Minutes of the Board of Directors meeting held on 25 November 2009 in the Boardroom, Royal Brompton Hospital commencing at 2 p.m.

Present: Sir Robert Finch (Chairman)
Mr R Bell, Chief Executive
Mr R Craig, Director of Operations
Mrs C Croft, Non-Executive Director
Mr N Coleman, 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
Professor Sir Anthony Newman Taylor, Non-Executive Director
Dr C Shuldham, Director of Nursing, Governance & Informatics
Mr D Stark, Trust Secretary & General Counsel

By Invitation: Ms M Hiscock, Acting Director of Nursing
Mr N Hunt, Director of Service Development
Ms C Johnson, Director of Human Resources
Mr P McCleery, Director of Planning & Strategy
Mr D Shrimpton, Private Patients Managing Director
Ms J Thomas, Director of Communications
Ms J Walton, Director of Fundraising

Apologies: None received

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

2009/220 MINUTES OF THE MEETING HELD ON 28 OCTOBER 2009

The Board approved the minutes.

The Chairman requested that in future,the Agenda page should be an A3 size folded into two at the back page of the Board papers – allowing the Agenda to be read alongside the rest of the papers without having to separate it from the bound papers. The Trust Secretary agreed to do so.

2009/221 REPORT FROM THE CHIEF EXECUTIVE

Mr Bob Bell, Chief Executive, updated the Board on the following:

- The Care Quality Commission (CQC) was today issuing a public statement on its Mortality Outliers Programme. This CQC process involved analysing data over time that suggested concerning trends in the death rate for specific conditions or operations and was different from other data on death rates, such as Hospital Standardised Mortality Rates (HSMR). The CQC had alerted the Trust that it would be included in this publication relating to cardiothoracic procedures at Harefield when various complications arose, in the period June to September 2008.
  Professor Tim Evans, Medical Director, confirmed that all the cases had been discussed at yesterday's Governance & Quality Committee and that they had been satisfied with the outcome. He confirmed the Trust was undertaking an analysis of this sub-group of patients as a whole to investigate whether we consider it to be a valid group to enable the Trust to continue to engage with Dr Foster issues. Mr Nicholas Coleman, Non-

Executive Director, asked if this would have any effect on the Key Performance Indicators (KPIs) and the Quality Accounts. Professor Evans agreed more attention needed to be paid to the KPIs that are employed and work is on-going on this. The Society of Cardiothoracic Surgeons had given notice that they were to change the matrix they used to calculate mortality rates. Professor Evans had spoken to the President of the Society and it had been confirmed that none of our surgeons are in disagreement with the Society.

Professor Sir Anthony Newman Taylor, Non-Executive Director, thought this was a potentially recurrent issue. He said because this organisation treated very complex cases, the usual parameters would be difficult to adjust for and he recommended appropriate planning be undertaken. He recommended the issue be discussed with a statistician, possibly Professor David Spiegelhalter at Cambridge University. Professor Evans emphasised that the KPIs specific to the Trust needed to be identified. Until there is some rationalisation of the various national government and academic agencies assessing us, there would continue to be difficulties for us.

Mr Bell emphasised that the Trust had specific challenges in terms of positioning and explaining to others who it was and what it did. The issue went beyond just mortality numbers and was consistently raised with our Commissioners. Professor Evans confirmed he would continue to liaise with the Chief Executive of the Society of Cardiothoracic Surgeons and would contact David Spiegelhalter and would report back to future Trust Boards as and when required.

In this issue Mr Bell felt the CQC was technically incorrect in assigning this alert procedure to us as an FT, as they were quoting it as us when we were still an NHS Trust. It should not be included in any alerts on FTs and Monitor is aware of this.

Mrs Jenny Hill, Non-Executive Director, felt the issue involved our external management and reputation image including brand and thought it a sensible idea to have discussion on clinical quality as a debate amongst ourselves without too much distraction from outside views and/or interference.

- Mr Bell welcomed to the Trust Mr Piers McCleery, who had taken up the post of Director of Planning & Strategy on 23rd November 2009. Mr McCleery had come to us from the global trading and financial services sector and would lead the Trust's work on long-term strategic planning. Mr Bell thanked Mr Robert Craig, Director of Operations, for undertaking this role in the interim, and in particular for his input in the lead up to FT authorisation achieved on 1 June 2009.

2009/222 <u>FINANCIAL PERFORMANCE REPORT FOR MONTH 7: OCTOBER 2009</u>

Mr Mark Lambert, Director of Finance & Performance, introduced the report for Month 07. He confirmed that October had seen a surplus of £0.5m giving a YTD surplus of over £4m which is a favourable variance against the target of £2m. Contributory factors to this were increased income from NHS activity, particularly in Transplantation and VADs (Ventricular Assist Devices), and higher than trend Private Patient (PP) income.

