Minutes of the Trust Board held on 25 February 2009
in the Concert Hall, Harefield Hospital

Present: Sir Robert Finch (Chairman)
Mr R Bell, Chief Executive
Mr R Craig, Director of Operations
Mr N Coleman, Non-Executive Director
Mrs C Croft, Non-Executive Director
Professor T Evans, Medical Director
Mrs J Hill, Non-Executive Director
Mr R Hunting, Non-Executive Director
Mr M Lambert, Director of Finance & Performance

By Invitation: Ms M Cabrelli, Director of Estates & Facilities
Mr R Connett, Head of Performance
Mrs L Davies, Head of Modernisation
Mr N Hunt, Director of Service Development
Ms C Johnson, Director of Human Resources
Mr D Shrimpton, Private Patients Managing Director
Ms J Thomas, Director of Communications
Ms J Walton, Director of Fundraising

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

Apologies: Professor Sir A Newman Taylor, Non-Executive Director
Dr C Shuldham, Director of Nursing, Governance & Informatics

Sir Robert Finch began the meeting by introducing himself as the new Chairman of the Trust. He reported he had already met with personnel in the Royal Borough of Kensington & Chelsea and the London Borough of Hillingdon and looked forward to meeting other key stakeholders at what was an important time for the Trust. He said that Foundation Trust (FT) status was his priority and he would be much involved in looking at the FT application and the developing strategy. He confirmed the Trust was committed to developing and maintaining two hospital sites in its delivery of excellence in heart and lung services. He had noted the need for redevelopment of in-patient facilities at Harefield and had already met with Mr Ray Puddifoot, Leader of Hillingdon Council on this issue. He would continue discussions with the local authorities on this subject and feed back developments to local stakeholders. The Chairman continued that, in terms of the constitution, he was looking forward to meeting with the FT Governors-elect on 9th March and, subject to achieving FT status, these meetings would be a regular process.

2009/014 MINUTES OF THE MEETING HELD ON 28 JANUARY 2009

The minutes of the January meeting were agreed as a correct record with one amendment, as follows: page 6, paragraph 5, line 1, to read Capital expenditure in December was over £1.1 million,……..

2009/015 REPORT FROM THE CHIEF EXECUTIVE

1. Academic Health Science Centres (AHSC)

Mr Robert Bell, Chief Executive, updated the Board on the DH designation process. 7 out of 15 proposals had been shortlisted and would be assessed by a panel of international experts. Applicants from London were Imperial College, King's Health partners and University College London partners. From outside London applicants were Oxford, Cambridge, Manchester and Birmingham. The Trust had received an approach from Guy's and St Thomas's but had confirmed that currently we were not aligning ourselves

with any particular application, and instead concentrating on achieving FT status. Mr Bell said the King's Health AHSC model could coincide with our own view of partnership models, and could be a partnership option whether or not FT status was granted.

Following a meeting between himself, Professor Sir Anthony Newman Taylor and Sir Roy Anderson (Rector of Imperial College), the Chairman had agreed to draft an agenda for the first session of the RB&H-Imperial working party to consider how best we might cooperate with Imperial College and the Imperial Trust in what was likely to be a non-exclusive relationship. Mr Bell thought the Chairmen and Chief Executives of both organisations would be involved once the working party was up and running. Sir Roy Anderson had distanced himself from the notion of a second "Imperial" AHSC.

Professor Tim Evans, Medical & Research Director, felt the Trust's existing relationship with Imperial presented the greatest risk because it did not suit the new regime. Professor Evans confirmed he was working on a draft paper setting out a new relationship consistent with the Trust's R&D strategy.

1. NW London reconfiguration

Mr Bell reported that NW London PCTs, in parallel with the Healthcare for London agenda, had engaged a "provider reference group" to address issues of reconfiguration. KPMG had been hired to look at the NW London provider 'landscape'. The initiative was PCT-led and a conclusion expected by April. Mr Bell explained that although we are situated in NW London, it was not the Trust's key market, providing no more than 14-15% of our activity. The Trust was willing to participate in the process but had declined to share the costs of the consultants. Mr Bell wanted the Board to be aware of the process in that it might not be as benign as was being promoted – the KPMG partner had indicated that the Trust would be included in the analysis if the FT application was unsuccessful. In a recent NHS London list, several London trusts had been identified as unfit for FT status and therefore subject to reconfiguration – and several of these were in NW London. The process was at the stage of generalities but could be a background issue to be raised with Monitor.

