ROYAL BROMPTON & HAREFIELD NHS TRUST

Minutes of a Meeting of the Trust Board
Held on 27 February 2008 in the Boardroom, Royal Brompton Hospital

Present: Lord Newton of Braintree, Chairman
Mr R Bell, Chief Executive
Mr N Coleman, Non-Executive Director
Mrs C Croft, Non-Executive Director
Prof T Evans, Medical Director
Mrs J Hill, Non-Executive Director
Mr R Hunting, Non-Executive Director
Nr N Lambert, Director of Finance & Performance
Mr P Mitchell, Director of Operations
Prof A Newman-Taylor, Non-Executive Director

By Invitation: Ms M Cabrelli, Director of Estates & Facilities
Mr R Connett, Head of Performance (Acting)
Mr R Craig, Director of Planning & Strategy
Mr R Sawyer, Head of Risk Management
Ms J Thomas, Director of Communications
Mr T Vickers, Director of Human Resources
Ms J Walton, Director of Fundraising

Apologies: Mr N Hunt, Director of Service Development
Dr C Shuldham, Director of Nursing & Governance
Cllr J Mills (Member, OSC on Health, RBK&C)

In attendance: Mrs R Paton (Minutes)

2008/11 MINUTES OF THE PREVIOUS MEETING HELD ON 23 JANUARY 2008
The minutes of the previous meeting were agreed as a correct record.

2008/12 REPORT FROM THE CHIEF EXECUTIVE
Mr Robert Bell, Chief Executive, wished to update the Board on three recent events in relation to the public profile of the Trust:

1. On February 5th the Trust had received a visit from HRH The Prince of Wales. This had been a formal event, arranged in association with the Soil Association, and His Royal Highness had met staff and patients on the subject of food, food services and organic produce. The Prince had since written an extremely warm letter to say how much he had enjoyed his visit; it was well known the Prince held in high regard the work of Mike Duckett, RBH Catering Manager, and the quality of the food at RBH. Trust chief executives from many parts of the country had attended the event, reinforcing the reputation and public support of the Trust.

   Prof Tony Newman-Taylor, Non-Executive Director, wished to reinforce recognition of the invaluable service given by Mr Duckett over the years in the provision of high quality food, much of which was organic and sourced sustainably in South East England.

   Mr Patrick Mitchell, Director of Operations, reported that Mr Duckett would be assessing options for Harefield, however as part of the cost improvement programme, costs would have to be borne in mind. He

emphasised that, while RBH catering costs were higher than in many Trusts, they were lower than many others, and success had not simply been achieved by spending more.

2. On 24th February the Trust had been the beneficiary of an event held at Her Majesty's Theatre, Haymarket: a "Singing for Breathing" concert with a cast made up of household names from the stage, screen and musical world. The 4-hour concert had been held in memory of a Trust patient who had been a prominent vocal coach, and attracted an audience of 1100. Proceeds would go to the Singing for Breathing Fund in support of singing training for patients with breathing problems. Ms Jenny Walton, Fundraising Director, reported that there had been good media coverage of the concert, which had also afforded access to some of the stars who had taken part with a view to future fundraising.

3. On 4th February an Annual Gala had been hosted at the Dorchester Hotel by the Chain of Hope charity, led by Sir Magdi Yacoub, to support children in the developing world with cardiac problems. Many of the Trust's staff had attended and were active on the charity's behalf. This was now an annual event which also helps to raise the public profile of the hospitals by their association with the charity.

The Chief Executive said these events were worthy of celebration, not only for the fundraising involved, but the goodwill and positive coverage which they engendered.

2008/13 HAREFIELD REFURBISHMENT AND REDEVELOPMENT

Mr Mitchell reported that a periodic review was being undertaken of the SLA with the "chambers" of local surgeons and the Hillingdon Hospital NHS Trust on the provision of non-cardiothoracic support. No concerns had been reported, but the arrangements needed to be kept under review.

