Royal Brompton & Harefield NHS
NHS Foundation Trust

Minutes of the Board of Directors meeting held on 26th January 2011 in the Boardroom, Royal Brompton Hospital, commencing at 2.00 pm

Present: Sir Robert Finch, Chairman
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
Mr R Hunting, Non-Executive Director
Ms Kate Owen, Non-Executive Director
Mr Richard Paterson, Interim Director of Finance
Dr C Shuldham, Director of Nursing & Clinical Governance

By Invitation: Ms J Axon, Director of Capital Projects & Development
Professor Andrew Bush, Professor Paediatric Respirology
Mr N Hunt, Director of Service Development
Mrs C Johnson, Director of Human Resources
Mr P McCleery, Director of Planning & Strategy
Mr R Goodman, Director of Pharmacy & Medicines Management
Mr R Morgan, Interim Chief Accountant
Mr R Paterson, Interim Director of Finance & Performance
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: Mr N Lerner, Non-Executive Director
Professor Sir Anthony Newman Taylor, Non-Executive Director
Mr Mark Lambert, Director of Finance & Performance

The Chairman welcomed everyone to the meeting, including a group of SpRs taking part in management training. The Chairman also introduced and welcomed Mr Richard Paterson, Interim Director of Finance & Performance.

2011/1 MINUTES OF THE PREVIOUS MEETING HELD ON 24TH NOVEMBER 2010
The minutes of the meeting were approved.

2011/2 REPORT FROM THE CHIEF EXECUTIVE
Mr R Bell, Chief Executive, reported that Mr Mark Lambert, Director of Finance & Performance, was now at home following discharge from hospital and was progressing with his recovery. Mr Bell, on behalf of the Board, wished him well.

- **Project Diamond (PD)**

Mr Bell updated the Board on the status of the PD funding. The Trust had received written confirmation that £9.1m had been allocated to the Trust for the current financial year, having satisfactorily addressed all the NHS London criteria to which this funding was attached. Several cash flows had already been

received and the balance was expected by year-end. This will enable the Trust to achieve financial balance for this financial year.

- **Budget**

Mr Bell said he anticipated a financial challenge for the coming year of approximately £25-30m, made up of a possible £8m of negative decline in the tariff income, £7.5m of loss in relation to the PD income supplement, approximately £7m in cost increases (wage increments, drugs & pharmaceuticals, agency use and contractors), and between £3m - £8m on in-year commissioning issues. The NW London commissioning intentions were to see a 12% reduction in our income from the 48% reduction in activity over the next four years. These commissioning intentions of the NW London NHS Sector had arrived yesterday – they were also looking at all Trusts making a 4% reduction through cost improvement. Mr Bell reminded the Board that the Trust as an FT had a statutory duty to balance financially and according to our IBP a £5m surplus was expected. The Trust faced a severe economic challenge and feedback from other London trusts confirmed they are all experiencing financial pressures somewhere in the range of 7 – 8% of turnover. Not everyone entitled to the PD funding had received it and this Trust had prevented this occurrence by taking a robust approach. Mr N Coleman, Non-Executive Director, said that without the PD money the Trust would have undershot the plan by £7-8m and that the possibility of a further undershoot should be factored in to next year's plan. The Chief Executive confirmed the loss of PD funding had been included in the £25-30m size of the financial challenge. Mr Coleman said that the 6-10% based on the £25-30m would be difficult to cover. Mr Bell said this would have to be achieved on a year-on-year basis. The Chairman emphasised that a bottom-up budget was necessary for the next financial year. Mr R Paterson, Interim Director of Finance, agreed that the 'devil was in the detail' of the budgeting process and there would be more discussion on the challenge to be faced in Part II of the meeting.

Mr N Hunt, Director of Service Development, outlined some of the current and future pressures coming from commissioners. We had received contracting and operational commissioning intentions from NW London acute commissioning unit, and South Central and East of England Specialised Commissioning Groups. Mr Hunt said that he would talk more to this subject later in the meeting relating to the paper he had prepared for Board discussion.

