Minutes of the Board of Directors meeting held on 24th April 2013 in the Board Room, Royal Brompton Hospital, commencing at 2 pm

Present:	Sir Robert Finch, Chairman	SRF
	Mrs Jenny Hill, Senior Independent Director	JH
	Mr Robert Bell, Chief Executive	BB
	Mr Robert Craig, Chief Operating Officer	RCr
	Pr Timothy Evans, Medical Director & Deputy Chief Executive	TE
	Mr Richard Paterson, Associate Chief Executive - Finance	RP
	Dr Caroline Shuldham, Director of Nursing & Clinical Governance	CS
	Mr Richard Hunting, Non-Executive Director	RH
	Ms Kate Owen, Non-Executive Director	KO
	Mrs Lesley-Anne Alexander, Non-Executive Director	LAA
	Dr Andrew Vallence-Owen, Non-Executive Director	AVO
	Mr Richard Connett, Director of Performance & Trust Secretary	RCo
By Invitation:	Pr Kim Fox, Prof of Clinical Cardiology	KF
	Ms Carol Johnson, Director of Human Resources	CJ
	Ms Jo Thomas, Director of Communications & Public Affairs	JT
	Mr Piers McCleery, Director of Planning & Strategy	PM
	Mr David Shrimpton, Private Patients Managing Director	DS
	Mrs Tracey Baker, Transplant and Divisional Support Manager	TB
In Attendance:	Mr Anthony Lumley, Corporate Governance Manager (minutes)	AL
Apologies:	Mr Neil Lerner, Non-Executive Director	NL

2013/28 MINUTES OF THE PREVIOUS MEETING HELD ON 27 MARCH 2013

The minutes of the meeting were approved subject to the following amendment:

- Page 3, item 2013/16, second para. heading: insert 'Provider' between 'NHS' and 'Licence'.

- Page 4, item 2013/17, first para., second bullet: delete 'aortic valve/' and 'infection' and replace with 'insertion' after 'chest drain'.

- Page 10, item 2013/27, second para. second sentence: delete the 's' from 'dues' ('due consideration').

Matters Arising

- Page 1, Safe and Sustainable High Court judgement 27 March 2013.
SRF indicated that BB would update Board members on the outcome in his report.

- Page 3, NHS Provider Licence: SRF said this would be included in the Board agenda in May 2013 for final consideration.

2013/29 REPORT FROM THE CHIEF EXECUTIVE

BB gave verbal updates on the following items:

Safe and Sustainable (S&S)

BB said Leeds had won the judicial review on 27 March 2013 and the judge had ruled that the consultation should be quashed and did not grant NHS England (which has replaced the JCPCT) leave to appeal. Subsequently, NHS England have indicated that they plan to seek leave to appeal. A great deal of attention has focussed on a dataset produced by the National Institute for Cardiovascular Outcomes Research (NICOR) - a subsidiary of University College London. This had been prematurely released before completion and used as evidence for the decision of NHS England to temporarily suspend all childrens' heart procedures at Leeds General Infirmary. The dataset was very satisfying as it had shown RBHFT (along with the Freeman Hospital in Newcastle) to have the best outcomes in the country. This illustrated the dichotomy behind the decision of the JCPCT to recommend the closure of the Trust's paediatric heart service.

BB reminded the Board that he had met Terry Hanafin, Chairman of the Steering Group for the Implementation of the JCPCT decision on 9 March 2013 (as reported to the Board on 27 March 2013). This had been an encouraging occasion as Mr Hanafin had expressed support for the Trust's view that there should be a 3 centre network solution.

SRF said the Secretary of State, Jeremy Hunt MP and Earl Howe, the government's health minister in the House of Lords, had given responses to questions in Parliament. The Secretary of State had said that it was important for all NHS reviews to use the most up-to-date statistics while Earl Howe had said that the Independent Reconfiguration Panel (IRP) would take account of population increases when it compiled its report.

