Royal Brompton & Harefield NHS
NHS Foundation Trust

Minutes of the Board of Directors meeting held on 20 July 2010
In the Boardroom, Royal Brompton Hospital commencing at 2.00 p.m.

Present: Sir Robert Finch, Chairman
Mr R Bell, Chief Executive
Mr R Connett, Trust Secretary & Head of Performance
Mr R Craig, Chief Operating Officer
Mr N Coleman, Non-Executive Director
Mrs C Croft, Non-Executive Director
Professor T Evans, Medical Director
Mrs J Hill, Non-Executive Director & Senior Independent Director
Mr R Hunting, Non-Executive Director
Mr M Lambert, Director of Finance & Performance
Mr N Lerner, Non-Executive Director
Professor Sir Anthony Newman Taylor, Non-Executive Director
Dr C Shuldham, Director of Nursing & Governance

By Invitation: Ms J Axon, Director of Capital Projects & Development
Ms J Anderson, Senior Nurse & Matron
Ms F Cox, Senior Nurse Specialist – Pain Management
Mr N Hunt, Director of Service Development
Mr P McCleery, Director of Planning & Strategy
Ms S Ohri, Deputy Director of Finance
Mr D Shrimpton, Private Patients Managing Director
Ms J Thomas, Director of Communications

Apologies: None

In Attendance: Ms E Mainoo, Executive Assistant
Mrs R Paton (minutes)

2010/58 MINUTES OF THE PREVIOUS MEETING HELD ON 1st June 2010

Mr R Craig wished to amend Minute 2010/49, page 5, paragraph 4, to read: "Mr Craig then explained that at RB in 2009/10 200 fewer cases had been undertaken compared to 2007/08……."

Mr N Coleman wished to amend Minute 2010/55, page 7. Where there was reference to the ARC, this should read 'Audit Committee'.

With these two amendments, the minutes were approved by the Board.

2010/59 REPORT FROM THE CHIEF EXECUTIVE

- Mr R Bell, Chief Executive, gave an update on progress between the Trust and Imperial College (IC) and Imperial College Hospitals NHS Trust (ICHT). Mr Bell confirmed that terms of association had been drawn up which would be the basis of a legal agreement between ourselves, IC and ICHT. Once the agreement had been formally signed, an Imperial College Academic Health Science System (ICAHSS) would be created for a term of three years with RB&H FT being the first associate member. Mr Bell had noticed a warming up of the relationship between the organisations. The Cooperation

and Competition Panel (CCP) had shown some interest in the new ICAHSS. Mr R Connett, Trust Secretary, reported that he had been in contact with the CCP and had provided reassurance that the present proposals did not involve merger of the institutions. Mr Connett had agreed with CCP that RB&HFT would discuss with CCP any future developments which may impact patient choice and CCP had indicated that they were happy for this contact to be made informally in the first instance.

- Mr Bell then updated the Board on progress with the proposals to establish an aortic dissection service in conjunction with Hammersmith and St Mary's Hospitals. A framework has been agreed upon which to develop the service. Services will continue to be provided from all hospital sites. However, Mr Bell noted that it may be necessary to have informal discussions with CCP about the proposal. Professor T Evans, Medical Director, confirmed that the framework was at an advanced stage of development and that there would be a meeting with colleagues at ICHT on 4th August to finalise proposals.

- Mr Bell reported on the recent publication of the White Paper by the Secretary of State for Health on the structural reorganisation of the NHS. The Board will need to have a series of discussions over the next quarter to assess the implications of this Paper on this organisation. PCTs and SHAs were to be abolished and commissioning would be undertaken by GP consortia. This action would change the Trust's relationships. Mr Bell explained that PCTs had not actually referred patients themselves, they were rather the purveyors of NHS income. He suspected the vast majority of specialist services would be centrally commissioned, but there is no clear information on this yet. Mr Bell said the Trust was working to produce detailed business intelligence about where our patients are referred from. Referrals are funnelled to the Trust from GPs via DGHs. The DGH referral patterns will become increasingly important. Monitor will become the economic regulator with powers related to the tariff and competition and will regulate all trusts on these matters. All Trusts are expected to become FTs. NHS Trusts will either become FTs, merge with an existing FT or close. There will be implications for the governance of FTs, and there is an expectation of new legislation to define the governance arrangements which may be more diverse than heretofore. The White Paper indicates a particular intention to abolish the PP cap.

