Minutes of the Board of Directors meeting held on 2nd April 2014 in the Concert Hall, Harefield Hospital, commencing at 10 30 am

Present:	Sir Robert Finch, Chairman	SRF
	Mr Neil Lerner, Deputy Chairman & Non-Executive Director	NL
	Mr Robert Bell, Chief Executive	BB
	Mr Robert Craig, Chief Operating Officer	RCr
	Pr Kim Fox, Prof of Clinical Cardiology	KF
	Mr Richard Paterson, Associate Chief Executive - Finance	RP
	Dr Caroline Shuldham, Director of Nursing & Clinical Governance	CS
	Ms Kate Owen, Non-Executive Director	KO
	Mr Andrew Vallance-Owen, Non-Executive Director	AVO
	Mr Richard Jones, Non-Executive Director	RJ
	Mr Richard Connett, Director of Performance & Trust Secretary	RCo
By Invitation:	Ms Carol Johnson, Director of Human Resources	CJ
	Mr Nick Hunt, Director of Service Development	NH
	Mr Piers McCleery, Director of Planning & Strategy	PM
	Mrs Carol Johnson, Director of Human Resources	CJ
	Ms Joanna Axon, Director of Capital Projects and Development	JA
	Sian Carter, Interim Director of Communications & Public Affairs	SC
In Attendance:	Mr Anthony Lumley, Corporate Governance Manager (minutes)	AL
	Ms Gill Raikes, Director The Royal Brompton & Harefield Hospitals Charity	GR
Apologies:	Pr Timothy Evans, Medical Director & Deputy Chief Executive	TE
	Mr Richard Hunting, Non-Executive Director	RH
	Mrs Lesley-Anne Alexander, Non-Executive Director	LAA

2014/13 DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING

None.

2014/14 MINUTES OF THE PREVIOUS MEETING HELD ON 29 JANUARY 2014

The minutes were approved.

NL said he noted that Action 14/05 did not have a date. As this was a record of a change of process and not an action it was agreed to remove it from the tracker.

NL said it had previously been agreed to elevate risks issues on the agenda. It was agreed that reports from committees of the Trust Board would be placed higher on the agenda in future.

2014/15 REPORT FROM THE CHIEF EXECUTIVE

BB said he would not be presenting a report. He would comment on items as appropriate.

2014/16 CLINICAL QUALITY REPORT FOR MONTH 11: FEBRUARY 2014

RCo highlighted the following:

- *Clostridium difficile*: The Monitor de minimis target of 12 will not be met for Q4. The Department of Health (DH) had set the Trust a target of 9 for 2014/15. There was also a change in reporting requirements. During 2014/15 there would be the potential for cases to be deemed non trajectory, subject to review by commissioners. This introduced a degree of clinical judgment. With the Operational Plan due to be submitted on Friday 4 April 2014 RCo recommended that because of the uncertainty regarding the new process the Trust should flag *Clostridium difficile* as a risk in the Annual Plan for 2014/15.

NL asked if judgements on which cases to report were being made by all Trusts? RCo said this was correct. BB said it was the first time in 4 years that the DH had changed the target. Monitor did not follow the DH target and had set the Trust the de minimis target for the last 2 years. This now begged the question what would Monitor do following the change in process? BB added that the Trust did not consider that it had an infection control problem.

- The 62-Day Cancer target was subject to agreement of 5 of the 7 breach repatriation requests the Trust had made and would potentially not be met for Q4. RCo reported that Buckinghamshire Healthcare NHS Trust had been sent 3 of the 7 breach reallocation letters, but had not agreed to any of these breaches being reallocated.

- The Care Quality Commission (CQC) had carried out an unannounced inspection of Harefield Hospital (HH) on 3 February 2014. The report published on 4 March 2014 showed full compliance with the standards inspected and contained many examples of positive feedback.

- CQC Intelligent Monitoring. The CQC's second report had moved the Trust's risk banding from band 3 to band 5. Staff were currently investigating why the indicator for in hospital mortality, cardiological conditions and procedures, had been flagged and described as an elevated risk.