BB ended his update by stating that the IRP was now expected to report to the Secretary of State by the end of the week commencing 29 April 2013.

2013/30 ACADEMIC HEALTH SCIENCES CENTRE (AHSC) - COMPETITION 2013

TE introduced the paper and described how the National Institute for Health Research (NIHR) had launched a new programme to designate AHSCs and gave a resume of the original designation in 2009. He reported that that the Trust had been invited to re-bid as part of the Imperial College Health Partners (ICHP) Academic Health Science Partnership (AHSP) in which, along with Imperial College (IC) and Imperial College Healthcare Trust (ICHT), RBHFT is actively engaged. TE added that he expected the Trust to be invited to apply as affiliates in an AHSC bid (i.e. as an NHS Provider partner to a university).

BB said Sir Keith O'Nions, Rector of Imperial College (IC) had said the Trust could become affiliates but had not defined what that meant. The issue to

be discussed therefore was does the Trust support extending the AHSP as part of an AHSC?

KO asked firstly what were the advantages of being part of an AHSC versus an Academic Health Science Network and secondly could the Trust be part of one and part of the other? BB said there had been a benefit in the original intention.

AVO said he was Chairman of the South West Peninsular AHSN. In his view, as this brought together the academic side and an NHS Provider and the commissioner, being associated with a newly designated AHSC would add value.

Commenting that Oxford had suffered through not being designated an AHSC first time round, KF said he wondered if the Trust might consider being a member of an AHSC with The Royal Marsden Hospital (RM) and Chelsea and Westminster NHS Foundation Trust (C&W). BB said this underlined why the paper was put to the Board (i.e. to consider its options). TE agreed that KF had made a good point. The Trust could partner with the RM via the Institute of Cancer Research (ICR) as the academic partner. KF said the Trust could consider a partnership with other universities – the University of London and ICR for instance.

The independence of AHSCs was discussed and AVO said the South West Peninsular AHSN is a company limited by guarantee and in that way was trying to maintain its independence.

KF suggested that letting IC know that the Trust was considering collaborations with other academic partners may help crystallise their strategic thinking.

It was agreed that TE will respond on behalf of the Trust taking account of the views expressed at this meeting.

2013/31 CLINICAL QUALITY REPORT FOR MONTH 12: MARCH 2013

Presenting the report RCo highlighted the following from Month 12. Monitor's Compliance Framework:

- There had been 2 failures against targets: C*lostridium difficile* and the 18 Week Referral to Treatment Time target for admitted patients. This would result in an Amber Red rating for Governance as forecasted in the Trust's 2012/13 Annual Plan.
- The 62 Day Cancer target had been met – 2 requests for breach repatriation had been agreed but 1 as yet had not been agreed.

Incidents

- Safety SI's (Serious Incidents): 2 breaches in March both of which related to grade 3 pressure ulcers.

NHS Standard Contract:

- 18 Weeks Admitted National Speciality: failure to meet the patient target at speciality level.
  Mixed Sex: 50 breaches for the year all as a result of delays providing step down from level 2 to level 1 ward care at Harefield Hospital (HH). RCo noted that this information would be published on the Trust website as required.

RCo also focused on the National Friends and Family Test for which the net promoter score (82%) was again a satisfying performance. This section included patients' comments on what would have improved their stay.

Invited by SRF to comment RCg gave the following assurances to the Board: firstly, from this Month onwards (April 2013 – M1) the Trust would be back in compliance on the 18 Weeks Admitted target; secondly, there had been around 30 breaches of the Mixed Sex target in Q3 in 2012-13, a much lower figure of 10 in Q4 and none to date in April 2013 (Secretarial note: there were no beaches recorded for April 2013). While it could never be guaranteed that there would not be any further breaches he was confident that better control measures were now in place.

