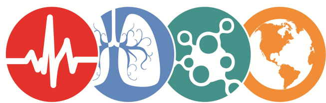

Royal Brompton & Harefield NHS
NHS Foundation Trust

Minutes of the Board of Directors meeting held on 23rd July 2014 in the Boardroom, Royal Brompton Hospital, commencing at 2 pm

Present:	Sir Robert Finch, Chairman	SRF
	Mr Neil Lerner, Deputy Chairman & Non-Executive Director	NL
	Mr Robert Bell, Chief Executive	BB
	Pr Timothy Evans, Medical Director & Deputy Chief Executive	TE
	Mr Robert Craig, Chief Operating Officer	RCr
	Mr Richard Paterson, Associate Chief Executive - Finance	RP
	Mr Nick Hunt, Director of Service Development	NH
	Mr Richard Hunting, Non-Executive Director	RH
	Mr Andrew Vallance-Owen, Non-Executive Director	AVO
	Mrs Lesley-Anne Alexander, Non-Executive Director	LAA
	Mr Richard Jones, Non-Executive Director	RJ
	Mr Richard Connett, Director of Performance & Trust Secretary	RCo
By Invitation:	Ms Carol Johnson, Director of Human Resources	CJ
	Mr David Shrimpton, Private Patients Managing Director	DS
	Ms Sian Carter, Interim Director of Communications & Public Affairs	SC
In Attendance:	Mr Anthony Lumley, Corporate Governance Manager (minutes)	AL
	Ms Gill Raikes, CEO, The Royal Brompton & Harefield Hospitals Charity	GR
Apologies:	Pr Kim Fox, Professor of Clinical Cardiology	KF
	Ms Kate Owen, Non-Executive Director	KO
	Dr Caroline Shuldham, Director of Nursing & Clinical Governance	CS

2014/58 DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING

None.

2014/59 MINUTES OF THE PREVIOUS MEETING HELD ON 21 MAY 2014

The minutes were approved.

2014/60 NOMINATIONS AND REMUNERATION COMMITTEE OF THE TRUST BOARD

SRF recommended that Mr Nick Hunt be appointed as an executive director and member of the Board. This was approved.

2014/61 REPORT FROM THE CHIEF EXECUTIVE

Report – Improving NHS Care

BB tabled copies of the King's Fund study *Improving NHS Care by Engaging Staff and Devolving Decision-Making*. This was launched at an event he had attended on the 15 July 2014 hosted by two government ministers of state and a former minister of the previous government. The report argued for the greater mutualisation of NHS organisations. The

Foundation Trust (FT) hospital model was one form of evolution and the next stage was greater independence and community ownership taking on responsibility for what was historically an NHS Trust. An illustration in the report had shown the Royal Brompton & Harefield Foundation Trust (RB&HFT) as having the fifth highest score for staff engagement amongst all FTs and NHS Trusts. The graph also showed the tenures of CEOs for the twenty highest-scoring Trusts and, as it appeared that the longer a CEO served the higher the score, the review advocated more organisational stability and advanced this model as one to emulate. BB said he surprised to read that the average tenure of a Trust CEO was less than two years.

Chelsea & Westminster (C&W) Collaboration
BB said a date had been set for the Board-to-Board (10 September 2014) but C&W's CEO had informed him that he could not make it and so wished to change the date.

In response from a question from NL as to whether this was an administrative problem SRF said this was the case.

Chelsea Campus Redevelopment
BB reported that a planned meeting for the 16 June 2014 between NHS England (NHSE) and the Royal Marsden Hospital (RMH) and the Trust had not taken place. It had been agreed that NHSE would draft the Terms of Reference (ToR) for a review of the Trust's redevelopment plans. He had seen RMH's response to the Terms of Reference and the Trust would respond to their commentary. RMH had a different take on the path the review would follow and this would mean it could go to September 2015. BB said this was unacceptable. He therefore remained sceptical and doubtful that the review would be concluded by September this year but he would keep Board members updated.

