ROYAL BROMPTON & HAREFIELD NHS TRUST

Minutes of a Meeting of the Trust Board
Held on 28 May 2008 in the Concert Hall, Harefield Hospital

Present: Lord Newton of Braintree, Chairman
Mr R Bell, Chief Executive
Mr N Coleman, Non-Executive Director
Mrs C Croft, Non-Executive Director
Mr R Hunting, Non-Executive Director
Mr M Lambert, Director of Finance & Performance
Mr P Mitchell, Director of Operations
Dr C Shuldham, Director of Nursing & Governance

By Invitation: Mr R Connett, Head of Performance (Acting)
Mr R Craig, Director of Planning & Strategy
Mr N Hunt, Director of Service Development
Ms J Thomas, Director of Communications

Apologies: Prof T Evans, Medical Director
Mrs J Hill, Non-Executive Director
Prof A Newman-Taylor, Non-Executive Director
Ms M Cabrelli, Director of Estates & Facilities

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

The Chairman welcomed members of the Board, the public, members of Heart of Harefield, and a group of nursing staff undertaking the Royal College of Nursing Leadership Course.

2008/49 MINUTES OF THE PREVIOUS MEETING HELD ON 23 APRIL 2008

There had been a printing error in the production of the minutes of the previous meeting which led to members receiving an incomplete version of the minutes. A complete set was being re-circulated and it was therefore decided to defer the review of the minutes until the next Trust Board meeting.

2008/50 REPORT FROM THE CHIEF EXECUTIVE

The Chief Executive, Mr Robert Bell, introduced Mr David Shrimpton, the new Managing Director for Private Patient (PP) services, who came to the Trust from Citibank. Mr Bell said that PP activity was a key generator of Trust income and that in this climate of financial challenge, the Trust was looking to ensure that its PP income had a steady base and realised its growth potential.

Mr Bell continued that, following the departure of Mr Tony Vickers as Director of Human Resources, the post had now been offered to Carol Johnson (previously Director of HR with PayPal), who had accepted the offer.

Mr Bell further reported that the Healthcare Commission had announced the results of the Patient Satisfaction Survey for England and he was delighted the Trust was rated by its patients as the second most satisfactory hospital in London and among the top ten in England. This result gives a positive message to staff in the quality of services being offered and, although there were some areas for improvement which would be assessed by the Management Committee, this was an outstanding score. Mr Bell noted that all the hospitals with high scores were specialist hospitals, and that out of the top five in London, all were FTs except this Trust.

Mr Nick Coleman, Non-Executive Director, reported that in the Prime Minister's recent preview of the Queen's Speech, he had commented on funding to hospitals in the future being broadly allocated on the basis of patient satisfaction and quality of care. The Prime Minister had indicated a number of parliamentary reform initiatives as part of the review being led by Lord Darzi. Recently, David Nicholson, NHS Chief Executive had confirmed that the tariff would in future be subject to a number of adjustments, one of which would be the introduction of a factor to compensate hospitals performing well on these scores. This should be welcome news for the Trust.

Mr Bell confirmed that year-in-year-out the Trust's patients reported high levels of satisfaction and looked forward to seeing how the new funding methods translated to our Trust. Mr Mark Lambert, Director of Finance & Performance, counselled caution, citing MRSA rates, in which the Trust had the best results in the country by Healthcare Commission measures, but had been penalised for reporting 7 cases rather than 5 in 2007/08 compared with 5 in 2006/07. It might be that the tariff would be based on rates of improvement.

Mr Bell reported he had received a letter from Professor Lord Darzi, Under Secretary for State, about the research being undertaken by the Trust. Lord Darzi had expressed his pleasure that the Trust would be receiving BRU funding which would ultimately lead to benefits for heart and lung patients. He had asked to be kept informed of the research as it progressed.

Mr Bell had also received a personal letter from Ruth Carnall, NHS London Chief Executive, thanking the Trust's staff for their efforts in 2007/08. She acknowledged the Trust had experienced disappointments, especially with its FT application and said that she wanted to help the Trust find the right solution for its future. She also asked for her thanks to be passed to the appropriate clinical team for the care given to a paediatric patient of her personal acquaintance.

Finally, Mr Bell reported that the new "Stereotaxis" catheter laboratory had opened at Royal Brompton in April, equipped with the latest magnetic navigational technology. On 24 June a VIP will visit the hospital for a formal opening ceremony in the unit and Board members were invited to attend.

