Royal Brompton & Harefield NHS
NHS Foundation Trust

Minutes of the Board of Directors meeting held on 24th November 2010 in the Concert Hall, Harefield Hospital, commencing at 10.30 a.m.

Present: 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
Professor T Evans, Medical Director
Mrs J Hill, Senior Independent Director (Acting Chair)
Mr R Hunting, Non-Executive Director
Mr N Lerner, Non-Executive Director
Professor Sir Anthony Newman Taylor, Non-Executive Director
Ms Kate Owen, Non-Executive Director
Dr C Shuldham, Director of Nursing & Clinical Governance

By Invitation: Ms J Axon, Director of Capital Projects & Development
Mr N Hunt, Director of Service Development
Mrs C Johnson, Director of Human Resources
Mr Rod Morgan, Chief Accountant
Mr D Shrimpton, Private Patients Managing Director
Ms J Thomas, Director of Communications
Ms J Walton, Director of Fundraising

In Attendance: Mrs R Paton (minutes)

Apologies: Sir Robert Finch – Chairman, Mr M Lambert – Director of Finance & Performance, Mr P McCleery – Director of Planning & Strategy

In the absence of Sir Robert Finch, Mrs Jenny Hill, Senior Independent Director, chaired the meeting. Mrs Hill welcomed everyone to the meeting and offered the Board's congratulations to Professor Sir Anthony Newman Taylor on his appointment as Principal of the Medical Faculty of Imperial College.

2010/98 MINUTES OF THE PREVIOUS MEETING HELD ON 27th OCTOBER 2010

Mr N Coleman, Non-Executive Director, felt that minute 2010/94 Risk & Safety Committee Report from Meeting of 19th October 2010, did not accurately reflect what he had said. Mr Coleman will liaise with the Trust Secretary and Head of Performance to revise the wording. With this amendment the minutes were approved by the Board.

2010/99 REPORT FROM THE CHIEF EXECUTIVE

Mr R Bell, Chief Executive, reported to the Board on the following:

- **NWL Strategic Commissioning Intentions**

The Chief Executive and Mr N Hunt, Director of Service Development, had attended a meeting on 22 November hosted by NHS North West London, at which the strategic commissioning intentions for the next 4 years were presented. This Trust was now considered to be part of a sub-section of the Sector known as the Inner NW London Cluster. The new Cluster comprises Kensington & Chelsea PCT, Westminster PCT, Hammersmith & Fulham PCT, Central London Community Health Services, Chelsea and Westminster FT, The Royal Marsden FT, RB&HFT, and Imperial College Healthcare NHS Trust. NHS North West London is facing a

£1bn financial gap over the next 4 years and is expecting healthcare providers to reduce activity to help close this. At this juncture Mr Hunt circulated a briefing note on the Sector's draft commissioning intentions to address the deficit, up to and including 2014/15. The proposal is to take the bulk of this money from acute care, principally through a reduction in acute activity, especially in non-elective in-patient and follow-up out-patient activity.

If this proposal was implemented it would have the effect on this Trust of a 12% reduction in income from a 48% reduction in activity. Mr Hunt said that there was a chance that these proposals would be taken up in contract negotiations for 2011/2012. He also reported that it had been suggested that any non-FT organisation not showing an IBP surplus by June 2011 would be integrated. Mr Hunt felt the intention was to reduce the number of healthcare beds in NW London. At the meeting, comments had been made on the expected needs of an increase in an ageing population but no mention was made of any population-based analysis, just the intention to reduce activity. There had been a lot of discussion about cancer services and A&Es but cardiovascular services had not been discussed. Mr Bell had made comment at the meeting and felt the proposal was not achievable and therefore these intentions had to be negotiated. Mr Bell said that NWL only accounted for 14% of our business. He explained that the NWL Inner Sector comprised of three FTs and one non-FT. This Trust was in a good financial state but Imperial College Healthcare NHS Trust was facing a significant financial problem, needing to generate major cost improvements in order to balance their books over the next four years. This Trust was now allied to Imperial in an Academic Health Science System. Mr Bell confirmed he would be attending a second meeting on 2nd December.