With reference to the overall upgrading programme, the Board was already aware that some delay had been caused by the addition of work supported by further monies allocated for infection control improvements, but the updated plan remained on schedule. Ward upgrades were proceeding to plan, the thoracic theatre redevelopment had begun and electrical supply work had commenced now that a suitable access point had been established.

Mr Mitchell also reported that a decision had been taken to purchase outright the temporary ward currently on lease to the hospital.

2008/14 RESEARCH & DEVELOPMENT – BIOMEDICAL RESEARCH UNIT APPLICATIONS

Mr Robert Craig, as Acting Director of R&D, presented the two Biomedical Research Unit (BRU) applications for members' information. He explained that although the Trust was engaged in various initiatives relating to the new R&D regime, the BRU applications were the most immediate. The good news was that the Trust had been invited to interview for both applications on 11th March and, to this end, initial rehearsals had been held. The scientific applications themselves had been circulated with the Board papers for information. Both Prof Newman Taylor and Prof Evans thought the scientific content of the applications extremely good, but recommended further practice on the presentations and interviews. Mr Nick Coleman, Non-

Executive Director, said it was clear that winning these two applications was enormously important to the Trust and asked if the Board could do anything to improve the team's confidence and chances of success. The Chief Executive felt that gaining BRU status was not just about acquiring money for research, but also about securing commitment from the DH for the Trust's future in R&D. He reminded the Board that the Trust was in partnership with Imperial College in these applications and he wished the enterprise to be recognised as worthy of on-going research funding. If not, the Trust could be facing a strategic "point of departure" and decisions would need to be taken on the future alignment of our services and priorities. The Chief Executive wanted the Board to own the applications, not simply endorse them – this was a Trust commitment. Prof Evans felt it would send the right message if the Chairman were able to attend the interviews, demonstrating how important the applications were to the Trust. The Board endorsed these sentiments entirely and the Chairman agreed to attend the interviews, although he already had other commitments that day. On behalf of the Board, he wished everyone well with the final stages of the applications and expressed his appreciation of the large amount of work undertaken in their production to date.

2008/15 APPROVAL OF THE TRUST CAPITAL BUDGET 2008/09

Mr Mark Lambert, Director of Finance & Performance, spoke to the paper. During the current year the Trust had made significant investments encompassing a number of major capital items including Stereotaxis, CareView, PACS/RIS and Theatre 6 in Sydney Street. As a number of these capital schemes were currently work-in-progress there was a high proportion of pre-commitment in the budget for 2008/09.

The Board approved the Capital Budget.

2008/16 PERFORMANCE REPORT FOR MONTH 10: JANUARY 2008

Mr M Lambert, Director of Finance & Performance, reported that the Trust for Month 10 had made a very creditable £138K surplus, giving a year-to-date cumulative surplus of £3,590k.

The Trust had been instructed by NHS London to deliver no more than a £2.4m surplus for the year, but at Month 10 we had overshot this amount and were at considerable risk of the trend continuing. Mr Lambert and the Finance team were exploring actions to reduce this surplus.

It was reported that the Chair of the Provider Agency had written to all Trust Chairs in the last few days saying that Trust performance should be judged on four objectives: 18-week wait target, accident and emergency (N/A to this Trust), MRSA and financial delivery. Mr Lambert explained that a Trust is not allowed to exceed its financial control total, otherwise it will be deemed to have failed in this area, with the Chief Executive and the Directors in the establishment being rated 'D' overall. Mr Bell, the Chief Executive, felt the Trust found itself in a bizarre situation in that having arrived at a deficit in early 2007/08, and through a lot of effort having turned around the situation, now found itself in this position. Having exceeded the appropriate target, we could be considered to be a failure. It was strange that a deficit would be welcomed! In reality we are being asked to stop doing work for one month and this could lead to the complete demoralisation of the leadership of this organisation. Mr Bell queried how, in one month, could the organisation be brought to a halt, only to step up activity again in April in order to reach

targets set for next year?

