ROYAL BROMPTON & HAREFIELD NHS TRUST

Minutes of a Meeting of the Trust Board held on 28 November 2007 in the Boardroom, Royal Brompton Hospital

Present:	Lord Newton of Braintree, Chairman Mr R Bell, Chief Executive Mrs C Croft, Non-Executive Director Prof T Evans, Medical Director Mr R Hunting, Non-Executive Director Mr M Lambert, Director of Finance & Performance Mr P Mitchell, Director of Operations Prof A Newman-Taylor, Non-Executive Director Mr C Perrin, Deputy Chairman 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
In Attendance:	Ms E Mainoo, Executive Assistant Mrs R Paton (minutes)
Apologies:	None received

The Chairman welcomed members of the Board, three SpRs undertaking management training and members of the public to the meeting.

2007/123 MINUTES OF THE PREVIOUS MEETING HELD ON 24 OCTOBER 2007

The minutes of the previous meeting were agreed as a correct record with the following amendments:

Item 2007/117, page 6, 2nd para: addition to the sentence: Dr C Shuldham, Director of Nursing & Governance, pointed out the difference between 'colonisation' and 'infection' by the bacterium, and that children under two may carry C.Difficile without harm.

Item 2007/117, Page 5, 2nd para: Mr P Mitchell, Director of Operations, reported that the paper on the 18-week wait target was still being prepared and should be ready for submission to the December Board meeting.

2007/124 REPORT FROM THE CHIEF EXECUTIVE

Mr Robert Bell, Chief Executive, spoke to the following issues:

Harefield Hospital Redevelopments

Malcolm Stamp, Chief Executive of NHS London's Provider Agency, had written to him about the Harefield options appraisal. The Capital Investment Committee had not been satisfied with work conducted by the firm Matrix and had asked for it to be addressed as a Strategic Outline Case (SOC) in line with NHS standards. Emerging issues (e.g. Healthcare for London, cardiac developments in London and the South of England) needed to be taken into account. This work would take some months and would involve further disappointing delay.

Mr Patrick Mitchell, Director of Operations, echoed this disappointment – there was now a new regime with different requirements. He and Mr Robert Craig, Director of Planning & Strategy, would undertake preparation of the SOC. They

could utilise Matrix's and other material, but as emerging themes from consultation on Healthcare for London would not be complete until next March, the SOC could not realistically be submitted until late Spring. Lord Darzi is also producing a national report, due in 2008.

The Board reviewed the current situation: the Healthcare for London plan is proceeding ahead of the rest of the country, and the London local elections (May 2008) could lead to further delays. The Chief Executive acknowledged that further changes were likely and with emerging trends in clinical care it was a challenging time. However, he reminded the Board that there was always uncertainty in planning – it was important to be aware of the uncertainties, but not paralysed by them.

Mr Charles Perrin, Deputy Chairman, asked if this delay would cause any operational problems in relation to the remedial work being undertaken, the condition of the buildings and equipment, etc. Mr Mitchell confirmed that the work at Harefield was progressing well and within timescale, and was being completed to a very high standard; this included: improvements to the general facilities, distances between beds, new bathrooms, additional infection control measures and centralisation of theatres. He therefore felt that a little more time had been 'bought' as a result of the remedial works – but that any delay was a cause for concern.

The Board discussed the fact that Healthcare for London highlighted the need for and role of specialist hospitals. The Chief Executive reminded the meeting that although the report supported specialist hospitals, it did not specifically single out support for stand-alone units.

In response to a query from Mrs Jenny Hill, Non-Executive Director, as to whether we might work with other trusts in London in a similar situation, the Chief Executive reported from talks with the CEO of the Royal National Orthopaedic Hospital (Stanmore), who felt equally frustrated. Mr Bell also reported that there was some pressure from the NHS centrally to explore arrangements with other organisations. He also reminded the Board of the June letter from Monitor which had recommended that the Trust "refine the capital strategy for the Harefield site".

