ROYAL BROMPTON & HAREFIELD NHS TRUST

Minutes of a Meeting of the Trust Board
Held on 23 April 2008 in the Boardroom, Royal Brompton Hospital

Present: Lord Newton of Braintree, Chairman
Mr R Bell, Chief Executive
Mr N Coleman, Non-Executive Director
Mrs C Croft, Non-Executive Director
Prof T Evans, Medical Director
Mrs J Hill, Non-Executive Director
Mr R Hunting (part), 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: Ms M Cabrelli, Director of Estates & Facilities
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

Apologies: There were no apologies received for absence

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

The Chairman welcomed members of the Board, SpRs undertaking management training, and members of the public to the meeting.

2008/38 MINUTES OF THE PREVIOUS MEETING HELD ON 26 MARCH 2008

The minutes of the previous meeting were agreed as a correct record with the following amendment:
Page 3, para.7, line 1 to read:……..Harefield Village Conservation Area Advisory Panel.

2008/39 REPORT FROM THE CHIEF EXECUTIVE

The Chief Executive, Mr Robert Bell, intimated that he had nothing to report under this item that was not covered elsewhere on the agenda.

2008/40 HAREFIELD UPDATE

Mr Patrick Mitchell, Director of Operations, reported that the membership of the Oversight Board had been increased and it would take forward work overseeing the Strategic Outline Case (SOC). The membership would include patient and public involvement together with some specialist commissioner input. As previously reported, the company *Care Consulting* were working with the Trust and undertaking a review of the 2006/7 options appraisal, together with the various constituent Trusts who were involved originally and who wished to remain part of the discussion. Northwick Park (NW London Hospitals NHS Trust) had now been included. Mr Mitchell envisaged that the Oversight Board would meet three or four times before the end of July.

Mr Mitchell confirmed that we continued to be successful in securing non-cardiothoracic support when required, as demonstrated by the audit of such needs. The Trust had re-engaged with Hillingdon Hospital to review the service agreement

and a review of the "chambers" model for surgeons was being undertaken.

Building works at Harefield were continuing and the external works had been completed (lintels). The upgrading of various wards continued, with an extension to the overall completion date due to a lift replacement. E ward was due to return to its normal location on 8th May, foundation works for the new thoracic theatres had commenced, and the increased electricity supply installation was progressing to plan. Mr Mitchell undertook to provide a written report for the May Board meeting.

The Chairman remarked on what a noticeable difference the refurbishment was making to the old buildings and wished to record the Board's thanks to the Director of Estates & Facilities and her team and to the Arts Manager for all their work and input in achieving this.

2008/41 RESEARCH & DEVELOPMENT

Mr Robert Craig, Director of Planning & Strategy and Acting Director of R&D, prefaced his report by saying that the preceding months had been focused on the Trust's trajectory to gain Biomedical Research Unit (BRU) status, but there had been significant developments in the NHS R&D regime going on at the same time, of which the Board needed to be aware. He presented his report which summarised the current status as follows:

BRU Status: Formal notification of the success of both applications had been announced on 9th April, these being 2 units out of 12 across the country. The designations would attract at least £9 million of National Institute for Health Research (NIHR) funds to the Trust over four years from 2008/09, including £400k p.a. more than had originally been made available. Decisions from NIHR were expected before the end of April on bids for up to £4M of additional funds for associated capital investment.

Wholesale changes were underway across all aspects of NHS R&D, with NIHR Comprehensive Local Research Networks (CLRN) now in place to support and provide infrastructure for NHS clinical research. The Trust was involved in the NW London Network, the Board of which was chaired by Prof Martin Cowie. Funding from NIHR would be channelled through these networks.

Separately, UK Clinical Research Network (UKCRN) Portfolio of Clinical Trials would centrally record "high quality clinical research" eligible for NHS service support costs funding. A number of initiatives intended to streamline the regulation and bureaucracy of research were described.

NIHR Faculty status for Trust staff would be vital, as membership would attract funding and as many research-active staff as possible needed to be encouraged to apply. Faculty membership was automatic for any researcher supported by a NIHR grant or designation and fell into several categories according to staff's seniority, experience and commitment to research.