2009/016 FOUNDATION TRUST STATUS

Progress with application and assessment

1. Monitor Assessment

Mr Robert Craig, Director of Operations, presented a summary of the current status of the FT application. Meetings with Monitor's assessment team were already underway on various topics and they were expected to attend the March meeting. The Board-to-Board meeting was scheduled for 30 March. Key pieces of work are the sensitivities to the base case of the business plan. Beyond that, Monitor would apply its own assumptions on our assessments and decide whether they had confidence in our assumptions. They would issue a schedule of sensitivities and predictions of any deficits and ask how we would address these: we would need to work these items into a mitigation plan.

The Chairman added that he had held a constructive meeting with Bill Moyes (Executive Chair of Monitor) and Stephen Hay (Chief Operating Officer). The issue of property had been discussed and the possibility of the DH seeking to extract some of our Estate's value pre-authorisation. The Chairman and Ms Maria Cabrelli, Director of Estates & Facilities, would be meeting with Monitor shortly to discuss estates matters. Dr Shuldham's continued absence on sick leave had also been discussed (and Ms Hiscock's position as Acting Director of Nursing). The Chairman had asked that any significant item arising should be raised with him.

From meetings held between Monitor and the Non-Executive Directors, Mrs Hill felt there had been concern about the Board and its ability to provide the right portfolio and skill-mix. Mr Nick Coleman, Non-Executive Director, felt that the primary issue emerging was the

financial model and the profitability of the Trust, especially for next and subsequent years. There was also an emerging list of half-a-dozen secondary issues, which would be probed. Mr Richard Hunting, Non-Executive Director, asked whether Monitor believed we could deliver on the financial plan.

Mrs Christina Croft, Non-Executive Director, said Monitor had been very interested in the composition of the Board and what information was available to the Board. At this juncture, the Chairman confirmed the Trust already had in hand the appointment of a Trust Secretary. In their "due diligence" work, PwC had recommended an additional, non-executive appointment to the Board of an individual with an accountancy and auditing background and this was in hand.

Mr Craig added that Monitor might ask what our plans would be if we did not achieve FT status, and an answer would need to be prepared for this.

2. Due Diligence

PwC had completed the Historic Due Diligence work commenced in December 2008 and their draft report had been received. Mr Mark Lambert, Director of Finance & Performance, reported that the results appeared credible. Because of the scale of the plan, a red traffic light had been allocated to the FSP, and early indication on forecasts was amber.

Mr Craig confirmed a further formal meeting of the Board would be needed in the first half of April to adopt the Board Memorandum and auditor's opinion.

3. Meeting with prospective Governors

A meeting between Board Directors and prospective FT Governors had been arranged for 9th March, at the Royal Brompton Hospital.

4. FT membership

In order to publicise the new assessment timetable and revived application, engagement with existing FT members and further membership recruitment work was under way.

5. Review of the Integrated Business Plan (IBP)

Mr Craig reported there had been no changes to the IBP since the Board last reviewed it, and it had therefore not been included in the meeting papers.

Mr Coleman said that if we achieve FT status there would be several work-strands to develop (i.e. governance, finance and property issues). The Chairman had informed Monitor that he wanted to look at the make-up of the Board, focusing on allocation of tasks to be done as an FT. Mr Bell emphasised that the financial target was the principal issue to be resolved for Monitor, and that the executives were completely focused on that – other issues were not a priority.

6. Feedback from Monitor on and review of the Constitution (including Standing Orders)

Mr Craig reported that Monitor's assessors had provided feedback on the draft constitution submitted to them on 2 February; this included some local requirements to render the constitution compliant with the NHS Act 2006. All requested changes and comments had been incorporated bar one: the outstanding issue related to the composition of the Governors' Council, specifically the identification of Higher Education Institutions (HEIs) which would be approached to appoint one or two Governor(s). We had not specified who might be approached, leaving it to the discretion of the Board of Directors as vacancies arose. However Monitor advised that this must be specified in the Constitution. Options available were:

(a) to include a list of HEIs which the Board may approach for an appointment, or

(b) to specify the HEI(s) the Trust will approach.
Mr Bell felt that, based in London, a liaison with a London establishment seemed logical and practical, but he wished to maintain flexibility for the Trust. The Board discussed several options, including the possibility of nominating IC and the University of London. each to provide a Governor. Professor Evans recommended adding Oxford and Cambridge. He pointed out that the Board already had a member who was also a senior member of IC and questioned the wisdom of another IC appointee in the form of a Governor. Mr Craig confirmed that Monitor's legal adviser had indicated that it would be acceptable to specify a list from which we could select. The revised constitution would be returned to Monitor at the end of the week for further review. Mr Coleman advised that it would be easier to change the constitution now rather than in the future. He felt that as a 'national' Trust, we should cast the net as wide as possible. Prof Evans suggested adding the National Institute for Health Research (NIHR) to the list, and this was agreed, making the following list: Imperial, UL, Oxford, Cambridge, and NIHR.