<u>Redevelopments at Royal Brompton Hospital (RBH).</u>
Devereux Architects had been retained to develop a master-plan for RBH. Their work had been completed and considered at the last Management Committee. Devereux had produced a feasible model for an innovative reconfiguration of facilities around Sydney wing, delivering consolidation of all patient services on a central site. Drivers Jonas, commercial property consultants and advisers, had been appointed to look at the potentially 'surplus' estate, but their response had been disappointing. There was no formal report – but they had placed a low value on the estate that Management considered to be low, with no supporting rationale for their conclusions. Mr Mark Lambert, Director of Finance & Performance, informed the Board that land value estimates would be commissioned from other advisers.

The Chief Executive reported that the Charitable Fund had agreed to create a Property Development Board to review its land and property assets which abut the hospital estate. He felt this new Board could give further insights into the relevant land values.

Collaboration with Imperial College (IC) Faculty of Medicine and IC Healthcare

NHS Trust
The Board was already aware of the joint submission to the National Institute for Health Research (NIHR) for two Biomedical Research Units; the short-list was expected to be announced imminently. We were jointly proceeding to identify and recruit either one or two permanent Research & Development directors. Involved in the process were Prof Schneider (IC), Prof Newman-Taylor (Non-Executive Director), Mr Bell, Prof Evans, Prof Fox, Prof Geddes and Mr Craig.

Furthermore, the Trust had agreed with IC and IC Healthcare NHS Trust to appoint jointly an academic leader as Professor and Consultant in Cardiovascular Surgery, and this initiative should be taken as indicative of our future relationship. The Charitable Fund had agreed to provide further assistance to the Heart Science Centre at Harefield, which is already an IC centre.

The Chief Executive confirmed that there was much activity taking place including an aspiration to create a network of IC hospitals. Prof Newman-Taylor reinforced the desire within IC to extend relationships with this Trust.

Collaboration with Royal Marsden and Chelsea & Westminster (C&W) NHS Foundation Trusts
The Chief Executive had held further meetings to try and reach workable models for collaboration; there had been stronger support from C&W for this idea. The Chairman confirmed that he would shortly be meeting the Chairman of C&W. Mr Lambert reported that joint representation with C&W had been made to ISS Mediclean on Agenda for Change matters, with a completely uniform approach.

Planning guidance
The Chief Executive reported that the Operating Framework for 2008/9 was to be issued by the DH in mid-December. National priorities would focus on the 18-week wait target, with healthcare-acquired infection also high on the political agenda. The question of improved access to primary care was also going to be highlighted.

DH guidance was expected by January 2008 with respect to Trust mergers, acquisitions and FT status. Our own FT application remained 'deferred' by Monitor. A new classification was being introduced by NHS London whereby applicant Trusts would be allocated a 'readiness' score between 1 and 5 (1 denoting the highest state of readiness). The Chairman felt this approach was more logical than setting specific timetables or 'waves' for each Trust. The Chief Executive reminded the meeting that the Trust already had both SHA and Secretary of State support for its FT application.

Healthcare Commission (HC)
The Chief Executive felt that the HC was taking an increasingly firm approach on issues and believed the Trust had to expect that there would be some matters that would bring negative coverage. For example, the Trust had no more than ten patient complaints over the past 12 monthswhich proceeded to independent review. As five of these had been referred back by the HC for review, the Trust was considered to be in a 'high risk' category as a poor proforma for handling complaints. However, as several of the five cases

related to patients who had died, the complaints involved an element of inevitable grieving and bereavement, which the HC did not acknowledge.

