ROYAL BROMPTON & HAREFIELD NHS TRUST

Minutes of a Meeting of the Trust Board held on 26 July 2006 in the Board Room, Royal Brompton Hospital

Present:	Lord Newton of Braintree: Chairman Mr C Perrin: Deputy Chairman Mr R Bell: Chief Executive Professor M Cowie: Director of Research and Academic Affairs Mrs C Croft: Non-Executive Director Professor T Evans: Medical Director Mrs J Hill: Non-Executive Director Mrs S McCarthy: Non-Executive Director Mr P Mitchell: Director of Operations Professor A Newman Taylor: Non-Executive Director Dr. C Shuldham: Director of Nursing and Governance
By invitation:	Mrs M Cabrelli: Director of Estates and Facilities Mr R Craig: Project Director Foundation Trust Status Ms J Ocloo: Chair Royal Brompton and Harefield Patient and Public Involvement Forum Ms J Thomas: Director of Communications Mr T Vickers: Director of Human Resources Mr D Wilson: Assistant Director of Finance
In Attendance:	Mr J Chapman: Head of Administration Mr R Sawyer: Head of Risk Mrs E Schutte: Executive Assistant

The Chairman welcomed members of the Trust staff and members of the public to the meeting.

REF

2006/92 MINUTES OF TRUST BOARD MEETING ON 29 JUNE 2006

The minutes of the previous meeting of the Board on 29 June 2006 were approved.

2006/93 REPORT FROM THE CHIEF EXECUTIVE

Mr Robert Bell, Chief Executive, reported on two matters;

(i) Hospital Infection Rates in 2005/6

On 24 July 2006 the Department of Health published summary details of hospital infection rates in England and Wales in 2005/6. Infection rates at Royal Brompton and Harefield Hospitals were among the lowest 5% in acute and specialist NHS Trusts and this was an excellent result in the context of the physical condition of some of the hospital buildings in the Trust. More detailed information was available from the Department of Health website or the Chief Executive's Office. Mr Bell said the aim in 2006/7 would be to achieve the best possible results in the NHS for the Trust.

(ii) Review of Trust Clinical Structures

Mr Bell reported that Professor John Wallwark had commenced a review of surgical services in the Trust and was engaging with clinicians throughout the Surgery Directorate. Professor Marc de Laval, Professor of Paediatric Cardiac Surgery at Great Ormond Street Hospital, had agreed to chair a similar review of Paediatric Cardiac Services. Terms of reference for both reviews were available from the Chief Executive's Office. Mr Bell said reports from both reviews would be given to the Trust Board in due course.

The Board noted the Chief Executive's report.

2006/94 <u>REVIEW OF HAREFIELD HOSPITAL AND SERVCIES</u>

Mr Patrick Mitchell, Director of Operations, gave an oral report on progress with implementation of the recommendations of the reviews of Harefield Hospital and its services. Confirmation was awaited from Hillingdon Hospitals NHS Trust on final details of general surgical cover for Harefield Hospital patients. An advertisement for nine consultant appointments at Harefield Hospital was booked for publication very shortly. The Trust's Fire Safety Consultants had confirmed sufficient ward-based staff had been trained to carry out evacuation procedures. Training for other staff is now taking place.

Tenders had been invited for the preliminary building works for adaptation of the main hospital building and a temporary ward, funded by the SHA special capital allocation of £2.3 million. The preliminary works were expected to start in September and the main scheme, which would take 60 weeks to complete, would start in October. The Trust had appointed Cyril Sweett Consulting to write the specification and lead the appointment of external consultants to

undertake the option appraisal of the future site of Harefield Hospital. Their report would be considered by the Trust Oversight Board and a final recommendation would be given to the Trust Board in December 2006 or January 2007.

The Board noted the report.

2006/95 RESEARCH AND DEVELOPMENT REPORT

Professor Martin Cowie, Director of Research and Development, presented a report which referred to six current issues relating to research and development in the Trust. The Annual Report had been submitted to the Department of Health and had been circulated to Board Members. The Outline Business Case for the EpiCentre was on schedule for completion in August. Oxford Management Consulting was reviewing the Trust's clinical trials activity and expected to complete the review in September.