Mr Craig confirmed that Monitor were to hold a legal meeting within a few days and there would still be time to complete this requirement if Monitor required further amendments.

On a separate point, Mrs Hill referred to para 9. Restriction on Membership, 9.3, line 3, and recommended removing the word 'personal'. The Board agreed this amendment.

2009/017 NHS LONDON PROVIDER AGENCY PLAN

Mr Mark Lambert, Director of Finance & Performance, explained that the Trust was required annually to submit to NHS London a plan for the next three years. Our draft plan had been submitted on 19 January, followed up with a telephone meeting on 5th February at which no serious issues had been raised. The final Provider Agency Plan had been submitted on 23 February and was exactly as included in the IBP.

Mr Lambert confirmed that the control total for the current year was £2.4m. A control total of £2.9m had been included in our draft plan of 19 January but we had received a letter indicating that it was extremely unlikely that an increase in the total would be allowed, so we had revised back to the lower total of £2.4m in the final submission. Mr Lambert then explained that he had received a telephone call that morning informing him that NHS London was at risk of undershooting its own control range and had asked if the Trust could, after all, increase its total. Mr Lambert thought the Trust's control total should not go above £3.4m and he was now awaiting a response from NHS London – but he wanted to inform the Board that a £1m increase in its surplus may be required of the Trust. Mr Craig said that while there might be scope to increase the control total, the Trust did have plans to spend any surplus by way of preparation for the following year's financial challenges. Mr Coleman felt that it was better to 'keep our head above water' than to help out this year.

2009/018 FINANCIAL PERFORMANCE REPORT FOR MONTH 10: JANUARY 2009

Mr Lambert reported that the Trust had made a surplus in January of £400K. The cumulative surplus stood at £2.2m at Month 10 against a £2.4m current control total. The FSP continued to deliver strongly and was on target to deliver £11.2m. There was a shortfall of less than £300k, which was an improvement on last year.

Capital expenditure in January was £500K, and spend to date is £1.3M behind our phased plan. Capital programme slippage continues to be concentrated on charitably funded projects. Action has been taken towards mitigating this by bringing forward spend from next year's requirement for medical equipment, estates work and IT projects.

Mr Coleman confirmed that the next Audit and Risk Committee would include a session on debtors and creditors. He noted that the cardiac surgery directorate seemed to be having trouble with income this year and meeting its FSP targets and asked if there was a

cause. Mr Craig replied that operationally this was partially about expenditure on work carried out to meet the 18- week target and work undertaken outside our campus.

Mr Coleman felt the overall financial situation appeared very good. Mr Lambert confirmed the current figures had taken into account monies spent on outside consultants; therefore the actual underlying position was stronger than demonstrated. Adjustments would be taken which might impact on profitability, i.e. schemes to benefit coming years. Mr Bell said that the Trust had a business model that clearly worked, but warned that Monitor would challenge us with downside scenarios. He emphasised the Board should be prepared to explain to Monitor that the Trust was not financially challenged and explain how we would be able to withstand possible downside scenarios. We were putting in place a FSP to sustain our position. Mr Hunting felt that the Monitor assessment team now understood our business model and Mr Bell emphasised that one of the key challenges would be the sustainability of the business model.

Mrs Hill referred to pay expenditure and bank and agency spend, asking how this would be addressed in the FSP and what strategically would be difficult. Mr Lambert explained that we were over-performing on total spells of activity, and this required temporary staff to deliver it. We were, in certain areas such as PICU, running quite high levels of vacancy and the pan-London arrangements for agency nursing rates had been breached, increasing our costs. In response, we had recently increased our bank pay rates to make them more attractive. Mr Craig confirmed the need to be less reliant on temporary staff and more accurate on planning and forecasting activity (albeit not losing flexibility altogether). There had been the added complexity of 18-week work in 2008/9. Mr Bell thought this would be the type of item brought up by Monitor.