2007/125 NWL DECONTAMINATION PROJECT FULL BUSINESS CASE

Mr P Mitchell, Director of Operations, presented the full business case (FBC) and explained this was the culmination of three years work with other trusts in NW London to centralise decontamination work following the CJD outbreak in 2000. InHealth Sterile Services Group is the preferred bidder and the Board's approval was sought to proceed to financial close. The Trust will receive some funding towards the initiative. Decontamination centres at RBH and HH will close. The reference bid is based on a project length of 15 years based on an 8-hour turnaround of instruments. An alternative next-day turnaround was also on offer as part of the bid and was being considered internally by the Surgical Directorate and Decontamination Working Group.

To optimise the best working arrangement for the Trust, it had been decided to rationalise the range of available instruments in a given surgical tray, thereby reducing the amount of necessary daily sterilisation; this would entail a major capital investment next year as additional instruments used less often would have to be purchased in order they were available at all times.

The project will deliver a compliant service for the next 15 years and would be overseen by a contract management board with representatives from each Trust. This Board would form a collaborative agreement between members of the Trust and the company.

The Chief Executive stressed the need to finalise agreement as the Trust is not currently compliant with the latest sterilisation legislation, thereby becoming a safety issue. In response to a query from Mr Perrin, Deputy Chairman, about improving the Trust's compliance until instigation of the project, Mr Mitchell confirmed that the instruments used for surgery were sterilised but the issue of compliance related to the configuration of the building. In terms of HCC standards the Trust needs to be compliant with the whole plan. If the facility were to break down, there is additional capacity countrywide and two sites have been designated as alternatives and this would be arranged by the company.

The Trust Board formally approved the project as outlined.

2007/126 SINGLE TENDER WAIVER (STW)

Mr Lambert explained that the Trust does waive tenders for procurement of certain equipment. Under Standing Financial Instructions, the STW has to be signed by an Executive Director of the Trust, and a regular report provided to the Board. For the first six months of the current year there had been 84 instances of STW for equipment totalling £2.2M, the majority being in respect of equipment for which there is only one manufacturer, which obviates tendering. In relation to the report, page 1, 2nd para, line 8: Lord Newton, Chairman, felt the wording was unnecessarily defensive and Mr Lambert noted this.

The Board noted the report.

2007/127 2008/09 FINANCIAL PLANNING

Mr Lambert presented the report to the Board for approval. He explained that the auditors required the budget to be set by the end of March 2008. The SHA

would require the Trust to provide a full draft budget for 2008/09 by mid-January, to be finalised by the end of February. The draft tariff had been set for 2008/09 and its potential impact reviewed by the Finance Committee. Mr Lambert explained there would have to be estimation in the budget preparation because, e.g. the final total of R&D monies to be received would not be known for some time.

In relation to the timetable on page 1 of the report, it was suggested the year dates be clarified for presentation purposes.

The Board approved the plan.

2007/128 RESEARCH & DEVELOPMENT UPDATE

Mr Craig presented his report to the Board.

Leadership

With the resignation of Prof Cowie as Director of Research & Development on 31 October 2007, Prof Michael Schneider, Head of Cardiovascular Science at Imperial College had assumed the role of Acting Director. Mr Craig had taken on responsibility for the Trust's research office and infrastructure.

National Institute for Health Research (NIHR).

- Transitional funding.

The DH had notified the Trust of revised indicative funding allocations for 2008/09 of between £10M and £12M, compared with £4.8M previously notified. Confirmation was due in February 2008.

- Biomedical Research Units (BRU)

Feedback on the Trust's pre-qualifying submission for two BRU status designations was still awaited. The short-list for full submissions would be announced shortly. Full submissions would be required in February 2008.

Academic Health Centres of the Future

Following investigation of this proposal, it had been decided the Trust was not likely to be successful in this initiative. Mr P Mitchell, Director of Operations asked whether the Trust might formulate a proposal with C&W but Mr Craig reported from a briefing meeting at which it had been clear that any proposal based on a specific disease was unlikely to be successful. The Chief Executive felt it would be surprising if anyone in London were to qualify.