The Board discussed the issue and how to respond. NW London seemed to be trying to deal with their financial problem by reducing activity, with no consideration of disease, epidemiology or demographics, etc. Mr Bell said that the plan of the Coalition Government was for PCTs and SHA's to be abolished and replaced by GP consortia and the National Commissioning Board. Professor Newman Taylor recommended the Board wait to see how the situation developed before responding. Mr Lerner reminded the Board that the current coalition government had promised to ring-fence the NHS and wondered if representation to politicians might help. It was noted however that despite the protected status of the NHS, £20bn of savings would have to be identified and that although these were supposed to come from e.g. reducing management costs at PCTs and SHAs, there was growing evidence that commissioners would seek to achieve this target by reducing payments for activity.

Mr Hunt reported that a national operating framework is to be issued in December and a further report on its implications would be brought to the Board. The standard NHS Contract is coming to the end of its 3-year term and will be renegotiated in January and February 2011.

Mr Bell said that Monitor will be interested in our business plan and income projections for 2011/12. It was noted that this would be a difficult year.

Professor Newman Taylor said that it was to be hoped that GP Consortia might take a more logical approach to analysing the health needs of NW London over the next five years. Services should be informed by the health needs of the community and not based on financial necessity.

Mr N Coleman recommended the Trust assess its strategy for the next four years in

order to ensure that the Trust can achieve a balanced financial position.

Mrs Hill summarised the debate saying that conversations should be recalibrated as the Trust came to understand the meaning / opportunities of the new environment.

- **Project Diamond (PD)**

Mr Bell reported that NHS London had sent the Trust details of its allocation of PD funds which for 2010/11 would total £9.1m, consisting of £7.5m transitional support and £1.6m of Market Forces Factor (MFF) on research income. This would be the last year for transitional funding but MFF would be recurring funding. Mr Bell explained that a number of conditions had been attached to the funding and had been set out in the NHS London letter dated 27th October 2010. Mr Bell had responded to the letter and said that conditions a), b) and c) were well known to the Trust. However, item d) was new and suggested that this funding came on the understanding that any pricing and contractual issues with commissioners were resolved this year before cash could flow to the Trust. This means that clearance would be required from the Commissioning lead for the NW London Sector. Because of the uncertainty surrounding quantum and timing of PD monies, it has been agreed with Monitor to account for the monies when the cash arrives, rather than to accrue. The Trust's liquidity position in December may therefore be difficult depending on when the PD cash is paid.

- **Collaboration with Liverpool Heart and Chest Hospital NHS Foundation Trust**

Mr Bell reported that the Trust had been approached by the Liverpool Heart and Chest Hospital NHS Foundation Trust to initiate collaboration with them. Three meetings had already been held and Mr Bell was energised by the shared vision with the Liverpool organisation. Imperial College Faculty of Medicine also shared this vision. The Trust will now proceed to establish Collaborative structures with national / international organisations.

Professor T Evans, Medical Director, explained that Liverpool was seeking an alliance in the cardiovascular area rather than respiratory, partly because the University of Liverpool did not plan to invest in cardiovascular medicine in the future. There will be 3 work streams:

i) A vehicle through which this alliance would be governed and publicised
ii) An interim operational group led by Professor Kim Fox and Dr Rod Stables
iii) Development of Joint Care Pathways

Mr Bell said that the initiative was about being bold and developing a collaboration which could be a global player in cardiovascular medicine. The interests of Imperial College Faculty of Medicine were being represented by Professor Michael Schneider who whole-heartedly supported the venture. A "British Institute of Cardiovascular Medicine" was envisaged which could develop new service and educational models and lead to new research discovery.

Mr Lerner said he would like to understand the controls, checks and balances for the scheme. Mr Bell replied that matters, while looking promising, were still at an early stage.