Mr Craig also outlined NIHR Funding for 2008/09 and confirmed that the Trust had secured infrastructure funding for the year of at least £14.4m (one allocation yet to be notified), compared to £24.6M for 2007/8, and an initial projection for 2008/9 of £16.5m.

The Chairman queried one item on UKCRN portfolio of clinical trials, asking why collaborations with industry would no longer be eligible for support. Mr Craig and Prof Newman Taylor replied that NIHR would not recognise a private arrangement between Trusts and a sponsoring organisation where there had been no open competition or

peer-review process in establishing the partnership/sponsorship, and NIHR had no influence over the purpose or priority of the project(s) involved. This represented a change from the previous regime.

With reference to the NIHR Faculty, Mr Richard Hunting, Non-Executive Director, asked if the various categories of membership might be regarded as a career ladder; Mrs Jenny Hill, Non-Executive Director, asked whether the NIHR Faculty was itself a real or 'virtual' organisation. Mr Craig replied that the NIHR Faculty was real in the sense that it would have an evolving membership of active researchers with associated funding – but it would have no physical base or 'campus'. He continued that, for example, an NIHR investigator could become a senior investigator; initial membership was linked to an NIHR grant or designation, but could be extended. The Chief Executive counselled caution in describing the Faculty as 'virtual'.

Prof Tim Evans, Medical Director, said clinical research results in clinical excellence and reinforced the views expressed that the Trust should encourage its clinicians to attain Faculty membership.

With reference to the table in Appendix 1 to the paper (listing successful BRU designations), the Chairman noted that four partnerships (in Sheffield, Southampton and Nottingham, as well as RB&H/Imperial College) had each been awarded 2 BRUs, accounting for two-thirds of the designations nationally.

The Chief Executive noted that it was becoming clear that there would be no other sources of guaranteed multi-year NHS research income – and that this was a new reality for a research-driven Trust like RB&H, which he did not yet believe was fully appreciated throughout the organisation.

2008/42 FOUNDATION TRUST APPLICATION STATUS

Mr Craig gave a presentation to the Board updating members on the current status of the Trust's FT application. The presentation addressed the process of re-assessment to be followed if the Trust asked Monitor to reconsider the application, and the six key issues contained in Monitor's deferral letter of 29th June 2007. Copies of handouts of the presentation are attached with these minutes.

Following the presentation, the Chairman thanked Mr Craig and reminded the Board that a decision would have to be taken on the future of the application in time for Monitor to be formally notified by their deadline of 30th June 2008 if the Trust wished the application to be reconsidered.

Mr Mark Lambert, Director of Finance & Performance, said the Trust faced significant financial challenges for 2009/10 when NIHR "transitional" funding was scheduled to fall to zero (from £11.7m in 2008/09). As discussed under the previous item, there was NIHR funding available, but little of it supported the Trust's acknowledged research strengths and agenda.

Mrs Hill asked if the Trust could apply for funding related to research projects involving the chronically sick. Mr Craig replied that it could, but that funding would only flow to the extent that RB&H itself undertook the research: he confirmed that the NIHR website was continually scanned for appropriate opportunities and 'calls'. A key feature emerging was that NIHR funding depends on patient- and people-based research. Where research studies involved small patient numbers (however complex), little NIHR funding would be forthcoming. Currently, large, community-based projects recruiting large numbers of patients (albeit for simple screening or investigations) were attracting the most NIHR funding.

Prof Evans confirmed that the emphasis was on community-based research. He was concerned about how the Trust could leverage its clinical assets; gaining BRU status was significant but wider success was not possible in isolation. The Trust did not have the workforce to access larger monies and projects.

The Chief Executive said there was a need to understand the context of how the whole NIHR business is changing – this was clearly around geographically-based units. Over the succeeding 2-3 years, the Trust would have to evolve its R&D model, thinking and collaborations.