2014/62 CLINICAL QUALITY REPORT FOR MONTH 3: MAY 2014

Tabling a re-issued paper, RCo said the highlights were.
Monitor Risk Assessment Framework

- *Clostridium difficile*: 4 cases in M3 reported to Public Health England. All 4 cases had been reviewed with NHSE and only 1 was adjudged to be have been caused by a lapse in care at the Trust which meant that only this single case counted against Monitor's de minimis threshold of 12. The target for Q1 had therefore been met. NL commented that this was a triumph for common sense (i.e. as a result of applying the new review process of all reported cases). RCo said he wished to record his thanks to Sally Kingsland at NHSE who had been instrumental in setting up this process. In response to a query from RP he confirmed that only lapses for 2014/15 were recorded so a proper comparison (a baseline) could not be made with the previous year.

- 62-Day Cancer target: Monitor and NHSE had withdrawn the additional 6% tolerance previously agreed with CQC. Therefore the threshold for achievement of this target is now 85%. Taking account of breach allocations confirmed up to 23 July 2014, performance for Q1 was 81.82%, still short of the threshold for compliance. RCo said he was in contact with West Hertfordshire NHS Trust about two outstanding reallocation requests and had asked if they could let the Trust know asap if they agreed. If both of these were reallocated the score would be 86.6% and the target would be met (and which would alter the Governance declaration - See minute 2014/64 below). [Note to the minute: RCo received an email from West Hertfordshire NHS Trust during the course of the Board meeting. This confirmed that reallocation of the 2 breaches was accepted by West Hertfordshire NHS Trust. The target was therefore met for Q1.]
- Care Quality Commission (CQC) – Intelligent Monitoring (IM): The Trust had received a letter from CQC on 18 July 2014 in which they notified the Trust that it would be move to band 3 from band 5 when the IM report is published on 24th July 2014. When the IM report had originally been sent to the Trust, pre-publication, the banding had been 3. Since then CQC had included an additional indicator, cancelled operations, and this had triggered the change in banding to one indicating higher risk. The other alerts which had triggered were:
  - Central Alerting System; because an alert relating to infusion pumps had not been closed by the deadline – replacement pumps were currently being identified and the alert would be closed once these had been procured.
  - IM mortality section; where there were 2 triggers, one for in hospital mortality for cardiological conditions, and a second for mortality associated with congestive heart failure. The second of these has been investigated and nothing untoward in the quality of care had been identified and the alert has been closed by the CQC. The first alert is the subject of continued investigation, the outcome of which will be reported to the G&Q Committee and the Risk and Safety Committee.

RCr sought to clarify whether CQC would look at the performance of a later period when they assessed the indicator next time. RCo said this was correct. RJ asked what the Trust's expectations were for this later period and the actions it would take? Cancellation nos. for the later period were lower, but RCo cautioned that while this indicator may be removed as a risk, there was the chance that other indicators, for example Never Events, could trigger risks and affect the rating. RJ said that while a 5 rating had been 'good', a 3 was 'disappointing'. AVO said the Risk and Safety Committee (RSC) had been looking at the things being done to address these issues.

RCr pointed out an error in the text (page 6, 2nd para) which should read 'CQC uses the banding … to prioritise inspection' and not 'Monitor uses ...'. RCo said he would amend the report.

Key Performance Indicators

- Incidents - Safety SI's (Serious Incidents): an outbreak of norovirus had occurred in June and there had been one SI in the same month (classified as a Never Event (NE) when a patient had left theatre with a retained swab). AVO emphasised that, as reported to RSC, this had been done deliberately in order to perform an x-ray and then return the patient to theatre; during this move the patient was not awake and there were no adverse consequences. It was only because the patient left theatre with the swab in situ that it automatically became a NE. (NL pointed out a typing error at 2.5.1, page 7 – should have been one SI in '2014' not '2013'. RCo said this would be corrected).
- Radiation Safety Incidents: two incidents. RJ asked if these were picked up by the RSC and were lessons learnt consequently? AVO confirmed that they were included in a written report and learning was included and was indeed focused on in some detail. NL concurred with this comment.

