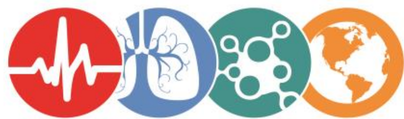

Royal Brompton & Harefield NHS
NHS Foundation Trust

Minutes of the Board of Directors meeting held on 22 October 2014 in the Board Room, Royal Brompton Hospital, commencing at 2 pm

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

2014/84 DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING

None. *[Secretarial Note: SRF and TE are shareholders in Re:Cognition Health. These interests are included in the current Register of Directors' Interest]*

2014/85 MINUTES OF THE PREVIOUS MEETING HELD ON 24 SEPTEMBER 2014

The minutes were approved subject to the following amendment:

Page 4, item 2014/75, last para., first sentence: add 'and, moreover all Board reports, … ' after ' … Report' and before ' … could identify the main points of concern'.

Matters Arising
SRF asked for an update on Wimpole Street. RP said this was progressing. The Trust's lawyers were in lease contract negotiations with those of the landlord Howard Walden Estates and, in parallel, with Re:Cognition on sub-letting part of the property. Leases would not be signed until financing facilities had been secured: the execution documents from the bank were expected imminently.

BB notified the Board that he would be updating them on some of the issues from his last strategic update in a Part II session which would be held in private following this meeting.

Action Tracker
(Action BD 14/77) The Board discussed the timing and scheduling of a presentation on Research to be given to the Board by TE following the successful Research Presentation previously made to the Charity. This would be finalised following this meeting and the Board informed.

In response to a query from KO on whether it was still intended to have a presentation from TE on strategic issues (as BB had previously intimated to the Board) BB said this was a separate matter to the research presentation which was the subject of the Action just discussed. He acknowledged though that it could still be included and, following a suggestion from NL that it could be discussed at the Board seminar in January 2015, BB said it could also include new appointments to clinical leadership posts and a plan for the next 2/3 years over how services would be distributed. Picking up on KO's comment that this and other issues should be aligned, NL said the Trust should also be aligning strategy and property development discussions. Noting that NL was currently a member of the Property Committee and would be kept informed through that channel, SRF said he was confident that from now until early Spring 2015 these subjects would be aligned though he recognised that the Board would need to be kept informed.

2014/86 REPORT FROM THE CHIEF EXECUTIVE

BB gave an oral report.

Chelsea Campus Redevelopment
BB confirmed that the 12 December 2014 timeline, for the publication of the a joint report by the two Trusts – the Royal Marsden Hospital (RMH) and the Royal Brompton & Harefield NHS Foundation Trust (RB&HFT) - and by NHS England (NHSE), would be adhered to. Discussions with RMH were very positive. There had been a long standing collaborative relationship between the Trusts and a close clinical understanding with daily cooperation.

Chelsea & Westminster (C&W) Collaboration
BB said Board members had attended a Board-to-Board meeting with C&W on 22nd September 2014 and a draft Memorandum of Understanding (MoU) on a joint collaboration on paediatrics had been drawn up. This awaited

endorsement by the two chairmen. SRF said the Board-to-Board was constructive. He had written to the chairman of C&W and said RB&HFT's aspiration was to join paediatric services. The first task was to find a suitable person to lead the service. BB added that having a joint site for the service should be viewed as an aspiration and not a requirement.

2014/87 CLINICAL QUALITY REPORT FOR MONTH 6: SEPTEMBER 2014

Introducing the report RCo said the highlights were.

Monitor Risk Assessment Framework

- *Clostridium difficile*: 2 cases in M6 had been reported to Public Health England and with 1 case from July 2014 and 7 in August that meant 10 cases were under review. To date 1 case had been adjudged to be have been caused by a lapse in care which would be counted against Monitor's de minimis threshold of 12. The target would therefore be met for Q2. NL asked if the 7 cases reported in August could be attributed to a single outbreak? CS said there was no evidence that the cases were related. Genetic typing had shown nothing to link them at the moment although in 2 of the cases it had not been possible to culture any organisms for testing. She added that in each case patients had not been in the same room, nor was there sequential overlapping of patients as had happened last year.
- Cancer 62 day urgent GP referral to 1st Treatment target M6: 16 breach allocation requests had been sent for Q2. 4 had been agreed so far. Milton Keyes Hospital and Southend University Hospital had been contacted to follow up the letters and the other trusts would be contacted shortly RCo noted that given the number of breaches, and the requirement to aggregate consultant upgrade pathway patients, even if all of the reallocation requests were agreed 9which is highly unlikely) it would still not be possible to reach the 85% required for the target to be met, The recommended declaration therefore for the Governance Declaration was that that this target was not met. All other Cancer targets had been met.
- Care Quality Commission (CQC): implementation of the 2 new regulations affecting Directors, Duty of Candour and Fit and Proper Persons Test had been delayed. It was now expected that ministerial sign-off would occur at the end of October 2014 and parliamentary approval would be given in mid November.