Mr R Hunting, Non-Executive Director, recommended the situation be referred to a political level. The Chief Executive said that if the challenge is that we cannot forecast appropriate surpluses, it would be helpful at the beginning of the year to know what we would be receiving for R&D. He noted also that national specialists groups were sending us ambiguous letters. Mrs J Hill, Non-Executive Director, suggested the Chair and Non-Executives might write to NHS London and Lord Warner on the matter. The Chief Executive said the Trust would comply with instructions, would not put the organisation at risk and would provide the right numbers. We would have to spend a lot to get us down to the level required and might even have to stop non-elective activity - a sort of forced shut down.

Mr R Hunting, Non-Executive Director, asked if this target could be achieved. The Board reported that a shut-down for PP activity could lose £1.6m in a month – this was a radical idea and clinicians would not be happy if this step was taken. The Board were confident for MRSA and 18-week targets.

Operational Performance

Mr Lambert then moved on to the operational report for Month 10. He wished to report some positive highlights: there had been no cases of MRSA in the last three months; total coding for ethnicity is reported at 83.1% which means we are within target, we are positively compliant with cancer waiting targets. The reportable cancelled operations have risen to 1.48% - if this can be kept to 12 per site for February and 8 per site for March, the Trust could still attain the 'underachieved' grade.

In response to a question from Mr R Hunting if our recent MRSA figures had been positively affected by any change in procedures, Prof Evans thought not, but confirmed there was a continuing policy of screening every patient coming into the hospital and that isolation treatment is used in the case of infection. For the future, Prof Evans, felt that C.difficile would become more prominent.

Mr P Mitchell, Director of Operations, reported the plant had been running optimally in order to achieve the 18-week target; this had led to the number of cancellations rising. He reported that pressure in one part of the hospital can lead to problems elsewhere and two weeks ago a 'no cancellation' policy had been adopted; any possible cancellation is reported to Mr Mitchell who will then work to mitigate against this happening. Surgeons are unhappy about this situation and work is being sent off-site to enable achievement of the 18-week target.

Mr N Coleman, Non-Executive Director, advised that when an organisation is operating to its sustainable limit, vigilance is necessary to recognise precursors that indicate the operation is being run too hard which could lead to problems. When the precursors start presenting, it is time to draw back. Prof T Evans, Medical Director, felt this was absolutely correct and gave the example that healthcare infections will rise when an operational machine is working at capacity. The Trust had already had to close part of ICU to enable deep cleaning due to one case of VRE bacteraemia. Prof Evans thought the precursor markers were already appearing and that there was need for some slack in the system. Sending work elsewhere meant clinicians were working off-site and this was not a good situation.

Mr Lambert reported a Serious Untoward Incident (SUI) in relation to clinical waste collection. Our waste disposal contractor had had a licence revoked and waste is building up on-site at RBH. Negotiations are being held with alternative providers but, in the interim, it is better that the waste is held securely on-site until a licensed contractor is found. Mr Mitchell, Ms Cabrelli and Mr S Moore, General Services Manager, have undertaken extra work to manage this situation and the Chairman, on behalf of the Board, thanked them for coping with this unforeseen work.

2008/17 2008/09 ANNUAL PLAN

Mr M Lambert circulated an updated final version of the Annual Plan for 2008/09, due to be submitted to the London Provider Agency by 29th February 2008. He pointed out that there is still significant uncertainty as confirmation is awaited for the level of certain NHS R&D income for 2008/09 and also of significant SLA income for clinical services.

The plan showed a surplus of just over 1.1% for 2008/09 and the subsequent years. The Chief Executive, Mr Craig and Mr Lambert had been at a meeting with NHS London earlier in February where it was made quite clear that as all trusts are aiming to become Foundation Trusts, the minimum acceptable surplus to both Monitor and NHS London was 1.0%.