Standard Contract:

- *Clostridium difficile*: this was now reported under the NHS Standard Contract in addition to the Monitor Risk Assessment Framework. One lapse of care as reported under Compliance Framework.
- Cancelled operations – Breaches of the 28-day readmission guarantee: RCo said this required further validation work. There had been 3 breaches in April (M1), 3 in May (M2), none in June (M3), i.e. a total of 6 in the 1st quarter. Year-to-date there had been 147 cancelled operations, compared with 205 in the previous quarter - a substantial reduction. NL said he noted this improvement but said the graph showing Cancelled Admissions and Operations as % of completed surgical spells was disappointing as there now appeared to be an 'up–tick' again. RCr acknowledged that, following recent improvements, the June total was disappointing, with particular pressures at RBH, but that the previous issues at HH had reduced significantly.
- The 18 Weeks Referral to Treatment (RTT) 'Admitted' and 'Non Admitted': RCo highlighted the graph in the report which illustrated that number of breaches was dropping and stabilising. The target continued to be met at the aggregate level (which is Monitor's requirement) but not at the level of all individual specialties (i.e. Admitted – National Speciality Other; Non Admitted – National Speciality Other, National Speciality Cardiology' and Incomplete Pathways Other) but this was to do with bringing the patient in for operations. RJ asked what the ramifications of not meeting the target would be? RCo said there were currently monthly review group meetings with commissioners and it would be discussed then. NH added that the strict contractual position was that the Trust could be fined. However, nationally there was money to tackle long waits and cancellations. The Trust had recently been successful in a bid for £900k to address waiting list work so it would not be logical for

(NHSE) to have given RB&HFT funds to address this but then want to take the money away by issuing fines. If fines were levied, the Trust would contest this strongly.

FFT (Friends and Family Test) Results.

- RCo highlighted that most improved wards in M3 were the lowest performing ones. NL asked what might be done to congratulate these wards? BB said there was no need to do this as this was a standard that they should be expected to achieve. NL pointed out that for some of the wards in poorer physical condition this work had been challenging but acknowledged BB's point that this was not a Board matter. SRF suggested that it was recorded that the Board noted the hard work of the wards and this was agreed.

The Board noted the report.

2014/63 FINANCIAL PERFORMANCE REPORT FOR MONTH 03: MAY 2014

RP highlighted the following performance in M03:

- I&E account: M03 was a better month. A break-even result had been recorded and the underlying performance was on plan. However, as a result of 'one off' items, the Trust was reporting an overall surplus of £400k for the month. At 31 March 2014 the Trust had overprovided by £200k the fines for failing to achieve the *Clostridium difficile* target; with the benefit of hindsight the Trust had also been conservative in valuing work in progress at the same date leading to the recognition in M03 of £300k of over performance relating to 2013/14. RP added that further unbudgeted over performance 2013/14 income would be recognised in July 2014 once received. There was a cumulative deficit of £2.2m for Q1 which was somewhat worse than budget (£1.7m deficit).
- Balance sheet cash: this was below plan, albeit better than Monitor's 10 days OPEX target, principally because NHSE and CCGs still owed the Trust over-performance monies from 2013/14. RP said he had been assured only yesterday (22 July 2014) that £3m of the £5m concerned, mainly from NHSE, was 'in transit'.
- Working Capital Facility: this had not been used to date but the Trust was intending to renew the facility in September 2014.
- CAPEX (capital spend): short of Monitor's 15% tolerance by about £0.5m. This would trigger a CAPEX reforecast in the Q1 submission for the remaining three quarters of the year.
- Continuity of Service (CoS) rating: the Trust would be reporting a (satisfactory) 3 rating at the end of July 2014 which would still have been achieved even with the absence of the one-off items he had referred to earlier. RP recommended that the Board make the required quarterly declaration that a CoS risk rating of 3 would be maintained by the Trust for the next twelve months (see Agenda item 2014/xx)
- Looking ahead: Some schemes within the Financial Stability Plan (FSP) for the current financial year were 'back-end loaded'. RP also highlighted

that, owing to a change of targeted premises, the contribution of £0.5m from Wimpole Street private practice would not be received in 2014/15.

- Project Diamond (PD): RP said he continued working with the Trust's PD peer group and *Ernst & Young:* they would be pushing for at least the transitional element of PD funding to be paid by NHSE. In his and the other PD Trusts' view, NHSE was confusing volumes with prices as the cause of specialist commissioning overruns.

The Board noted the report.

2014/64 REPORT ON NURSE STAFFING

RCr presented the report on behalf of CS. The first Nurse Staffing Report had been presented to the Board in May 2014, but this report was slightly different and in two parts. The first part was the (first) six-monthly Ward Nursing Establishment Review; the second part (Nurse Staffing Report April & May 2014) was a follow-up to the report received in May. It was proposed that, in future, this part would be incorporated into the Clinical Quality Report.