Noting that the increase in SIs year-on-year was around 40% JH asked if there was any assurance that this was not indicative of any broader issues that would need to be addressed? CS replied that this assurance could not be given but certain themes had emerged and measures were being taken to respond to them – for e.g. a new programme for (the prevention of) pressure ulcers had been put in place. She added that it was acknowledged that the Trust should start early to tackle problems. There was assurance for the Board in that the Trust is now ready to begin this process.

LAL commented on the forecast governance rating of amber red and indicated that she thought that this might indicate a lack of ambition on behalf of the Trust.

RH pointed out that RCo's summary had not included the complaints target which the Trust had 'Not Met'. Invited to comment on the increase in the number of complaints for which replies had not been sent within 25 days, CS cited some difficult individual complaints which had required more detailed handling and which had resulted in slower formal processing. The Board acknowledged that although this target did not form part of the compliance framework set by Monitor, it was never-the-less, still an important indicator in the Clinical Quality Report.

The Board noted the report.

2013/32 <u>FINANCIAL PERFORMANCE REPORT FOR MONTH 12: FEBRUARY 2013/FINANCIAL RISK RATING</u>

Introducing his report RP said it was a shortened paper without the usual narrative owing to the demands of year end accounting. Accounts for the

year had been submitted to Monitor on 22 April 2013 but remained subject to audit. He highlighted the following performance in M12:

- I&E account: the results reported for the month had been distorted by year end adjustments. Hence there was a reported surplus of £3.9m but approximately £2.6m of this related to items not wholly attributable to M12. Elimination of these items left a surplus of £1.3m which was one of the best monthly results due to a large extent to the performance of Private Patients (PP).
- Balance sheet: this was a sensibly conservative balance sheet, subject to external audit which would commence in the week beginning 29 April 2013.
- Actual capital expenditure against plan came in at 69% which was below 75% (+/- 25%), the tripwire for Monitor's target for budgeted spend. For 2013-14 the regulator had narrowed the range to 85% (+/- 15%). This represented the only 'grey mark' (as opposed to a 'black mark') against performance in M12. RP said that he and RCg would be considering how to achieve this narrower range.

RP reminded the Board that the Trust is required to make a quarterly statement that it will achieve a minimum Financial Risk Rating (FRR) of 3 over the next 12 months. The Trust was still working on the 2013/14 budget which was not proving an easy task: while he was determined to report a planned FRR3 for the year RP said it may be that in the first 2 quarters this would not be achieved. He reported that NL had agreed that in the absence of a phased budget for 2013-14 the Trust can still make a statement that it anticipates FRR3 for the next 12 months. In response to a query from RH on whether the guidance from Monitor would allow such a statement (i.e. knowing that performance may not achieve FRR3 in Qs 1 and 2) RP said this was not totally clear. However, the Trust could only submit a 'yes' or 'no' to the question when the response is uploaded to the regulator. SRF asked him if it was reasonable to give an affirmative in these circumstances? RP said it was. BB commented that the Trust had written covering letters with its submission before and will do the same this time.

RP reported that the Trust's Q4 performance had been sufficient to report to Monitor an FRR rating of 3 for the quarter (and for 2012/13 as a whole) and that it anticipates achieving a FRR of 3 for the following 12 months. This was confirmed by the Board.

The Board noted the report.

Action: submit Q4 results and accompanying statements to Monitor via the MARS portal.

2013/33 <u>2013/14 BUDGET UPDATE</u>

RP said the report showed work in progress in developing this year's budget. The Trust's target is to deliver a budget with a 1% surplus of £3.2m which would also achieve a FRR of 3. Overall the draft budget currently disclosed a deficit of £1.3m which meant that the Trust would be looking to

address a shortfall of £4.5m. 2013/14 would be, as expected, an extremely difficult year with the need to make savings in year of £12m. The Trust was squeezed on tariff and income and also on the cost side (pay increments, and reduced contribution from the Trust's Charity). In mitigation, RP said there would be some improvements including better PP performance than expected in light of the figures from M12 of 2012-13. Furthermore (and not reflected in the draft budget) there had been positive negotiations with NHS England to date which was now responsible for commissioning c.85% of the Trust's NHS income and there was also money 'owed' the Trust from over performance. He added that RCg's team were still looking at potential productivity improvements.