Mr R Craig, Chief Operating Officer, agreed there were many unanswered questions. He felt the Trust should be prudent but should also take advantage of policy gaps in order to influence the agenda. Future commissioning arrangements are uncertain and it is not yet clear how GP commissioning consortia will function. Mr Craig said that the Trust should take advantage of anticipated changes to the system in order to secure the trust referral base.

Mr N Hunt, Director of Service Development, said that specialist commissioners will need to agree budgets with GP groups. The Trust should work to persuade GPs to change current relationships and referring patterns.

There was a discussion about the strategic impact of the proposal contained in the White Paper. Mr Bell said the Trust needed to understand the shift of entities and concepts. To date, Monitor had been the independent regulator of FTs and under William Moyes as Executive Chairman had championed their cause. The Monitor Board, now under Steve Bundred is indicating that FTs have to stand on their own feet, they are no longer protected in the same way. Monitor will be

regulating all provider organisations in future. There will be a change in the regulatory relationship between Monitor and the Care Quality Commission with Monitor regulating the quantum of healthcare provision and CQC the quality. The result of this change is likely to be a national health system rather than a national health service. Mr N Coleman and Mrs J Hill, Non-Executive Directors, both commented on the nature of the changes and their impact on the plurality of service provision and the relationship of Trusts to parliament and the DH.

Mr Bell said the main challenge for the Trust was the sustainability and viability of the organisation at a time of change and economic uncertainty. Trust operations will need to tighten up as it was no longer possible to carry on as in the last 5 years. Mr Bell confirmed that any further DH briefing papers would be brought to future meetings of the Board for discussion.

Professor Sir Anthony Newman Taylor, Non-Executive Director, emphasised the need for the Trust to consolidate its position as the national provider of choice for heart and lung services.

Mr N Lerner, Non-Executive Director, asked if there was any indication of a date for the Health bill to go before parliament. Mr Bell gave some details of expected timescale. 1 April 2012 will be the date by which the NHS Commissioning Board will be fully established. Mr Bell thought that enabling legislation would be announced in the Queens Speech in November.

2010/60 PATIENT SAFETY & OPERATIONAL PERFORMANCE REPORT FOR MONTH 3: JUNE 2010

Mr M Lambert, Director of Finance & Performance, introduced the report for Month 3 and highlighted the following items:
HSMR Ratio is well under 70%.
Serious Untoward Incidents (SUIs): there had been one SUI reported in the month relating to retained tissue following a post mortem. The tissue should have been returned to the family for burial.
HCAIs: MRSA bacteraemia rate is still zero, and there had been no cases since October 2008.
MRSA screening rate remains above 1 which indicates achievement of this indicator.
C.Difficile one case in May so far this year, trajectory is 6 for first three months.
Surgical Site Infection Surveillance Service (SSISS): national average is 4.3%, for May the Trust rate was 4.0%.
Cancelled Operations: Variance from trajectory is 0.87%, so target underachieved against a target of 0.80%
18-week waits. The top-down assessment has been abolished but we are still required to collect data.
With regards to the indicators it is likely the format of this report will change when it becomes more certain what targets develop.