The Department of Health had indicated that it anticipated bids for funding by medical research centres at the middle of an indicative range which for Royal Brompton and Harefield would be £3 million to £6 million per annum. This was about 20% of the Trust's 2006/7 research and development subvention. Professor Cowie commented that from the information released by the Department of Health for the 14 comprehensive and specialist centres there was a clear indication to transfer funds from centres in London and medico-political considerations appeared to exist in relation to funding some specialist centres at a higher range.

Professor Newman Taylor, Non-Executive Director, said the indicative bid range for which Royal Brompton and Harefield had been given leave to apply was disappointing and appeared to suggest for certain specialist centres that the ratio between the qualifying criteria of research outputs and research income were inversely related. Representations to higher authorities might prove to be counter-productive but the media might be engaged especially in relation to research into respiratory diseases where the burden of disease was highest and research funding was least. Mrs McCarthy said engaging the media should be a constituent part of a Trust communication strategy led by the Chief Executive that would influence decision making at appropriate times.

Mr Bell explained that additional communications support had been used over the past six months to examine the consequences of a

research and development income shortfall, working with the Trust's communication team and Imperial College with external advisors.

Professor Cowie also referred to the Human Tissue Act 2004 which comes into operation on 1 September 2006. The Trust would be a corporate license holder for processing, storage, analysis and disposal of human organs and tissue with three designated individuals responsible for compliance with the legislation. Professor Newman Taylor said it was important that services provided by Imperial College departments and staff within the Trust were firmly embedded within Trust systems and regulation relating to human organs and tissue.

Professor Cowie also drew attention to a report from the Trust Internal Auditors on action to address research governance issues that were identified three years ago. The Auditors had now made six recommendations. Mrs McCarthy commented that research governance and strategy issues should be referred to the Audit and Risk Committee which reported to the Board. The Acting Director of Finance was reviewing Standing Orders and Standing Financial Instructions for research governance as well as for Trust governance. Mr Charles Perrin was nominated as a Non-Executive Member of the Joint Research Management Committee. The Chairman said that other Non-Executive Directors who wished to be members should inform him.

The Board thanked Professor Cowie for an informative report.

2006/97 RACE AND EQUALITY SCHEME FOR 2005-2008

Mr Patrick Mitchell, Director of Operations, presented the draft Race Equality Scheme for 2005-2008 to the Board for adoption. The Trust had published its first Race Equality Scheme in 2001 and had revised it in 2005 in accordance with the requirements of the Race Relations (Amendment) Act 2000. Since March 2005 constructive criticisms, which the Trust had welcomed, were received from the Patient and Public Involvement Forum, the Strategic Health Authority, the 1990 Trust and Trinity Development on the revised RES. Notably these highlighted failures to comply with general and specific duties under the 2000 Act. There were weaknesses in the way impact assessments were undertaken, staff were insufficiently trained for the task and their understanding of legal requirements under the Race Equality Scheme were thereby limited and the methodology employed made independent verification and audit difficult. This weakened the integrity of the process and the conclusions drawn

from it. The Scheme was perceived to focus race equality as a human resources issue and thus insufficiently addressed the needs of BME patients and delivery of services. There was little presented evidence that the Trust was creating capacity to develop and mainstream race equality and it was unclear how the action plan would be fulfilled. There was a lack of information in relation to race and race equality in the Trust and the absence of BME staff at Board and senior management levels was highlighted.

Mr Mitchell said the draft Race Equality Scheme and action plan for 2005-2008 responded to and addressed the criticisms. The Trust had implemented systems and processes to ensure that impact assessment review complies with the 2000 Act. Impact assessment had been applied to all Trust policies specific to critical care, being the area where it was considered any discriminatory practice or function would have the greatest consequence. Under the action plan full assessments would be undertaken where relevance is indicated. To ensure that consultation with stakeholder groups takes place on matters that relate to the RES the Trust will work with them and with black and minority communities to remove barriers to proper consultation. Information will be made available as far as is possible on request and in accessible formats.