PP income was almost £2m against a budget of £1,917k, a favourable

variance of £76k.
Salary costs had been concerning in the past and for Month 07 were overspent by £2,597k, a £120k adverse movement from the previous month. Nursing pay was significantly overspent in the YTD, driven principally by activity volume.

Mr Lambert reminded the Board it had previously requested an informal reforecast be submitted to them. Mr Lambert confirmed the surplus for the year had been set at £3.8m therefore this could not formally be reforecasted.. The situation had been affected recently by the introduction of ECMO beds in Intensive Care. The ECMO procedure is exceedingly complex, requires twice as many nursing staff and has led to the need for two shifts of consultant staff to manage all the ICU work. The ECMO patients are mainly H1N1 cases and Dr Jeremy Cordingley, Consultant in Intensive Care Medicine, and his staff are doing an outstanding job in maintaining the service. Mr Lambert and Mr Hunt, Director of Service Development, would be discussing the issue of payment for this service with the National Commissioning Group (NCG). NCG are happy with the daily costs, but discussion is needed about payment for other treatments incurred when these patients step down from ECMO treatment. Mr Craig confirmed that, notwithstanding the income we receive for ECMO, the Trust has the busiest Intensive Care Unit in London in terms of these kinds of cases and, as a result, our normal operation could be severely compromised. The ECMO income is better than the normal rate, but if we are also to maintain normal operations throughout all surgical cases this will have an impact as well. Mr Craig added that current indications are that this wave of swine flu will not last as long as previously predicted.

Mr Bell emphasised that the ECMO service is likely to stay, therefore it was necessary to prepare for this and establish correct financing. Professor Evans felt there was a political agenda involved here. He said there should be a nationally-funded respiratory failure service with reimbursement for the whole service.

Mrs Jenny Hill, Non-Executive Director, asked how education and training for this emerging clinical service would be supported. Professor Evans explained that the Trust had already been bidding to become an ECMO centre and training had been undertaken in anticipation of this. Staff were already very familiar with the technology and currently there were personnel at the Leicester ECMO Centre and in Germany undertaking further training.

Mr Coleman asked if more ITU provision was necessary to support the ECMO service. Mr Craig said that capital planning recently had been about capacity and critical care. Royal Brompton had a consolidated high dependency unit in Sydney Street and there is also an Adult Intensive Care Unit. He felt that the High Dependency Unit step-down was key to making this work well but if ECMO remained at present volume, there would be a pinch point for longer than he would like.
Prof Evans suggested there is a capital bid contained within ECMO which should be put to NCG to ask for capital monies, accordingly.

Mrs Christina Croft, Non-Executive Director, asked if this situation would lead to an increase in cancelled operations.Mr Craig replied that for Royal Brompton the situation was tight, but for November the scheduling team were managing reasonably well. He agreed there would be further short-term cancellations, but efforts were being made to use the capacity to its potential whilst still

maintaining a sensible and reasonable balance. Mr Lambert confirmed there had been only 3 cancellations and none had been related to ITU availability.

Mr Lambert turned to the Financial Stability Plan (FSP).Following the review process undertaken in the summer there had been a reallocation of £3.4m of central schemes. Performance YTD had delivered £8.1m against a target of £8.4m, an exact shortfall of £264k. The Trust was on-line to deliver a full-year outturn within £0.5m of its target. Mr Craig said this was the first month of operating within the revision brought into the report. The situation was 97% achieved to budget and the same level of achievement was forecast for the end of the year. The biggest pressure was the challenge for PP income and the winter performance would be telling.

Mrs Hill referred to the 97% achievement against budget and asked what percentage of this was recurrent. Mr Craig confirmed that of the £15.1m, £13.2m was recurrent and £2m non-recurrent.

Mr Lambert then reported on the capital programme which had a total current budget for the year of £25.8m. Total current spend was £5.6m, £7.5m was committed, and forecast to spend by end of year was £20.89M. Forecast slippage in 2009/10 is indicated at approximately £5M, the main element of which is £4m for strategic projects, specifically the BRU Heart scheme. The units are due for completion in May 2010, so the slippage is moderate and still on target.