RCr said the main feature of the Ward Nursing Establishment Review was the Safer Nursing Care Tool used to review establishments in all areas bar paediatrics, which had used a Royal College of Nursing (RCN) tool more appropriate to children's services. There had been some inconsistencies of approach and some teething problems which were alluded to in the report. NL asked if the nine 'expectations' in the introduction had been addressed? RCr said in theory this was correct though no single audit tool would have allowed more accurate and robust answers. NL then asked if he was assured that CS's team had exercised judgement and documented the process sufficiently? RCr said CS and her team had certainly been satisfied that the staffing levels were correct but he did not know how clearly documented the tool's use had been. RCr offered to follow up the point and report back.

Action: RCr to follow up documentation of the audit tool.

RCr continued his summary of the first report and noted the nursing skill-mix was much richer for our Trust than most benchmarks. RCr pointed out that there were good reasons for this but it was a matter of judgement and debate.

NL referred again to the 'expectations' section and the Trust's responses. While this was useful he wondered if not all the responses clearly addressed the expectations. For example: what did the response to number 4 - 'Identified as part of the Nursing Strategy' – mean?; and the answer to expectation 6 referred to 'internal courses' but it was not clear if Trust staff had sufficient time to attend these. RCr replied that i) the expectation was being addressed through the Trust's Nursing Strategy; and ii) the Trust did have some challenges in relation to attendance on e.g. mandatory training courses, but this reference was more about professional development. He

suggested that cross-referencing the staff survey may have been a better response. AVO added that the Risk and Safety Committee had looked at the staff survey and noted that the score for 'stress' was the best result. This could be fed into this report. CJ agreed and said for training and development the Trust consistently showed a high score.

NL said asked how 'Boards receive monthly update' was defined – did it mean the Board literally received reports each month (which had not been happening*)* or, as and when reports came to the Board, they set out performance by month? RCr replied that he interpreted the guidance as requiring the Board to look at the most recent monthly information at every meeting – that is it should be looking at the 'current staffing levels' report monthly. NL then asked how practically this would be achieved? RCo replied that the establishment paper was the first of its kind. The 'current staffing levels' would now be presented monthly in the same way the FFT dashboard was produced and then included in Board papers. The principle was that it was brought to the Board in the monthly performance report (Clinical Quality Report).

NL asked what 'values-based recruitment' (as had been written in response to expectation no. 9) meant? RCr explained that recruitment was not focused solely on candidates' skills and experience, but also on 'softer' characteristics such as attitude, empathy and ethos. NL said this reply was very helpful.

RCr concluded the Nurse Staffing report by summarising the second paper on current staffing levels ('Nurse Staffing'). This included tables that now appeared on NHS Choices website. The data had been in the public domain since early July but, as yet, there had had been no reaction from members of the public or the media. AVO said that he felt that the comments in the tables did adequately explain why there were shortages where these occurred, and that no unreasonable explanations had been given. RCr said the report was the result of a joint effort from the Operations and Nursing teams, and this would continue.

2014/65 FRIENDS AND FAMILY TEST FOR STAFF

Introducing the report, CJ said it reinforced BB's earlier points about staff engagement. RB&HFT compared well with the rest of the country but one Trust had scored higher. She would be following up with that Trust to ask how they were doing that. CJ added (in response to a query from SRF) that while 100% would have been good she could indeed be described as being satisfied. NL acknowledged that the comments from staff were very good but suggested that while it was not necessary to have the same numbers of 'negative' comments as well as good, perhaps one or two could be quoted to show balance and demonstrate that the Board was not being fed good news to "pat themselves on the back". This was agreed.

2014/66 AUDIT COMMITTEE (AC)

(i) REPORT FROM MEETING HELD ON 15 JULY 2014

NL said this was a brief verbal update as he had not seen the draft minutes as yet. The committee had received the usual update from the Trust's Internal Auditors. This had included a piece of work on Monitor's Provider Licence (which was satisfactory); benchmarking assumptions behind the 2 year plans submitted to Monitor provided interesting comparisons with other positions taken by other FTs which was something to be borne in mind. The AC had also received a report from the Counter Fraud expert and reviewed the Fraud Awareness Survey. This suggested there was still work to do to raise awareness of the risk of fraud in the Trust. Finally the appointment of External Auditors: after tendering and the invitation for bids just two firms had responded. It had been recommended to the AC, who then recommended to the Governors, that the appointment of Deloitte be approved. The Governors duly agreed to this at their Annual General Meeting held on Monday 21 July 2014.