2009/019 <u>OPERATIONAL PERFORMANCE REPORT FOR MONTH 10: JANUARY 2009</u>

Mr Lambert introduced the report and commented on the following points:
Clinical Outcomes: Mortality. Status still strong on a positive variance of 0.15 per 100 admissions.
MRSA: no cases in January. Still 2 cases year-to-date (YTD) – against a limit of 5.
C. difficile: 14 attributable cases YTD – against a limit of 23.
GRE and VRE: No attributable cases
Complaints responses were 93% in the quarter against a target of 90%
Outbreaks of infection showing 1, which was an outbreak of Norovirus
Safety SUIs : 1 in January
Cancelled operations: still showing 'underachieved' at 1.23%
18-week waits: 95% for admitted patients against a target of 90%, and 98.2% for non-admitted patients against a target of 95%. This maintained the strong performance since the Autumn.
Staff sickness continued at 3.22%, however the Trust remains in the top percentile for the country.

Mrs Hill asked how the Trust compared its clinical outcomes against similar organisations. Professor Evans replied that this was very difficult to do; Dr Foster data could be referred to for benchmarking purposes, but the data received was aggregated HES data, and not always accurate for the purposes to which it was put. A cardiothoracic benchmarking club had been formed, but comparative data was not yet available. Mr Lambert reported that hospital standardised mortality ratios (HSMR) were reported, but as this Trust was one of the consistently highest performers, it was of little improvement value.

Mr Bell said we could expect increased focus on the measurement of quality and confirmed a Board session would be undertaken before 30 March on the issue. Mr Richard Connett, Head of Performance, was asked to prepare relevant briefings before the next Board meeting. Mr Craig reported that Monitor had raised the question of benchmarking and felt that, as a leading organisation, the Trust should be developing in a

leadership role – including international peers (e.g. Cleveland Clinic). Mr Coleman agreed.

Mr Coleman referred to the month of January when the trajectory for C.difficile continued in the wrong direction, there had been an outbreak of Norovirus, and a reported SUI, and asked if there was any connection. Professor Evans said he could not comment on the SUI and that it was difficult to say what caused the outbreak of Norovirus – other surrounding hospitals had also experienced outbreaks but the Trust had experienced a very local problem. As regards to C.difficile, Prof Evans explained that this was encountered at different times. This incident was on the Harefield site and had been dealt with quickly; he felt there was no link between the three items. Mr Hunting pointed out that with very small numbers, i.e. very low rates of infection, tiny changes which would not normally be significant could appear so.

2009/020 FINANCIAL STABILITY PLAN (FSP)

Mr Craig delivered a presentation to the Board on the FSP as at 25 February. He explained there were more than 70 initiatives incorporated in the plan and emphasised the significant financial challenge for 2009/10, whether we become an FT in May or not. A large funding gap needed to be bridged and the plan would continue to evolve. A project management team had been set up to ensure the process was followed and adequately tracked. The cost base for the organisation needed to be re-set and there are a large number of schemes within the 70 initiatives which are related to multiple departments. The larger schemes spanned across different divisions and were therefore much more complex to deliver.

Financial Stability Plan

The gap to bridge next year was approximately £15m (but might change). Our aim is to deliver as much of this as possible in 2009/10. There would be full-year delivery for some schemes in the following years.

Challenge Rating: 1

Rating 1 is the most straightforward to implement and will deliver just over £2m in value – it traverses different work streams

Challenge Rating: 2

This rating has the highest number of individual schemes but still lies within the action of the department or division, a particular management team or manager. This will deliver over £4m when fully implemented.

Challenge Rating: 3

Relative value here is higher in a smaller number of schemes. This will deliver £6m when implemented.

Challenge Rating: 4

This rating involves the most difficult items, carrying complex difficulties and relationship issues both in and outside the organisation. Will deliver £3.2m when implemented.

The Current Estimate: is £16m as at 25 February 2009. This did not cover the full extent of the original plan on which further work continued. New initiatives were also emerging.

Mr Craig said these initiatives would drill down to make the hospital as efficient and productive as possible. Mrs Lucy Davies, Head of Modernisation, had worked on some of these initiatives which would deliver much value:

Length of Stay

Mr Craig confirmed that a comparison had been undertaken against Dr Foster and

analysis had indicated we could improve and reduce length of stay. Mrs Davies said this was a complicated project. A small, expert group had brainstormed ideas to improve on length of stay and put specific numbers on bed days that could be saved. A lengthy list was prepared of 30+ different schemes, now reduced down to 15, which included patient safety, improved outcomes and reducing stay. The schemes included:

- reduction in the rate of re-operation for bleeding after surgery
- reduction of post-op wound infection rate.
- Consolidation of high dependency units at RBH.
- Improvements to scheduling processes, pre-op length of stay, and reduction in the numbers of cancellations
- Improvements to discharge processes has already been implemented in MCU at HH.

