that site-based working groups including clinicians already addressing the problems; further information would be available in February. The service was running so close to maximum capacity that one emergency had a knock-on effect. The Board discussed whether ITU should be expanded; a 6-bed recovery unit was planned for HH, but would take 12 months to deliver. At RBH high dependency units were to be centralised: Professor Evans explained that evidence shows that working at 85% capacity achieves optimum efficiency, but that currently the Trust is experiencing overwhelming demand and higher capacity. Work was being undertaken in critical care to maximise throughput.

The Chief Executive confirmed that the issue for the Trust was what capacity it could cope with. He reminded the Board that underperformance at the beginning of the year had been due to the inability to discharge complex cases; he understood the desire to undertake more complex cases but this had to be done with regard to other factors such as the agreement of the PCTs. This position was a key difference between us and the DGHs.

With reference to the new-to-follow-up ratio for outpatients, Mr Lambert explained that the Trust undertook just over 7 follow-up appointments to every new one. Even allowing for chronic conditions and long-term patients, the Trust's ratio was out of step with other centres. However, Mr Nick Hunt, Director of Service Development, said the PCTs acknowledged that as a specialist trust, we should not to be measured in the same way as others.

No MRSA cases had been reported in November 2007.

Data completeness on patients' ethnicity was still an area for concern, especially at RBH. Mr Mitchell reported that a retrospective collection of data was being undertaken in some areas and that process issues were being addressed.

Sickness absence was showing 'underachieved'. Reporting is becoming more comprehensive and returns have increased by 15%-20% overall. The system for internal sickness monitoring was changing, bringing the Trust's method into line with the requirements of NHS London. Long-term sickness would be extracted to make figures more representative.

The summary of the Governance & Quality Report for July – September 2007 had been circulated to the Board. Dr Caroline Shuldham, Director of Nursing & Governance, confirmed that in the area of infection control the Trust would be receiving financial support for deep cleaning as part of the national programme and this work would be completed by the end of March.

The Trust had also been allocated money to conduct a review of nurse staffing, as inadequate nurse staffing had been one of the factors identified by the Healthcare Commission in their review of the Maidstone and Tunbridge Wells NHS Trust. A project plan would be developed for this review

With reference to clinical audit and effectiveness, progress had been made in the collection of mortality data and Professor Evans drew attention to the good quality of clinical care evidenced by the mortality results and the positive impact for patients.

The Board discussed the Healthcare Commission (HC) investigation of the Trust's complaints, triggered in part by a higher than average number of second-stage complaints being returned to the Trust for further action, and in part by commentary from the PPI Forum. Dr Shuldham confirmed the reasons for the investigation were multifactorial. The Chairman remarked that during the Audit and Risk Committee, Ms J Ocloo, PPI Forum Chair, had noted the reasons cited for the investigation but stated that the PPI Forum had not, to her knowledge, raised any major issue with the HC; she had agreed to look into this and report back to the Audit and Risk Committee. Dr Shuldham felt it remained our understanding that the HC increasingly undertook "triangulation", which might include PPI comments. She said no report had been received since the July meeting with the HC, however an amber category had been allocated to the Trust for core standard C14a (complaints). The Chief Executive felt the Trust might expect to be identified by the HC in this area.

2007/141 <u>18-WEEK- WAIT PROGRESS REPORT</u>

Mr Mitchell introduced the Report. The project presented a huge amount of work for the Trust. Earlier in the summer it became apparent that the project plan in place was not sufficiently robust to cover the work required to deliver the national targets. In September the structure of the project was changed and Kelly Goulding was appointed as full-time project manager. The project would be coordinated by a steering group, reporting monthly to the newly established Modernisation Board.

Mr Mitchell explained that an assumption had been made that patients would be in the primary or secondary care sector for up to 5 weeks of the trajectory before being referred into the Trust. The plan was for the Trust to then ensure that outpatient review and diagnostic tests would be completed in weeks 5 to 10 patients and for intervention work to be completed in the final 8 weeks of the 18 week plan.

The Trust did not currently have clock start times of 90% of patients because

this was not made available by referring Trusts. From January 2008 all Trusts were required to tell hospitals receiving referrals the "Clock Start" time and from 20th January the Trust was expected to report a 100% "Clock Start" rate. 8 additional temporary staff would be allocated to pursue this information from referring centres.

Mr Mitchell reiterated that the project was a major enterprise with a huge amount of work yet to accomplish. Outpatient clinics would need to be reviewed to discharge patients as necessary to allow waiting new patients to be seen promptly. Areas for concern were sleep studies (where activity at Harefield had doubled and there were large numbers waiting) and in cardiac surgery (140 cases to be undertaken by the end of March in addition to the normal workload). To address this, a 6-day working week is currently under discussion with staff. Consultants would also need to increase their workload to manage this. This might also lead to further pressure on the cancellation rate and critical care, and therefore careful planning was necessary.

The Chairman thanked Mr Mitchell for the enormous amount of work undertaken to produce the plan. Mr Mitchell wished to thank Richard Goodman and Kelly Goulding for all their work in recent months.

At this juncture, Mr Hunt recorded his thanks to the Harefield League of Friends for providing sleep recording machines at Harefield. The Chairman also added the thanks of the Board for this gift.

Mrs Jenny Hill, Non-Executive Director, felt this project was bringing about a huge shift in practice, and that there might be opportunities to exploit the organisation's capacity to undertake more work in the future. Mr Mitchell confirmed the Trust was seeking to make this provision once the 18-week 'backlog' of patients had been cleared. Some local DGHs had already requested additional work be undertaken at Harefield. However, this relied on PCTs approving the volume change in contracted activity.

2007/142 AUDIT AND RISK COMMITTEE

i) Minutes of Meeting of 12 September 2007

Mr Hunting (Chairman – Audit & Risk Committee) presented the minutes. With reference to the Payroll Report, work was continuing to bring under control the rate of errors, which had been below 1% since May 2007. The Chairman noted the system had improved since the service had been brought in-house.

Mr Lambert reported that two temporary staff were now employed on recovery work, that the rate of overpayments was dropping and that the pay-spend is back on budget.

ii) Report from Meeting of 5th December 2007

Mr Hunting presented the report for information. With reference to the Annual Health Check, the HC had confirmed a score of 'good' for Use of Resources – a higher rating than previously achieved.

iii) Audit and Risk Annual Report

Mr R Hunting presented the report for information.

All of the above were noted.

iv) Audit & Risk Committee Revised Terms of Reference

The committee had undertaken a review of its Terms of Reference; these remained similar to the standing Terms of Reference with additional wording to Page 4, Duties, b) Internal Audit, final paragraph, as follows: "Where material objection to the plans and associated assignments that cannot be resolved through negotiation these will be referred to the Audit and Risk Committee for arbitration and resolution."

The Board agreed the Terms of Reference with this addition.

2007/143 COMMENTS FROM MEMBERS OF THE PUBLIC

Mr David Potter, on behalf of the Rebeat Club, wished to congratulate the Board on the Trust's improved financial performance and the exceptional standards of quality of service provided. He wished the Board and Trust staff a very happy Christmas and a healthy and successful New Year. These sentiments were also endorsed by the Heart of Harefield and the League of Friends – and gratefully received and reciprocated by the Chairman.

2007/144 DATE OF NEXT MEETING

Wednesday 23rd January 2008 at 10.30 a.m. in the Concert Hall, Harefield Hospital