A lifetime of specialist care

Royal Brompton & Harefield NHS
NHS Foundation Trust

Minutes of the Board of Directors meeting held on 24 September 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
	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 Philip Dodd, Non-Executive Director	PD
	Pr Kim Fox, Professor of Clinical Cardiology	KF
	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 Carol Johnson, Human Resources Director	CJ
	Ms Joanna Smith, Chief Information Officer	JS
In Attendance:	Mr Anthony Lumley, Corporate Governance Manager (minutes)	AL
	Ms Anne Hall, Consultant Microbiologist & Infection Control Doctor	AH
	Ms Lindsay Condron, Heart Assessment & PP Operations Manager	LC
	Ms Archana Baweja, Finance Manager - Private Patients	AB
	Ms Gill Raikes, CEO, The Royal Brompton & Harefield Hospitals Charity	GR
Apologies:	Mr Richard Jones, Non-Executive Director	RJ

2014/72 <u>DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING</u>
None.

SRF welcomed Philip Dodd to his first Board meeting since his appointment as a Non-Executive Director.

SRF notified members that a 'Part II' meeting would be held immediately following this meeting to discuss the recent Board-to-Board meeting with Chelsea & Westminster Hospital and the proposed joint venture.

2014/73 <u>MINUTES OF THE PREVIOUS MEETING HELD ON 23 JULY 2014</u>
The minutes were approved.

NL asked if an update on the Francis Report (Action BD 14/16) was due to be received by the Board this autumn. CS confirmed that the aim was to produce a report for the meeting on 22 October 2014.

In response to a request for an update on Action BD 14/64 RCr clarified that it was not documentation of the audit tool (i.e. the Safer Nursing Care Tool) but an audit trail of the use of the tool that had been asked for. He confirmed there was no formal documentation but next time there would be. NL asked if the Trust would be able to retrospectively show how those judgements were made? RCr said he felt certain this could be explained, even if a new Patient Services and Nursing director had yet to be appointed to replace CS once she had left. CS assured the Board that the results were not amended. The Safer Nursing Care Tool gave an indication and then judgement was applied.

2014/74 REPORT FROM THE CHIEF EXECUTIVE

BB gave an oral report.

Chelsea Campus Redevelopment

BB said the Terms of Reference (ToR) for the review had not yet been finalised. The intention was to produce 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), to be finalised on 12 December 2014. There had been general agreement between the parties during the process of finalising the ToR. RMH had not shared their response to the draft ToR with the Trust and vice versa. BB said he was inclined to be positive - this was not an independent review but rather an engagement process to be welcomed and encouraged. TE added that the sub-groups continued to meet including one he attends with the medical director of RMH. There were positive synergies and clinical relations with RMH had been excellent and remained so.

SRF said the publication of the review would hopefully lead to a new SPD published by the Royal Borough of Kensington & Chelsea (RBK&C) in Spring 2015. BB said there would be a joint statement signed by the three organisations. From a facility planning point of view this was not something for NHSE to comment on though they could comment on the values and benefits of collaboration.

SRF said that he and AVO had recently met with Sir Malcolm Grant (MG), Chairman of NHSE. They had briefed him fully and it had been a positive and helpful meeting. SRF said he had assured him (in answer to a direct question on whether there was division within the Trust) that RB&HFT's Board and Council of Governors were united. MG said he wanted NHSE to resolve this issue in a positive and helpful way.

PD asked if the ToR covered the standing and powers of the parties and what would happen if they cannot agreed a way forward? BB said the comments of each body would go directly to the Royal Borough. The intention was to publish a joint statement but if one party did not agree it could add a sidebar.