Standard Contract:

- 18 Weeks Referral to Treatment Times (RTT) Admitted: the 90% target had not been met at the 'other' national specialty level (85.92%). The Trust had commissioned off site additional capacity to address this.
- Cancer 62 – reported as required under the NHS Standard contract where GP referrals are reported against an 85% target. This was at 60% so was reported as 'Not met'.

Key Performance Indicators

- Incidents: there had been 3 Safety Serious Incidents in M6. Two of these were pressure ulcers and the third was a fall. There had also been 2 radiation safety incidents. A check had been made with the radiographers on 21 October 2014 and a team meeting had taken place to review the incidents and ensure lessons were learned.
- Complaints: this was slightly below target (90%) at 86.8%.

NL said he noted that cancelled operations at HH had ticked down and was therefore moving in the right direction. RJ asked what was an achievable target given that zero was not realistic? RCr said the aim should be for zero but he agreed that this was probably unrealistic.

SRF said the Management Committee had discussed the 16 re-allocation requests. It must be unacceptable that Luton and Dunstable Hospital had referred a patient to the Trust on day 157. TE concurred and said it was not in the interests of the patient affected. Andrew Menzies-Gow (newly appointed Director of the Lung Division) had given a presentation on the cancer services review to the Risk and Safety Committee (RSC). The challenge was for the Trust to take control of the pathway leading to surgery. TE said he had asked the 'NHS Cancer Tsar' to review the action plan. As a follow up to the action points from the plan, discussions had been held with respiratory consultants and meetings with other Trusts had taken place. The aim was to take ownership of the pathway in terms of waits and work with Mount Vernon Cancer Centre regarding oncology and radiotherapy support.

With regard to the radiation safety incidents, RJ said he was pleased with the actions outlined. He wondered whether the outcome should be reported back to the Board. RCo said it was reported here when incidents occurred they triggered a report to the CQC. RCo proposed that outcomes should be reported via the RSC. AVO, as Chair of the RSC, endorsed this plan.

PD said the system for 62 day cancer target performance monitoring was patently wrong. As other tertiary Trusts were reporting the same difficulties this was reassuring to a degree, and the Trust was not failing quiet as badly as the figures show. He asked when would the Trust recruit (new staff?) and be able to give reassurance over the figures? TE said providing assurance over the target was difficult but he could reassure the Board that staff would be recruited.

NH said that 62 day cancer target performance was almost the only topic of discussion in NHSE Clinical Quality Review Group (CQRG) meetings. They were trying every single possible route to do deal with this including engaging the CQRG for the referring hospital. NL said this might be interpreted as 'moving the deckchairs around' and was different to the solution outlined by TE. If there was recruitment within the UK that would move the problem somewhere else, or was the Trust going to recruit from abroad? TE said the organisation would recruit where it could and it did raise some questions about future strategy. CS said the process described

by NH was an attempt to influence the quality of care in Trusts and not about moving deckchairs. NL said he accepted this explanation.

LAA voiced her shock at the 2 referrals over 100 days. She felt that the Board should endorse escalation. SRF acknowledged the strength of her feeling and added that it was not acceptable for himself, as Chairman, to see these numbers. RCr said often the teams in other Trusts simply did not know about the on-going referral and wait.

BB said the Management Committee had discussed escalation many times. He had wanted to escalate in a more 'political' sense but had deferred to TE's advice and heeded his view to avoid too much 'boat rocking'. The root of the problem started with the clinicians elsewhere. Currently the trust was not in control of the pathway and The Trust was at the end of the pipeline and had to assert control. This was a systemic problem and a policy issue.