NL requested that the Trust report back to the Risk and Safety Committee (RSC) on its investigation of the cardiologcal mortality indicator and then bring it back to the Board as part of a wider report. This was agreed. He congratulated all the Trust's staff in getting an excellent report following the inspection.

- Incidents - Safety SI's (Serious Incidents): 2 SIs in February 2014. Both related to pressure ulcers. There had been 1 radiation incident. NL said the SIs had not yet come to the RSC. He suggested the

Board note it now and that it come back to the Board after the RSC had discussed it. This was agreed.

- Cancelled operations: a higher than normal reported number of cancelled operations at HH caused by high bed occupancy and problems with data capture and recording. There had been 7 breaches of the 28-day standard in February 2014.

RCr highlighted the report in Section 4 which he had asked for and which set out the background and pressures. The service for patients awaiting surgery at Harefield had been poor in recent months. He had written to apologise to the patients most severely affected and would also be apologising to others who had the same experiences. He had spoken with Ken Appel, Public Governor North West London on the subject that morning. The report set out the steps being taken to address the issues which included keeping a control of planned elective admissions, protected theatre operating times for inter-hospital transfers and the use of capacity elsewhere. RCr said he was confident the experience of patients was now being better managed, but noted that the situation (and e.g. nos. of cancellations in March) would not improve immediately. KO asked if the actions were new and was uneasy about how effective they would be. RCr said some of the actions had been discussed by the Board in January 2014. NL said RCr had approached him to discuss the problems and he had appreciated that. He asked if the actions were radical enough or were only effective at the margins? RCr said the long term issue was about adequate capacity across the pathway of care, not just in theatres or critical care. NL asked if the Trust could use 'out-of-hours' capacity in the short term? RCr replied that this often happened, but there was no point in scheduling extra theatre cases if the ward and critical care beds were not available.

BB said the more pressing issue had been scheduling and this had been addressed with a change in personnel and new oversight. KF suggested a solution to the problem might lie in common waiting-lists for both sites - Royal Brompton Hospital (RBH) and HH combining their resource. BB did not believe this would be the right action as the patient pathway meant it would be challenging to manage bed capacity across the Trust. The Trust had been looking at capacity elsewhere and last year 60 patients had been treated by our teams in the private sector. He added that it was not the case that RBH capacity was the solution to HH capacity constraints as there were often critical care pressures on both sites, and the Trust had closed a theatre at RBH for urgent remedial work only the previous week. RJ asked if the error in reporting required a correction to figures for the previous months? BB said retrospective corrections were rarely permitted. It was more salutary to move forward and build on the lessons learned. RCr acknowledged the point but said it would divert staff efforts whilst the identified problem was still being addressed.

- 18 RTT by National Speciality – Incomplete Pathways: the 92% target had been missed at the 'other' national specialty level (91%). 18 Weeks 'Admitted' and 'Non-admitted' pathways were compliant across all specialties.

The Board noted the report.

Action: RSC to receive report on cardiologcal mortality indicator and then report to Board at a later meeting.

Action: investigation of the SIs to be considered by the RSC and then the Board (AVO)

2014/17 FINANCIAL PERFORMANCE REPORT FOR MONTH 11: FEBRUARY 2014

Introducing his report RP highlighted the following:

- M11 was the first time the Trust could see a real picture of underlying performance before we start to make year end closing adjustments. Project Diamond (PD) and some critical care transplant income were recognised in the month. They had not been recognised in results until paid because of the concern that they might be disputed. Hence the previously reported position had been conservatively stated.
- M11 in underlying terms had been disappointing but taking account of the PD and critical care income recognition the Trust had made a YTD surplus of £2.9m against plan of £1.5m.
- Balance sheet – cash. Some progress had been made on debts owed by NHS commissioners. As of today (Wednesday 2 April 2014) all over-performance monies currently due from NWL and NHS England (NHSE) had been collected
- Continuity of Service (CoS) rating: although not required to report this rating at the end of M11 the Trust would have reported a rating of 4.

