Minutes of the Trust Board held on 29 April 2009
in the Concert Hall, Harefield Hospital

Present: Sir Robert Finch (Chairman)
Mr R Bell, Chief Executive
Mr R Craig, Director of Operations
Mr N Coleman, Non-Executive Director
Mrs C Croft, Non-Executive Director
Professor T Evans, Medical & Research Director
Mrs J Hill, Non-Executive Director
Ms M Hiscock, Interim Director of Nursing
Mr M Lambert, Director of Finance & Performance
Professor Sir A Newman Taylor, Non-Executive Director

By Invitation: Mr R Connett, Head of Performance
Mrs L Davies, Head of Modernisation
Mr N Hunt, Director of Service Development
Ms C Johnson, Director of Human Resources
Mr D Shrimpton, Private Patients Managing Director
Ms J Thomas, Director of Communications
Ms J Walton, Director of Fundraising

In Attendance: Mrs R Paton (minutes)

Apologies: Dr C Shuldham, Director of Nursing, Governance & Informatics

2009/045 MINUTES OF THE MEETING HELD ON 25 MARCH 2009

Professor Sir Anthony Newman Taylor, Non-Executive Director, wished to amend item 2009/030, para. 4 to read "…was concerned the Board should have early indication of any problems from the Trust running at near maximum capacity. He suggested 3 indicators could be: infection rates, number of cancelled operations and increase in sickness absence."

Mr Nick Coleman, Non-Executive Director, wished to amend item 2009/032:Trust Risk Register, para. 3 to read "Mr Coleman reminded the Board that the Director of Nursing, Governance & Informatics had added a target for the risk rating number – the target risk rating…".

With these two amendments, the minutes were approved.

At this juncture the Chairman updated the Board on progress with Academic Health Science Centres (AHSC). He had held meetings with Sir Roy Anderson (Rector of Imperial College) when consideration was given to issues which needed to be addressed. Sir Roy had subsequently responded to the Chairman's suggested outline terms of reference for the working party, and further discussions would be undertaken by the Chairman, Sir Roy and Sir Anthony Newman Taylor in due course.

2009/046 MINUTES OF THE MEETING HELD ON 15 APRIL 2009

An extraordinary meeting of the Board had been held on 15 April 2009 and the minutes were approved with the following amendment: Page 1, "By Invitation" to read: "…..Mr C Glazier (Partner, PricewaterhouseCoopers)"

2009/047 REPORT FROM THE CHIEF EXECUTIVE

Emerging Infectious Disease Outbreak (A/H1N1 "Swine" Influenza)

Mr Robert Bell, Chief Executive, reported that the Trust took very seriously the

emerging infectious disease outbreak in Mexico and the potential spread to the UK and London in particular. Policies and plans were already in place to deal with infectious diseases and specifically pandemic flu. The Trust's infection control and flu planning teams had raised the Trust's state of preparedness and the three core objectives would be: to protect all patients and staff from infection; maintain the hospital sites in an infection-free state in the event of a major pandemic; and assist the NHS in the care of potentially infected members of the public. Regular contact was being maintained with the Health Protection Agency (HPA), NHS London and the DoH team. Mr Richard Hunting, Non-Executive Director, asked what medical opinion was on this infection, which seemed to vary in strength between Mexico and other countries. Professor Tim Evans, Medical Director, confirmed that he was involved in the planning for response to a pandemic and that the virus was responsive to the anti-viral drug Tamiflu; it was not yet known why the virus had different effects but the HPA were working on this. Professor Newman Taylor said there was uncertainty about the true size of the problem in Mexico and that there could be a lower death rate than currently being reported. He felt we might see sporadic cases during the summer, to be followed by a stronger outbreak in the autumn and winter.

Provider Landscape Reconfiguration: Phase 1 Report – NW London (NWL) PCTs Collaborative Programme

Mr Bell reported that NW London PCTs were continuing with analysis for the potential reconfiguration of local Trusts: Phase 1 had now been concluded – eight potential reconfigurations had been mapped, from which four preferred options would undergo further examination under Phase 2. In all four "Phase 2" options, this Trust was envisaged to remain as a "stand-alone" organisation and would not be subject to takeover or merger. Mr Bell felt that some changes would occur and that if we did not become an FT, we were unlikely to be considered to remain a stand-alone solution. He continued that the group had taken account of the fact that change led to challenge and could be politically unpalatable.