2008/43 OPERATIONAL PERFORMANCE REPORT FOR MONTH 12: MARCH 2008

Mr Lambert introduced the operational report for month 12, and highlighted the following items:

- PP cumulative activity was showing an adverse variance for the year of 4.6%.
- The final position for reportable cancellations was 1.39% Trust-wide, which was expected to deliver an "underachieved" rating ("achieved" was likely to <0.8%) – this was a creditable result given earlier performance.
- The new-to-follow-up ratio of outpatient appointments was still an area for concern relative to comparable centres (March ratio was 1 new : 7.17 follow-up appointments). This was not a national target, but PCTs were taking an increasing interest.
- Mixed-sex accommodation remained an area for concern, the problem being mainly in critical care and paediatric areas. There remained reservations as to whether these areas could be successfully segregated without recourse to adopting single cubicles for all patients.
- Infection control: the Trust had been clear of MRSA from October to date, i.e. 5 consecutive free months. The Trust would therefore have achieved this indicator provided the Healthcare Commission (HCC) use the same banding methodology to assess 2007/8 as in previous years. The Trust finished the 2007/8 year with 36 cases of *C.difficile* in patients aged over 2 years, and 3 cases of GRE bacteraemia. Mr Lambert further reported that in March 2008 the HCC had published a number of comparative indicators which confirmed the Trust had the best results in England during 2006/7 for MRSA (measured as incidence per 1,000 bed days), and for *C.difficile* in the over 65's (measured per 1,000 bed days).
- Coded ethnicity data for month 12 was 83.5% complete and therefore met the HCC target (provided the HCC threshold does not change).
- 18-week waits: Mr Mitchell said that referral data and 'clock stops' for March were 100% complete. The Trust was waiting to hear if certain exclusion categories would be accepted. Indications were that, for admitted care, the Trust would achieve 72% against a target of 85% and for non-admitted care, 83% against a target of 90%. The Trust had been working with the Support Team from the DH, who had commented positively on our efforts and progress made. Mr Mitchell said that all staff involved in achieving this result against a difficult background were to be congratulated. He also reported that other Trusts were finding it difficult to achieve the 18-week target for cardiac (and neurological) interventions.

Mr Nick Coleman, Non-Executive Director, was concerned about the accuracy of forecasting of some measures in the report and asked if any lessons could be learned. Mr Richard Connett, Acting Head of Performance, clarified that the figures to which Mr Coleman referred were year-end, not month-end results – and this explained the discrepancy.

Mr Coleman raised the subject of *C.difficile* and the need for the Trust to agree future

local targets. Mr Connett explained that the SHA set the overall expectation, which is that RB&H will reduce the number of *C.difficile* cases to 26 attributable cases by 2010/2011. There had been no numerical target figure for 2007/08. Instead the HCC required the Trust to set a trajectory for reduction to 2010/2011. Whether or not this had been agreed with our Host PCT (K&C) was assessed by the HCC. In the future we would have to provide two figures – total cases and attributable cases. Dr Caroline Shuldham, Director of Nursing & Governance, confirmed that, for *C.difficile*, 48 hours from admission to diagnosis was the 'cut-off' time for being regarded as attributable. The Chief Executive reminded the meeting that, irrespective of the numbers agreed, a year-on-year reduction had to be demonstrated.

Mr Coleman referred to Serious Untoward Incidents (SUIs) and noted that 4 had been reported in the year. He asked Dr Shuldham if there were any conclusions or common factors in the underlying causes, which might be a cause for concern. Dr Shuldham confirmed that following investigation, appropriate action to prevent recurrence had been taken in three of the cases, and one case was still under review. The Chief Executive felt that each case involved very different circumstances, and that root cause analysis had highlighted very different issues; corrective measures had been put in place but there were no common, underlying factors.

2008/44 YEAR END FINANCIAL PERFORMANCE AND REPORTING

Mr Lambert reported that the accounts for 2007/08 were in the process of being closed. The Trust was required to submit a draft financial statement to the SHA on 1st May, to be signed off by the Board at its June meeting. The Trust was showing a surplus of £2.359m, which was within the 'control total' of £2.379m set by NHS London. This surplus was reached after taking into account an adjustment for 'incomplete spells' (i.e. work in progress at year-end) – made up principally of intensive care bed days. The surplus was also reached after a charge resulting from reducing the maximum remaining economic lives of the buildings at Harefield to 25 years. This adjustment is necessary to ensure that the "control total" is reached.

Mr Lambert stated that discussions were still ongoing between the DoH, Audit Commission, NHS London and local auditors regarding, inter alia, the agreement of the correct accounting treatment for incomplete spells.