NL said pay remained a serious issue as it was £1m ahead of plan in M11. RCr said £200k of pay costs reported in February related to previous periods.

The Board noted the report.

2014/18 RESEARCH UPDATE

SRF said the Management Committee had examined the report in depth and had received a full briefing from TE and no issues had arisen.

NL noted that the Trust was targeting recruitment of a lower number of Trust patients into National Institute for Health Research portfolio studies in 2013/14 than the previous year. SRF asked RCo to clarify with Dr Angela Cooper the reason for this. ["Note to the minutes: The recruitment target is based on an agreement between the NIHR CLRN and the Trust about predicted recruitment for the forthcoming year based on the number of known studies (which change from year to year), Their recruitment targets and previous performance. Hence in 2013/14 (and without knowing final outturn for 2012/13 which can accrue several months after year end) the Trust expected a similar recruitment to 2012/13. We have yet to see final year recruitment

figures for 2013/14 which may exceed 1500 (although it is not expected to reach 1800). It is a result of the nature of the studies that we had open to recruitment during 2013/14 compared to 2012/13."

The Board noted the report.

2014/19 FRANCIS REPORT UPDATE

CS said the update, which gave a flavour of the work done to date, had been considered by the Risk and Safety Committee (RSC) at its meeting in February 2014. It was reported then that KPMG recommended that the Trust RAG (Red – Amber - Green) rate each recommendation and this was now included in the Board paper. The RSC had concluded it was a positive report and noted that KPMG had also suggested that it was discussed at the next Board meeting to meet the requirement for discussion by the Board in public. AVO said the RSC had been impressed by the amount of work done within the Trust.

NL asked why the Information recommendation (244) had no text in the part of the table marked 'Comments regarding current position'? CS said the Board had been given a presentation at its last meeting on IT strategy and it was clear that the Trust's Chief Information Officer (who had been designated as responsible for the Trust's response to the recommendation) was very conscious of these issues. NL proposed that an update on progress with the Francis Report recommendations be given to the Board in 6 months' time; to be presented by the Director of Nursing and Clinical Governance or her successor.

Noting that the majority of actions in red required actions from third parties to go from 'not started' to at least 'underway', RJ asked if the Trust could do anything to push this along or work in parallel? CS said that in these instances there was nothing that the Trust specifically should be doing. What could be done was the Trust could, and would, participate in their consultations. These recommendations had been included because at some point they would have implications for the Trust.

The Board noted the report.

Action: CS (or successor following appointment) to update the Board in the autumn (2014).

2014/20 STAFF SURVEY RESULTS

CJ said the staff survey presented a positive picture. There had been a push on appraisals. Also equality and diversity training although this had only run every two years. It would be run every year from now on.

NL asked if the staff score on discrimination being higher than peers was a worry? CJ said there had been no formal grievances and it was not an issues that was being seen on a day-to-day basis through complaints.

RJ asked if bullying and harassment was a concern? CJ said it had been higher. Once again there had been no formal grievances. RJ asked if there was a concern staff were not reporting incidents. CJ said RB&HFT was a high pressure environment. It could therefore be higher. It was known where the pressures were. There were team building activities, and interventions to address this and the Trust had identified staff to act as ambassadors and model high standards of conduct.
KO congratulated CJ on the higher number of appraisals but noted the comments on how appraisals are structured. She encouraged CJ to continue to improve this area. KO asked what the other survey had been cited in the report as affecting the response rate? CJ said this had been an internal safety climate survey.

AVO said that given last year's figures this was a good result and added his congratulations.

BB said that on 1 April 2014 he had been invited with four other acute Trusts (Moorefields Eye Hospital, Wrightington, Wigan and Leigh NHS Foundation Trust, Leicester Royal Infirmary, Clatterbridge Cancer Centre) chief executives to meet with Francis Maude MP and Norman Lamb MP. The Trusts were seen by the MPs as leaders in staff engagement. This had been a pleasant surprise. BB concurred with CJ that 14% for discrimination and 25% for bullying & harassment in a high pressure environment were low figures. More importantly in a Trust likes ours stress levels were higher as there was a lower tolerance for mistakes.