In order to achieve the required level of surplus and based on current assumptions the Trust is required to develop a financial stability plan for 2008/09 of approximately £11 M. This target is extremely challenging and had required some hard decisions to be made to achieve it.

It was then discussed whether the Board wants to budget for a higher surplus. CEO re-iterated that the Trust has to deliver a minimum of 1.0%. He pointed out that no BRU income is included in the current plan as we have not had confirmation of the success of our bids.

Mr N Coleman asked if the Trust could satisfy Monitor if it reopened its application for FT status. The Chief Executive replied that he thought probably not. To achieve the required outcome in 2008/09 requires the taking out of significant cost. The position in future years is even tougher with the complete withdrawal of NIHR funding. Mr Coleman then stated that changing the surplus here would not necessarily lead to FT status. Submitting these plans does not prejudice the Trust's FT application. The Chairman reminded the Board that it is expected every Trust becomes an FT in due course. The Chairman said we have to agree to this document as it is and it seems to be a reasonable framework, incorporating a good base position and we will fight the FT position on another day. Mr R Craig, Director of Planning & Strategy, stated that the Trust will have to make clear which figures are unsure or are assumptions. The Chairman said it was necessary to write a covering letter with the submission, pointing out the difficulties we are experiencing.

NHS support costs are very significant, not all known yet. With reference to R&D funding for 2008/09, the Chief Executive reported it had been announced yesterday that we were in the top five UK Trusts to receive substantive funding: Imperial College Healthcare Trust would receive £26m, University College London Hospitals £17.5m, Great Ormond Street £13.5m, Bart's £12.6m, Royal Brompton & Harefield £11.7. All other Trusts below this

level received less than £10m. Mr Lambert confirmed that the annual plan had been updated to take account of this late information.

With reference to Appendix 1: Annual Plan Self-Certification, Mrs J Hill asked if the Chief Executive felt confident about the quality statements. Mr Bell replied in the affirmative, with certain caveats. It was confirmed that K&C PCT was signing/had signed the SLA but that other PCTs had either not communicated or were in no hurry to sign. The Chairman said this fact should be included in the covering letter to the London Provider Agency in order that they might influence London PCTs, however they would have no jurisdiction over PCTs outside London.

It was highlighted that as of the date of this meeting, there was also uncertainty regarding the level of income from the National Commissioning Group for our transplant and LVAD programmes. The KPMG report, which the Trust and NCG jointly commissioned, demonstrates that the Trust used £2m of transplant income to subsidize its VAD programme, something the Trust has always been very open about. NCG are looking to remove these funds, albeit partially replacing them with other streams of funding that cannot be confirmed until March 2008. We have therefore requested clarification and included the worst case scenario in the Annual Plan.

The Chief Executive said that if this income stream is not guaranteed, he might have to propose we suspend the LVAD programme - we cannot continue with something that is not being funded. Mr N Coleman asked if any pressure could be applied - we are after all trying to deliver a patient service here. The Chief Executive said the NCG would say they fund transplantation plus VAD equipment at cost and that we ourselves have taken the decision on the additional VADS funding as part of our transplant programme. Prof T Evans, Medical Director, reported the Trust had undertaken 82% of the national VAD programme this year, so it seems to be largely our problem – if we said we would discontinue the LVAD programme, this would probably be welcomed by certain people in the DoH. The Chief Executive agreed that this was the reality, and felt it was a case of who would withdraw first. The Chairman counselled the Trust to assess the situation very carefully before taking any action but if income continues to be withdrawn, the Trust could not continue with the full programme.

The Board approved the draft Annual Plan and the Chairman asked that a covering e-mail along the lines indicated previously be sent.

2008/18 <u>18 WEEK WAIT TARGET</u>

Mr P Mitchell, Director of Operations, explained that for this initiative, from 1st March, the Trust needs to ensure that 85% of admitted patients are treated within 18 weeks and 90% of patients treated in Outpatients within 18 weeks.