Mrs Hill remarked on the complexity of the schemes which would require consistent, efficient management and skilful leadership and pose a big challenge. Mrs Davies felt complexity related more to the bigger items, and less to items in categories 1 and 2, but agreed there was a need for strong management and staff support. Mr Coleman asked to what extent people were supportive of the plan. Mrs Davies felt management and senior nurses were supportive, and engagement with clinicians was gaining. She looked to the Medical Director, consultants and clinical managers for support and said that clinical outcome and patient safety was much involved here, the relevance of which appealed to clinicians. Mr Coleman recommended engagement with staff from the outset to guard against failure. Mrs Davies agreed and added that we could not afford to fail.

Mr Craig said that Monitor would want evidence of a contingency plan against this plan failing to deliver its targets. Budget-setting was proceeding, which would provide scope for further changes.

Mr Coleman reported from his one-to-one meeting with Monitor he had been asked how patient safety was being factored into the FSP. It was agreed that the Board had already addressed this issue, and Professor Evans said that the Lead Clinician in Clinical Risk had been involved in specific Length of Stay initiative. It had been agreed that the initiative was not so much about reducing length of stay, but more about reducing pre-op bleeding, etc.

Mrs Hill said this was an initiative of great significance and it was absolutely imperative that the organisation supported it. She suggested a positive, transformational identity – but Mr Craig felt that the “FSP” already had an identity that was well-established, and counselled against changes which might confuse at a time of growing engagement.
It was agreed that the Chairman and Chief Executive would address senior clinicians to support the Plan if required.

Mr Bell reminded the Board that the impetus for change was a financial one – and that the focus of the Trust should be on the financial challenge ahead, although improvement and quality of service had to be at the forefront in implementing the plan.

Mr Craig then turned to the subject of changes to the workforce. There were a number of different initiatives, of which five had a value of around £1m. Up to 115 posts could be affected. The turnover rate was dropping (from 12% to 10%), possibly because of the changed economic climate, and although removal of some posts could be linked to vacancies, there would be some redundancies and redeployment over the next year. Some people would be leaving quite soon and severance costs would be incurred this year rather than next.

Ms Carol Johnson, Director of Human Resources, commented that every organisation had to look at its establishment year-on-year and the Trust had an imperative to undertake this in the coming year against a backdrop of very difficult economic circumstances. Ideally

much might be achieved via natural wastage. Job-planning meetings had already been held with clinicians, which were already more productive and generating cost-savings. Mr Craig confirmed he would update the Board on this issue regularly and that, in Dr Shuldham's absence, some of the Modern Matrons would take on more of the leadership role in nursing.

The Chairman took the opportunity to report that Mr Craig was assuming responsibility for Governance, and Mr Lambert Informatics while Dr Shuldham was on sick leave.

2009/021 REGISTER OF DIRECTORS' INTERESTS

The Board noted the updated Register.

2009/022 ANY OTHER BUSINESS

Mr Lambert asked the Board to note that Dr Caroline Shuldham has been appointed as the Trust Senior Information Risk owner (SIRO).

Mr Lambert noted that during her temporary absence he will be taking responsibility for Informatics and therefore will cover the SIRO role at Board level.

2009/023 QUESTIONS FROM MEMBERS OF THE PUBLIC

Mrs Jean Brett, Chair of *Heart of Harefield*, welcomed Sir Robert as the new Chairman. Mrs Brett assured Sir Robert and the Board that Heart of Harefield was maintaining its watching brief on the Foundation Trust application.

Sir Robert thanked Mrs Brett for her comments. He then confirmed that one of the issues on his agenda was to start a process of master planning for the Harefield site, understanding how integral it was to the life of the village. He would be attending meetings with the Planning Department of the London Borough of Hillingdon and would report back any developments to the local community. He felt it was absolutely fundamental that this important institution went ahead with the support of the community.

2009/024 DATE OF NEXT MEETING

Wednesday 25 March 2009 at 2.00 pm in the Boardroom, Royal Brompton Hospital.