2007/129 CONTINGENCY PLAN PROGRESS REPORT

Mr Craig presented the progress report. He explained that the draft Contingency Plan had been designed to address changes in R&D funding arising from *Best Research for Best Health*. The initial draft had identified measures which projected an improvement of over £40M per annum to the Trust's I&E position by 2012. However the McKinsey assessment work had concluded the more modest sum of £24M - £29M.

The report included details on the status of income areas and the six work-streams identified by McKinsey's analysis, each of which have an executive director lead with Mr Craig as co-ordinator, reporting progress to the Management Committee and Board as necessary. Mr Mitchell reported that the full amount of savings from recent process improvement groups had not yet been quantified; he said there was also a lot more work to do with private practice (PP).

Mr Craig emphasised that the plan did not set out to deliver every measure by 2008/9 – it was a three-to-four year exercise, on which focus would need to be maintained.

At this juncture, the Board discussed the PP income situation which was below plan, due in some degree to loss of cardiology work. However, there were several newly appointed clinicians this year who would grow their own private practices. Reinstatement (pro tem) of four cath labs into service at RBH would also bring improvement.

Arrangements were being made to fill the recently vacated PP General Manager role, with responsibility for developing a new structure for PP services. The Chief Executive wished to believe in the 'upside' earnings potential identified by McKinsey's analysis. The Trust would need to work collaboratively with consultant staff to develop this business. Mr Lambert reminded the Board that private practice was a £20M operation, one of the largest in the NHS. The Chief Executive said that note was being taken of how Gt Ormond St would handle its situation, both in relation to specialist practice, and as an applicant FT.

Mr Mitchell reported that a number of London Trusts were investigating possible collaboration for marketing in the Middle East, working as a group of hospitals and sharing resources. The Chairman felt that this would not only be promoting the health services, but London as a whole. The Chief Executive reported that related developments in the United Arab Emirates would be monitored closely.

2007/130 INFECTION PREVENTION AND CONTROL

The subject remained a major priority for the NHS and Dr Caroline Shuldham, Director of Nursing & Governance, presented the report which brought together all the different aspects, standards and requirements the Trust had to meet and against which performance was monitored.

Standards: Hygiene Code. This formed part of the declaration under the healthcare standards, outlining the range of duties relating to improvement of infection control practice and dealing with occurrences. The Code also required us to have a series of clinical care protocols. If the HC undertook a spot check this would be the first thing they would look at.

Healthcare Standards. Infection came into several of the domains listed. The Saving Lives programme had evolved from previous initiatives and the changes overlapped with healthcare standards. It was imperative that everyone was involved in infection control and to this end there was an on-going programme in the Trust with leads for each 'challenge' area.

Risk Management Standards: Standard for Clinical Care. There was to be a risk management inspection at the end of 2008 for which the Trust was already preparing. The three broad areas of review would be: documentation; evidence of implementation; and monitoring.

Clinical Actions: High Impact Interventions. Within this area was the issue of possible carrying of infection by visitors to patients. Visitor access would need to be reviewed according to appropriate guidelines, necessary changes implemented and audit undertaken. Reducing the risk of C.Difficile is very relevant – necessitating an antibiotic policy, adherence to this and close monitoring/auditing. Infections needed to be reported as Patient Safety Incidents and root cause analysis undertaken – and entered on death certificates when appropriate. With reference to facilities, we would receive £176K for 'deep cleaning' and the Estates and Facilities Directorate were involved in this area.

The infection control team was monitoring the current building and decanting

works at both sites; involvement of modern matrons in cleanliness of the environment was being reinforced; other local trusts had implemented strict dress codes and the Trust would look at this, although it was felt to be more of a public confidence issue than necessarily one of infection control per se. For education purposes, the possibility of on-line systems and collaborating with IC was being investigated; the SHA and PCTs were all asking trusts to review and report back on the Healthcare Commission's report into the outbreaks at Maidstone and Tunbridge Wells NHS Trust – an action plan had already prepared; additional funds of £300K had been received in 2006/7 for various environmental changes in paediatrics.