NL asked if the trend for the Friends & Family response rate was in decline or increasing? CS said it was increasing from when we had begun.

The Board noted the report.

2014/88 FINANCIAL PERFORMANCE REPORT FOR MONTH 06: SEPTEMBER 2014

RP highlighted the following performance in M06:

- I&E account: the EBITDA (earnings before interest, tax, depreciation and amortization) outturn as shown in Annex A of the report was the best indicator of where the Trust was financially. For M06 this was just slightly ahead of plan (£2.1m against £1.9m) while, cumulatively for the first 6 months it was £9.2m against plan of £9.1m. At the surplus/deficit level the Trust was behind plan both monthly and YTD (year-to-date). RP said the 'culprit' (again) was capital donations not yet received as a result of certain elements of the CAPEX programme being behind schedule.. The Trust would eventually catch up on this timing difference but probably not in this financial year.
- Balance sheet cash: this was £3m behind plan mainly because Private Patient (PP) debtors had ballooned. Liquidity, used by Monitor to assess financial performance, was on plan and capital expenditure was within Monitor tolerance levels. For NHS debtors most of the 2013/14 balances outstanding from commissioners had been received. Of the remaining balances he did not expect any substantive write offs.
- Project Diamond (PD): RP believed that in common with prior years the intellectual and economic case for PD funding was accepted. The issue that remained, however, was whether the system had the money required (£100m) to pay? The Shelford Group, which represented ten Trusts most of which were based outside London, was also seeking additional funding for complex cases and was slightly ahead of the PD group of Trusts in pursuing this.
- Continuity of Service (CoS) rating: a (self-assessed) rating of 4 had been maintained at September 2014. RP said he could recommend the Board to make the required Q2 quarterly declaration to Monitor that a

minimum CoS risk rating of at least 3 would be maintained by the Trust for the next twelve months (see Agenda item 2014/91).

Noting that liquidity had deteriorated by 0.9 days since August 2014 and the report stated this was driven by the acceleration of the capital programme, RJ asked if this acceleration continued would it be a problem? RP said he was confident that the Trust would keep the capital expenditure programme going through continuing ITFF funding.

The Board noted the report.

2014/89 AUDIT COMMITTEE (AC)

(i) REPORT FROM MEETING HELD ON 14 OCTOBER 2014

NL said the committee had received the usual progress report from the Trust's internal auditors (KPMG) and had noted satisfactory progress, including some recommendations that went back a long way. Those concerning I&T would mostly be dealt with in 2015. Reports from the internal auditors had also been received on statutory/mandatory training and Healthcare at Home. These reports had provided the AC with significant assurance, in line with management expectations, with recommended improvements accepted by management. The AC had also received a presentation from the Counter Fraud expert. The Trust's counter fraud procedures were audited by NHS Protect. All areas were green (the highest rating). NL concluded his summary saying the Audit Plan of Deloitte was received and discussed. The update on the health sector was always interesting. They had identified potential generic issues for the Trust. Sue Barrett was the new lead partner.

(ii) MINUTES FROM THE MEETING HELD ON 15 JULY 2014

The minutes were noted.

2014/90 RISK & SAFETY COMMITTEE (RSC)

(i) REPORT FROM MEETING HELD 14 COTOBER 2014

AVO gave an oral update. Jerry Sivanathan, Head of Clinical Coding, had given a presentation on clinical coding and the committee learnt about a 'behind the scenes job' but non-the-less a very important one. The RSC had also received a progress update on the Francis Report. A second meeting of RSC Non-Executives and Staff and Patient Governors would be held in November 2014. An annual update on progress against the Francis Report recommendations would be produced. One Never Event (a retained swab) had been reported. The Medical Director was now required to report the surgeon to the GMC if there was an issue. TE confirmed this was correct and that all Never Events were routinely reported to the GMC. Other highlights included: a presentation from Andrew Menzies-Gow on the cancer services review and a very good Matrons Report.

AVO gave an update on Ebola readiness. The Trust was, in actual fact, doing a lot in response in terms of exercises and preparations. TE added that he could provide further reassurance in 4 areas: firstly, staff education

and training was being led by Dr Anne Hall (Consultant Microbiologist & Infection Control Doctor); secondly, an action plan on site; and thirdly, patients who access primary angioplasty would go to HH first before coming to RBH. This was a back up system to the screening being carried out at Heathrow Airport. Fourthly, the Trust did have a number of staff members who were members of HM Armed Forces so there was a lot of knowledge in the Trust. SRF thanked AVO and TE for these updates which provided assurance that staff were prepared and protected.