To collect data, 6 whole-time administrators and a project manager have been engaged. The administrators are looking at 18 week clock start dates, working closely with Directorates and contacting referring hospitals to establish clock start dates. 6-10% of our patients are referred direct from their GP but 90% are referred from 130 different Trusts.

An audit week was held in January which established that 85% completeness was achieved for clock starts; the Trust needs to achieve 90% completeness by the end of April. Work is being undertaken to define 'start'

and ‘stop’. As part of the audit, four sources of referral onto the 18 week RTT pathway were established: GP initiating direct referral; new external Trust; RB&H initiating a new pathway for existing patient; existing, external trust referring to RB&H for continuation of an existing pathway.

Mr Mitchell explained that there is a focus not only on achieving the 18 week wait targets, but ensuring there are no breaches of the national waiting list standards which are monitored as part of the Healthcare Standards process. The Board remarked on the valiant efforts being made to juggle the targets here and appreciated the huge amount of work undertaken. The Chief Executive confirmed the Trust would do nothing to compromise patient care. The Chairman confirmed that all executives have the full support of the Board in these difficult times trying to meet targets.

2008/19 RISK MANAGEMENT REPORT

In Dr Shuldham’s absence, Mr Ray Sawyer, Head of Risk Management, presented a report which provided Board members with an overview of their responsibilities for Health and Safety and Risk Management, and of the arrangements in place to fulfil these obligations.

Risk Management Strategy

Mr Sawyer explained that effective risk management by the Trust is required to be demonstrable to a range of external review organisations, including the Audit Commission, the Healthcare Commission and the Department of Health through the annual submission of the Statement of Internal Control. The Trust’s arrangements for the implementation of risk management were detailed within the Risk Management Strategy, which highlighted the cascade of responsibilities for risk management from the Chief Executive, through the nominated lead Executive Director (Director of Nursing & Governance), to all staff. Mr Sawyer highlighted the few changes which had been made to the current strategy.

The Board approved the Risk Management Strategy.

Assurance Framework

A key provision of the Risk Management Strategy was the maintenance of an Assurance Framework to provide the Board with an overview of the potential risks to the attainment of its objectives, and the controls and assurances that these controls remain effective. The Assurance Framework was provided to the Board for its Review.

The Board noted the Assurance Framework and the risk issues identified.

Health & Safety

Mr Sawyer reported that, whilst the management of Health & Safety was part of risk management, it was subject to a separate range of legal requirements enacted under primary legislation and enforced by the Health and Safety Executive (HSE). Mr Sawyer reminded the Board that the Trust had recently hosted an inspection by the HSE with specific reference to the management of legionella, asbestos, stress and patient moving and handling. He was pleased to report to the Board that no breaches of legislation had been identified, and the observations offered were being taken forward satisfactorily.

The Institute of Directors had, in conjunction with the Health and Safety

Commission, published a Directors' Guide to effective health and safety management. Mr Sawyer brought this to the attention of the Board and asked them to note its provisions. The Chairman said that the Government had agreed to accept this as a voluntary code but there was significant pressure for this to become statutory.

The provisions for the management of health and safety in the Trust were detailed in the updated Health & Safety Policy, which had been included in the Board's papers and offered for their review. Mr Coleman raised some details of wording, on which he agreed to liaise with Mr Sawyer outside the meeting.

Subject to these minor amendments, the Board approved the Health & Safety Policy.

Risk Register
The identification of risks relating to the health and safety of both the Trust's patients and staff were routinely identified through the process of risk assessment and collated in the Trust's Risk Register. Mr Sawyer noted that further training was being undertaken to ensure that the identified risks were being reviewed to fully reflect the control mechanisms being developed.

Mr Coleman noted that some high-level risks detailed within the Risk Register appeared not to have shown improvement, and the potential consequence of such risks materialising. Mr Sawyer assured the Board that controls were in place and were reviewed to ensure that the likelihood of such events materialising was kept at a minimum, however there would always be material, residual risk e.g. in areas of clinical practice. Prof Newman Taylor reported that a great deal of effort was taken to deal with clinical risk, but agreed there would always remain the possibility of unplanned and untoward events.