NH was invited by SRF to update Board members on negotiations with NHS England. NH said that the Trust had met with them not just formally to discuss the contractual relationship but at a senior management level. BB had been present with Anne Rainsbury, Regional Director for London representing the commissioner. NH said there was now a less adversarial relationship than had been the case with the previous commissioner (London Specialised Commissioning Group). There was an advantage in having a large amount (c£200m) with one stakeholder. The residual contract income of c£20m would come from the Clinical Commissioning Groups (CCGs). Discussions with CCGs were less advanced but there was nothing as yet to cause alarm.

SRF asked if Project Diamond (PD) funding was included in the Plan? RP confirmed this but added that contingencies on Pay and Non-Pay costs were now only £1m each, halved from the figure in 2012/13, and on PD income halved from £3m to £1.5m. He was aware that other Trusts from the PD group were all including PD income in their budgets for 2013-14 which helped justify the Trust's position.

RP said the final budget for 2013-14 will come to the Board in May 2013 where it will be included as the first year of the Forward Plan 2013-16.

The Board noted the report.

2013/34 <u>CAPITAL INVESTMENT PROGRAMME</u>

Introducing the report RCg said this was a work in progress but the Board's approval was sought to continue spending on projects still on-going from last year and for those in an advanced stage of planning. The report also included an early indication of the potential size and scope of the capital programme over the next 5 years, to show Board members the level of investment needed. The aim was also to ensure investment remained within the range set by Monitor as RP had described in his Finance Performance Report.

SRF asked whether Chelsea redevelopment plans were included? RCg said they were and referred the Board to the line 'Long-term redevelopment' within the budget but said that this was no more than a preliminary figure at

this stage. SRF asked if expenditure to be incurred on the master plan would be considered by the Management Committee? RGg confirmed this was the case and said it would be discussed at the next Management Committee meeting in May 2013.

Noting that 60% of the capital budget was about ongoing maintenance JH asked if that proportion would go up over the next 5 years? RCg said he would like to think it would go down as a proportion of total investment but he suspected that the Trust would need to invest at that level to maintain its current assets.

AVO asked when would the redevelopment projects be put in to the budget? SRF said there would be increasing spend as the Trust moves towards obtaining consent for a master plan. A paper would then be produced setting out the expenditure. However, actual spend on bricks and mortar would for not happen for 3 to 4 years. RP said that the 'long-term redevelopment' line included only the estimated planning cost (i.e. professional fees) for the next 3 years.

The Board agreed that RCg had the authority to continue capital spending as outlined in the report and approved the initial capital investment programme for 2013/14.

2013/34 MODERN MATRONS' REPORT: JAN-MARCH 2013

Introducing the report TB said it was intended to inform the Board of standards of cleanliness, compliance with hand hygiene standards, innovations and improvements and mandatory surveillance. In terms of hospital cleanliness there were now high expectations of ISS in the delivery of the cleaning contract. In response there had been stricter cleaning of isolation wards and measures were being taken to improve compliance with the 15 minutes rapid response target. A main theme of this section of report was the improvement in communications.

TB said hand hygiene initiatives included an electronic hand hygiene database and training of physiotherapists in the respiratory suctioning technique. She added that other improvements would be centred around the national 'Safety Thermometer' CQINN (Commissioning for Quality and Innovation) building on the success during the first year of the CQINN which had seen a decrease in the number of acquired pressure ulcers.

Referring to the single case of MRSA described in the report CS said root cause analysis was undertaken and steps to improve procedures in pharmacy introduced.

AVO suggested that this report should considered by the Risk and Safety Committee (RSC). The Board agreed that the Modern Matrons' report would go to the RSC ahead of the Board.