AVO said this illustrated the value of specialist hospitals.

SRF congratulated CJ and asked her to continue to bear down on harassment and bullying, encourage use of the appraisal system and provide more equality and diversity training.

2014/21 <u>BORROWING FACILITY FROM INDEPENDENT TRUST FINANCING FACILITY (ITFF)</u>

NL asked RP to explain the 'negative pledge' aspect of the facility. RP said there were significant commercial advantages of this form of borrowing. However, there were two items which required prior approval from the ITFF: firstly borrowings from other lenders secured by Trust assets and secondly major asset sales >10% of the Trust's balance sheet. This second potential restriction was highly relevant to the Trust's redevelopment ambitions. RP added that the Trust had been wholly transparent with ITFF in their negotiations: indeed, its correspondence with the Trust could be viewed on their web site. He had asked the CE of the ITFF to confirm in writing that these approvals would not be unreasonably withheld. The CE had done so adding that it was not the ITFF's desire to hold back the Trust from reasonable activities. The only circumstances in which it might demur would be if the Trust was in default or if its CoS rating was deficient. RP said the Loan Agreement had been reviewed by the Trust's lawyers and the Finance Committee. NL said he fully supported establishing an ITFF facility.

RP presented for approval the draft loan agreement and related documentation (the 'Finance Documents') from the Independent Trust Financing Facility which would enable £30m to be borrowed over three years from April 2014. The Trust Board is required to state its agreement to the proposal and to provide the specific assurances and confirmations below.

IT WAS RESOLVED

1. To approve the terms of, and the transactions contemplated by, the Finance Documents to which the Trust is a party;
2. To execute the Finance Documents to which the Trust is a party;
3. To authorise Mr Richard Paterson, Associate Chief Executive – Finance, to execute the Finance Documents to which the Trust is a party on its behalf; and
4. To authorise Mr Richard Paterson (or, in his absence Mr Robert Craig, Chief Operating Officer, or as the case may be the successor in each of their respective roles) to sign and/or despatch all documents and notices (including any utilisation request) to be signed and/or despatched by the Trust under or in connection with the Finance Documents to which the Trust is party.

Certified to be a true extract from the minutes of a duly convened meeting of the Board of Directors validly held on the date shown above.

…… Trust Secretary

…… Chairman

2014/22 DEBTOR WRITE-OFFS

RP said the proposed write off over £50K was recommended by the Finance Committee for approval by the Board.

SRF asked if there were any lessons to be learned? RP said the Trust collected deposits in advance from self-paying private patients. Sometimes there were additional clinical complications which subsequently emerged. As write offs were very rare this illustrated that the internal procedures were essentially sound.

NL said the Finance Committee had looked at a write off that was even larger. The Committee had asked for further detail and would discuss it and then report back to the Board.

The Board agreed to the write off the debt over £50k as set out in the report and noted the write off of £16k which had been approved by the Finance Committee.

2014/23 ANNUAL PLANNING REVIEW – OPERATIONAL FOR 2014/15 AND 2015/16

Operational Plan

PM introduced the report and said that previously the Annual Plan had been submitted at the end of May. This had been split into two parts and Monitor now required firstly the submission of an Operational Plan and secondly a five year Strategic Plan to be submitted at the end June 2014. The second part would therefore come to the Board for approval. The Operational Plan had a clinical quality section and was largely a compendium of existing reports for example the Francis report response discussed earlier.

Following comments from SRF and NL it was agreed to make the following amendments:

- 1.2.2.2 take out reference to potential financial penalty imposed by Monitor if *Clostridium difficile* target is exceeded
- 1.2.2.4 v) remove phrase 'building on progress made in FY 13/14''
- 1.2.3 NL questioned the implication that proceeds from Chelsea could be used to fund development at HH. RCr said the Trust did not have a longer term plan for HH as yet.
- 1.2.5.4, second bullet, third sentence: delete 'for each campus'

AVO noted the concentration on risk management and wondered if a statement could be added on maintaining levels of excellence to counteract the focus on matters such as *Clostridium difficile*. SRF concurred and said the document should be about expressing the Trust's vision. RP cautioned against too much change in the tone and language and instead bear in mind the audience.