2009/048 FOUNDATION TRUST STATUS

The Chairman reported that following the Board-to-Board meeting with Monitor on 30th March, the Trust had been given three issues to consider: (1) finance and the downside case, (2) additional information requested on the proposed London-wide cardiovascular review, and any 'downside' issues that might affect us; and (3) to what extent NEDs had assessed patient safety issues relating to our programme of initiatives to reduce costs.

Commenting on item (1), Mr Mark Lambert, Director of Finance & Performance said that PwC had carried out a due diligence exercise looking at the Trust's working capital. After reviewing the Trust's projections and applying their own downside assumptions, PwC had given a 'clean' opinion on working capital and the Trust's Financial Reporting Procedures.

In relation to item (2), Mr Robert Craig, Director of Operations, reported that the Trust had been informed in March that, as part of the next stage of Healthcare for London planning, NHS London planned to launch a review of cardiac and vascular services in the capital during the new financial year, but there had been no further details. The Trust had alerted Monitor to this initiative and they had suggested we speculate on possible terms of reference, and possible adverse implications which might result for the Trust. Mr Craig confirmed that some work had already been done on this to show:

- the Trust's strengths in entering into such a review, taking into account the quality and volume of work we undertake.
- a subjective assessment of a downside scenario, which might be the loss of

50% of cardiac activity from London PCTs (which might amount to 5% of turnover and up to £3m EBITDA contribution). This had been submitted to Monitor in mid-April.

Mr Bell reminded the Board that NHS London had indicated this review was to have been inaugurated in April but had still not started.

The Chairman turned to the item on NED challenge on the Financial Stability Plan (FSP). The Chairman had written at length to Monitor, stating that he had been more than satisfied on this issue, had listed the board meetings and seminars attended, and the extensive work carried out by the NEDs, particularly in relation to patient safety. The Chairman said this should be an agenda item for the monthly Board meetings. Mr Lambert confirmed that at the May Board meeting he would be reporting on Month 1 for 2009/10, which would include a 'benefits tracker' for the FSP. Mrs Jenny Hill, Non-Executive Director, said that qualitative indicators would also be needed in the report in future. Mr Craig agreed, adding that we needed to find a reliable and replicable way of achieving this and that Mr Richard Connett, Head of Performance, would be assessing this.

The Chairman then reported to the Board an issue which had arisen on Monday 27th April. Monitor had informed him by telephone that there would be a delay in the FT application process to allow the Care Quality Commission (CQC) to follow up some mortality data provided by the Dr Foster Unit at Imperial College – and that Monitor's Board would therefore not be considering the Trust's application at its April meeting. The Chairman stressed that the Trust had in place a robust and transparent reporting system for all mortality across the organisation. The cases highlighted by Dr Foster had already been reviewed within the Trust and he was confident the CQC would be satisfied when this information was shared with them. The Trust's case-mix was necessarily more complex than most, yet our mortality rates were some of the lowest in the country. In this instance the Dr Foster Unit was focusing on 'complex, combined and repeat CABG' procedures only and we had yet to understand the cohort of patients selected – it was not recognised by the Society for Cardiothoracic Surgery (SCTS) or Central Cardiac Audit Database (CCAD). The Chairman confirmed that we were in contact with the Dr Foster Unit to understand how they had arrived at these results. He regretted this delay in the FT authorisation, had spoken to the Chief Operating Officer of Monitor who had confirmed that he hoped the issue would be dealt with quickly and, apart from this, that it was his team's recommendation that the Trust should be authorised as an FT at their next Board meeting.

Professor Evans reported that he had commissioned a further review of the 26 deaths referred to, in order to try to identify linkages between these deaths and whether any changes to our systems were necessary. Professor Evans was drafting a report for the Board which should be completed within a week. Mr Bell said he was confident, despite this development, that the Trust would still be authorised in due course. The Chairman wished to reflect on the enormous amount of work undertaken so professionally by many of the executive team in the FT application.

2009/049 <u>GREAT ORMOND STREET HOSPITAL (GOSH) COLLABORATION REPORT</u>

Mr Bell reminded the meeting that, at the request of the Boards of both GOSH and RBH, a Joint Steering Board had been convened in November 2008, chaired by Mr Charles Perrin, to examine the concept and potential of collaboration in respect of children's heart and lung services. This aspired to the creation of a UK service which would become an international benchmark, treating patients from neonates to 16 years, integrating best practice of both institutions.