BB said Ebola was not an airborne disease which raised some doubt about the efficacy of screening at Heathrow. There was more concern over cases that might be referred to the Trust. RJ asked how many current Trust staff had experience of Ebola and were members of the armed forces? TE said there were about four staff who were on stand-by to be deployed to Sierra Leone.

(i) MINUTES FROM THE MEETING HELD ON 15 JULY 2014

The minutes were for noting only but AVO referred to the minute on the mortality outlier alert which had identified that some patients were wrongly coded. Mortality for the Trust was now down in line with the national average. He also highlighted the minute on National Inpatient Survey in which the Trust had received 'green' for 7 out of 9 sections and his comment that perhaps more could be done to manage the expectations of patients. AVO added that the National Staff Survey had been positive.

2014/91 Q2 MONITOR DECLARATIONS 2014/15: (i) GOVERNANCE DECLARATION (ii) CONTINUITY OF SERVICE (CoS) RATING

RCo presented Paper E. The Board agreed that the following governance statements are made:

For Finance, that the board anticipates that the trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months.

For Governance, The Board agreed that the governance statement that plans were in place to ensure ongoing compliance with all existing targets should be declared 'not confirmed' because the 62 day cancer target had not been met for Q2.

Otherwise, that the board confirms that that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework page 22, Diagram 6) which have not already been reported.

Consolidated subsidiaries: Number of subsidiaries included in the finances of this return = 0 (zero).

Action: Upload declarations to the MARS portal before 4pm Friday 31 October 2014 to ensure compliance with Monitor's reporting requirements.

2014/92 RECOMMENDATIONS OF THE REPORT OF THE INDEPENDENT HILLSBOROUGH PANEL

RCr introduced the paper. The Trust had been asked by NHSE to bring this report to board. The Independent Panel had reported in 2012. The recommendations were ostensibly for NHS ambulance services but there were also recommendations relevant to NHS bodies. The Trust's responses and actions outlined in the paper had been developed by the emergency planning team and also seen by the operations team.

RJ asked how frequent both incidents and exercises were and what had been learnt from them? RCr said there were different sorts of exercises depending on the circumstances – for example an evacuation or a physical test. A recent evacuation exercise had occurred on Elizabeth Ward (September 2014). RCr said he had asked the emergency planning lead what her last report was on an incident. This was the burst water main in mid-August 2014. The Trust had discovered that its plans were not the same as Thames Waters'. NH said a table top plan was being held at HH today (22 October 2014). TE said the last major incident was the fire in the Royal Marsden Hospital in 2005.

2014/93 RECOMMENDATIONS OF ADVISORY APPOINTMENTS COMMITTEE

The Board were presented with two ratification forms for the appointment of consultant medical staff by AVO for a Consultant in Histopathology Specialising in Cardiothoracic Pathology and by TE on behalf of KF for the appointment of a Consultant Paediatric Cardiologist with interest in Inpatient Cardiology.

LAA asked if the Trust was disappointed at the small number of applicants (for the post of Consultant in Histopathology) and the even smaller number of those who were suitably qualified? TE said it was always disappointing when there were low numbers but because the post was so specialised it was not too surprising.

Noting that the last day of service of the locum in post was the end of 2013, PD asked if that was standard practice? BB said it depended on the post and noted that a locum had been in place during the interim period.

The Board ratified the appointment of:

- Jan Lukas Robertus as Consultant in Histopathology Specialising in Cardiothoracic Pathology and;
- Giselle Rowlinson as Consultant Paediatric Cardiologist with interest in Inpatient Cardiology.

SRF congratulated Dr Libby Haxby, Duncan Macrae and Andre Simon who had recently received Adjunct Readerships from Imperial College. It was agreed that, through the Chairman, the Board would pass on its congratulations.

2014/94 QUESTIONS FROM MEMBERS OF THE PUBLIC

None.

NEXT MEETING Wednesday 26th November 2014 at 10.30 am in the Concert Hall, Harefield Hospital