2011/3 CLINICAL QUALITY REPORT FOR MONTH 9: DECEMBER 2010

Mr R Connett, Trust Secretary & Head of Performance, distributed an updated report and Governance Declaration for Monitor to the meeting. He highlighted the following:

- Incidents: There had been two Serious Untoward Incidents (SUIs) reported in November 2010, as follows: an incident had occurred in May 2010 relating to a patient admitted for CABG who suffered complications after chest drain insertion, followed by cardiac arrest and neurological injury. A second incident occurred in October 2010. This incident related to tissue retention following removal of a pacemaker (Human Tissue Act requires SUI report). There had been a further incident In M09 December 2010 when a patient died following an attempted double lung transplant due to a mismatch in size of the donor organ (incorrect size data had been given by NHS Blood & Transplant).

  Mr Coleman noted that the number of SUIs being reported were twice that of last year and asked if this should be of concern. He confirmed that the Risk & Safety Committee (RSC) would look at this issue. Dr C Shuldham,

Director of Nursing & Clinical Governance, said that she would bring root cause analysis to the RSC. She confirmed that in July 2011 there would be a formal annual review of SUIs in the previous year to assess any possible trends. She continued that from the report last year it had been concluded that SUIs were often related to instrumentation in procedures (e.g. chest drains), or related to something being either given or not given. Mrs J Hill, Non-Executive Director, referred to the problem with the double lung transplant and wondered if the investigation undertaken was sufficient; Mr Coleman said this would be kept in mind by the RSC.

- Health Care Acquired Infections (HCAI): there had been 3 cases of C.difficile in December at Harefield Hospital. Dr Shuldham said the cases had been sporadic and there had been no cross-infection. The trajectory YTD was 20 cases, and the indicator had been achieved. The current trajectory had been set for 2010/11 at 27 but the DoH had proposed the trajectory for 2011/12 be set at 7. The Trust felt this to be unrealistic and proposed a trajectory of 24; the outcome of negotiations on this would be reported to the Board.
- Surgical Site Infection Surveillance Service (SSISS): The CABG SSI rate had increased to 9.65 per 100 operations, which is above the CQUIN Target of 6.3 per 100 operations. However, the Q3 performance overall is 5.64, so will be within the CQUIN target. Mr Coleman pointed out that 18 months ago the same problem had arisen; he recalled that in April the RSC had been tracking the safety actions being taken and had subsequently removed the item from the watch list. The Chief Executive agreed that concerns being expressed were legitimate but cautioned that when comparing statistics there should be an appropriate period of comparison. Mr Bell felt that assessing numbers on a monthly basis might not be the best method and said that it might be more meaningful to report this measure on a quarterly basis. Mr Coleman referred to Key Point 5: reduction in surveillance activities in March 2011. Dr Shuldham said that this would be addressed. Dr Shuldham referred to the rise in rate and explained that each wound infection was counted separately but that there might be more than one wound infection in one patient – the data is recorded this way as requested by external organisations. Mr R Hunting, Non-Executive Director, suggested that in future the data should be presented both monthly and quarterly. Professor T Evans, Medical Director, agreed that some patients were more susceptible to wound infection and that it would be good to see data on a quarterly basis as well as monthly. It was agreed to produce both reports in future.
- Cancelled operations: There had been 29 cancelled operations in December 2010: 6 at Brompton and 23 at Harefield. The YTD position is 1.04% against elective admissions, which is an underachievement against the CQC target of 0.80%.
- Cancer Targets, 62-day targets: Mr Connett reported on inclusion of patients upgraded to a 62-day pathway by their consultant alongside those on a 62-day pathway initiated by a GP. He had checked with Monitor regarding reporting expectations under the Compliance Framework and it had been agreed to report aggregate performance. Q3 performance against target, adjusted for breach repatriation, is 80.65%, so the Trust has achieved compliance with this indicator.
- 18-week Referral to Treatment Time Targets, Median Waits: The Trust total is 7.61 and the Trust is not meeting the median wait target for the non-admitted patient pathway. A review is being undertaken of the process for clock stops in out-patient settings.
- Complaints: 8 of the 9 complaints received in M8 had been responded to within the designated time. A more detailed complaint report would come to

the Board in the future.