The resulting report and proposal allowed for three phases:
(1) setting up a Joint Clinical Board to agree clinical priorities, develop networks and partnership working, set targets and agree timetables;
(2) the formal creation of a single service collaborating on two sites,
(3) transfer to single site if available.

Mr Bell thought it was a notable achievement that the two Trusts had arrived at this stage without any outside intervention or coercion. There was also the possibility that the collaboration might be widened to include another centre, i.e. Guy's & St Thomas' FT Children's Services (Evelina), and a preliminary meeting had already been held. Mr Bell went on to say that some staff inevitably took a sceptical and short-sighted view, but agreed there could be 'collateral cascades' with other services e.g. for adult congenital heart disease. Mr Bell asked the Board to receive the report and consider its recommendations.

The Chairman confirmed that he was aware of concerns amongst some RBH staff. Professor Evans reported that he had met with clinical leaders in Paediatrics and other relevant groups to discuss the content of the report. The aims of the report were welcomed in terms of improving clinical services for children across London, but there was wariness of the strategic implications. Professor Evans had informed clinicians of the likely implications of current pan-London (and possibly national) reviews which reinforced the need to be seen to be leading such discussions. He concluded by reporting that those he had spoken to were happy with Phase 1 of the proposal.

With reference to 'collateral cascades', the Board would need to evaluate these in Phase 1, and in deciding whether to proceed to Phases 2 and 3. It was felt the document was short on a number of specific opportunities at this stage, e.g. the possibility of a cardio-respiratory Biomedical Research Unit being developed for paediatrics.

Professor Newman Taylor had found the report to be helpful and supported proceeding with Phase 1, but agreed evaluation of the consequences of proceeding further was needed, particularly to a possible single site. With regard to related services, the arguments in the document related to cardiac rather than respiratory services: he felt there were good relationships between the hospital groups and flows of patients (ACHD, adult CF and severe asthma). He emphasised that collateral problems would need close examination, but felt the scheme could deliver very real benefit to patients. He felt we should progress to Phase 1 and go through a clear 'gateway' decision at that point. Mr Nick Coleman, Non-Executive Director, found the joint venture proposal very exciting and understood that GOSH was also enthusiastic. However, he felt there was a need to guard against the two institutions holding very different views of the future and this needed to be understood sooner rather than later at Board level. Mrs Hill felt the world-class focus of the scheme was excellent, but pointed out the need for care in relation to the NHS partnerships with referring and surrounding hospitals. Mrs Christina Croft, Non-Executive Director, agreed that the concept was exciting and felt that improved patient care was the driving force. She agreed that Phase 1 was acceptable but care needed to be taken to maintain patient flows and R&D benefits.

In response to Mrs Hill's concerns, Mr Bell pointed out that the Board had agreed a memorandum of understanding with Chelsea & Westminster NHSFT (C&W) with regard to paediatric services for NW London and C&W had obtained similar understandings from GOSH. There were two independent exercises taking place – (1) PCTs in NW London seeking tenders for provision of specialist paediatric

services (excluding cardiac); and
(2) A Healthcare for London initiative, looking at paediatric services at secondary (but not necessarily tertiary) level.

Mr Bell said he personally thought the prospect of moving to a single site was remote, in the near term, requiring capital investment beyond everyone's current capability. The report was very non-committal about what a single site might be and this would not become clear until the preliminary phases had been completed. He felt it might be beneficial to propose a Trust-to-Trust board meeting before confirming anything and to decide if there were shared interests. Mr Bell thought it would be an undertaking of at least 2-3 years to bring the concept to reality and many things could change in such a timeframe. He did not want a repeat of previous failed projects.

Mr Craig, who had been a member of the steering group, thought a phased approach was important, and agreed that Phase 1 should begin with a board-to-board meeting to set clearer and more exact terms of reference than currently contained in the report. Professor Evans agreed with Mr Craig's comments and said the clinicians would very much welcome a board-to-board interface. He was concerned that there was a widespread perception that this was a short-term takeover, and such a meeting could provide reassurance and direction on this.

The Chairman summarised that the Board was happy to proceed to Phase 1, and set up a Board-to-Board meeting with clear terms of reference as its goal.

2009/050 FORMATION OF WORKING PARTY FOR HAREFIELD DEVELOPMENT

The Chairman said he was very keen to begin the process of looking at a planning application for the development of the HH site, which would follow FT authorisation. He proposed a small working party and suggested that this could be chaired by Sir Michael Partridge. Heart of Harefield would be involved as a stakeholder in working with the Committee as also the HSC and the local community.