In conclusion, Dr Shuldham explained that the report was a distillation of many documents and requirements, and that the Trust was working hard on effective infection control for both patients and staff.

The Chairman thanked Dr Shuldham and her team for the vast amount of work involved in producing the report and the work it described. He stressed the importance of protecting the reputation of the Trust, the NHS as a whole, and ensuring patient safety.

The Chief Executive reported a culture of 'zero tolerance' in relation to reported MRSA and C. Difficile levels. We had one of the lowest infection rates in the country but a statistically insignificant increase might still be regarded as the Trust 'failing' – it was all a matter of perception.

The Board discussed issues which arose from the report: the dress code had already been brought to the attention of the consultant body; research had shown that treatment of organisms was one of capacity, the plant of the hospital and patient immunity; it was likely the Trust would need to restrict access for visitors and relatives to particular parts of the hospital – and this would be a public relations issue (a group involving PALS was already looking into this). In respect of MRSA, many people could carry the bacterium, there was a difference between 'colonisation' and 'carrying', and carriers could infect others.

2007/131 <u>PERFORMANCE REPORT</u>

Mr M Lambert, Director of Finance & Performance, reported that the Trust for Month 7 had made a profit of £1,530k. The cumulative I&E position for the year-to-date is a profit of £1,271k. With regards to key financial performance indicators, the risk rating metrics used by NHS London have moved to 3 from 2 in previous months. If this risk rating can be maintained the Trust's monthly meeting with the Provider Agency will be changed from monthly to quarterly.

NHS London, the Trust's regulator, had recently requested the Trust to submit a reforecast for the rest of the financial year. The Trust had done so and increased the forecast outturn by £0.7M to £2.4m.

Mr Lambert reported that he understood that there was considerable potential financial surplus in NHS London and that there would need to be an agreement with DoH on how the surplus could be spent.

NHS London have stated that they need to know if we are going to exceed £2.4m by the end of the year, but Mr Lambert said this would be difficult to assess as December and January are historically quiet months for activity and there would be two Easters in this financial year (April 2007 and March 2008).

The Chief Executive said the Trust might achieve £2-3m but had pressures upon it, for example NCG (specialist commissioning for transplantation) is saying they want to take money back from us and they are part of the SHA. Mr Lambert said agreement had been made to reduce the 2007/08 SLA by £700k, the sum identified in the KPMG report. The Chief Executive felt we are in a situation of mixed messages and finds it incomprehensible.

With reference to page 3 of the Finance Report, Prof Newman-Taylor pointed out that the surplus had come from improved coding and it was an important issue to get the coding right. The Chief Executive said admission coding problems had also led to loss of income in the first quarter and that there was no chance to retrospectively recover this amount.

With reference to Page 9 of the Report, the Chairman wished to make a change to the penultimate line to read '…...July commitment of £10m to fund research and equipment may not be required to be paid……'

Operational Performance

Mr Lambert went on to the operational report for month 7. With reference to the Healthcare Commission ratings, for cancelled operations the Trust is currently reporting 'underachieved'. Limiting cancellations to 8 for each site per month would deliver 1.18%, but if this could be reduced to 4 on each site, our score would be 0.98% which would help us to maintain an 'underachieved' grading. Mr Mitchell reported that there is a working group looking into this and reporting monthly to the Management Committee.

The healthcare infection report is now showing monthly figures and has been expanded to include C.diff and GRE bacteraemia. To date, there have been 7 cases of MRSA, with a baseline of 5 – allowing 1 standard deviation of variation – the maximum number of cases would be 7. Therefore if we have no more MRSA cases for the year we could still achieve the target.

We are still showing no breaches for cancer waits, resulting in 100% of patients being seen within 31/62 days.