- **Q2 Review with Monitor: 19th November 2010**

Mr Bell reported that a face-to-face review with Monitor had been attended by himself, Professor T Evans, Mr R Craig, Dr C Shuldham, Mr R Morgan and Mr R Connett. The meeting had been very professional and Monitor had been satisfied

by the Trust responses to their questions. The Trust will remain on monthly reporting until the financial rating regains level 3.

2010/100 CLINICAL QUALITY REPORT FOR MONTH 7: OCTOBER 2010

In the absence of the Director of Finance & Performance, Mr R Connett, Trust Secretary & Head of Performance, introduced the report and highlighted the following:

- Incidents: There had been one "Never" Event which was also a Serious Untoward Incident (SUI) relating to the death of a patient following misplacement of a feeding tube. This event had been reported to the National Patient Safety Agency. A full internal investigation was underway with root cause analysis and would be reported to the Risk & Safety Committee, probably at its next meeting.
- Health Care Acquired Infections (HCAI). There had been two cases of MRSA bacteraemia reported in relation to two patients transferred to the Trust (one from another hospital, and one from a care home). Application is being made to have these removed from the trajectory as the MRSA bacteraemia was present at the time of admission.
  Mr Coleman noted there had been 4 cases of C.difficile reported in October. He was assured that these did not appear to be related cases and Trust performance was well within the overall trajectory.
- Cancelled operations: there had been 31 cancelled operations in October, 9 at Brompton and 22 at Harefield. Work continued to improve the situation. Mr Lerner noted some cancellations had been caused by unavailability of surgeons. Mr Craig explained that this can be caused by surgeons working overnight (e.g. for transplantation) when they would not be available to return to their usual rota until after they had taken a rest period. Mr Craig was not aware of any particular reason for this spike in the numbers.
- Cancer Targets. 62-day Urgent GP Referral to First Definitive Treatment: there had been three breaches of the target in Month 7, resulting in a performance of 57.1% against a threshold of 79%. Work is on-going with the cancer managers to prevent any further breaches. One breach related to a case being referred at day 62 and the other two cases were complex cases.
- 18-week Referral to Treatment Time Targets. The Trust had received from NHS NW London a request for contract variation in relation to the Operating Framework for 2010/11 covering the 18-week target. This variation would introduce monitoring against the median waiting time. Mr Bell said this was concerning as penalties could be imposed on a new target on which there had been no discussion. There was a debate about how this change should be handled. Mr Lerner observed that in the commercial world contracts with inherent risks were set at a higher price. Mr Bell explained that tariff is set nationally and the Trust cannot change it. In response to Mrs Hill's request, it was agreed that changes to commissioning metrics would be reported through the Clinical Quality report as they occurred.
- Complaints: cases responded to within the set timetable were YTD 77.8% against a target of 90%, with rates slipping a little for Month 7. The Board discussed the issue and it was agreed that a follow-up paper explaining the management of complaints would be brought to a future board meeting.

Section 3 – CQUIN Measures Q2

Mr Connett reported receipt of confirmation from the Commissioner that full payment is being made for Quarter 1. Future payments will be dependent on achievement of the milestones for Quarter 2, Quarter 3 and final payments will be made dependent on the overall achievement against the 10 CQUIN schemes at

Quarter 4.

Section 4 – Briefing Paper: Single Sex Accommodation
Mr Connett presented the briefing document which discussed single sex accommodation issues in terms of interim guidance issued by NW London. The Trust will report all breaches from January 2011 and there will be financial penalties attached to this. Mr Lerner referred to the model for potential loss of income which might occur and said this could be a serious matter.

The Board noted the report.

2010/101 FINANCIAL PERFORMANCE REPORT FOR MONTH 7: OCTOBER 2010
In the absence of the Director of Finance & Performance, Mr Rod Morgan, Chief Accountant, presented the report for Month 7 and highlighted the following:
The Trust had made a surplus of £450k in Month 7. This followed break-even at M06 which had been preceded by 5 months of deficit, so the trend was upwards.