Statement

BB said he believed it was a good moment to make a 'state of the nation' comment about the organisation. At the last Board meeting he had reported on *Improving NHS Care by Engaging Staff and Devolving Decision-Making* in which RB&HFT had been rated in the top 5 Trusts in the country. To this he added a recent report by the Association of UK University Hospitals in which the Trust had been rated the best in respect of Friends and Family Test, the best in staff satisfaction, and one of

the best in patient satisfaction. Added to this *HSJ* had recently ranked the Trust as one of best places in to work in the NHS. BB said that putting these in the context of Monitor's assessment of performance as Green for governance and 4 for Finance showed that morale was good and the staff were positive and committed. The Trust had shown that it could manage the financial challenges. It did occasionally miss out on one or two targets but these could only be addressed by systemic changes. This positive report counterbalanced the attempts made in the summer to undermine the Board which had been designed to create dissent. BB assured the Board that he had a 'grip' and the Trust was moving forward. The mission was sacrosanct.

KO asked how did BB communicate these very positive external messages to the organisation? BB said the senior management team had heard the messages and public forums were held for staff. Staff knew they were doing well and did not need to be told as such. It was rather that they should hear how strong the Board's commitment was.

2014/75 CLINICAL QUALITY REPORT FOR MONTH 5: AUGUST 2014

Introducing the report RCo said he had simplified the layout of the report and Section 1 was now presented in the following order: Monitor, Care Quality Commission (CQC), NHS Standard Contract, Incidents, Clinical Outcomes and Workforce Targets. The highlights were.

Monitor Risk Assessment Framework

- The Trust had remained rated Green for Governance for Q1 in spite of not meeting the Cancer 62 day urgent GP referral to 1st Treatment target. Although this had been declared met by the Board at its meeting in July 2014, the final reconciled position on 5th August failed the target in aggregate (when GP referrals and consultant upgrades from 18 week pathways are combined). Monitor had been contacted straightaway to ensure transparency.
- Cancer 62 day urgent GP referral to 1st Treatment target M5: 11 breach allocation requests have been sent. One has been agreed so far. RCo said that for Q2, whether the target was aggregated or not, it was still looking unlikely that the target would be met. The cancer review, commissioned by the Medical Director, had been completed and an Action Plan to implement recommendations would be considered by the Management Committee. RCo reported that he was also working with Jo Champness, Senior Service Specialist for Blood and Cancer at NHS England in order to identify ways in which performance could be improved, he noted that the Trust's Cancer Manager had begun a series of meetings with referring centres with the aim of identifying the reasons for hold ups in the diagnostic phase of the patient pathway.
- *Clostridium difficile*: 7 cases in M5 had been reported to Public Health England and with 1 case from July 2014 that meant 8 cases were under review. To date 1 case had been adjudged to be have been caused by a lapse in care which meant that so far only one case counted against Monitor's de minimis threshold of 12. The forecast was that the target would be met for Q2.
- Care Quality Commission (CQC) – two new regulations would come into force in October. These were the Duty of Candour (Regulation 20) and the Fit and Proper Persons Test for directors (Regulation 5).

Standard Contract:

- *Clostridium difficile*: commissioners methodology was similar to Monitor's with the exception that a target of 9 was used rather than 12 and the target was profiled throughout the year, so reporting was against the trajectory for the month in question rather than the annual target. Measured this way the target was met with 1 confirmed lapse to count against a trajectory of 4 at month 5.
- Urgent operations cancelled for a second time: There has been 1 such cancellation at Harefield Hospital in August, which happened as a result of the failure of the Picture Archiving and Communications System (PACS).
- 18 Weeks Referral to Treatment Times (RTT)
    - Admitted: the 90% target had not been met at the 'other' national specialty level (88.67%).
    - Incomplete: the 92% target had not been met at the 'other' national specialty level (90.72%).

  Additional capacity has been commissioned at the Cromwell and Wellington Hospitals to ensure the waiting time for cardiac surgery can be reduced.
- Cancer 62 – reported as required under the NHS Standard contract where GP referrals are reported against an 85% target and consultant upgrades to a cancer pathway from an 18 week pathway are reported separately as there is no target set for consultant upgrades.