Budget

RP thanked RCr's team for their work in supporting the compilation of the budgets. For 2014/15 for the fourth year running the Trust would need to realise c.£12m in savings. For the Strategic Plan the Trust was required to produce five year projections and annual 4% efficiency plans built in. He had told BB that in the later years the budgets are likely to show deficits. From discussions with his peers in other Trusts there was a strong chance that the majority of Trusts would be reporting a deficit budget for 2015/16.

The planned surplus for 2014/15 was £2.3m which was less than 1% of revenues. This was demanding but was achievable subject to receipt of Project Diamond (PD) monies. The Department of Health (DH) and NHS England (NHSE) had recently intimated that PD might cease with effect from 2014/15. This appeared at odds with the understanding for many years that PD would be consolidated into tariff, the target date for which had been 2015/16. The NHS tariff for any given service is based on the average costs of all those Trusts delivering that service across the country. Because RB&HFT is a specialist hospital procedures are typically more complex and time-consuming thereby incurring greater costs. All the PD Trusts had combined to write to DH and NHSE to express concern at the proposed

shift of goalposts and its timing. All PD Trusts had put PD funding in their budgets for 2014/15 and 2015/16. RP said in his judgment he thought that at least the major part of PD would be paid to the Trust in 2014/15.

Highlighting the 2015/16 budget RP said the summary showed a deficit of £5m which would be made up from cost saving programmes. This was achievable based on prior years. A break even budget for 2015/16 was achievable and would be reported to Monitor.

NL asked if assuming a 5.4% increase in NHS income excluding PD on top of the tariff deflator of 1% meant effectively a 7% increase in figures? RP said that was probably right. NL asked if an increased level of activity was achievable? RP pointed out that some of this growth actually represented the full year effect of service developments introduced in 2013/14. RCr agreed and pointed out that the projections were not all based on inpatient capacity. He had not had to apply a generic over-performance expectation and the growth plans were tied to specific proposals.

BB said the underlying premise of the budget was that the Trust believed that the demand for services was still out there and would continue to be. The risk was whether commissioners will continue to commission from RBHFT? Budgets should not be looked at in isolation. While the expectation was that revenue from NHSE will be impacted, the Trust was not anticipating them not wanting to commission from RB&HFT. Specialty activity was incrementally in demand. In three to four years' time there would be limits to capacity from commissioners but they would not be able to limit demand. The Trust was a supply led organisation. NL acknowledged this analysis and said that some allusion to it in the introduction to the budget would be helpful.

NL asked if there was the inpatient capacity to generate the increase in Private Patient (PP) income or was more inpatient capacity required? RP said that for much of 2013/14 some of the PP facilities were closed for refurbishment. The 2013/4 PP performance showed that when a third of the existing facilities had been unavailable the Trust had coped very well.

NL asked with the pressure other Trusts would be under would that leave RB&HFT short of cash? RP said deficits and cash did not necessarily go hand in hand. A number of Trusts (including some which were not Foundation Trusts) had requested assistance from the ITFF. NL asked if the cash plan reflected the pressure our customers would be under? RP said the reference was not to customers but other provider Trusts. Our Trust to Trust income was modest.

BB said the Board should be careful about who it makes comparisons with. He had met with a Trust Chief Executive who explained that their PP income, twice that of RB&HFT's, was augmented by high charity donations to their operational base.

Financial stability plan (FSP)
RCr reminded members that the Board was expected to make a statement about the effect of the budget on the safety of its services. Although this was a responsibility of the whole Board, it was an audit expectation that the views of both the medical director and nursing director should be minuted. The paper had been shared with all divisional directors, general managers, Governance and Quality Committee and Management Committee members – none of whom had raised a concern.

