ROYAL BROMPTON & HAREFIELD NHS TRUST

Minutes of a Meeting of the trust Board
Held on 23 July 2008 in the
Concert Hall, Harefield 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, Non-Executive Director
Mr M Lambert, Director of Finance & Performance
Mr Patrick Mitchell, Director of Operations
Dr C Shuldham, Director of Nursing & Governance

By Invitation: Ms M Cabrelli, Director of Estates & Facilities
Mr R Connett, Head of Performance
Mr R Craig, Director of Planning & Strategy
Mrs L Davies, Head of Modernisation
Dr A Hall, Director of Infection Prevention & Control
Mr N Hunt, Director of Service Development
Mr D Shrimpton, Private Patients Managing Director
Ms J Thomas, Director of Communications

In Attendance: Ms E Mainoo, Executive Assistant
Ms R Matthews, Senior Nurse – User Involvement
Mrs R Paton (minutes)

Apologies: Prof Sir Anthony Newman Taylor, Non-Executive Director

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

2008/72 MINUTES OF THE PREVIOUS MEETING HELD ON 19 JUNE 2008
The minutes of the June meeting were agreed as a correct record.

2008/73 REPORT FROM THE CHIEF EXECUTIVE
Mr Robert Bell, Chief Executive, wished to draw the Board's attention to the fact that the Trust was constantly under scrutiny from NHS London in relation to:

- 18-week waits (for which the Trust is not currently meeting 2008/09 targets);
- The financial control total for 2007/08 (which the Trust exceeded with the 2007/08 surplus and is therefore considered to have failed). Notification was still awaited of the control total for 2008/09.
- Healthcare-associated infections (HAI), in which the Trust has a very good record. Notwithstanding this, 7 cases of MRSA in 2007/08 exceeded the SHA's stated target of 5.
- "Spot-checks" of all Trusts by the Healthcare Commission on arrangements for the prevention and control of healthcare-associated infection – RB&H had been notified that its visit would take place between August and October 2008.
- Moves to reconfigure and realign paediatric surgery in NW London (minute 2008/61 refers); and the wider issue of Healthcare for London and the implications of the most recent Darzi Report.
- The future of the Foundation Trust application.

The Chief Executive continued that the SHA viewed these items as strategic issues for this Trust and that the Board should be actively engaged in addressing these matters. The outcomes would be regarded as measures of our success – both short- and long-term.
The Chairman agreed that the Board should recognise how many demands were currently on the Trust.

2008/74 FT APPLICATION

Mr Robert Craig, Director of Planning & Strategy, introduced the report. Monitor had extended the deadline for a decision on 'reactivation' of the application to 30 July 2008, and the Board now needed to take this decision. The paper set out the options and the eleven points that arose from Monitor's deferral letter (June 2007) and from later discussions. The outstanding issue of the SOC for Harefield Hospital (item 6) would be discussed later on the agenda (2008/75) and the decision would be included in the report.

The Board then discussed the pros and cons of reactivating the application. The Chief Executive stressed it was important to remember that the Trust's application had previously been deferred on 6 points, 5 being largely around financial issues and one around refinement of the plans for the HH redevelopment, as set out in the paper.

The Chief Executive stressed that the application had to be completely convincing to Monitor on items such as the Trust's purpose, the impact of ongoing withdrawal of guaranteed R&D funding, and environmental issues such as Healthcare for London and High Quality Care for All (the Darzi Report).

Mr Mark Lambert, Director of Finance & Performance, felt the Trust was financially strong in the long-term, but reminded the Board of the challenge. Transitional R&D funding would reduce to nil in 2009/10 (a further income reduction of £12m), and a recurring 3% efficiency requirement was built into the tariff (approx £6m pa). By 2011/12 he felt confident of a sustainable surplus. But the Trust would need either to bridge a gap of £18m in 2009/10, or £12m pa for two years (2009/10 and 2010/11) – having successfully delivered the 2008/9 budget. Monitor clearly thought this would be a challenge. Mr Lambert thought it would be possible, but far from easy, to demonstrate a viable plan to satisfy Monitor.

Mr Lambert further suggested engaging third-party support to provide an additional challenge and assurance to the plans submitted to Monitor. Professor Tim Evans, Medical Director, felt certain the organisation could deliver and had proved it could "earn its way" out of trouble. The current financial position was very encouraging, but it was crucial the Trust could also deliver consistently on cost control. The organisation was running very close to 100% occupancy, with very little flexibility (at least until further critical care beds were commissioned later in the year). In relation to delivering efficiencies, it was noted that Mrs Lucy Davies had taken up the role of Head of Modernisation and would be overseeing all such opportunities within Operations.