- Single Sex Accommodation: The Trust is required to report non-clinically justifiable breaches to the DH and the Trust had submitted a zero return for the period. In future breaches would be subject to fines from commissioner to be levied at a charge of £250 for each patient affected.

Section 3. Governance Declaration for Monitor

Mr Connett confirmed that all targets in the compliance framework had been met in Qu 3 and the Trust was fully compliant with all the registration requirements of the Care Quality Commission. Therefore the Declaration 1 can be signed and the Trust Governance Rating will remain green. This declaration will be uploaded via the MARS portal. Mr Hunting asked if there were any criteria which might be challenged. Mr Connett felt all results were robust and external audit and internal audit assurance would be available to Board members.

Section 4. Controlled Drugs Governance & Activity

Mr R Goodman, Director of Pharmacy & Medicines Management, presented the report for July – September 2010. He confirmed that the total incidents reported had risen to 57 (the highest since records began in 2008). There had been no amber or red reports. Mr Goodman was not concerned by this total and said that the drug most reported was morphine, but that morphine was the drug most used in the Trust.

The Board noted the report.

2011/4 FINANCIAL PERFORMANCE REPORT FOR MONTH 9: DECEMBER 2010

Mr Richard Paterson, Interim Director of Finance & Performance, presented the report. He said that performance for the month had been poor due to particularly low activity in the week between Christmas and New Year. Trust costs were largely fixed so the outturn depended on income. ECMO service activity had been expensive and there were discussions underway to recover these costs. Income had been booked on a conservative basis. The underlying deficit for the month was £1.0m and cumulative YTD was £4.6m. £5.1m of Project Diamond funding had been received resulting in a surplus for M09 of £4.1m. The financial risk rating (FRR) had improved to a 3. The Financial Stability Plan (FSP) had schemes identified to deliver savings of £11.5m and £8.6m of income contribution. Forecast outturn for savings is £9.6m. Accrued debtors, representing NHS over-performance, amounts to £9m. In respect of disputes, there may be some potential for dispute with South Central SHA. At the present time the Trust is not in dispute with North West London commissioners.

In relation to Cash, the Trust drew for one month £5m from the working capital facility (pending confirmation of the PD funding). Mr Paterson felt this might not be the only time this action would be take in this harsh economic climate. He would be meeting with Barclays next week to cement arrangements for use of the working capital facility.

The Chairman asked Mr Craig to update the Board on the status of the FSP. Mr Craig reported that the current year-end forecast, without mitigating actions, was a shortfall of £1.9m (approx. 10%) against the original plan. Mitigating actions related to:

1. Adjustments to PP fees, which are scheduled to deliver over £300k by year-end;
2. Further procurement savings (the biggest area of shortfall, forecast to deliver £2.6m of a target of £4m). Focus has been on the five largest suppliers –

with whom the Trust spends a total of almost £25m per annum – to achieve further benefits. Mr Craig expected to see an improvement in the procurement area due to these mitigations, in the short- and long-term.

3. Temporary staffing. Progress being made in Q3 had been compromised as a result of the acute flu demands in AICU, which resulted in a doubling of temporary staffing expenditure in December (from £100k to £200k per month).

Mr Bell felt the discussion demonstrated that there was a limited amount that could be done to address the challenge through incremental improvements in procurement and activity. Mrs J Hill, Non-Executive Director, said it seemed as if our emergency work carried a high financial risk and the Chairman commented this was 'penalty' rather than 'risk'. Mr Hunt returned to the tariff for emergency work and said that David Flory, Director General – NHS Finance, had written to PCTs and Trust Chief Executives confirming that some trusts had been suffering from winter pressures resulting in an imbalance between emergency and elective work and that some of the monies retained in respect of the 30% emergency cap might be distributed to offset this imbalance. Mr Hunt confirmed he had written to the main commissioners about the contract, invoking the letter from the David Flory, asking them to create a methodology to pay for this emergency work.