NL asked if CS could state whether she was satisfied with the detail of the budget? CS said she was absolutely happy to endorse it. It was a well thought out budget. There had been no reductions in clinical staff. She suggested that the reason endorsement from medical and nursing directors was a requirement was because Trusts had made savings by reducing clinical, often nursing, staff. Such Trusts were now increasing nursing staff.

RCo read out comments he had received from TE. He confirmed that the divisional directors', management and Governance & Quality Committees had all discussed RCr's comprehensive paper on the potential effect of the financial stability plan for the financial year 2014-15 and were not only content that they would not adversely affect clinical services, but regarded them as likely to bring improvements to the Trust's processes and systems of care.

Capital Programme
RCr said this was an exciting programme but it came with real challenges. The two-year planned spend was £71m. Key elements of this were £16m for IT strategy, plus significant imaging investment, planning costs, critical care beds and ward beds at HH. The summary and planning assumptions for five years had been reviewed by the Capital Working Group. However, there was a risk to the delivery of £42m in 2014/15. It was unlikely that the programme would actually be fully delivered in this period as not all projects yet had tendered prices or contractors' programmes. The proposal therefore was to defer £6m to 2015/16.

SRF asked how the £30m improvements planned for HH would fit into the master plan? RCr said there was no formal master plan for HH at this stage, although the Trust had commissioned some initial architectural proposals.

NL asked for more detail on the changes made since the budget had last been discussed by the Board. RCr said there was greater certainty now about IT in 2014/15, the nature of the investment in imaging in Harefield Hospital (HH) and the refurbishment of the last theatre at HH. NL asked if the Trust could be confident it had adequate contingencies? BB said his assumption was that the Trust would be under spending rather than overspending. As the paper indicated, the Trust did not have a history of spending capital amounts on this scale and would take time to 'gear up' to this threshold of spending.

RP noted two items which were exceptional in this regard – redevelopment fees ('out-of-house' costs) and IT. In these areas, there was capacity to spend more money than historically had been the case.

The Board gave its approval to proceed. SRF said he would pick up discussion of the HH developments separately with RCr.

Subject to the amendments to the content suggested above, the Board authorised SRF, BB and RP to sign off the Operational Plan.

2014/24 ANNUAL REPORT PROCESS

RCo said the report set out the framework for the Annual Report 2013/14 and identified those officers responsible for the various elements. It took into account the updates made to Monitor's Annual Reporting Manual in March 2014 which included the introduction of a requirement for a Strategic Report. NL said the new format would be a big challenge. It was agreed that the Audit Committee would have responsibility for the 'fair, balanced and understandable' review of the Annual report in the first instance, prior to final consideration by the Trust Board on 21 May 2014.

2014/23 AUDIT COMMITTEE

(i) MINUTES FROM THE MEETING HELD ON 21 OCTOBER 2013

The minutes were noted.

(ii) REPORT FROM MEETING HELD ON 18 FEBRUARY 2014

The unconfirmed minutes of the meeting held on 18 February 2014 were tabled. NL said the committee had discussed the new format of Annual Report.

2014/24 RISK AND SAFETY COMMITTEE (RSC)

(i) MINUTES FROM THE MEETING HELD ON 21 OCTOBER 2013

The minutes were noted.

(ii) REPORT FROM MEETING HELD ON 18 FEBRUARY 2014

The unconfirmed minutes of the meeting held on 18 February 2014 were tabled. AVO said the committee had agreed that a meeting would be organised between Non-executive directors and the staff governors and patient elected governors. The committee had also reviewed the top risks. It had noted that compliance with the NHS Fire Code was not mandatory. RCr said more details of the planned maintenance works for Fulham Road would be presented to the next RSC meeting at the end of April 2014.

2014/25 RECOMMENDATIONS OF ADVISORY APPOINTMENTS COMMITTEE

KO reported on the advisory appointments committee for a Consultant Radiologist (RBH) noting a particularly strong field of candidates. The appointment of Annand Devaraj was ratified by the Board.