Mr N Lerner, Non-Executive Director, noted the Trust had significantly missed the target on complaint response times. Dr C Shuldham, Director of Nursing & Governance, reported there was difficulty in getting complaint responses completed within 25 days following investigations. The Board asked if there was need for more support but Dr Shuldham said what was needed was for people involved in the process to give it priority. Mr Craig added that what was being measured by the target was speed of response. The process involves the production of a letter that is accurate, but is written in the right tone. Fewer complaints are being received but these may be more complicated and can

involve many staff and other organisations necessitating a collective response. Mr Craig felt that more senior focus needed to be given to the investigations. Mr Bell further explained that within the 25 day timeline, the complainant receives at least one telephone call, an acknowledgement letter and a further letter if the reply is going to take more than 25 days. The timeline can be challenging and there may be a process problem involved.
Mr N Coleman, Non-Executive Director, emphasised that there were approximately 60 complaints received a year – he felt that staff should not be taken away from more important work in order to deal with the response target.

Controlled Drugs (CDs) Governance & Activity, Year Ending March 2010
Mr R Goodman, Director of Pharmacy & Medicines Management, introduced the report. There had been 37 incidents reported during Q4 2009/10, 33 being graded green and 4 yellow. The total for the year was 30% higher than that for 2008-09, partially due to the inclusion of potassium injections and Tamiflu and to an increasing reporting culture. The majority of incidents reported related to errors in the administration of medicines (32%) and prescribing (20%), followed by loss of CDs (16%). During Q4, errors in the use of morphine (11 incidents) continued to be reported more frequently than any other medicine. Reports of incidents relating to the prescribing of medicines increased from 14% in 2008-09 to 20% in 2009-10. Reports of the loss of CDs reduced from 19% last year to 16%. Losses can be related to some very viscous liquid medicines occurring during dose measurement. The highest number of CD incidents was reported by the paediatric directorate; improvement in the use of CDs has now been achieved in the paediatric directorate and the situation remains stable.
A total of 127 audits of wards and departments had been completed during the year (100% complete). There had been 294 identified breaches of the policy, the majority relating to record-keeping at ward level.
Key improvements in the period included the purchase of new software (Abusable Drugs Investigational Software). A review of the reconciliation of liquid medicines at daily stock-checks had revealed that small losses during the measuring process resulted in significant loss over a period of time and practice has been amended to correct this. Training sessions had been undertaken to improve awareness and knowledge of controlled drugs, and a bespoke bung device had been developed to prevent spillage and loss of liquid medicines.

Mr N Lerner enquired about the management of CDs and whether there had been any substantive losses. Mr Goodman reported that it was not always possible to account for everything and that losses did happen. He stated that single incidents were closely monitored but that surveillance would be maintained in the event of a more regular occurrence and patterns would be looked for.

Governance & Quality Summary Quarter 4 2009-10
Professor T Evans, Chairman of the Governance & Quality Committee, presented the report. He referred to the item on mortality following percutaneous coronary intervention (PCI). The number of deaths following PCI had increased at Harefield over the last 12 months and the Trust had received an alert from Dr Foster which Dr Foster had copied to the Care Quality Commission. Review of these cases had demonstrated the situation related to the complexity of procedures which included a high proportion of primary angioplasties and was not indicative of poor quality of care. This finding was reported back to Dr Foster who had issued a second letter. Professor Evans said he was concerned about the approach that Dr Foster had taken in their second letter because of the implied criticism of clinical practice. Professor Evans confirmed that the Trust

was formulating a further response to the CQC and that any further correspondence would be brought to the Board in due course.

Modern Matrons' Report, April-June 2010
Ms J Anderson, Senior Nurse & Modern Matron, presented the report. Key points were as follows:

Hospital Cleanliness Update
Quality assurance audits had confirmed good standards of cleanliness in most areas, however there had been some fluctuations in the overall audit scores. The Modern Matrons, Facilities and Infection Prevention & Control Teams continued to work in close collaboration with ISS Mediclean to ensure standards are maintained. Following the loss of an ISS Mediclean training manager, staff refresher training provision is to be reviewed. It is proposed to introduce a micro fibre cleaning and disinfection system across the Trust.