JH asked if, with the establishment of the Facilities Management Contract Collaborative Working Group to monitor such a large contract, anything had changed for the better or worse? CS said Board members would recall that the contract was introduced last year. There had been problems initially hence the group was set up. The Trust was not yet at where it wanted to be but there had been improvement. BB said there seemed to be a commonly held belief that the private sector could always do things better and that contracting out was more efficient. In this instance he awaited evidence to support this view.

The Board noted the report.

2013/35 NHS COMMISSIONING & INCOME FLOW

NH gave a presentation which was followed by questions from Board members.

RH asked how the Trust was engaging locally now that so much of the Trust's services are being commissioned nationally? NH said that, with Jo Thomas, he had attended a workshop organised by the Royal Borough of Kensington and Chelsea's (RBKC) Health and Wellbeing Board. These boards were funded and keen to engage with local providers. BB said that he and other board members had attended a meeting on 18 April 2013 at RBKC. A councillor had said it was important to engage with local partners. NH said that in addition to the relationships with service commissioners there were also other commissioners the Trust should be aware off whose remit impacted on health. An example was Education Boards. All of these were additional flows that could have been added to the illustrative diagram he had presented.

TE said he had attended a meeting this morning where 50 out of 152 Health and Wellbeing Boards were present. He had noted that there were very different ideas amongst them on what they should be concerned with. For example, some of them believed they can intervene in A&E issues. Mental health was very prominent as was social care. Healthwatch England, with much of its membership drawn from the Local Government Association, also has a health remit and sees its role as advising health organisations.

2013/36 MONITOR DECLARATIONS 2012/13 – Q4

(i) GOVERNANCE DECLARATION

RCo pointed out that information detailing sources of assurance regarding the learning disability indicator had been included this time as requested by NL when the last declaration was made in January 2013. He reported that failure against 2 indicators (*Clostridium difficile* and 18 week referral to Treatment Time) would result in an Amber/Red rating. This was forecasted in the 2012/13 Annual Plan submitted to Monitor.

The Board agreed the following declarations.

For governance, that:

The board is satisfied that plans in place are sufficient to ensure: on-going compliance with all existing targets (after the application of thresholds) as set out in Appendix B of the Compliance Framework; and a commitment to comply with all known targets going forwards.' **NOT CONFIRMED**

'Otherwise:
The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per Compliance Framework page 17 Diagram 8 and page 63) which have not already been reported.' **CONFIRMED**

Action: submit statement, and send to Monitor via the MARS portal.

2013/37 FOUNDATION TRUST CONSTITUTION

RCo updated the Board on changes to the Trust's constitution that are required (to ensure compliance with the Health and Social Care Act 2012) which had come into effect on 1 April 2013 following further commencement orders effective from the same date. The changes follow the model Constitution published by Monitor and have been incorporated by DAC Beachcroft LLP into the Trust's constitution. Approval from the Board at this meeting and then from the Council of Governors on 20 May 2013 was required. He and SRF went through the changes highlighted in the report point by point. Comments were made on the following:

- 1.13 Significant Transactions: RP said he thought it would be helpful to have a definition. He said that 10% of the value of gross assets made sense and was the figure used by Monitor for investment appraisals. SRF agreed and said if it had been left to the Trust to work out a figure independently it would have ended up being about the same figure anyway. CS asked if the Trust's gross assets was defined? RP replied the number was part of the balance sheet. SRF added that even without this specific constitutional change he could not imagine the Trust not wanting to ask the Governors for their view when the expenditure was material. The Board confirmed RP's proposal.
- 1.15 Mergers acquisitions: KO asked if this meant all mergers and acquisitions? SRF said it did. KO commented that this could be cumbersome because by definition some acquisitions could be small in value. RP agreed this was confusing. RCo agreed to seek clarification of the matter.
- 3.2 Roles and duties of governors: The issue if Directors and Officers insurance was raised under this item and it was agreed that RCo would provide information on the arrangements the Trust has put in place, this being of particular benefit to new Board members.
- 2. Annex 4 Appointed Governors: BB queried why the Trust should consider having CCG appointed Governors as opposed to having a representative from NHS England? He suggested consulting with Monitor on how this should be interpreted. It was agreed to that RCo would seek the view of Monitor.