2008/51 <u>FT APPLICATION – NEXT STEPS</u>

Mr Robert Craig, Director of Planning & Strategy and Acting Director of R&D, reported that work continued to take forward the six specific issues identified by Monitor in their deferral letter of 29 June 2007 (and reported in detail at the April meeting). The main challenge remained of the financial pressures to be faced in 2009/10 and 2010/11. Contact with the Monitor assessment team had confirmed they would expect to undertake a full, three-month assessment, including a Board-to-Board meeting, if the Trust reactivated its application. The Trust would also have to decide if a further period of public consultation would be required. The Chairman and Chief Executive of the NHS London Provider Agency had offered to facilitate further informal contact with Monitor before reactivation of the application and the Trust was keen to take this up.

Mr Bell confirmed that a decision on the application would have to be taken at the next Board meeting on 19 June, as the Trust's decision had to be notified to Monitor before the end of June, i.e. either to resubmit or withdraw the application. Mr Bell said a number of steps had been taken in the past year to address the six specific issues but he was not sure that all conditions had been, or could currently be, fulfilled. The Board deliberated the risks and benefits of pursuing the application. The letter from Ruth Carnall had made specific reference to the application; Mr Bell pointed out that from amongst all the acute care trusts in London, there were only five FTs, and there

had not been a single FT authorisation since November 2006 (Kings College, which had undergone a lengthy deferral). The rest of the country was pressing ahead, but London has stalled. Mr Bell reminded the Board that the Trust still held authorisation from the Secretary of State to proceed to FT status, subject to Monitor's authorisation.

In informal contact with Monitor, Mr Coleman had discussed the very difficult judgement to make in terms of the reputational risk (and opportunity cost) in an unsuccessful application. He had conveyed what was being done to gain a better understanding of the financial position in the coming years, and the Trust's level of confidence in the light of reducing R&D funding. Monitor had offered further discussions to help to review the Trust's position, and had not ruled out the possibility of a longer period of deferral if that seemed appropriate. Mr Coleman was following up this offer.

Mr Craig reminded the Board that one of the six key issues raised by Monitor was the "revision of the capital strategy" for the HH site. A Strategic Outline Case (SOC) for HH services was currently being formulated but the view of NHS London on the SOC was not expected until late in the year, which might influence a deferral period. The Chairman commented that timing was always likely to be difficult.

Mr Lambert reminded the Board of the expected financial challenges. In 2009/10, the remaining £11.7m of annual transitional R&D funding would disappear. The NHS tariff would, as usual, demand a 3% efficiency saving. Together, these would create a £18m gap between income and expenditure which would have to be filled. For the current year, savings and other measures to the value of £11m had been fed into the budget – further measures to meet the challenge of 2009/10 might take well over 12 months to identify and deliver.

The Chairman said that even if we could not bridge the gap in one year, we would need to be able to demonstrate (to ourselves, Monitor and others) considerable progress. Mr Mitchell confirmed that work was already being undertaken on this and to this end the Trust was reviewing its "Modernisation agenda" in order to step up productivity, efficiency and activity.

Mr Bell stressed the need to balance our whole economic situation. There was satisfaction about gaining BRU status but this only brought in £2.4m per annum. He said the Trust would not be able to find £18m solely in patient care income alone. He asked if it would be prudent to go ahead with the FT application knowing that next year would be financially difficult and without the ability to prove we could remedy the situation in the future. Mr Bell said that the management team was confident the Trust could be successful, had generated surpluses again in 2007/08 and would repeat this again this fiscal year. However, he questioned whether the Trust as an organisation could be convincing in a Board-to-Board meeting that the challenge could be met, and asked if the Trust was willing to go forward with this risk.

The Chairman said we would need to address the £18m gap, whatever type of body we were. He was concerned that addressing such a significant gap should not undermine the quality of staff, services, facilities etc which had again been noted earlier in this meeting and were the source of the Trust's ongoing success. It was a question of what was in the best interests of the Trust and the best timing.

Mr Richard Hunting, Non-Executive Director, remarked there seemed to be an imbalance in that research money was being withdrawn, yet cost-reductions and efficiencies would inevitably affect clinical services. He asked if the Trust should retreat further in its research programmes. Mr Bell replied that while R&D programmes were under review, it was not possible to take out research funds without affecting

patient services (and the McKinsey work had confirmed this). Of the historical funding, approx £20m was embedded in the Trust's infrastructure, and the balance of approximately £8m in direct research costs. There were other sources of research income (viewed in partnership with Imperial College), bringing the overall total closer to £50m, although the balance of these funds was channelled in a different way. The question was one of "re-sizing" the organisation as a whole.