Estates & Facilities
The HH thoracic theatre and changing room refurbishment project is entering its final stages. Collaborative work between the theatre, IPC, contractor and Project teams has maintained continued service delivery in a safe working environment. The refurbishment of HH ITU side-rooms is also nearing completion. Some minor ward refurbishment has been deferred due to funding constraints. The Board was requested to support the Estates team to progress preventative maintenance and minor works to minimise infection risks.

Hand Hygiene
Ms Anderson reported that the compliance rate was static at 68-71%. Individual areas continued to implement the "My Five Moments of Hand Hygiene" initiative. The Audit Department are developing a hand hygiene database in order to feedback performance to the Divisions.

Audit & Surveillance
Audits undertaken included a peer review of theatre practices and environment, Trust-wide coronary artery bypass graft surgery antibiotic prophylaxis, IPC audit of staff knowledge on inoculation/splash injuries, audit on staff compliance with correct use of personal protective equipment, leg incision audit related to donor vein harvesting as part of CABG surgery.

Root Cause Analysis (RCA), Outbreaks and Incidents
RCA had been undertaken on one case of *C.difficile* at RB and 6 cases of VRE at HH.

Evidence of Innovation/Improvements
The pain management service had launched the booklet "Epidurals for Pain Relief after your Surgery"; a trial of safety cannulae had commenced in June; a contract had been awarded to Huntleigh Health Care for a total bed management service; a diabetic specialist nurse had been appointed at HH.

The Board noted the report.

Mrs J Hill, Non-Executive Director, felt the whole Patient Safety and Operational Performance Report would be an excellent marketing document and recommended it be presented on the Trust web-site. It would be even more helpful if some of the data was benchmarked against other providers. Mr Bell said the data needed to be presented in a more patient-friendly way, could be

uploaded to the website and updated monthly. It was agreed that the Director Communications and Head of Performance would consider how this might best be achieved.

2010/61 FINANCIAL PERFORMANCE REPORT FOR MONTH 3: JUNE 2010

Mr M Lambert, Director of Finance & Performance, introduced the report. Mr Lambert confirmed the Trust had reported a deficit of £2.2M in the first month of the year, a deficit of £1.6M in Month 2, and had made a small surplus of £100k in Month 3. There was a cumulative deficit of £3.7M. The plan submitted to Monitor had forecast a deficit of £3.3M at month 3.

PP was performing very strongly. Mr D Shrimpton, Private Patients Managing Director, said PP activity was lower, but profitability of contracts had been improved which had resulted in greater revenue per patient.

Mr Lambert said the deficit of £3.7M represented a significant challenge. Additional to the FSP a financial austerity plan was to be delivered. The austerity plan would have a value equivalent to 5% of pay costs and would need to deliver £6-8M.

Mr Lerner asked whether all of the FSP schemes had been identified and allocated yet. Mr Craig answered that schemes had been identified including those in phase 3 of the FSP. Phase 3 includes the austerity plan measures and brings the total value of the FSP to £27 m.

Mr Lerner asked why there was an over-spend on pay given that pay spend should be easy to forecast. Mr Lambert explained that the variance in pay was primarily due to the hire of bank and agency staff to meet increased activity – this kind of demand cannot be forecast so easily. Mr Bell said activity income was on target but pay costs were too high.

Mr Craig said further measures would be brought in as part of FSP phase 3. Changes have already been made to the way recovery is run at RB – it is not run overnight at RB with care being provided instead by flexing critical care capacity in other areas.

Mr Lambert confirmed there was still no indication of any Project Diamond funding, so this had not been accrued into our accounts. This funding had been worth approximately £12M last year, without which the Trust would have made a deficit in 2009/10.

Mr Coleman commented on the FSP – that £20M is about 10% of turnover. Mr Coleman said that adding on another £6m would be very difficult to handle in nine months. The Chairman said that this was for the executive to consider.

Mr Bell said that this would be tough, most of the savings would come from the pay envelope and people would probably feel hard-done-by. Savings would be generated by a mixture of recruitment freezes, reduced agency spend and renegotiating the terms of the shared income distribution with consultants regarding private practice fees.