The Chief Executive reminded the Board of the meeting with Lord Warner and Malcolm Stamp when the SHA Provider Agency had confirmed its support for the FT application and urged further progress. The possibility of financial support from the SHA had been raised and they had agreed to consider their options in this regard. Mr Bell thought the SHA was well intentioned but was unsure of the outcome, and certain it could not be relied upon at this stage. Any such grant would necessarily be short-term, and the Trust would need to demonstrate its long-term viability, albeit with a longer transition period. The Chairman felt the idea should not influence any decision taken on the FT application.

The Chief Executive said that the Executive team could develop a financial recovery plan for the coming years and demonstrate its ability to overcome the withdrawal of R&D

funding which had begun 15-18 months before. He was also confident of responding to external, third-party challenge.

The Chairman referred to the generation of income from the Trust's intellectual property (IP) (contained in the FT paper). The report stated that income was unpredictable at this stage and had therefore been excluded from future financial projections. However, commercial income was understood to be able to grow to £5.5M by 2012. Mr Craig agreed the paragraph should be reworded to provide clarity, and confirmed that Monitor's assessor case in 2007 was broadly in line with what was now proposed. The Chairman cautioned against projections which might be considered speculative.

The Chief Executive commented that the original application had been supported by both the SHA and the Secretary of State. He continued that the challenge was Monitor's assessment, risk-tolerance and the level of evidence required. He was concerned that plans, however robust, may never be accepted in full. Monitor would have to decide if the Trust was a risky proposition and – if so – whether it was an acceptable risk.

The Chairman reminded the Board of its conviction that Foundation Trust was the best means of achieving the Trust's goals, but recognised that the history of the application and ongoing R&D funding challenges added new dimensions to the decision.

The Chairman asked each Board member whether they wished to take the decision to reactivate the application on the basis of the paper's content and the subsequent discussion. Board members were unanimous in their decision to reactivate the application.

It was agreed that the Trust must do everything possible to demonstrate to Monitor efforts made to bridge the funding gap; provide evidence and further third-party support; and show that the infrastructure was in place to secure research funding. A new clinical structure was in place, a new research strategy would be in place in the autumn; income for clinical services was growing services, as was demand.

The Chairman confirmed that the Board had unanimously decided to reactivate the application for FT status and instructed that Monitor be informed of this decision.

2008/75 HAREFIELD STRATEGIC OUTLINE CASE (SOC)

Mr Patrick Mitchell, Director of Operations, introduced the SOC and notified the Board that Mr Steve Wrigley-Howe of *Care Consulting* (who had helped develop the document) was in the audience.

Mr Mitchell reminded the Board that the SOC had been the responsibility of the Harefield Redevelopment Oversight Board, which he chaired. The SOC provided an overview of the current services provided, the requirement for an in-patient facilities re-build, the national and local strategic context, the services and facilities required, options for delivering these facilities, and an assessment of funding and affordability. Options were assessed and short-listed to two proposed to be taken forward to Outline Business Case stage: either to partially re-build facilities at HH, or totally rebuild at Mount Vernon. Encouragement had been received from Commissioners, who (together with the SHAs and London) had now recognised the need for a cardiothoracic centre in NW London. This was a positive change from previous positions. The Chairman also felt the SHA now recognised Harefield as an important and valuable institution and that the primary angioplasty service had furthered this status.

The case for change was based on the health and safety of the plant at HH, the expectations of our Commissioners and patients, and the suitability and flexibility of our facilities for delivering services. Work on affordability showed that the cost of a re-build at HH would cost £48m-£51m, and for re-build at Mount Vernon £95m- £101m (the latter

being double because the build would be twice the size of the HH build). The figures were fully inclusive, including VAT, and were considered affordable in view of potential sale of Trust assets. Mr Lambert confirmed that the HH rebuild cost was within the Trust's notified prudential borrowing limits. Work on the projected costs had been undertaken by *Cyril Sweett* (Quantity Surveyors) and Mr Lambert had confidence in their work. It was noted that Commissioners had said their ideal was to see HH services co-located with other services. The Chairman felt this indicated that a full re-build at HH would be ruled out on the grounds that the Commissioners would not support this as a long-term solution. Mr Mitchell confirmed the Trust continued to maintain dialogue with Specialist Commissioners in all three areas and that there was an issue with long-term development of a specialist trust on its own site. However, this type of support to the HH site had improved in the last three years, and had been confirmed by audit. It was felt these commissioners would prefer long-term to see a co-location operation but would give support to a medium-term option if it were affordable and deliverable.