Key Performance Indicators

- Incidents - Safety SI's (Serious Incidents): There had been 2 SIs in M5: both relating to pressure sores.

LAA said she felt that it would be helpful if the covering paper for the Clinical Quality Report and, moreover all Board reports, could identify the main points of concern. It was agreed that RCo would discuss this further with AVO, chairman of the Risk and Safety Committee.

BB said the report highlighted that the Trust continued to be concerned about cancer waits and cancellations. However, virtually everything else was not a major concern. The Management Committee would continue to examine these issues is depth. Though there were no immediate solutions BB emphasised they were a 'concern' and not about harm. It was a reporting issue rather than anything else. Cancer breach reallocations were a key issue. The procedure was that he writes to these Trusts but there were no other mechanisms. The Trust was exposed to the way clinicians in other Trusts, often repeat offenders, had handled those patients. LAA said the repatriation section in the report was useful but none-the-less felt an accompanying sentence was required to provide reassurance to the Board. NL asked if there were any plans to look at the system? BB said there were not. TE said that on the care front the Trust had attempted to engage with the London Cancer Alliance but they had said the Trust had to deal with the referring Trusts. TE added that this issue should come before the CQC when they come to inspect the Trust. He had been involved in advising CQC on standards for specialist heart and lung hospitals and Papworth Hospital would be inspected before Christmas with RB&HFT likely to be inspected early in 2015. He suggested that the Clinical Quality Report could be headed in sections that correspond with the five questions about the domains CQC would look at (safe, effective, caring, responsive, well-led).

Noting that a lot had been done at HH to address cancelled operations at HH, NL asked if in the meantime the trend was up? RCr said that a single data point for

one month could not illustrate a trend. Any cancellation was to be avoided and the Trust would always be cognisant of the distress this could cause patients. Since the poor situation at the end of last year the Trust had dealt with the issue and process. He would be more comfortable when cancellations were below 10% on both sites, though the aim should be for it to be below 5%. He confirmed in response to a question from NL that there was nothing to add from what was happening in September.

It was agreed that an update on cancelled operations be included in the Board agenda in the early part of 2015.

The Board noted the report.

2014/76 FINANCIAL PERFORMANCE REPORT FOR MONTH 05: AUGUST 2014

RP highlighted the following performance in M05:

- I&E account: The Trust was reporting an overall deficit of £0.8m against a planned deficit of £0.6m in what was traditionally a slower month. Within operating costs there had been some ups and down but it was overall on plan. Furthermore, the £200k adverse variance was related to capital donations not yet received so this was likely to made up for later in the year. Activity was doing well, better than plan and prior year. RP said this was against the familiar scenario of year-on-year tariff reductions and, cost increases, hence having to run faster to stand still. Nursing costs are under better control than prior years. There was a cumulative deficit of £1.5m Year to Date which was worse than budget (£1.0m deficit) though, as with the monthly outturn, the £0.5m shortfall was due to non-receipt of capital donations.
- Balance sheet cash: this was deteriorating. The Trust was still waiting for £2.4m from last year although he could report that most of this had been collected in September. The level of Private Patient (PP) debtors had risen to £14m over the summer which was a historic high. Assets were sitting in debtors not cash. Liquidity however was on plan. After M06 an updated cash forecast would be presented to the Board.
- Continuity of Service (CoS) rating: although not required to report this to Monitor for M05, it would be a '4', the best available.
- Project Diamond (PD): RP said he continued to work with the so-called 13 PD Trusts to argue the financial case and lobby for a lasting change to retain this element of funding. The group continued to push the argument that complex cases were not properly compensated for by tariff*. An analysis of 2013/14 NHS inpatient spells* had shown that for patients costing the Trust more than £100k each the trust loses c.£10m on costs of £25m. The political case was being led by Sir Robert Naylor (Chief Executive of University College London Hospitals NHS Foundation Trust). A meeting of PD Trust CEOs was scheduled where this would be debated further.