The Board was in agreement with this.

2009/051 CORPORATE GOVERNANCE ISSUES

(i) Appointment of Company Secretary

Mr Lambert confirmed that as an FT the Trust should have a company secretary. 80 expressions of interest had been received and out of 4 candidates already interviewed the number had now been narrowed down to a field of 3.

(ii) Appointment of Additional Non-Executive Director

The Chairman confirmed that Monitor and PwC both supported the appointment of an additional NED to the Board with an accounting background. He was aware of interest from four people: two from KPMG former partners, one from PwC and one from Deloitte. An appointment would be made by the Governors' Council following FT authorisation.

It was agreed the issue of whether the Audit and Risk Committee should be split would come back to the Board at a future date.

2009/052 FINANCIAL PERFORMANCE REPORT FOR MONTH 12: MARCH 2009

Mr Lambert reported on the month of March and at the end of the financial year 2008/09. The surplus for the year was £3.173m, which was successfully within the notified control range of £2.8m to £3.5m set by NHS London. A number of year-end adjustments had been made – which approximately netted to zero, so a

surplus of £3.2m was the underlying performance of the Trust. The closing cash position was £2.7m (in line with that permitted by DH guidance).

On the capital programme, the substantial amount of £4.7m was spent in March, and the Trust had undershot its capital resource limit by £60k, which was a good performance.
Mr Coleman remarked on the strong overall performance for the year, but wished to draw attention to underachievement in performance in the FSP by some directorates. Mr Lambert said there had been an excellent achievement on savings generally, i.e. 97% achievement of the FSP. He agreed there had been some underperformance on savings in Surgery and Anaesthesia/Critical Care, due to very high levels of activity requiring employment of agency staff, and said there had to be an element of trade-off. Mr Craig said the non-achievement in Surgery on both sites and Critical Care at RBH had been driven by initial plans that had proved unnecessary, and the extra activity had had to be undertaken in an expensive way. 18-week access targets had also had an influence. Mr Coleman felt the Board might need to grapple with the activity and workforce levels. Mr Bell replied that we had set the budget for 2009/10, and if our additional opportunities were delivered, a very substantial surplus was possible, and our challenge would be to manage the consequences of that.

Mr Lambert continued that activity had had a slightly slow start in April but was picking up in late April in line with plan – influenced by the Easter break. Mrs Hill felt that performance in cardiac surgery needed attention over coming months.

2009/053 <u>OPERATIONAL PERFORMANCE REPORT FOR MONTH 12: MARCH 2009</u>

Mr Lambert introduced the report and commented on the following points:

- Clinical Outcomes: Mortality. The YTD rate was 0.92 deaths per 100 admissions (a reduction of 0.12 per 100 admissions compared to the 5-year average).
- Healthcare acquired infections: MRSA. There were no cases in March, giving a YTD total attributable of 2 cases against a limit of 5.
  C. difficile: There was 1 attributable case in March, giving a total of 19 in the full year against a limit of 31.
- Complaints: more than 90% of complaints were replied to within 25 days.
- Outbreak of Infection. There was one outbreak of rotavirus in Paediatrics and Rose Ward was closed to elective admissions for a short period.
- Serious Untoward Incidents. There were 2 SUIs reported in March, one being the outbreak of infection and one the death of a patient transferred from a maternity unit.
- Cancelled Operations: The final year position was 1.23%, which fell within the 'underachieved' band, although there had been a slight improvement in recent months. Reasons were much as before: high occupancy of intensive care beds or insufficient theatre time. The transplant programme at Harefield had been exceptionally busy which impacted on routine cardiac surgery. Mr Coleman pointed out there had been an encouraging downward trend which needed to continue. Mr Craig said there were signs of progress at RBH in scheduling and leadership but there was still some way to go. At HH there were some more fundamental problems to address. There would be enhanced recovery facilities on site from mid-year onwards and this would help. Mr Craig thought it would take longer to improve the HH figures downwards in line with RBH levels.
- 18-week waits: all targets continued to be achieved.
- Workforce: Staff Sickness. The rate was 3.08% (an improvement on the previous month) which placed the Trust in the top quartile for the country.