CS said that the statements of principles in Matters Reserved to the Board should reflect the centrality of care of the patient in the mission of the Trust. She suggested that the principle 'The board of directors as a whole is responsible for ensuring the quality and safety (etc.) …' be amended to 'The board of directors as a whole is responsible for putting the patient first and ensuring the quality and safety ... '. This was agreed.

Subject to inclusion of the above amendments, and clarification of the composition of appointed Governor, the Board approved the constitution and noted that as the updates involved changes to the powers and duties of governors, a governor will be required to present the changes to a meeting of the members of the Foundation Trust (which is being held on Monday 22 July 2013). There is a requirement that members ratify these changes through a vote of those members who attend this meeting.

2013/38 AUDIT COMMITTEE (AC)

(i) MINUTES FROM THE MEETING HELD ON 19 FEBRUARY 2013

Noted.

(i) REPORT FROM THE MEETING HELD ON 23 APRIL 2013

RH gave a verbal report on behalf of NL and RP added his comments. The AC had considered reports from Internal and External Audit and also the Trust Counter Fraud service. Having previously reported to the Council of Governors that the Trust would be running a tender exercise for an external auditor this summer the AC had agreed to defer this for a year. The AC had also considered a first draft of the Annual Report.

2013/39 RISK & SAFETY COMMITTEE (RSC)

(i) REPORT FROM THE MEETING HELD ON 23 APRIL 2013

AVO gave a verbal update and highlighted the following:

- Quality at HH: red indicator. The College of Surgeons had been impressed by what they saw.
- Francis report: the committee would be having a proper discussion on this in July 2013 and will report back to the Board.
- Role of RSC vis-a-vis Governance and Quality Committee. A paper on this would come to the next meeting
- Quality Report section of Annual Report: the RSC had looked at this.

RSF asked LAL if she had anything to add as this had been the first RSC she had attended**.** LAL had no comments. SRF thanked her for her involvement.

2013/40 QUESTIONS FROM MEMBERS OF THE PUBLIC

Ken Appel (KA) mentioned that David Potter, Chair of ReBeat and a former Vice Chairman of Heart of Harefield, had been seriously ill. He reminded the board of the significant contribution David had made to HH over 17 years. SRF agreed that Mr Potter was a valued friend of Harefield and said that the Board wished him all the best. It was agreed that NH would convey this to him.

KA said that in the House of Lords sometime ago he had heard about the promotion of telemedicine. He had concluded that this would be of immense benefit to the NHS and a potential source of income for the Trust. He asked if it was possible the Trust could make use of it? In reply BB said the Trust already undertook various telemedicine clinics and initiatives. He acknowledged that there was always scope to do more but noted that in his experience income generation was not the primary benefit of using such technology.

KA asked whether he should encourage the West Hertfordshire Hospitals NHS Trust to refer patients to RBHFT? BB said this was not a Board matter and Boards should not be involved in referrals. This was an operational decision for doctors. SRF advised KA that he should take as reasonable and prudent steps as he could.

Peter Kircher asked a question about delays in admission of patients to Harefield. It was agreed that NH will follow this up with PK.

SRF informed the Board that Peter Rust (Patient Governor – NW London) had sadly passed away. RCo and Anthony Lumley would be attending his funeral on the Trust's behalf and SRF said he had written to Mr Rust's immediate family offering his condolences.

DATE OF NEXT MEETING

Wednesday 22nd May 2013 at 2 pm in the Board Room, Royal Brompton Hospital.