In relation to investment at Harefield, Mr Bell confirmed that the capital investment initially identified for the redevelopment of HH in the Integrated Business Plan had been approximately £25m. If the Trust had wished only to satisfy Monitor, we could have said we would not undertake this project at all – but that would have undermined our stated goals. Mr Bell said that becoming an FT clearly remained part of the Trust's strategy, but the issue remained one of timing for our authorisation process.

The Chairman agreed that it remained the case that FT status would be the most desirable next step, but the question of timing was crucial. The Board would return to this issue at its next meeting.

From the floor, Mrs Jean Brett of Heart of Harefield confirmed that the group had strongly supported the Trust's FT application from the outset. She felt there were now concerns about the process, linked with R&D funding. The Trust had had its application deferred, and yet was a 3-star, financially successful Trust held in high esteem by its patients and the research community. The basic problem was the removal of research money by the very body which repeatedly rated the Trust's research programmes 'strong'. She was also concerned about the independence of Monitor and its accountability. Monitor had stated that the Trust would fall into deficit and breach its terms of authorisation. Yet FTs had recorded significant deficits, e.g. Bradford Teaching Hospitals (where Monitor had intervened) and UCLH (where it had not) – there was no consistency. Mrs Brett was suspicious of Monitor's stance towards the Trust and thought another angle involved. Heart of Harefield felt the application should have gone straight through, the problem was not of the Trust's making. She further noted that Monitor had subsequently declined an invitation to attend Hillingdon Council's meeting of the Health and Scrutiny Committee. She asked if the Trust really wanted to reactivate its application, revisiting what seemed to be a 'poisoned well' after deferral first by the old NW London SHA and subsequently by Monitor. She thought it ridiculous that one of the best trusts in the country did not achieve FT status because of government action on research monies. She agreed with the Board that the timing of any re-application would be important and offered Heart of Harefield's support if it was needed.

2008/52 HAREFIELD UPDATE

Mr Patrick Mitchell, Director of Operations, presented a progress report on the remedial work and redevelopment of Harefield Hospital and its services. There was an important amendment to item 1, Provision of non-cardiothoracic services, page 1, line 4 – to read "……as a result of non-cardiothoracic support not being available".

Mr Mitchell informed the Board that he was liaising with the Estates Directorate to try to bring forward the current forecast of 1st March 2009 for completion of works to the main building; this would then be followed by a refurbishment of ICU. Work on the thoracic theatres was complex, being based on existing buildings, but would allow the theatre to continue working. This scheme was currently due to be completed in November 2009, although it was hoped this date could also be brought forward.

In terms of clinical leadership, the Trust was considering the implementation of a new clinical management structure based on care groups. A Director of Cardiothoracic Anaesthesia and Critical Care was to be appointed at the end of June.

Mr Mitchell further reported that following the recommendation for fire training, a fire evacuation exercise had been recently undertaken in conjunction with other agencies, including the London Fire Brigade, London Ambulance Service, Hillingdon PCT and Hillingdon Hospital. The exercise had been planned over the last 8 months and focused on the (unoccupied because of refurbishment) transplant unit, utilising volunteers who acted as patients. The Trust had received very good feedback from the other agencies involved and a similar evacuation was planned for the Fulham Road wing (RBH) in September, which would be filmed for training purposes. The exercise had gone very well and the DoH Planning Officer remarked on the magnitude of the operation. Mr Mitchell wished to express his gratitude for the work undertaken by Catherine Philpott (Emergency Planning Officer).

Mr Coleman asked whether this evacuation exercise would help reduce the risk of a fire (on the Risk Register). Mr Mitchell felt it had provided valuable insight into how to deal with the consequences of such an occurrence and therefore the item might be rated lower. Dr Caroline Shuldham, Director of Nursing & Governance, asked how the experience might be applied to personnel who had not been directly involved. Mr Mitchell confirmed that each individual agency involved would produce a report, and the Learning & Development team would, together with Hillingdon Hospital and the Chelsea & Westminster Hospital, be developing staff training over the next 12 months over all four hospital sites (i.e. inc RBH and HH). Much had been learned about finding a "place of safety" for evacuees, and about communication issues. Mrs Christina Croft, Non-Executive Director, thought that the knowledge gained from the exercise would probably rewrite part of the risk register. Mr Coleman agreed to refer this issue to the Audit & Risk Committee.

The Chairman, on behalf of the Board, wished to record thanks and congratulations to all involved.