The Chief Executive referred to the business model and said the Trust needed a pay structure which was less rigid and allowed more flexibility. The future of the Financial Stability Sub-Committee was discussed. The group's chairman, Mr N Lerner, had said the committee provided a small focus group which allowed proper drill-down into issues. The matter would be discussed with Monitor and a decision taken on the Sub-Committee's future at the next Board meeting.

Professor Evans returned to the subject of ECMO and said that even though this had caused financial pressures, the service had revealed the Trust at its very best and wished to see the work of the staff involved acknowledged. It was agreed that the Chairman would convey his thanks to the staff and that this would be organised through Ms J Thomas, Director of Communications.

Mr Coleman turned to the £3m adverse shift in the Trust financial position over the last three months and asked what guarantees there might be for the next 2-3 month period. Mr Craig confirmed the Trust lost £1m in December, but in November and October there had been £450k profit in each month, so the underlying position had improved by £1m in months 7 and 8. Mr Bell confirmed a loss was made in December but that pay costs were static. Activity was lower in both PP and NHS areas, but pay costs remained the same.

At this juncture, Mr Paterson distributed the Financial Commentary for the Monitor Q3 declaration. Mr Paterson said that with the payment of Project Diamond monies the financial risk rating had returned to 3. He explained that there was a declaration which was required to accompany the Q3 MARS upload template.

The statement reads: 'The Board anticipates that the Trust will continue to maintain a financial risk rating of at least 3 over the next 12 months'. Mr Hunting stated that he was not content to agree to this declaration because having heard of the financial challenges facing the Trust in 2011/2012 he did not think that an FRR of 3 could necessarily be guaranteed. Mr Bell said that he expected to be able to set a budget for 2011/2012 that would deliver an FRR of 3.

It was agreed to defer a decision on this declaration until after the Part II Board discussion of the 2011/2012 financial challenge.

The Board noted the report.

2011/5 NHS OPERATING FRAMEWORK & PAYMENT BY RESULTS FOR 2011/12

Mr N Hunt, Director of Service Development, presented the paper based on the Operating Framework and draft Payment by Results guidance issued by the DH for the year ahead. Mr Hunt said that further guidance was expected on how the finance would work. Application of the tariff would lose the Trust 6%, but at this stage there was also an attachment on which care groups would be affected, the tariff for critical care (adult) would have to be negotiated locally, emergency readmission following elective care would not be paid for, cystic fibrosis funding would need to be agreed locally, the children's specialist top-up had been reinstated, and the cancer and cardiac top-up had been withdrawn. There is a possibility that an increased tariff for specialist cardiac services could be negotiated. With regards to the tariff being a maximum, i.e. without the possibility for Trusts to compete on prices, providers in London could be expected to compete for work from within and outside London. Commissioning intentions had been received from NW London, South Central and East of England which echoed the Operating Framework and, in some cases, proposed greater restrictions on earning capacity.

The Board noted the report.