Modern Matrons' Report on Cleanliness and Infection Control, January-March 2009 Mr Peter Doyle, Service Manager and Snr Nurse for Critical Care (HH), introduced the report:

- Cleaning audits had confirmed achievement of the benchmark score at 94% which represents a continuing year-on-year improvement. The scores for cleanliness audits on the wards were being displayed for patients and visitors to see.
- The Trust has received extremely positive feedback from the Patient Environmental Action Team (PEAT) inspections; actions highlighted for improvement included the issue of equipment storage and the need for a stairwell floor replacement at Harefield.
- A 'bed-space cleaning' process following patient discharge has been implemented. Nursing teams have found response from ISS to be prompt. The installation of new ward macerators at HH has been welcomed.
- Hand hygiene compliance has increased steadily but there are still some problems with compliance (as with the dress code) amongst some clinical staff. Mr Coleman confirmed that the A&RC were monitoring this issue and were concerned. Mr Bell and Professor Evans confirmed that actions were taken with staff who refused to comply with Trust policy, but the available sanctions were either too crude or too inadequate to offer real disincentives.
- Mr Doyle continued there had been an increased incidence of C.difficile linked to the ICU at HH. A root cause analysis had been undertaken followed by the implementation of several initiatives, which appeared to be successful.
- An outbreak of viral diarrhoea on Rose Ward had resulted in bay closures and issues identified for action such as ward reorganisation and restriction of visiting.
- The surgical site infection surveillance programme would be extended to include cardiac valve surgery patients. Previous problems reported with water sampling in the Bronchoscopy Unit at RB had led to remedial works and the problem had now been resolved.

The Chairman thanked Mr Doyle for his report.

2009/054 Q4 PROVIDER AGENCY RETURNS

Mr Lambert presented the report to the Board which gave a quarterly update of service performance for submission to the NHS London Provider Agency. The papers included the Monitoring Self Certification document.

The return was accepted by the Board.

2009/055 ANNUAL HEALTHCHECK – CORE STANDARDS: FINAL DECLARATION

Mr Connett presented an update to the paper which had previously been discussed at the Trust Board meeting on 25th March 2009 and the Audit and Risk Committee on 28th April 2009.

- Core standard C11b – Mandatory Training: all areas had now achieved more than the 70% target set by the Risk Committee. Additional information had been included in relation to fire training to cover the 2 multi-agency practice evacuations, one at each hospital site, and the evacuation training for the upper floors of the Sydney Street building undertaken by Coopers Associates. The additional practical training had augmented classroom training and brought the overall achievement to over 90%.
- Core standard C20b – supporting patients' privacy and confidentiality: new information had been received relating to the patient survey 2008. This showed that the Trust had been rated in the top 20% of trusts for three questions relating to privacy of discussion and examination and being treated with respect and dignity. The Trust was rated in the middle 60% for single sex

accommodation (and in the bottom 20% for segregation of bathrooms). Mr Connett advised the Board that taken overall there was sufficient evidence of compliance with C20b and he advised a declaration of compliance with all of the core standards. Mr Coleman confirmed the ARC had also assessed this, and recommended that the Trust was compliant.

The Board approved submission of a fully compliant declaration.

2009/056 RECOMMENDATIONS OF ADVISORY APPOINTMENT COMMITTEE

The Board received the recommendation for the appointment of:
Dr William Ding-Cheong Man, Consultant Chest Physician

The appointment was approved by the Board.

2009/057 QUESTIONS FROM MEMBERS OF THE PUBLIC

Mr K Appel, Prospective FT Governor, said he was concerned about the infection control risk from visitors to the Trust. He asked if a more visible facility for hand-washing might be made available at the hospital entrances and visitors were required to hand wash. Mr Bell confirmed that gel dispensers were available at hospital entrances and that the Trust Infection Control team had already assessed the practice of imposing hand washing for all visitors but had found no evidence this would lead to better infection control practices, or guarantee to a reduction in rates of infection. Gel dispensers and notices at entrances to wards and other strategic areas had already been put in place. Professor Evans agreed that visitors were very often dressed inappropriately but would look to the recommendations of the Director of Infection Prevention & Control. Mr Bell was not sure if we could further improve on the current arrangements without infringing personal freedoms.

The Chairman agreed to ask the ARC to look at this issue.

2009/058 NEXT MEETING

Wednesday 27 May 2009 at 2.00 pm in the Boardroom, Royal Brompton Hospital

2009/059 EXCLUSION OF PRESS AND PUBLIC

The Chairman asked that member of the public and press withdraw so that a confidential matter could be discussed under a Part II agenda.