Mr Mitchell then reported on the preparation by *Care Consulting* of a Strategic Outline Case (SOC) for Harefield. The HH Oversight Board had been remodelled and representation from PPI and the SHAs had been invited. As part of the process, a Non-Financial Appraisal of options was required. The establishment of key strategic constraints/hurdles had been fundamental to the process, together with establishing our own aims for the proposed redevelopment. The conclusion of the work undertaken to date pointed to development either on the Harefield or Mount Vernon sites. The Oversight Board would look at the non-financial assessment using the appraisal criteria including access, clinical infrastructure, recruitment, patient and public support, etc. to see if any further options should be included or eliminated. Further work was now needed on the short-listed options and this would refer back to the Oversight Board before being brought before the Board itself in July.

2008/53 NHS STANDARD CONTRACT BRIEFING

Mr Nick Hunt, Director of Service Development, presented a briefing paper on the 2008-2011 NHS Contract.

The Trust had agreed and signed a 3-year contract with Kensington & Chelsea PCT in their role as host commissioner, detailing the contractual relationship between the Trust and commissioners. Once agreed with the host PCT, the contract format and schedules were binding on all PCTs – with, typically, one lead-PCT for each SHA. It was a very detailed contract and the Board should be reassured that the Trust had negotiated the non-mandatory clauses.

Mr Hunt further explained that there were several clauses around the 18-week wait initiative and that failure to achieve relevant targets would incur a financial penalty

(from January 2009 onwards) of up to 5% of NHS elective care revenue. It was therefore critically important that the Trust adhered to the designated milestones. Mr Hunt also reported that the Trust had been able to negotiate a clause with reference to *C.difficile* targets, so that if less than 50 cases occurred in a contract year, then no financial adjustment would apply. The Chairman felt this decision indicated a more common-sense approach to assessment of this infection and felt there were, refreshingly, signs that differences in the workings of specialist trusts were being acknowledged. The Chief Executive counselled caution, stressing the difference between what had been negotiated in our contract with our commissioners (and contractual redress) and what were our standing NHS targets. He confirmed that, relating to *C.difficile*, the Trust was still required to demonstrate over a three-year period year-on-year reductions and would be penalised in performance ratings if this was not achieved. For incidence of MRSA in the 2007/8 year we had a target of five with one standard deviation (i.e. seven – albeit statistically meaningless) which may or may not be accepted by the Healthcare Commission.

The Chairman thanked Mr Hunt for his report.

2008/54 FINANCIAL PERFORMANCE REPORT FOR MONTH 12: MARCH 2008

Mr Lambert reminded the Board that the Trust had been set a 'control total' by NHS London of £2.4m surplus for 2007/08. At February 2008 the Trust had made a year-to-date profit of £4.5m and in order to reach the control total, it had been necessary to incur a deficit in Month 12. The Trust had implemented some redundancies to improve efficiency, arranged for some surgical private patients to be treated in the private sector, undertaken accounting adjustments and revisited its treatment of capital items. The Trust had also to account for an adjustment for 'incomplete spells' and there had been various correspondence between the DoH, Audit Commission (for external auditors), NHS London and local auditors Deloitte & Touche to try and agree the correct treatment.

The control total had been reached after a charge resulting from reducing the maximum remaining economic life of the buildings at Harefield to 25 years, a conclusion supported by a chartered surveyor opinion. The situation was now subject to audit. The Chairman felt there was an air of uncertainty pending a reply from the SHA financial director. The Chief Executive said that the Trust's official year-end position was a surplus of £2.3m which was in line with the control total if the adjustments are accepted; if not accepted, our surplus would be £4.9m. He felt there was no ambiguity from his point of view.

MONTH 1: April 2008

Mr Lambert reported that for the month of April the Trust had made a surplus of approximately £100K, which he felt was an excellent result taking into account the fact that the Trust was receiving £1m per month less in funding this year than last.

Mr Coleman drew attention to the risk rating metrics table which was now showing a rating of 3. Mr Lambert explained that the change in risk rating was the 'liquidity' rating, showing red (a consequence of the cash regime applied to non-FTs). The Trust had had to spend approximately £13m of cash in March, which had been used to pay creditors and pre-payments of capital schemes, and this had affected the liquidity ratio. Mr Lambert agreed that the table should have a note explaining this – as it had when first introduced to Board reports. In reply to a further query from Mr Coleman on capital, Mr Lambert confirmed £19m had been spent in 2007/8. Mr Coleman thought it was unfortunate that when we had agreed to spend £23M we did not achieve this. While some projects had slipped, they had been substituted, and Mr Lambert and the Chief Executive pointed out that the budgeted £23m included approx £4m of contingency funding which had not been required.