Mr Lambert then spoke on the current status of service line reporting. For the first six months of this year income and costs had been analysed by HRGs on a line- by-line basis and this needed to be placed into core groups and would need to be vetted by Management Committee Meeting before being presented to the Board

2009/223 <u>OPERATIONAL PERFORMANCE REPORT FOR MONTH 7: OCTOBER 2009</u>

Mr Lambert introduced the report and highlighted the following:

- The Trust's HSMR ratio was showing a 3-year average of 72.4 (National Index = 100). The ratio had been 75 last month. Mr Lambert explained that Dr Foster had recently recalibrated all of the HSMR data.
- Incidents: there had been no Outbreaks of Infection, Never Events or IRMERs in Month 7. There had been one Safety SUI which related to a potential risk of aspergillus infection as a result of building works in the cardiac catheter laboratories at Harefield Hospital.
- Healthcare Acquired Infections (HAI's): there had been no cases of MRSA bacteraemia at Month 07 (the last one being in November 2008).
  MRSA Screening levels were above 1.03.
  C.difficile: there were 7 cases against a trajectory of 15 YTD.
  For GRE/VRE there are no national targets available.
- Surgical Site Infection Surveillance (SSISS): 5.56% at September. RBH rate for September was 10.42% and for HH 1.64% per 100 operations. These rates are still high in absolute terms. Professor Evans reported that Mr Daryl Shore, Consultant in Cardiothoracic Surgery, was leading an improvement initiative at RBH. A lot of work had been undertaken, including the 'lock-down' of RBH theatres with greater restriction on personnel circulation. Professor Evans thought it would be New Year before outcomes might be established. He confirmed that strategies implemented at HH in October 2008 had had a favourable impact on SSI

rates.

Mrs Hill asked what was the cost implication of patients acquiring a wound infection. Mr Lambert explained that the issue had been looked at with statisticians from Southampton University. Statistically it does cost the Trust a considerable amount of money per patient because they will stay on the wards for longer for which we do not get paid. A set payment is attached to a procedure and not to length of stay.

Mrs Hill referred to the quality aspects in this situation and said there must be a point at which the patient aspect is brought into increased focus rather than the clinical side. Mr Bell confirmed these discussions take place on an ongoing basis at Management Committee Meetings..

Mr Craig confirmed the FSP included an initiative for SSI improvement. The additional cost per patient acquiring an infection is £40K. Mr Lambert said that one of the underlying NHS tenets is that quality of service saves money in the long run.

Mr Coleman referred to root cause analysis (RCA) undertaken on deep sternal wounds and resultant recommendations. He asked how the Board could secure assurance that recommendations were being put in place and were taking effect. Mr Lambert confirmed that RCAs are undertaken with the clinicians involved together with the Lead Clinician in Clinical Risk. Dr Caroline Shuldham, Director of Nursing, Governance & Informatics, explained that items were brought back to the Audit & Risk Committee together with relevant actions taken. There is a Wound Group within the Trust which looks at these issues. Appropriate measures are put in place and the final assurance will be revealed in the outcomes. The system is multifactorial and it might never be known which improvements will have made the difference. Mr Bell said what is certain is that non-implementation of actions and interventions would lead to reoccurrence of infection.

- Cancelled operations YTD position is 0.75% against elective admissions (which is a creditable value against previous years).
- Cancer: 62 day urgent GP referral. An additional tolerance of 6% had been agreed with the Care Quality Commission, giving a threshold of 79% and currently performance is at 85.7%.
- 18 week wait: Admitted 96.5%. Non-admitted 98.6%.
- PP activity is underachieved with an adverse variance of –3.1%.
- Patient Admissions Complications: slightly over target with 20 against a target of 18.
- Patient Admissions Procedure Cancelled: 5% variance from target.
- PCT target for Complaints: 69% of complaints in the quarter had received a response within 25 days against a target of 90%. This was an improvement on the previous quarter. Dr Shuldham commented that the procedure had not been given enough attention, however staff had been in negotiation with many of the complainants and had agreed longer response times and there had been some complicated cases. Improvement in the system was being sought. Mr Bell acknowledged that Dr Shuldham had been away from the Trust for a time during the period and there had been slippage in the system.
- Staff sickness: the absence rate continued to fall and was 2.47% in

September, which is one of the best sickness rates in the NHS. Ms Carol Johnson, Director of Human Resources, said that sickness monitoring is now being undertaken actively by managers, with the HR team liaising with a specific person in each nursing team and involvement from Occupational Health. Ms Johnson noted the improvement had helped with staff morale.

Mr Lambert asked if the Board wished the Financial and Operational reports to be presented in a different order at future Boards. It was agreed to reverse the order for Boards going forward

Mr Coleman asked when a report on Quality Accounts might be expected. Mr Lambert confirmed there was a Quality Accounts Working Group, chaired by himself, which reported to the Governance & Quality Committee.
There was still ongoing national consultation and we are awaiting final guidance as to what should be included.