Information on staff ethnic profile will be reported monthly and employment monitoring data, as it becomes available, will be used to examine whether there is adverse impact on any racial group. The results of monitoring will continue to be published annually and key data reported to the Trust Diversity Steering Group and quarterly to the Trust Board. The Trust had reviewed provision of training to staff relating to equality and diversity issues and substantive changes had been implemented in 2006. All new staff were receiving equality and diversity training as part of their induction programme. The training was mandatory for all staff and to date more than 230 staff had undergone a bespoke training programme run by the Trust Equality and Diversity Coordinators. Training for senior managers and Board Members was being provided externally and was due for completion by August.

The Trust had launched an equality and diversity portal on its intranet site and was improving the content and accessibility of information on its internet site. An equality and diversity newsletter was being developed. Equality and diversity staff networks would be created and partnerships formed with local external groups.

On monitoring the Trust's compliance with the RES and implementation of the action plan, Mr Mitchell said the Board would receive a quarterly report and an annual report would be published. Monitoring would include public consultation and consultation with focus groups, patient and staff surveys and data analysis. Compliance would also be included in NHS performance management.

Mr Mitchell concluded that the Trust would achieve its equality and diversity objectives through the Scheme. The objectives were to make measurable improvements each year in reducing and eradicating race inequality and provide evidence to support it, to minimise actual or potential negative outcomes from the services the Trust provides and to develop a workforce that is diverse and inclusive.

Ms Josephine Ocloo, Chair of Royal Brompton and Harefield Patient and Public Involvement Forum said that she wished to acknowledge the hard work of the team working on the Race Equality Scheme and the work that had been completed to date to allow a revised RES to be presented to the Board. The Forum she said were particularly pleased that training on equality and diversity was now taking place for Trust staff, senior managers and Board members and that staff forums had been set up to allow for a debate on promoting race equality to take place as this had not existed before. Ms Ocloo also thought it was important to establish forums to allow more patients from BME backgrounds to participate in the debate as she had been the lone voice as someone from a BME background raising issues and drawing to the Trust's attention their lack of compliance with their legal obligations to promote race equality and diversity for a number of years.

Ms Ocloo reiterated the point made previously by Patrick Mitchell, that the Race Equality Scheme was the main way for the Trust to achieve its race equality goals and therefore she felt that it was now important to get it right. The main disagreement that she had concerning the revised Scheme was in relation to the arrangements for carrying out full impact assessments. This she said had been an issue of ongoing debate between the Forum and the Trust as the Board was well aware and which required the Trust under the RR(A)A to state in particular, those of its functions and policies, or proposed policies, which had been assessed as relevant for the performance of the general duty and arrangements for assessing and consulting on the likely impact of proposed policies on

the promotion of race equality. Ms Ocloo said that whilst the current Scheme did not address this requirement she was prepared to support the revised scheme if it stated clearly the arrangements for when full impact assessments would be carried out across all Trust functions and services and the arrangements for consulting on this process and any action plan agreed to tackle any issues. This she felt was not set out clearly at the moment in the revised Scheme. She said she was however pleased that Patrick Mitchell had now confirmed by email, prior to the Board meeting that he was happy to receive any amendments to the current Scheme, which would highlight or clarify this issue further.

The Chairman said that the main point of contention between Ms Ocloo and Mr Mitchell appeared to be in relation to making clearer the issue of intent regarding the process of carrying out full impact assessments and agreed that Ms Ocloo should submit any amendments she thought necessary to clarify the process. He said that the Board acknowledged and was grateful to Ms Ocloo for her contribution to the debate over race and equality issues in the Trust over the past five years and the progress that that had ensued. He said subject to Ms Ocloo submitting her amendments, there was agreement over the Trust's objectives for equality and diversity and in what the Scheme and the action plan proposed. He therefore commended the Scheme and the action plan to the Board for approval, which was given.

2006/98 MEETING OF FINANCE COMMITTEE ON 26 JULY 2006

Mr Charles Perrin, Chairman of the Finance Committee, gave an oral report on matters considered at the Committee meeting earlier in the morning. The Committee had reviewed a report on performance for June 2006 and had approved two write-offs of £16-17,000 each. On Foundation Trust status, the Committee had learned that the Trust had received two offers, one of which was in writing, to provide working capital when the Foundation Trust comes into operation. Both offers required further consideration. Recommendations to approve working capital would be submitted to the Trust Board in due course. The Committee had also considered in detail the proposed budget for 2006/7 and was prepared to recommend it to the Board for approval.