Mr Mitchell said the Commissioners genuinely wished to find a solution to this long-standing situation. Mrs Jenny Hill (Non-Executive Director) recommended strengthening references in the SOC to the long-standing issues and historic lack of solutions.

At this juncture, Mr Mitchell requested the Board's approval of the SOC for submission to the SHA to request leave to proceed to OBC on this proposal. He confirmed that the SOC did not require a decision between the HH or Mount Vernon options - both could be taken forward for evaluation at OBC stage.

The Chief Executive did not believe the Board was being sufficiently clear in its proposals. This was the second time the Board had gone through this exercise in less than two years - the Board's stand must be clear. Past evidence suggested that, unless the Trust made a decision, nothing seemed to happen. In reviewing the FT application, Monitor would want an answer on this item i.e. whether redevelopment of HH was the Board's aim and whether it was affordable. The fact remained that building facilities at HH were not fit for purpose, the Board had a responsibility to deliver services to patients in an appropriate environment and firm plans to address that requirement were needed. The Chairman and Chief Executive both asked colleagues to consider what decision would be taken if the Trust were already an FT.

Mr Craig reminded the Board that its current, adopted position was to favour a partial rebuild of HH – this was what had been included and modelled in the IBP. If, in the light of further analysis, an attractive and feasible alternative emerged, the Board could review its decision.

The Chairman asked the Board to consider the options. Prof Evans repeated his view that, ideally, clinicians would prefer new facilities on a larger campus that could still serve current markets, but were wary of grandiose schemes which consumed time, effort and money but were not delivered. If redevelopment at Mount Vernon were feasible and affordable within 3 years, it would be his preference. If not, redevelopment at Harefield was essential. Other Board members felt that further analysis (at OBC stage) might favour the Mt Vernon site but, at this stage, there was insufficient information to revise the Board's view.

The Chief Executive repeated his belief that services were being delivered in inadequate facilities at HH and a decision needed to be taken on its future. He agreed that the ideal solution would be to build at another site with related services, but he had to be realistic and pragmatic. The Trust had a responsibility to provide appropriate services and he felt that the only plausible option on the evidence available was to redevelop inpatient facilities on the Harefield site.

The Chairman felt the Board was broadly in agreement to continue with the existing IBP proposal, although recognising it was not immutable, and would therefore proceed on that basis.

From the floor, Mr David Potter wished to enter a plea as a representative of the ReBeat patient group and as a member of Heart of Harefield that the Trust should not 'chase visions' but practise what was achievable – 8 years had already elapsed since the Paddington vision had been adopted. Mr Dennis Gulliford (Secretary – Rebeat) asked if it would be possible for the Trust to change its mind on any decision taken now once it had achieved FT status. He felt the position with Mount Vernon was by no means constant, with two other Trusts being involved in that site already. The Chairman said the Trust could not go disingenuously to Monitor, but Mr Craig said a five-year plan would always be subject to change and further iterations as new information arrived.

2008/76 PATIENT SAFETY – OUR PRIORITY

Dr Caroline Shuldham, Director of Nursing & Governance, introduced the report. She explained that a lot of work had been undertaken on risk management, events and incidents, and the proposal now was that the organisation should focus on patient safety and develop into a High Reliability Organisation (HRO). The report outlined the key attributes of an HRO which encompass working to a high level of safety, anticipation and prevention of failure, effective communication between staff, education and learning from events, etc., thus ensuring that patient safety is the responsibility of every member of staff.

Dr Shuldham continued that the Trust was participating in the National Safety Campaign and the Leading Improvement in Patient Safety (LIPS) initiative run by the NHS Institute for Innovation and Improvement. Some Board members had attended a patient safety improvement workshop and one of the main objectives which emerged was that the Board should be closely involved in developments. The aspiration was to change the way we look at patients in our care and try to maintain a focus on patients and patient safety.
In order to achieve this, the following objectives had been suggested:

- zero tolerance of infection, e.g. MRSA, C.difficile and VRE
- elimination of cancellations in theatre or catheter labs (in the first year reduce by 50%)
- use of information in a more constructive way
- patient safety as a key focus when we improve our facilities and environments

Dr Shuldham requested the Board's full support and continuing endorsement for this initiative to make patient safety its number one priority.

Mrs Hill offered her wholehearted support. She suggested that patient safety should be a permanent item on the Board's agenda in order to take this forward.