2009/224 EXTENSION TO ISS DOMESTIC AND CATERING CONTRACT

Mr Craig introduced the item and explained the Board was being asked to approve a 2-year extension of the Trust's contract for domestic services at both hospitals and catering services at Harefield provided by ISS Mediclean (ISS). Mr R Hunting, Non-Executive Director, reported that the ISS company had experienced some difficulties at Kingston Hospital. Mr Craig agreed there had been some low-level issues at Kingston, with former company employees contacting the Kingston Executives about possible employment of illegal workers. Mr Craig confirmed that ISS had responded professionally and demonstrated that they were following all legal requirements. Mrs Hill added that she was aware of another Trust where there had been difficulties towards the end of a contract when there had been a lack of investment in staff training resulting in a decline in the quality of service. She asked if continuing training was part of the proposed contract. Mr Craig felt the issue was all about the quality of the management and currently an exemplary job was being accomplished and he had no concerns. Mr Bell confirmed that ISS staff is subject to the same training requirements as Trust staff and the Trust expected the same if not higher standard from ISS. Mr Bell reminded the Board that it was considering a contract extension, not a new contract. Mr Lambert said that the cleaning staff at both sites were highly rated, but that there was some criticism of the food at HH and this was being addressed as part of the new agreement. He added that it may take up to 12 months to draw up the contract.
Mr Coleman cautioned that if this company had problems at other hospitals, this Trust might be tainted by the collateral damage of adverse publicity. Mr Bell felt that if problems should arise, the Trust would just have to deal with the issues.
The Board approved the contract extension As et out in the Paper

2009/225 ANNUAL HEALTH CHECK 2009/2010 – INTERIM DECLARATION OF COMPLIANCE WITH CORE STANDARDS

Dr Shuldham presented the paper prepared by Mr Richard Connett, Head of Performance. Dr Shuldham explained that the Trust was in the position of needing to declare for the last time against the Healthcare Commission Core Standards prior to registering with the Care Quality Commission. Before the Board was the summary of the changes to six core standards where there had been significant Board discussion for incorporation in the 2008/09 Core Standards Declaration.
Dr Shuldham highlighted the following:

- Standard C2 which refers to child protection. A full report had been given to the Board last month. This continued to be an area of risk and all organisations were concerned that they should be doing everything possible to protect children. The SHA had requested additional information for a further declaration of our performance on Safeguarding Children. We continued to do everything we could to maintain the standard.
- Standard C4 about proper decontamination of reusable medical devices. We had already outsourced our decontamination requirements at HH and RBH is soon to be outsourced to appropriate new decontamination centre.
- Standard C11b - mandatory training for staff. There is continual emphasis on maintaining this standard. Safeguarding children should achieve 100% through level 1 training material. Further focus is needed for infection control training in order to achieve the full target.
- Standard C17 - effective discharge arrangements. There is a comprehensive audit on discharge arrangements and further work is needed to ensure the effectiveness of discharge arrangements.
- Standard C24 - emergency planning. There had been a further exercise on flu preparedness on the Royal Brompton site.

Dr Shuldham concluded by saying that overall the recommendation is the Board support the declaration of compliance but also further work will continue as we go through registration with the CQC.

The Board supported the declaration to submit the same to CQC by 7 December 2009.

2009/226 REGISTER OF DIRECTORS' INTERESTS

The Register as at 5th November 2009 was presented to the Board for information by David Stark, Trust Secretary & General Counsel. Both the Chairman and Professor Sir Anthony Newman Taylor had further updates for the Register and Mr David Stark, would arrange for these amendments to be made and added to the Register.

2009/227 QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chairman raised the subject of the number and frequency of meetings which Executives had to attend. The current annual pattern included 11 Trust Boards and 6 Governors' Councils. Executives had discussed this and concluded that meetings, in any given year of the Directors could possibly be reduced to 8, meetings of the Corporate Trustee to 4 and would encourage the Governors to reduce their Council meetings from 6 to 4. Mr Stark agreed to look at meetings for the coming year 2010. It was decided that the Trust Board arranged for 16th December 2009 at Harefield would be cancelled and this needed to be publicised.

As the next meeting of the Board would be in January, the Chairman thanked the Directors for their support during the year and wished everyone the Season's greetings for Christmas and the New Year.

2009/228 DATE OF NEXT MEETING

27th January 2010, at 2.00 p.m. in the Boardroom, Royal Brompton Hospital.