NL said the finance team should be credited for managing the Trust's finances in difficult circumstances and in a complex situation. RP acknowledged NL's comments with thanks but also said that they applied equally to the operations team under RCr. (SRF) asked that RP and RCr relay the Board's gratitude to their respective teams.

NL commented that this was an encouraging result overall when seen against the pressures being felt nationally.

The Board noted the report.

2014/77 RESEARCH UPDATE

TE drew members attention to two changes in the format of the report. Firstly, a short section – Recent Media Interest – had been added with input from the Trust's Communications team. Secondly, an update ('Emerging Research Strategy') on new themes that had emerged from the research Away Day in March 2014 had also been added. This described the interface of the Trust's research vision with clinical services. The collaboration of the Academic Health Science Centre at ICHT was an example of the new approach.

TE said he hoped to be reporting four academic promotions to the next Board. Three of these were Adjunct Readerships (Dr Libby Haxby, Duncan Macrae and Andre Simon) and the fourth was an Adjunct Chair (Diana Bilton). SRF asked TE to pass on the Board's congratulations to these people. He added that he had found the presentation to the Royal Brompton & Harefield Hospitals Charity was very helpful and suggested it was repeated to the Board. RH said he had observed that the presentation was not designed for that audience and it would therefore need some editing or changes. It was agreed that RH would liaise with TE on the content and scheduling of the presentation and RCo would schedule at which meeting it would be received by the Board.

RH said that an award to BB should also be highlighted. The Trust's CEO had been appointed as an Adjunct Visiting Professor at Imperial College London (ICL) in recognition of his role in ICL's Institute of Global Health Innovation which was headed by Lord Darzi.

AVO asked firstly, if anything could be done to improve the numbers of patients in time and target studies and secondly, whether the evaluation of medical devices included cost benefit analysis? TE replied that for time and target the Trust did well in those it led on itself but less so in multi-centre trials (though recent figures since this report was written had shown an improvement). He agreed that the Trust should not be complacent – the Trust had done well within divisions but should aim to do better. With regard to AVO's second question TE said he agreed that cost-benefit analysis should be developed as part of evaluation.

The Board noted the report.

Action: RH and TE to liaise on representing the recent talk to the Charity to the Board and RCo to schedule when it would be received.

2014/78 PP AT WIMPOLE STREET

RP said that he was presenting the report on behalf of David Shrimpton (Private Patients Managing Director) who was working overseas. Lindsay Condron (Heart Assessment and Private Patients Operations Manager) and Archana Baweja (Finance Manager - Private Patients) were in attendance to assist in answering any questions from Board members. The paper had been considered in detail by the Finance Committee and so he proposed only to provide an overview. A question raised at the committee about the internal rate of return of this initiative per Appendix B. IRR 24% which is healthy but appropriate as the project was not without risks. He drew the Board's attention to the risks set out in section 7 of the paper.

RP said the Trust had approached Barclays for a loan of £10m. This had now been examined by their credit team who were insisting that the loan be fully asset-

backed with 'hard' assets, principally equipment. In the current schedule of Wimpole Street works equipment totalled slightly under £5m. Barclays were asking for the other £5m to be secured on similar assets elsewhere in the Trust. RP said it was natural to think hard about this proposition. However, those assets would not be used as other security and the risk that the bank would foreclose was small. The Trust would ensure its debt service payments were timely. The loan repayment profile had been agreed in principle. This would be modest for the first four years and 'balloon' in year 5, with the option to reschedule the balloon in year 3.

RP reported that the landlord, Howard de Walden Estates (HDWE), expected the Trust to sign the lease in early October 2014 although they might be prepared to wait a couple more weeks if necessary. Negotiations were continuing with Re:Cognition for a sublet of one and a half floors of the building on essentially identical terms to those being offered to the Trust by HDWE.