2006/99 PERFORMANCE REPORT FOR JUNE 2006

Mr David Wilson, Assistant Director of Finance, gave a report on the financial performance of the Trust up to 30 June 2006. A surplus of income over expenditure of £1,934,000 was reported. The Trust had

to deliver a 1% surplus under the NHS operating framework for 2006/7 which equated to a full year budget surplus of £2.1 million. It was planned to deliver the surplus through the SHA contribution to the payment to Partnerships UK (PUK), NHS incentives for achieving a financial surplus in 2005/6 and transitional funding for implementation of payments by results. The Trust had received the SHA contribution to the payment to PUK and the other two contributions had been confirmed. On income, Mr Wilson said about 30% of SLAs remained to be agreed. There was concern that some PCTs might redirect SLA planned activity to local hospitals but at 30 June 2006 NHS activity was within 1% of activity of 30 June 2005. Private patient activity had significantly increased in the first quarter of 2006/7 resulting in a favourable variance of £200,000.

Mrs McCarthy said a more cautious interpretation of the financial report could be appropriate. The Board would be very concerned that 30% of SLA income had not been agreed. If activity was relocated and substitute referrals did not occur the Trust would face a considerable financial problem. There was also a considerable debt owed by BUPA and a reported capital overspend by the IT Department.

Mr Bell said the greatest concern of the Executive Directors was the degree of risk arising from financial difficulties major PCTs were currently encountering. The Trust relied considerably on PCT income and if this was not sustainable it would be addressed. The Trust was in a better financial position at 30 June 2006 than it was a year previously and the Executive Directors were confident the Trust would meet its financial objectives and targets.

Mr Perrin confirmed the Trust was in a better financial position at the end of June 2006 than it had been at the same time in previous years. The Board should however be concerned that 30% of SLAs had not been agreed. The history of previous years showed that payments were made eventually, often after very difficult negotiations. In the Foundation Trust financial regime the position would be different as binding contracts would be in place between the Trust and PCTs. Mr Perrin said the Finance Committee had raised concerns about compliance with the Better Payments Practice Code which had deteriorated in June. This required further work. The Committee also noted performance was measured against an interim budget whereas in future performance would be monitored and measured against a firm budget for the year. The report to the next Board meeting would also foreshadow financial reporting as a

Foundation Trust. Mr Perrin also said a major concern related to delivery of the planned 1% surplus from non-recurrent income which would be closely scrutinised in the course of the application for Foundation Trust status.

The Board noted the report.

2006/100 APPROVAL OF BUDGET FOR 2006/7

The Board received a report which recommended adoption of the Trust budget for 2006/7. The budget provided for income of £207,042,000 and a net income surplus of £2,114,000. The Department of Health research subvention would be £28.8 million and the Trust savings target for the year £5.9 million.

The Board confirmed the budget.

2006/101 REPORT FROM MEETING OF THE REMUNERATION AND TERMS OF SERVICE COMMITTEE

The Chairman reported orally on matters considered and decisions made by the Remuneration and Terms of Service Committee at a meeting on 20 June 2006.

2006/102 APPOINTMENT OF CONSULTANT IN RESPIRATORY MEDICINE

The Board confirmed the decision of an Advisory Appointment Committee to recommend the appointment of Dr. Andrew Menzies Gow as Consultant in Respiratory Medicine with a special interest in Asthma.

2006/103 FOUNDATION TRUST APPLICATION

A progress report from Robert Craig, Foundation Trust Project Director, on progress with the application for Foundation Trust status was received and noted.

2006/104 PROCUREMENT PERFORMANCE REPORT FOR 2005/6

A report from Mr Kevin Hudson, Commercial Director, on procurement performance in 2005/6 was noted.

2006/105 COMMENTS FROM MEMBERS OF THE PUBLIC

Mr Kenneth Appell, a member of the Patient and Public Involvement Forum, referred to the rates of infection in Royal Brompton and Harefield Hospitals for 2005/6 that the Chief Executive commented on in his report. Mr Appell said he attended the Trust Infection Control Committee as the PPIF Representative and said the reported results could not have been achieved without the commitment of the

staff to prevent and control hospital infection. He had been impressed by the work of each member of the Infection Prevention & Control Committee. Infection was one of the highest risks in the treatment of patients in Royal Brompton and Harefield Hospitals and Mr Appell asked whether or not account was taken of it in Department of Health research and development funding.