AVO reported on the advisory appointments committee for a Consultant in Aortopathy. The proposed appointment was of an extremely experienced

candidate. The appointment of Christoph Nienaber was ratified by the Board.

NL reported on the advisory appointments committee for a Consultant in Cardiovascular Magnetic Resonance. The panel had asked that a development plan be put in place to support the proposed candidate. NL added that TE might wish to get involved in the process of appointing locums into these posts at an earlier stage in future as they often became leading candidates. KO said there were often good candidates but that they sometimes needed additional assistance to achieve the grade expected of a consultant. The appointment of Francisco Alpendurada was ratified by the Board.

The appointment of Francesco Del Sindaco as a Consultant in Anaesthetics was ratified by the Board.

2014/26 REGISTER OF DIRECTORS' INTERESTS

It was agreed that as there was some information that needed correcting a note would be sent to all directors asking their corrections. SRF said at the next Board meeting the appointment of directors to sub committees would be confirmed.

2014/27 PAEDIATRIC JOINT VENTURE WITH CHELSEA & WESTMINSTER (C&W)

RCr said the Strategic Outline Case (SOC) showed that a definitive proposition was still lacking. The paper asked the Board for consent with continuing to develop the case. The £522K estimate for the cost of moving forward to the Outline Business Case (OBC) stage could change. RCr said he had confidence in C&W's commitment to provide the space. He was also satisfied that all relevant Trust services could be accommodated and commissioned in the new facilities from April 2020. RP added that the SOC identifies the financial challenges inherent in the proposal. Notwithstanding these, RP recommended that the OBC should be developed given the considerable strategic benefits of the project.

BB said paediatric services were not money making. Working teams at Management Committee had been asked to go back and explore the business case because as Accounting Officer he could not endorse the venture on the basis of the current financial analysis which did not pass the test of public probity. BB said that the proposal was being discussed by the Trust Board of Chelsea & Westminster NHS FT this week. The proposal currently before the Board was to approve the undertaking of further work following which a report would be brought back to the Board.

SRF asked about the timescale for approval of the OBC? RCr said that it was intended that the OBC would be developed by July 2014, but that he thought this might be optimistic and that a realistic expectation would be to progress to a Full Business Case by year end.

The Board authorised the development of an OBC for the proposed partnership.

2014/28 QUESTIONS FROM MEMBERS OF THE PUBLIC

Gillespie Robertson (GR), Chairman of the Dovehouse Street Resident's Association addressed the Board. He said that he was privileged to live in area with three prestigious hospitals in the vicinity including RBH where his granddaughter is a patient. He asked if the Trust's Board was aware of local residents concerns regarding potential impacts of the redevelopment project on the locality?

SRF said the Board was aware of the issues and it would do everything it could to alleviate those concerns raised by the local community.

GR asked if it would be possible for Dr James Thompson, Chairman of Kings Road Association of Chelsea Residents (KRACR), to address the Board at a future meeting? SRF suggested that Dr Thompson write to him regarding this matter.

GR said that he wanted the Board to be informed by, and listen to the residents regarding the redevelopment.

SRF referred to a meeting he had had with GR on 20 March 2014 and confirmed that the Trust was committed to continued engagement with residents who were always welcome to make suggestions.

Kenneth Appel (KA) said he would like to congratulate the Trust on the results of CQC inspection. This only confirmed what we already know – that the RB&HFT is a jolly good hospital. However, he said that the Trust should not rest on its laurels. He thanked CS's for her report. He also had noted that staff appraisal were very satisfactory with the exception of one department at HH which he was assured would be attended to. KA said a major part of his activity was looking at clinical complaints. Most of these were due to communication problems around cancelled operations and waiting times. Patients were anxious about when they would be transferred. Could the Trust allay patients' anxieties?

RCr said part of managing cancelled operations was making sure messages were transmitted. The position was very fluid. He acknowledged that there was some of the information needed to be improved.

NEXT MEETING

Wednesday 30th April 2014 at 2.00pm in the Board Room, Royal Brompton Hospital