RP said, in summary, that the Board was asked to approve delegating the finalisation and execution of financing and lease arrangements to a Board sub-committee.

AVO asked if there was a risk that the consultants would not be prepared to let their patients be treated in other hospitals? TE said the projections suggested the Trust should be able to accommodate an increase in work. This was already happening (albeit with NHS patients) at the Cromwell Hospital. He had more concern about the risk of overworked clinicians. In reply to a question from AVO he confirmed that the Trust's consultants were already going to the Cromwell Hospital and the Wellington Hospital on alternate Saturdays.

NL said the Finance Committee had reviewed this business case and fully supported the report's recommendations. PD supported borrowing in the name of the Trust. He agreed that it was extremely unlikely Barclays would foreclose on key operating equipment. In the event of difficulties it was more likely the bank would look to be recompensed from RB&HFT's cash flow.

NL asked, given that the Trust had only approached Barclays, if RP could confirm that the request was in-line with market practice? RP said it was acceptable given that the terms were good and the Trust already had an existing relationship with Barclays on another asset financing.

PD noted that it was normal for a bank to look for a contribution from equity partners, i.e. the Trust. Contribution was dependent upon risk from 50% to 90%. For RP to have got close to 100% of the capital value is good. Having to provide full security was the quid pro quo.

LAA said she fully supported the proposals. She asked if there was a conflict of interest for SRF and TE? SRF confirmed that neither he nor TE had had any involvement in the negotiations. RCo added that those interests were already disclosed in the published 2013/14 annual report.

BB returned to the issue of the risk of consultants not letting their patients be treated elsewhere. He emphasised that these were the consultants' PPs, not the Trust's.

KF asked if the facility would be confined to use of our consultants? BB said this was not the case. An operating model would be created, a managing group established and policies in place about whom the Trust decides to grant 'privileges' to use the Wimpole Street facility.
The Board approved delegating the finalisation of financing and the lease agreement to a sub-committee of the Board. SRF, RP, NL and RCr indicated that they were content to act in this capacity.

2014/79 REVOLVING CREDIT FACILITY

RP introduced the report. He drew attention to the material adverse effect clause. PD said this clause was entirely normal.

There was produced to the meeting a revolving credit facility agreement (the Facility Agreement) between Barclays Bank PLC (the Bank) and the Foundation Trust setting out the terms and conditions upon which the Bank is prepared to make available to the Foundation Trust a facility (the Facility) in the maximum principal sum of £10,000,000.

IT WAS RESOLVED

1. That the borrowing by the Foundation Trust of up to the full amount of the Facility on the terms and conditions set out in the Facility Agreement is in the interests of and for the benefit of the Foundation Trust and that such terms and conditions be and are approved and accepted.

2. That the Foundation Trust has the capacity to enter into the Facility Agreement.

3. That by entering into the Facility and performing its obligations under the Facility Agreement the Foundation Trust will not be in breach of any restriction imposed by law, the constitution and standing orders of the Foundation Trust, any condition of its Licence or any agreement to which the Foundation Trust is a party or by which the Foundation Trust is bound.

4. That Mr Richard Paterson, Associate Chief Executive – Finance; and Mr Robert Craig, Chief Operating Officer are authorised to sign the Facility Agreement on behalf of the Foundation Trust in their capacity as board members to indicate acceptance of the terms and conditions, and to sign and/or despatch all documents and notices (including any Utilisation Request, as such term is defined in the Facility Agreement) to be signed and/or despatched by it under or in connection with the Facility Agreement.

5. That the Bank is authorised to act in all matters concerning the Facility upon instruction from the Foundation Trust signed in accordance with the Bank's mandate for any of the accounts of the Foundation Trust held with the Bank current from time to time.

2014/80 INFECTION CONTROL ANNUAL REPORT 2013/14

CS introduced Anne Hall, Consultant Microbiologist & Infection Control Doctor. AH said she was the Trust's Deputy DIPC – Director of Infection Prevention & Control and then went through the highlights of the report.