The Chairman said the current funding related to the additional costs incurred in supporting research and development. Professor Cowie's report and the research and development annual report referred to future funding arrangements.

Mr Appell also asked when a future Board meeting would take place at Harefield Hospital. The Chairman said meetings were taking place at Royal Brompton Hospital until structural repairs to the Concert Hall at Harefield had finished. The Concert Hall was expected to be available for Board meetings in October but he had learned that morning that it could be back in use in August. The Chairman said he would look into the question of when Board meetings could resume at Harefield Hospital.

Mr John Ross, an Executive Member of Heart of Harefield, referred to a letter of 3 May 2006 which explained why meetings could not be held at Harefield Hospital and another venue in Harefield would be found for the July meeting. Mr Bell said the Trust had agreed to transfer two meetings planned at Royal Brompton Hospital later in the year to the Concert Hall at Harefield Hospital to compensate for holding the May and July meetings at Royal Brompton Hospital. This was still the plan. The next Board meeting was scheduled for Royal Brompton Hospital and the Chairman said that the venue had to take account of holding the Trust AGM the same day.

Mrs Jean Brett, Chair of Heart of Harefield, explained that the Trust's 3 May 2006 letter to her was relayed to the Heart of Harefield Committee. The reason for the change of the May Board meeting to London was understood and accepted. However the letter also assured that attempts would be made to find an alternative venue in Harefield for the Board's July meeting. This not having been followed through had caused a problem. Therefore Heart of Harefield would prefer and find it helpful for the September Board meeting to be held at Harefield Hospital. The Chairman said that he would reconsider the venue for the September meeting.

Mr David Potter, Vice-Chairman of Heart of Harefield and Chairman of Re-Beat, then made a statement. At its conclusion the Chairman said that the Board would take note of what Mr Potter had said and added that it was not proceeding on the basis that Heart of Harefield and Re-Beat had disappeared. The statement had obviously been carefully prepared; and if Mr Potter provided a note of it he would ensure that it was appropriately recorded.

Mr Potter has subsequently provided this note;

"Mr Potter, Vice-Chairman Heart of Harefield and Chairman of Re-Beat, said that following a considerable amount of pressure, comment and lobbying by members of the public and supporters he had been asked to make a statement on behalf of Heart of Harefield and the members of Re-Beat. Harefield Hospital has very many supporters in the community as the Board well know and they have not gone away.

He did not wish to be unduly provocative particularly as there has been a mood of harmony for quite a while now but he had been charged with recording that the public and patients continue to be concerned about the possibility of hidden agendas that may still surround the future of Harefield Hospital and the services it provides.

He applauded the recommendations of the Sir Michael Partridge – Mark Taylor review but had the perception that some Board Members would work against those recommendations to the detriment of Harefield Hospital, its services and the population it serves so well.

Any attempt to ignore the views of the public and patients or to prevent them adequately voicing their views, and this is something that has been debated quite a few times and he did not wish to return to that situation, would be extremely strongly resisted. There have been many occasions when it was felt the rhetoric about public and patient involvement had been ignored by many in the NHS, this Board less so than some others, but a number of Harefield supporters, and this is linked in part to the location of Board meetings, feel that we could be returning to that situation. There has been some perceived concern at recent Board meetings in that respect. Because we have abided by the harmony that has broken out does not mean we are not still keeping a watchful eye on what is happening.

He hoped the Board were familiar with the new document recently issued by the Department of Health, 'A Stronger Local Voice' which quite positively encourages participation by the public and patients and communities. Let us not return to the days of rhetoric.

The public will not be ignored or prevented from voicing their views and they have demonstrated in the past that they are not incapable of voicing those views.

He would therefore, as he had been asked on behalf of a lot of people, and there is massive support in the village, in the Hospital and patient support groups, put the Board on notice that Harefield supporters have not gone away and any attempt to prevent the public from expressing their views would be considered a breach of their human rights.

2006/106 NEXT MEETING

The next meeting of the Trust Board would take place on Wednesday 27 September 2006. The Chairman would consider the venue.

Lord Newton of Braintree
Chairman