Mrs Christina Croft, Non-Executive Director, asked if the PCTs had acknowledged the debts associated with the incomplete spells. Mr Lambert confirmed that statements had been sent to relevant PCTs and no objections had been lodged. Mrs Croft then asked what would be the residual financial value of Harefield's buildings if the revaluation proceeded. Mr Lambert said the total book value would be approximately £40m, but reminded the Board that this did not necessarily represent an 'open market' value. Mr Lambert also reminded the Board that this exercise would reduce the impact of any future 'impairment' charge on the Trust's accounts if a decision were taken to demolish and replace any Harefield buildings.

The Chairman regretted the uncertainty, and confirmed continuing pressure not to exceed the 'control total'. He had received a letter from the CEO of NHS London's Provider Agency advising him to consider the Trust CEO and management team to have failed in their duties if the Trust did not meet this figure. The Chief Executive noted that an accounting result was being imposed on the Trust, and the Board should be transparent on that issue.

Prof Newman-Taylor asked what view was held by the Trust's external auditor (Deloitte & Touche). Mr Lambert said this had been discussed informally and advice received that it would assist any audit to have the corroborating opinion of a chartered surveyor. He confirmed that chartered surveyor had been commissioned to provide an

opinion which was due shortly.

Mr Lambert felt that, in the interests of transparency, the Trust should be able to show how the reported result had been achieved. The Chairman agreed that the fundamental requirement was to provide a true and fair statement of the Trust's accounts, and felt Mr Lambert's proposal for their presentation was appropriate. The Chief Executive said that he, as Accounting Officer, would not sign qualified accounts - the accounts had to be fair and accurate.

As the position remained uncertain, Mr Lambert agreed to bring a further update to the next Board meeting.

2008/45 AUDIT AND RISK COMMITTEE

1) Minutes of Meeting of 5th December 2007

Mr Hunting had chaired the meeting and invited comment from the Board.

With reference to minute 08/38: Counter Fraud Service, the Chairman was concerned that a report issued by the Counter Fraud Services, based on an inspection in 2005, apparently showed little development in the Trust since that date. Mr Hunting explained there had been a problem in the Counter Fraud Unit, and the Trust had subsequently changed relevant personnel internally. The situation had greatly improved and he did not feel the same comment would be made now. Mr Lambert said he had received written confirmation from the London Counter Fraud Service that they were much happier with progress made in the most recent six months.

Minute 08/42: Statement of Internal Control 2006/07 Action Plan.
The Chairman noted that Ms J Ocloo (Chair of the former PPI Forum) had raised the Trust's performance in relation to the HCC review of complaints. Dr Shuldham explained the following background: of approximately 80 complaints received in one year, 10 were taken by complainants to the HCC, and 5 were referred back to the Trust for local resolution, equating to a 50% 'referred back' rate. Although the absolute numbers were very small, this rate (50%) was high relative to other Trusts. Considerable discussion had been held with the HCC, including explanations being given and accepted for four cases, and the Trust admitting shortcomings with one case. As a result of these exchanges, and despite the warnings received, the Trust had not been 'named' in the HCC report. There had also been questions of the statistical validity of HCC's analysis.

A huge amount of work had been required to address the issue, and the Chairman thanked Dr Shuldham and Mr Connett for their efforts. He felt that a statistical anomaly should not have driven such an 'industry' of correspondence and debate.

2) Report from meeting of 25th March 2008

The report was received by the Board.

The Chairman confirmed that Mr Nick Coleman had agreed to take on chairmanship of the Audit & Risk Committee and, on behalf of the Board, he thanked Mr Richard Hunting for his work as outgoing Chairman.

2008/46 ANNUAL HEALTH CHECK CORE STANDARDS – FINAL DECLARATION

Mr Connett explained that for 2007/8 the Trust was required to make a declaration of compliance against the Core Standards set by the Healthcare Commission (HCC), and reminded the Board of the discussion at the March Board meeting on this issue. Assessment by internal auditors (Thames Audit) had concluded that there was 'reasonable assurance' against all standards bar three, where there was 'limited assurance'. These were:

Standard C4c – Decontamination
No further guidance had been received from the NW London Decontamination Project or the DH. It was recommended that the Board therefore proceed to declare the Trust compliant, based on the understanding that while Trust decontamination facilities do not meet all of the requirements of the latest EU Medical Devices Directive, surgical instruments were known to be clean, sterile and fit for purpose. The Chairman requested the paragraph be re-worded slightly for the purposes of clarity and, with this caveat, the Board agreed to declare the Trust compliant.