Mr Coleman asked why an additional £6m was needed and said that he was concerned this level of savings may have a negative effect on patient safety. Mr Bell reassured Mr Coleman that the executive would not take action that would affect patient safety adversely. Mr Bell said that the reason for the £6m

additional savings target was that this was the value equivalent to 5% of the pay bill.

Mr Coleman said it was highly commendable that action was being considered now rather than being left to later in the year.

2010/62 SAFEGUARDING CHILDREN ANNUAL REPORT

Mr R Connett, Chair of the Safeguarding Children Steering Group, presented the report, which gave an update on progress following the previous annual report presented to the Board on 28th October 2009. The report had been brought forward this year in preparation for the Safeguarding Improvement Team (SIT) visit to the NHS Kensington & Chelsea area in September this year. This report will form part of the briefing pack for the review team. Trust involvement in the visit is expected to be limited to interviews with the Named Nurse, Named Doctor and Executive Director lead for safeguarding children.

Mr Connett gave highlights of the Action Plan for 2009/10 which included:

- undertaking a training needs analysis and commencement of Level 3 training in March 2010
- identifying funding for a safeguarding Children Adviser
- Designated Nurse for safeguarding children at NHS K&C has attended the Trust safeguarding Children Steering Group regularly
- Internal audit opinion of significant assurance being reached as a result of a review undertaken by the London Audit Consortium.

Priority Actions for 2010/11 included named professionals undertaking level 4 training, achievement of required training levels for Level 1 / 2 & 3 by November 2010, providing an induction programme for the Safeguarding Children Advisor, and the introduction of reporting of performance indicators.

Mr Connett asked the Board to approve the revised web declaration which had been included in the papers. This was agreed.

2010/63 HEALTHCARE FOR ALL – LEARNING DISABILITIES (LD)

Ms F Cox, Senior Nurse Specialist – Pain Management, and Chair – Healthcare for All Steering Group, introduced the Update Report of Activity at July 2010. Ms Cox explained that this initiative related to adults aged 18 and over but that for local purposes it would encompass all age groups. In this Trust the Patient Advice and Liaison Service acted as the point of contact with the family and carers of a patient with LD. Ms Cox confirmed that no training on LD had been provided within the Trust in the past 5 years but that a training programme had now been agreed and would be implemented shortly. Trainers local to both sites had now been identified and training sessions for staff would take place in the latter part of 2010.

Ms Cox said there was currently no way of identifying the types of learning disability experienced by people referred to the Trust. The Trust Patient Administration System (PAS) allowed for flagging of safeguarding adults, or safeguarding children issues, but the capability for LD was not yet fully implemented. Identification of patients with LD needs to be incorporated into any future PAS replacement.

With regards to accessible information, some work had been undertaken in the Trust, e.g. revision of the complaints leaflet, provision of DVDs on visual

explanation of treatments for congenital heart disease. Further work needed to be done such as exploring the suitability of Easy Read letters, the format of information leaflets, engagement with people with LD about suitability of all information, assessment of the use of BrowseAloud software for the Trust website, evaluation of the Hospital Passport (in use at RBKC and Chelsea & Westminster) and the development of the relationship with the Royal Borough of Kensington and Chelsea (RBKC) LD team who were very inspirational in this area. Further work was necessary to put in place protocols to provide suitable support for LD patients and their carers.

The Trust Membership & User Involvement Manager had liaised with the Trust patient and public involvement leads about including people with LD on the patient panel. A potential candidate from RBKC had been identified to join the Trust Healthcare for All steering group.

Ms Cox confirmed that on-going work would include engagement with PAS managers and clinical audit. She said that if the BrowseAloud system was to be adopted in the Trust, this would cost approximately £8.5K plus the cost of the Hospital Passport at £1K. Ms Cox reported that she had identified an individual to takeover leadership of the Healthcare for All group in the future. It was agreed that Ms Cox would liaise with the Director of Nursing & Governance about this.

The Board noted the report.