The Board noted the Risk Register and the risk issues detailed within it.

Corporate Manslaughter
Mr Sawyer brought to the attention of the Board the new Corporate Manslaughter Act, which provides for legal action against an organisation where failings of senior management lead to a fatality. The Chairman explained that the legislation would make it easier to litigate in relevant cases, as it held an organisation collectively responsible, rather than requiring the identification of a responsible individual.

The Chairman was keen to ensure that the Board should take greater responsibility for Health & Safety matters, with a review at least once per year of any shortcomings.

The Chief Executive reminded Board members that the current process was for these matters to be reported to the Audit and Risk Committee which, as a committee of the Board, was part of Board deliberations and provided a review of this aspect of risk management through the quarterly reports which it received. The minutes of the Audit and Risk Committee came to the Board with specific issues of note or concern highlighted. The Director of Nursing & Governance was the Executive Director assigned responsibility for risk management, and would ensure that relevant information was referred to the Board.

The Chairman stressed that the Board needed to take an interest in, and be fully briefed on, these matters, and wished to ensure that adequate reporting to the Board was maintained. The Board agreed that appropriate reports from the Audit and Risk Committee should come to the Board.

In response to a query from Mr Coleman, the Board confirmed that the Audit and Risk Committee fulfilled a statutory requirement and was the Board committee dealing with risk, while the Finance Committee was not a statutory requirement, and undertook scrutiny of financial matters and the executive team's financial management. The Chief Executive felt that there was good Board-level engagement in these issues and reminded the Board that a (currently) monthly performance report was also submitted to the SHA.

Noting the discussion and approvals gained, the Chairman thanked Mr Sawyer and his team for all the work undertaken to produce the items discussed.

2008/20 REGISTER OF DIRECTORS' INTEREST

Mr Lambert submitted the updated register to the Board. Mrs Croft, Mrs Hill and Lord Newton reported that they had further amendments to be included and agreed to liaise with Mr Lambert to arrange this.

2008/21 CODE OF CONDUCT & CODE OF ACCOUNTABILITY

The code was submitted to the Board and adopted.

2008/22 COMMENTS FROM MEMBERS OF THE PUBLIC

Mr Kenneth Appel (representing patients through his membership of the PPI Forum) remarked on the forthcoming dissolution of the PPI Forum and the impending inception of LINks (Local Involvement Networks). He asked how the new groups might be involved in relation to the BRU initiative. Prof Newman Taylor replied that there was a real role for PPI in looking at research applications, identifying relevance to patients and public, and influencing the design of studies. He referred Mr Appel to Section 10 of the BRU applications which included aims for PPI involvement. Mr Appel agreed to discuss the issue further with Rachel Matthews, Senior Nurse – User Involvement.

Mr David Potter, Rebeat Club, wished to congratulate the Trust and its staff for its continuing service to patients and its financial performance. He added he was mystified by the way the NHS centrally seemed to be being managed for political benefit.

In relation to the Risk Management Strategy, Mr Appel asked about the provision of mandatory training for medical staff in the area of adverse incidents. Although covered under separate policy provisions, Prof Evans confirmed that consultant medical staff had to undergo annual training in a number of areas, including infection control, basic life support, and blood safety. This training was integral to the staff appraisal system, which was closely monitored. Mr Appel enquired further in relation to similar training for nursing staff, particularly in the area of medication (medicines management). Prof Evans confirmed that there was a similar set of mandatory requirements for nursing and other professional staff. Mr Sawyer explained that the Trust complied with the Clinical Negligence Scheme for Trusts (CNST) requirements at Level 2, which incorporated compliance with these training

requirements. He agreed to supply relevant information to Mr Appel.

2008/23 DATE OF NEXT MEETING

Wednesday 26th March 2008 at 10.30 a.m. in the Concert Hall, Harefield Hospital