2007/132 CARDIOLOGY PROPOSAL FOR AGFA HEARTLAB

Mr Mitchell presented the proposal. The Trust was replacing the whole picture archiving and radiology information systems (PACS/RIS) across both hospitals and this would be in place by May 2008. The opportunity had arisen to extend the project to integrate the cardiology modules and bring together other imaging systems into a common reporting system. The idea had been favourably received by cardiologists across the Trust and capital funding was available. The Management Committee had endorsed the idea.

The Board approved the proposal.

2007/133 QUESTIONS FROM MEMBERS OF THE PUBLIC

In relation to delays on decisions for the future of Harefield, Mr Kenneth Appel, Rebeat Club, felt that this was not in the interest of patients and seemed to be a re-run of political problems as encountered over the Paddington development. The Board had presented an adequate case which was in the interests of the public and patients and this should be strongly represented to anyone who wished to oppose progress. Mrs Jean Brett stated that Heart of Harefield would continue with its endeavours to progress the situation.

MrAppel had noted the excellent relationship between the Trust and C&W and enquired as to the situation between Harefield and Hillingdon Hospital. The Chief Executive confirmed that excellent relations had always been maintained with Hillingdon and had strengthened particularly over the last two years for non-cardiothoracic support services.

Mr Appel also felt that complex problems often arose because of personality and communication issues, and might be better addressed if handled in a more personal way, thus preventing development of an issue into a serious complaint. The Chairman agreed that this was a common problem.

Mr Appel went on to express his support for the Infection Prevention and Control report, particularly for the ideas around access for visitors. Finally, he enquired as to the origin of bad debts and the Chairman explained that these currently arose from BUPA and international PP work, but were being pursued.

Mr Don Chapman, Harefield League of Friends, referred to his question at the previous Board meeting (about recycling): Could he have assurance of a report back on any progress. Mr Mitchell reported that approaches had been made to both K&C and Hillingdon Boroughs, and the fruits of those approaches would be reported back.

2007/134 <u>ANY OTHER BUSINESS</u>

<u>Mr Charles Perrin</u>

The Chairman noted with great regret that this would be the last Board meeting for Mr Charles Perrin, Deputy Chairman, as he had now fulfilled his term of office. On behalf of the Board, he wished to thank Mr Perrin for his long-standing services of fourteen-and-a half years (dating back to the predecessor (Royal Brompton) Trust). The Chairman commented that Mr Perrin was one of the great public servants he had known, giving generously of his time, commitment and conscientious support to the Trust and the Charitable Fund. He would be greatly missed but had the gratitude and thanks of all.

Mrs Jean Brett, Chair of Heart of Harefield requested that her comments on the retirement of Charles Perrin be reported in full as made available for the Trust. "Mr Perrin having been a non-executive director for over 14 years, was a remarkable public service achievement. The Trust had been most fortunate for Charles Perrin's background was at the most senior levels possible, in a prestigious bank of ''the old school''. That financial expertise had served the Trust well in his position of Vice-Chairman and by his chairing of various Trust committees – such as that overseeing the charitable funds of the Trust. It was rare even in London Trusts for a Trust to gain a non-executive director with such talents. Therefore those working with Charles Perrin, in whatever capacity, will have learned much almost by osmosis. Mrs Brett commented that he has been so generous of his time to the Trust while working pro bono, that she had wondered how he had time for anything else. While much more could be said, her attendance and comments had been to make it clear that from both sides of the fence, Charles Perrin's commitment to the public service ethos is widely admired".

Mr Perrin thanked everyone for their kind comments and said it had been a real privilege to be associated with both hospitals. His time with the Trust had been interesting and at times great fun, and he was extremely grateful to colleagues for their assistance. He wished the Board and the hospitals the

best of luck for the future.

2007/135 DATE OF NEXT MEETING

Wednesday 19 December 2007 at 3.30 p.m. in the Concert Hall, Harefield Hospital