2010/64 QUARTER 1 MONITOR SUBMISSIONS

(i) Governance Self Declaration

Mr Lambert introduced the document which set out Trust performance for Q1 2020/11 measured against requirements of Monitor's Compliance Framework. Mr Lambert recommended a self-declared rating of amber/green for the following reason: the Trust scored 1.0 on the Compliance Framework because of the moderate concern recorded by the Care Quality Commission in respect of compliance with the Fire Code. Mr Craig confirmed the work to rectify the situation had now been completed.
The Board approved the submission of Declaration 2.

(i) Financial Monitoring Commentary

Mr Lambert introduced the document which set out the financial performance of the Trust for Q1 2010/11 as required by Monitor's Compliance Framework. The Trust was showing a financial risk rating of 2 which is consistent with the business plan.

Mr Bell reminded the Board that the compliance framework of Monitor is a self-certification process. The Trust will need to self-certify for the next three quarters in relation to financial performance. If this falls below the required level this could trigger monthly review by Monitor and there would be a potential for intervention by the regulator.

2010/65 REGISTER OF DIRECTORS' INTERESTS

Mr Connett presented the Register of Directors' Interests for information. The Chairman reported he had some minor amendments and would contact Mr Connett about this.

2010/66 REVISED STANDING FINANCIAL INSTRUCTIONS

Mr Lambert introduced the item and circulated an additional paper at the meeting on changes to the SFIs as a result of the organisation ceasing to be an NHS

Trust and gaining Foundation Trust status.

SRF requested clarification of the insurance arrangements for directors and others.

The Board approved the Standing Financial Instructions.

2010/66 AUDIT & RISK COMMITTEE

Report from Meeting of 20th July 2010

Mr Neil Lerner, Chair – Audit Committee, reported:

- The Audit Committee had reviewed a report from Internal Audit on the Board assurance framework which gives only limited assurance. This gave rise to a debate on the inter-relationship between the Board assurance framework and the Trust's risk management assessment process.
  It was agreed that the Chief Executive and Director of Nursing & Governance would have further discussions with Internal Audit and an appropriately amended report be brought back to the Audit Committee
- It had been agreed that the Audit Committee would carry out a process of self-assessment of the Committee's activities during 2010/11 and that this might constitute a short report for inclusion in the Annual Report in future.
- The Audit Committee had received a report from Deloitte LLP regarding the preparation of the Trust's Quality Report for 2009/10.

Mr N Coleman, Chair – Risk & Safety Committee, reported highlights from the meeting as follows:

- The Committee had reviewed and approved the consultant recruitment policy. It was decided that this should be brought to a future Board meeting
- Surgical outcomes at HH – concluded this could now revert to regular monitoring
- Discussed whether a clinical ethics committee would be helpful
- Looked at SSIs and concluded that numbers were close to normal now and could be monitored generally again
- Reviewed the root cause analysis into SUIs
- Reviewed the clinical audit programme
- Reviewed the patient experience statistics
- The Committee had undertaken a snapshot assessment of the Mid Staffs issues and found good assurance. There were some areas of relevance, work was still in progress, but there appeared to be no evidence of any risk of failure in the Trust on the scale of the Mid Staffordshire scenario.

It was confirmed that the two committees had now split, the split having been approved by the FT Governors at their meeting on 13th July 2010. The question then arose as to whether the two committees should be held on the same day as the Trust Board. Mr Lerner said he would contact Executives to check their preference.

At this juncture, Mr Connett confirmed he would be constructing a timetable of all Executive meetings.

2010/67 QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chairman of the local residents association made himself known and asked to speak to the Chief Executive after the meeting.

2010/68 ANY OTHER BUSINESS

Mr Connett reported that Monitor had confirmed that there was no longer a requirement for the Trust to hold an Annual General Meeting. Therefore the pre-arranged AGM would now be cancelled (date had been fixed for 22nd September 2010).

2010/69 DATE OF NEXT MEETING

22nd September 2010 at 10.30am in the Concert Hall, Harefield Hospital