The cumulative deficit now stands at £4m, which is £1.6m higher than the planned deficit. Mr Morgan said that, going forward, comparisons against plan were likely to be adverse but that the Trust was planning to achieve a break-even position by year-end.

Cash at 31st October was £12.4m against a plan of £13.4m with debtors and creditors being managed in that context. There was an expectation that PD cash would be paid in December, but the Trust may need to draw on its working capital facility of £18m. Mr Bell said the cash situation was serious and he wanted to ensure that the Trust Board was aware that the working line of credit ('working capital facility') would need to be drawn on before the next meeting of the Trust Board. This course of action was supported by the Board.

Mr Morgan distributed an additional paper entitled: Monitor Financial Commentary Month 07 2010/11.

Mr Bell drew the Board's attention to the fact that there was a discrepancy between the declaration made by the Board at the end of Q2 and the M7 commentary. Mr Morgan explained that while the Financial Risk Rating (FRR) averaged 2.9, this would not be rounded to 3 because of an overriding rule that if 2 of the 5 risk rating items scored 2, the maximum allowable rating was 2. The 2 FRR items in question are liquidity and EBITDA. It was agreed that this would be explained in the financial commentary and that Monitor would be informed through upload of the commentary to the MARS portal at the end of M7.

At the suggestion of Professor Newman Taylor, Mr Morgan agreed to investigate whether accruing for the £1.6m MFF PD monies would improve the EBITDA sufficiently to score this as 3.

Mrs Hill reported she had attended a FSSC meeting and had been impressed with the depth of the discussion about stock and procurement. There was some discussion about stock being purchased in bulk and whether this might be disadvantageous in respect of the 11/12 financial year. Mr Craig provided reassurance that bulk orders would be used in this financial year. There were however some discounts with suppliers which offered additional opportunity this year and these would be assessed before making any commitment.

The Board noted the report.

2010/102 2010/11 Q2 SERVICE LINE REPORTING

Mr R Morgan, Chief Accountant, presented the report which incorporated a completed set of Service Line Reports for Q2 2010/11 and the Q1 HRG profitability analysis. For the first time the report showed a comparison between Q1 and Q2. Mr Morgan said that a detailed understanding of why some service lines were unprofitable was emerging.

Mr Craig confirmed that there is a noticeable change in use of the information in that there is now real engagement within the Divisions. The list of the top 15 HRGs is proving very useful with action already being taken as a result.

Mr Coleman requested that for future reports any movement in the trend should be highlighted.

Mr Bell said that it was clear from the NWL commissioners meeting that the Trust was engaged in delivering some lines of service which don't make money. It was agreed that it was difficult to make comparisons about profitability across organisations because of the different costing methodologies employed, with the Trust system being perhaps the only one based on actual costs rather than budget lines.

Professor Evans requested that SLR be developed to reflect the Care Group structure. Mr Craig said that a draft was already available.

Mr Bell said that CABG was £2k per case higher than the national average which went some way to explaining Trust losses.

2010/103 ROLE OF THE RESPONSIBLE OFFICER (RO)

Professor T Evans, Medical Director, introduced the item. Following the DoH's requirements and guidance relating to the appointment of a Responsible Officer, Professor Evans had written to the Trust Chairman on 3 September 2010 outlining his views concerning the aims and objectives of the process. Professor Evans emphasised that the process was still evolving and there were areas of substantial uncertainty. There was little knowledge as to how the reporting lines to the GMC would work, how the RO would be audited in terms of success, or how implementation of the systems would be budgeted for. The revalidation requirements represented a step change in regulation of the consultant body and the Trust was perhaps better placed than most to achieve this, given the robust approach taken to their management.

Mrs Hill said this initiative involved defining the role of the RO and the Medical Director and the many functions expected of the role.