In response to the Chairman's question, Dr Shuldham confirmed that the first-year cancellation target was challenging but informed. Mr Mitchell reported that, from the beginning of August new arrangements would be in place to bring the level of cancellations down. The Chief Executive emphasised that cancellations were a patient safety issue and there could be no compromise on this objective.

The Board endorsed the initiative.

2008/77 PATIENT AND PUBLIC INVOVLEMENT STATEGY 2008-2011

Rachel Matthews, Senior Nurse – User Involvement, presented the proposed Patient and Public Involvement (PPI) Strategy for 2008 -2011. She informed the Board that progress had been made with PPI since 2006 and that the new strategy was timely given the focus that the NHS Next Stage Review (Darzi Report) would place on the experience of patients

and the quality of care they receive.

The new strategy will place particular emphasis on local ownership for PPI across the organisation by individuals and teams. This would require staff to build and maintain ongoing, constructive, relationships with patients, relatives and representatives of the community and the voluntary sector. The plans for 2008 – 2011 also highlighted the need to demonstrate better how patients and the public actively influence the Trust's activities and how this brings benefits for all patients.

Mrs Hill congratulated Ms Matthews on an excellent report. She felt that patient involvement needed to be linked to the right areas and that the plan needed to be an integral part of everything the Trust is involved in. Until now PPI had been an end, not a means, and now needs to become a means to an end.

Mr P Mitchell confirmed that PPI was integral to the equality and diversity programme and development of the work of the Trust. Mrs Christina Croft, Non-Executive Director, agreed that it was an excellent plan and reinforced issues that had been discussed at the Tanaka Business School course. More attention should be paid to valuing patients' time and designing services around their needs.

On behalf of the Board, the Chairman endorsed the strategy and thanked Ms Matthews for all her work involved in the production of the plan.

2008/78 RECOMMENDATIONS OF ADVISORY APPOINTMENTS COMMITTEE

The Board received the recommendation for the appointment of Dr Rebecca Lane as Consultant in Invasive & Interventional Cardiology at Harefield Hospital. The appointment was approved.

2008/79 FINANCIAL PERFORMANCE REPORT FOR MONTH 3: JUNE 2008

Mr Lambert reported that for Month 3 (June 2008) the Trust had made a surplus of £547k, with a year-to-date surplus of £834k. This represents a favourable variance of £262k against budget. Mr Lambert reported that the Trust still awaited its 'control total' for the current year to be set by NHS London. He continued that the Trust was effectively earning its way to this positive variance. The financial stability plan was showing a minor negative variance which he is assured will be recovered.

The Chairman referred to the red indicator for the Risk Rating metric for Return on Assets. Mr Lambert explained that the budget was slightly 'back-ended' and was delivering a rating of 3 overall (which was the minimum requirement for FT approval). He said he would check this indicator but felt the Return on Assets rating would certainly recover.

The Chairman referred to the increasing level of Bank and Agency expenditure. Mr Lambert explained that these related to increased nursing costs – the Trust had increased its income through higher levels of activity and consequently higher levels of temporary staff. It was noted also that specialist nurse agencies were currently increasing their rates. Prof Evans said that if the current level of capacity was to be sustained, this would lead to an expansion of support staff posts. Mr Mitchell confirmed that bank staff were used in preference to agency staff where possible.

Mr Nick Coleman, Non-Executive Director, again enquired about the delivery of the capital programme. As Chair of the Capital Working Group, Mr Mitchell confirmed that resources were available but not all schemes were yet operational. Mr Coleman felt that a quarter of capital should be spent in the first quarter of the financial year but that there was no sign of this happening yet – the Board needed some assurance that this would recover. Mr Mitchell replied that the Trust often spent the majority of its capital in the latter half of the year, but thought this might be advanced this year because some elements of the plan

were already in place from prior years. Mr Mitchell said the Capital Working Group would be able to report to the Board on its spending schedule.