The Board went on to discuss the overdraft (working capital) facility which had been negotiated with the Royal Bank of Canada as part of the FT application process in 2007. The Chief Executive confirmed that if the FT application was reactivated, terms would have to be renegotiated but the Bank had been happy to offer the Trust a higher limit, and he did not anticipate problems. He further remarked that if we had already been an FT we would have reported a profit for the year of £4.9m (against the Monitor assessors' projection of a £1.3m loss). He felt this was a notable difference.

With reference to the item: Agreement of NHS Balances, page 8 of the report, it was reported the Trust was disputing a sum with Mid Essex NHS Trust. Mr Hunt confirmed this was in actual fact Mid Essex PCT. The Chairman then declared an interest in that his wife was a non-executive director of that body.

2008/55 OPERATIONAL PERFORMANCE REPORT FOR MONTH 1: APRIL 2008

Mr Lambert introduced the operational report for Month 1, and highlighted the following items:

- The reportable cancellations position for April for both sites was 1.62%, equating to a failure of the target. This was an indication of how 'hot' we were running the plant and the Director of Operations was monitoring the situation.
- Infection control: the Trust had been clear of MRSA from October 2007 to date, i.e. 6 consecutive months. For *C.difficile* there were 3 cases in April, therefore the target was met.
- Cancer waiting times were currently 100% met on target, pending an assessment on reallocation of 2 breaches to their referring trusts.
- New to F/U outpatient appointments in relation to peer group – our ratio remained very high for April being 1:7.41 (national rate is 1:2.3)
- Patients sharing accommodation with the opposite sex was still an area for concern in critical care
- Staff Sickness absence was 3.07% against an internal target of 3% and therefore just underachieved.
- 18-week waits: Mr Mitchell, Director of Operations, reported that cardiac surgery was the main problem area and he would be liaising with surgeons on how to manage this. All other specialties were on line to meet the 18-week wait requirements by December. The SHA had agreed we did not need to focus on retrospective April and May data-gathering, in order to allow us to catch up and get items in line by December.

In response to a query from Mr Coleman, Mr Richard Connett, Acting Head of Performance, explained there were various requirements under which the Trust worked and data was being ratified for the HC rating. This would include the 18-week waits and he expected the item would be subject to an 'extenuating circumstances' claim.

Mr Coleman then referred to the Serious Untoward Incident (SUI) reported for April. Dr Shuldham confirmed the SUI related to the death of a patient: the incident had been investigated; the family were in touch with the Trust, much of what had transpired was well understood and mitigating action had been taken. She confirmed there was no common theme inherent in the SUI and previous events.

Mr Coleman also noted the performance report in relation to the NHS contract discussed earlier in the meeting, and queried the differences. The Chief Executive explained that the performance regime covered both PCT contracts and national/SHA-monitored targets. Our performance management requirement was currently monthly on the SHA template. Mr Lambert added that the Trust did not yet know what actual thresholds would be applied to Trust performance for 2007/8 by the HC, and that

confirmation of these would only be received in October.

2008/56 PATIENT SATISFACTION SURVEY

Dr Shuldham spoke to the report prepared by Rachel Matthews, Senior Nurse for User Involvement.

There were two surveys: the in-patient survey which was part of a national programme generally undertaken every year, and the out-patient survey which in 2007 was a voluntary survey. The previous surveys had been undertaken three years previously, which had allowed changes to be seen in the interim. The Picker Institute Europe organised the surveys and fed back their conclusions.

The Trust did well in both surveys and was placed in the top 20% of Trusts for overall patient care. The Picker Institute had also identified specific areas for improvement and subsequently issues around discharge processes are being looked at. Comment was made about the issue of single-sex accommodation (in critical care and some washing facilities), but this was an observation rather than a complaint.

Dr Shuldham reported that the out-patient survey had shown much improvement since the previous survey in 2004. Areas highlighted for attention were the offering of choice of appointment times and this had already been the subject of discussion. The subject of reduction in time waiting for appointments was also raised, but this was now being addressed by the 18-week-wait initiative.

The Chairman said that the survey results were encouraging and on behalf of the Board wished to congratulate staff on the results. He wished to thank all involved and Rachel Matthews for compiling the report.

2008/57 QUESTIONS FROM MEMBERS OF THE PUBLIC

Mr David Potter, Rebeat Club, wished to thank Trust staff for providing an excellent Theatres Open Day at Harefield. He reported that a patient had commented on how much more confidence he had in his treatment since attending the event. The Board extended its thanks to Jackie Burbidge, Theatre Service Manager at Harefield, and all other staff involved in organising the Open Day.

2008/58 DATE OF NEXT MEETING

Thursday 19 June 2008 at 2.30 p.m. in the Board Room, Royal Brompton Hospital