Mr Lerner wished to acknowledge the fantastic job which Professor Evans undertakes for the Trust. He realised the role of the RO was an onerous one and wanted to ensure it was not too demanding. It would be necessary to make sure the roles of the RO and Medical Director were appropriately resourced. There needed to be an awareness of the complexity of the role, its demands and accountability. The support team would need to be adequately resourced. Professor Evans felt resources were adequate for the first year but reported that the majority of Medical Directors viewed the initiative with concern. If managed in the wrong way, there could be very significant problems with the NHS.

Mrs Hill said a decision had to be taken on who would be the RO. There was a

discussion about the role of the RO and the inter-relationships between this role and that of the Director of Nursing and Clinical Governance and the Chief Executive (who is the accountable officer in law).

Mrs Hill summarised the discussion saying that Professor Evans would be designated as Responsible Officer for a period of 1 year and that a report would be brought to the Board within 6 months to clarify the dependencies of the post, and provide assurance that adequate support mechanisms were in place. The designation would be reviewed by the Trust Board after 12 months.

2010/104 INFECTION CONTROL ANNUAL REPORT

In the absence of the Director of Infection Prevention & Control, the report was presented by Dr C Shuldham. Dr Shuldham highlighted the following:
In November 2009 the Trust had undergone a Hygiene Code Inspection by the Care Quality Commission; the Trust had passed the inspection without any conditions and a caveat from a previous inspection had been removed. Another such inspection was expected this year. The year had been a very active one in infection control. Work had been undertaken in preparation for the flu pandemic and in treating flu victims who had arrived with the Trust. The MRSA bacteraemia rate last year had been extremely good – for 2009/10 there had been zero cases. For C.difficile there had been 10 cases against a trajectory of 29 but with no outbreaks. There had been some issues with the performance of the cleaning team and inspections and remedial work had been undertaken with the Directorates. A lot of work had been undertaken in wound infection particularly with the group of patients who fell into the national benchmark for coronary artery bypass grafts. There had been a high rate of infection but following a lot of work moving into 2010/11, sustained improvement meeting the national average rate is being seen. Other groups of patients with surgical wounds are now being monitored.

Attached to the report was the Infection Control Team Annual Programme for 1010/11. This was approved by the Trust Board.

2010/105 REPORT FROM CHAIR OF FINANCIAL STABILITY SUB-COMMITTEE (FSSC)

Mr N Lerner, Chair – Financial Stability Sub-Committee, presented Paper F.
He said that in addition to the formal meetings of the group he had regularly met with the Chief Operating Officer and the Chief Accountant to assess performance and review financial projections.

In summary, there had been some delays in capacity coming on stream, There were FSP shortfalls in respect of clinical supplies savings (£0.7m) and pay savings (£0.6m).

The 'most likely' scenario showed a £1.7m year-end deficit. Further FSP savings had been identified to mitigate this position with the aim of achieving break-even, although this would be challenging.

A more detailed bottom-up forecast of income will be available by the end of November.

No account had been taken of PD money and the committee felt this was prudent because there were certain significant conditions attached to the PD money and no cash had yet been received. The plan submitted to Monitor took no account of PD money.

Mr Lerner reported that cash is going to be very tight during Q4.

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Mr Lerner assured the Board that the FSSC will continue to liaise with the Chief Operating Officer and Chief Accountant, and will continue to update the Trust Board.

2010/106 COMPOSITION OF COMMITTEES

Non-Executive Directors raised a number of questions in relation to this paper. Mr Connett will confer with NEDs and the Chairman and bring a revised paper to a future meeting of the Trust Board.

2010/107 ANY OTHER BUSINESS

Mr Lerner referred to the tendering for the Internal Audit and Counter Fraud Services reported upon at the previous Board meeting. The Internal Audit appointment had been awarded to KPMG. The award of the Counter Fraud Services had been reviewed. As a result, a decision had been taken to recommend to the Board that Park Hill should be appointed rather than London Audit Consortium. The Board agreed with this recommendation.

2010/108 QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions.

2010/97 DATE OF NEXT MEETING

Wednesday 26th January 2011 at 2.00 pm in the Boardroom, Royal Brompton Hospital