C11b - Training
Participation in mandatory training programmes resulted in 102% attendance (i.e. ahead of target) for fire training, 113% for Health & Safety, 72% for manual handling associated with patient care and 87% for manual handling associated with loads. The final percentages for manual handling represented an improvement on the forecast of 66% contained in previous Board papers. Mr Connett recommended a declaration of compliance, based upon good progress towards achievement of targets set by the Risk Committee. The Board accepted this recommendation.

C12 – Research Governance
Sufficient evidence was achieved to support a declaration of compliance by publishing an article in the Patient Focus newsletter with information about research projects, including links to appropriate websites. The Board agreed to declare the Trust compliant.

Third-party commentaries
Mr Connett reported that commentaries had been received from LB Hillingdon and the Royal Borough of Kensington & Chelsea (K&C). A draft commentary had recently been received from the PPI Forum, upon which the Trust had been invited to comment on matters of accuracy. The Chairman asked Dr Shuldham and Mr Mitchell to review the Forum's statement and bring any material comments to the next Board meeting. The Chief Executive suggested this be done in conjunction with a review of the results of the latest patient survey in order to provide a broader patient perspective.

With reference to comments from K&C Oversight & Scrutiny Committee on Health, the Chairman noted that they were unclear about the terms "limited assurance" and "reasonable assurance". The Board felt that K&C should be informed that these were standard auditors' terminology, and that "reasonable assurance" was the highest attainable level.

Mr Coleman commented on the lower than average score achieved by the Trust for reporting injuries and dangerous occurrences in the "comparative indicators". Mr Connett agreed that this highlighted the need for a focus on manual handling training as manual handling incidents accounted for a significant number of the RIDDOR reports. Mr Lambert commented that the number of staff trained in manual handling was significantly better than last year, but further work was required.

Hygiene Code Board Statement
The Board discussed the statement provided by Dr Anne Hall, Director of Infection Prevention & Control, as a declaration of the Trust's compliance. The Chairman questioned the wording on laboratory support and comments about the desirability of further isolation rooms. Dr Shuldham felt the latter statement was true, in that the Trust provides an adequate isolation service (as required by the Hygiene Code) but that the Trust sought to be better than adequate, and that further such rooms would be beneficial. The Chairman agreed that the Director of Infection of Prevention & Control should express her opinion clearly, but that this was a statement of the Board. Dr

Shuldham agreed to discuss the wording of these points with Dr Hall.

With reference to statements about MRSA and *C.difficile* rates, the Chairman requested the punctuation be improved in order to clarify what the "over-65s" related to (i.e. *C. difficil*e only).

The Chairman also commented on the necessity to provide different, organism-specific leaflets, and wondered whether patients might prefer to receive only one, more general leaflet on infection. Dr Shuldham agreed that general information was important (and available), but that this was a reference to patients once they had acquired an infection, when more detailed and specific information was required.

HCC Inspection

Dr Shuldham circulated to the Board a copy of an e-mail received from the HCC giving details of their intention to undertake an inspection of acute trusts' arrangements for the prevention and control of healthcare-associated infections. These inspections would take the form of spot-checks, to be undertaken on the same day as the Trust is notified of the visit. The Trust would be given notice of the three-month period in which the inspection would take place, but not the exact date. Dr Shuldham assumed the inspection would take place between July 2008 and March 2009 as the Trust had not been notified of a visit in the April-June 2008 period. The e-mail gave information on arrangements for the visit and on criteria against which Trusts would be measured. The HCC would request certain information from the Trust in advance in order to inform its visit.

2008/47 BOARD COMMITTEE ARRANGEMENTS

The Chairman informed the Board that he had instigated a review of Board Committees, with a particular emphasis on the role of the Finance Committee. In the meantime, he had asked Mrs Croft and Mrs Hill to join that committee in order to ensure that its meetings would be quorate. Recommendations would be brought to a future meeting.

2008/48 DATE OF NEXT MEETING

Wednesday 28 May 2008 at 10.30 a.m. in the Concert Hall, Harefield Hospital