2011/6 PAEDIATRIC CYSTIC FIBROSIS UNIT

Professor Andrew Bush, Professor Paediatric Respirology, introduced the item and outlined the historic background to the current provision. He said that the treatment for cystic fibrosis had moved on and cross-infection was now a high-level issue. The current provision in Rose Ward was no longer fit for purpose. There was a need for separate cubicles with *en suite* facilities to provide for cohort segregation of CF patients as mandated by national and international guidelines. The recent CF Trust accreditation visit to the Trust had highlighted a mean waiting time for admission of 18 days compared to National Standards of less than 3 days. Unless improvements were undertaken there would be a risk to the future of the clinic, with possible reduction in size and resultant loss of income and possible impact on the size of the adult clinic. It might also mean the need to set up a clinic elsewhere. A family currently treated had highlighted the shortfall in standards and were offering some substantial funding towards improvements. Ms Joanna Axon, Director of Capital Projects & Development, reported on the plan which had been formulated to make provision for a dedicated 7-bed Paediatric Cystic Fibrosis Unit adjacent to Rose ward, and a 7 *en-suite* bedroom adolescent / adult unit at Level 5. Planning consent had been secured for this scheme. The total project cost was £4.8m. The project would fall into two parts and would require the closure of theatre 6 for a 3-month period which had been agreed with the Theatre Users Group. There would also be the opportunity to improve the air-conditioning for theatre 5 and to upgrade the plant in theatre 6, in order to meet current regulations. Ms Axon requested the approval of £4.8m for the project, plus the opportunity to improve plant at a cost of £655k, the total being £5.45. External charitable funding had been secured for up to £1.8m with the major donor family guaranteeing commitment of £1m, and plans had been based on the guaranteed £1m. The Trust's financial commitment would equate to up to £4.45m, assuming the £1m. With regards to the 'shortfall', debt funding analysis had been undertaken based on the Charity's

current loan facility of base rate plus 2.51% and 5.5% during the construction period. Based on these assumptions and a 6.0% discount rate the total net present value return is £1.16 million and IRR 39%. Equity funding would be an alternative.

Ms Axon confirmed the project construction start date would be around October, with theatre closure in November, December and January – this being the optimal time with regards to theatre usage. If there was a project delay resulting in theatres being closed for longer than the planned period, the loss of income to the Trust would be £320k per month.

The Chairman confirmed the project had been approved by the Management Committee and discussions would be held with the Charity with regards to the funding. He reminded the Board that the outcome of the London paediatric review was uncertain.

The Board approved the project in principle, subject to funding and the outcome of the paediatric review.

2011/7 COMPOSITION OF BOARD SUB-COMMITTEES & CORPORATE TRUSTEES

A paper outlining the membership of the Board Sub-Committees was submitted to the Board for information and to ensure clarity of the responsibilities devolved to Board members. The Board said the Financial Stability Sub-Committee and its membership should be added. It was noted that the Trust constitution allowed for only three sub-committees of the Board, others being regarded as *ad hoc* committees. Additional committees would need the authorisation of the Council of Governors. The Board proposed the Property Committee should be an *ad hoc* committee.

This was approved.

2012/8 QUESTIONS FROM MEMBERS OF THE PUBLIC

Mr David Potter, ReBeat, asked for an indication of the content of the following Part II meeting and the Chairman confirmed that discussion would be about the budget challenge for the coming year.

Mr K Appel, Governor, raised the following issues:

- The Government's intention to remove the capping on PP activity and how the Trust might best take advantage of this to offset the loss of income.
- The reason for some cancelled operations being lack of beds and whether it would be possible to increase the number of beds.
- The issue of patients (e.g. from West Hertfordshire) preferring to be referred to local units (e.g. Harefield) rather than a central London hospital. Mr Appel said he had raised this issue with West Hertfordshire Trust and would continue to do so. Notwithstanding the fact that referrals can be influenced by consultant relationships, Mr Appel emphasised that patients have the right to choose where their treatment will be.

In reply, the Chairman assured the meeting that the Board was aware of the need to maximise profitable PP activity and he confirmed there would be assessment soon of the expected removal of the PP cap. The outline development of the RB site included a new wing dedicated to PP, possibly with 90 beds rather than the current 30 and the Royal Marsden Hospital might also wish to join the Trust with this venture.

Professor Evans referred to patient referral to London and confirmed he had

already spoken to West Hertfordshire on how best the needs of patients could be served. Sometimes patients are offered quicker treatment if they agree to attend a London hospital. Professor Evans continued there had to be an understanding of capacity but the situation was being looked at and the Trust was attracting more work from surrounding trusts than in the past.

The meeting closed at 4 pm

2011/9 DATE OF NEXT MEETING

Wednesday 30th March at 10.30 a.m. in the Concert Hall, Harefield Hospital