2008/80 OPERATIONAL PERFORMANCE REPORT FOR MONTH 3: JUNE 2008

Mr Lambert introduced the operational report for Month 3, and highlighted the following items:

- Cancelled Operations. The M3 cumulative cancellation rate was 1.48% and if this trajectory continued, the Trust would underachieve on this indicator (but see minute 2008/76 above)
- Workforce – Sickness Absence. The rate continued to rise (albeit very gradually) and further analysis would be undertaken. The newly appointed HR Director would address the issue on commencing with the Trust from 11 August.
- Rate for MRSA Bacteraemia. No cases were reported in June – and there had now been no cases in the 9 months since October 2007.
- 18 Week Wait. Mr Mitchell reported that indications were, for admitted care, the Trust was achieving 72% against a target of 85% and, for non-admitted care, 89% against a target of 90%. Following a huge amount of process improvement, waiting times had been reduced. The area of concern was Cardiac Surgery and focus was now centred on this area to improve by December, together with management of referrals on the 18-week pathway and how to target trusts to refer much sooner. The Trust had 74 different organisations referring patients and was now focusing on the main referring Trusts to encourage improvement. Mrs Davies, Head of Modernisation, would be working with Mr Mitchell on the 18-week initiative, and reported that the experiences of Papworth and Liverpool Hospitals would be sought.

2008/81 Q1 PROVIDER AGENCY RETURN

Mr Lambert presented the quarterly report to the Board for approval and to be signed by the Chairman and Chief Executive for submission to NHS London Provider Agency. The papers included the Monitoring Self Certification document, a spreadsheet of healthcare standards and targets, and a Commentary on the Return (an amended version was distributed to the Board).

The return was accepted by the Board for signature by the Chairman and the Chief Executive

2008/82 INFECTION PREVENTION & CONTROL ANNUAL REPORT

Dr Anne Hall, Director of Infection Prevention & Control, presented her report. She explained that the activity and duties of the Infection Prevention & Control Team were laid out in the Health Act 2006 and detailed in the Report.

Dr Hall said it had been a very challenging year for infection control at both a national and local level, encompassing stringent targets e.g. for the reduction of MRSA. The Trust's target (5 cases) was very low and the Trust had achieved an extremely good level – the best in the country by HCC measures. She explained that as a tertiary centre, the Trust often received patients already infected with MRSA. There was also increased awareness in the media and public arena of other infections, notably C Difficile and VRE.

The Trust was currently awaiting the HCC "spot-check" inspection between August and October when an assessment would be undertaken of the organisation's arrangements for prevention and control of healthcare-associated infections.

There had been a number of changes within the staffing of the Team during the year, but Dr Hall was confident of its ability to maintain high standards. Mr Coleman asked if this had caused instability or hindered progress. Dr Hall acknowledged that levels of education and checking of compliance with protocols had suffered at times, as the team had worked very

hard to ensure patients were not put at risk and e.g. updating policies was deferred in order to deal with direct patient care.

Dr Hall thanked the Board for its support of the Infection Control Service and specifically thanked Dr Shuldham and the Head of Performance (Mr Connett) for their assistance. Dr Hall requested the Board's continued support to ensure full implementation of the Health Act 2006 and that the Report be noted and the future programme agreed, these being duties under the Health Act 2006.

Mrs Hill asked if there was anything the Board could do to better support the service. Dr Hall replied that the Board could assist by encouraging clinical and non-clinical staff to make compliance with the Health Act a priority. She went on to highlight the focus on the forthcoming 'spot-check' inspection. Dr Shuldham reported that awareness needed to be increased and no area should be complacent. In preparation for the inspection, internal 'spot checks' were being implemented around the hospital and Board members were invited to attend if they wished – dates would be circulated confidentially.

The Chairman assured Dr Hall that she and her team had the full support of the Board and registered the Board's thanks for all the work undertaken, both to produce the Annual Plan and throughout the Trust.

2008/83 QUESTIONS FROM MEMBERS OF THE PUBLIC

Mr Don Chapman (League of Friends) asked for details of recycling within the Trust. Ms Maria Cabrelli, Director of Estates & Facilities, agreed to provide Mr Chapman with an update on this issue. The Chairman also requested a brief report on recycling be submitted to a future Board meeting.

Mr Dennis Gulliford referred to the Trust accounts for the previous year, and the potential for Directors to be judged to have failed in securing a healthier result than expected. He felt that in the commercial world a profit would have been welcomed. The Chairman agreed that it was puzzling. Mr Lambert commented that although the Trust had reported a healthy surplus of approximately £3.5m for 2007/08, this had overshot the £2.3m control target, breaching NHS London's requirements. The Chief Executive further reported that the debate with NHS London and auditors over the year-end accounts might also have a detrimental effect on the Trust's overall performance rating for 2007/08, despite it being out of the Trust's control. Mr Lambert indicated that the Trust would raise its objections if this proved to be the case.

2008/84 DATE OF NEXT MEETING

Wednesday 24 September 2008 at 2.00 pm in the Board Room, Royal Brompton Hospital.