(i) MINUTES FROM THE MEETING HELD ON 20 MAY 2014
The minutes were noted.

2014/67 RISK & SAFETY COMMITTEE (RSC)

(i) REPORT FROM MEETING HELD ON 15 JULY 2014
AVO gave an oral update. The committee had considered the CQC IM rating, in particular the cardiology indicator in the mortality section and the congestive heart failure issue. The cardiology indicator had been discussed in the previous meeting (see note below) and the figures had improved. A majority of the congestive heart patients had co-morbidities and many had been admitted for 'end of life' care which clearly had an impact on the mortality figures.

RH commented that there had previously been an issue with Dr Foster in connection with cardiology mortality in PCI (Percutaneous Coronary Intervention). TE noted that it was difficult to reconcile the concerns raised by Dr Foster with the returns made to BCIS (the British Cardiovascular Intervention Society). However, he went on to reassure Board members that, if the figures continued to trigger an alert, the Trust would come back to review this area all over again.

AVO said that a review of cancer services at Harefield had been undertaken. This review had taken a broad look at the underlying position and had concluded that many of the problems were due to issues further 'upstream' in the pathway (e.g. delayed referral), but that there were also some issues within the Trust which needed to be considered. Strategic recommendations would be brought to the RSC. Operational issues would be considered by the Management Committee.

AVO concluded his summary by reporting that the RSC had looked in detail at the patient survey. It had noted that feedback facilities had improved, but there was still more to be done around communication with patients by clinicians. This was useful feedback which would be acted on.

(i) MINUTES FROM THE MEETING HELD ON 28 APRIL 2014

The minutes were for noting only but AVO referred to the Action Point on the cardiology mortality figures. There had been a major review of the HH cardiology mortality figures which had been initiated right at the beginning of the alert. This was again discussed at the clinical governance meeting at HH which AVO had attended. It was confirmed there that, once the ambulance was logged as heading for HH. even a death before arrival would always be ascribed to the HH figure. In spite of that, the Trust's figures had improved significantly since the initial alert.

The minutes were noted.

2014/68 REVALIDATION ANNUAL REPORT 2013/14 STATEMENT OF COMPLIANCE

TE presented the report and drew Board members attention to four actions: firstly, the on-line quarterly template (this had been done); secondly, the submission of an Annual Report to the Board (i.e. this report itself); thirdly, signed statement of compliance (which BB as the Trust's CEO would sign after this meeting); and fourthly, independent review by KPMG (internal auditors) which the Trust had passed.

It was agreed that BB would sign the statement of compliance.

2014/69 Q1 MONITOR DECLARATIONS 2014/15: (i) GOVERNANCE DECLARATION (ii) CONTINUITY OF SERVICE (CoS) RATING

RCo presented Paper H. The Board agreed that the following governance statements are made:

For Finance, that the board anticipates that the trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months.

For Governance, that the board confirms that that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework page 22, Diagram 6) which have not already been reported.

Consolidated subsidiaries: Number of subsidiaries included in the finances of this return = 0 (zero).

Action: Upload declarations to the MARS portal before 4pm Friday 31st July 2014 to ensure compliance with Monitors' reporting requirements.

2014/70 RECOMMENDATIONS OF ADVISORY APPOINTMENTS COMMITTEE

The Board was presented with one ratification form by RJ for the appointment of two Consultants in Critical Care Medicine and Cardiothoracic Anaesthesia (RBH); and one ratification form by RH for the appointment of a Consultant in Adult and Paediatric Cardiothoracic Anaesthesia (RBH). RH said his panel had interviewed two candidates.

They had unanimously agreed to appoint one of these but had offered a locum position to the other candidate.

The Board ratified the appointment of:

- Dr Mary White as Consultant in Critical Care Medicine and Cardiothoracic Anaesthesia (RBH);
- Dr Sachin Shah as Consultant in Critical Care Medicine and Cardiothoracic Anaesthesia (RBH) and;
- Dr Cathy O'Donoghue as Consultant in Adult and Paediatric Cardiothoracic Anaesthesia (RBH).

2014/71 QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions from members of the public.

NEXT MEETING Wednesday 24th September 2014 at 10 30 am in the Concert Hall, Harefield Hospital