- A number of infections were reported to the DH including MRSA, *Clostridium difficile* and *Staph aureus* and *E. coli* bacteraemias. In 2013/14 there was no MRSA bacteraemia in the Trust. 2 patients were found to have MRSA bacteraemia in other hospitals following discharge from Royal Brompton but as these occurred some time after discharge following a post infection review which involved staff from Public Health England (PHE), they were both deemed to be not attributable to the Trust.
- *Clostridium difficile*: There were 19 cases last year, 16 of which were attributable to the Trust. These were sent for typing and there was no evidence of cross infections. However there were 3 patients with *C. difficile* infection who were linked temporally and spatially at RBH. Unfortunately the reference lab was unable to grow the organisms and so was unable to tell whether the cases were linked or not. The new target for this year was 9 cases and each case would be reviewed by the co-ordinating commissioner to decide whether that case should count against our trajectory. There had been 7 cases last month which were currently being typed.
- Methicillin Susceptible *Staphylococcus aureus.* 31 were reportable to PHE. 16 were not attributable to the Trust as they had occurred within 72 hours of admission. 6 were related to endocarditis, 5 to lines inserted outside the Trust.
- *E-coli*: For 2013/14 the Trust had 8 cases 2013/14 (5 at HH and 3 at RBH). Of these, 3 cases were secondary to a urinary tract infection 2 of which were community acquired. Overall the figures were lower than the previous year (13 cases). The aim for 2014/14 was to reduce instances of patients acquiring these affections.
- Surgical Site Infections: the aim of the surveillance programme was to increase the surgical procedures covered by the surveillance programme and to lower the overall wound infection rates. Melissa Rochon and Dr Julian Jarman, won the prestigious Nursing Times Award, Infection Control Category in 2013.
- Hand Hygiene: In conjunction with many other Trusts, RB&HFT had implemented the World Health Organisation's hand hygiene programme 5 Moments for Hand Hygiene: before touching a patient, before clean/aseptic procedures, after body fluid exposure/risk, after patient contact, and after touching patient surroundings. The average compliance score was 85% against the target of 90%. Bare Below the Elbow was up to 97%.
- Domestic services/cleaning: in 2013/14 PLACE Assessments (Patient Led Assessment of the Care Environment) replaced the PEAT Assessments. The cleanliness section for RBH achieved 95% while HH achieved 97%.

Carbapenemase Resistant Enterobacteriaceae: SRF asked for an explanation of what Carbapenemase Resistant Enterobacteriaceae (CRE) are. AH said this was an issue that has prompted unusually dramatic health warnings including one from the Chief Medical Officer for England who had warned of an antibiotic doomsday scenario. Carbapenems were very broad spectrum antibiotics which were used in very sick patients. The enterobacteriaceae were organisms including E. coli which lived in the colon of all of us and caused a wide range of infections particularly post operatively. These were now becoming resistant to the carbapenem class of antibiotics. AH said there was the risk that the prevalence of CRE could take us back to 20-30 years. It could make coronary surgery much more risky and the Trust could lose more patients. A couple of patients had been admitted into the Trust. However, there was a very robust CRE policy in place. AH added that this had caused some disruption on wards and some clinical colleagues had been resistant. PHE had been brought in to talk to them. Screening especially of patients who come in from abroad has been instigated within the Trust in an attempt to pick these patients up early and prevent spread.

AH said in summary it had been a busy and challenging year with some successes and some difficulties. TE said this was an excellent report and added that he had asked AH to chair the Ebola Preparation Committee. AVO agreed it was a great report. NL said the presentation was excellent.

SRF said the Board commended the report, noted its contents and approved the priorities for the coming year.

2014/81 RECOMMENDATIONS OF ADVISORY APPOINTMENTS COMMITTEE

The Board was presented with one ratification form by RH for the appointment of a Consultant in Microbiology and Infection Control. TE said this was an excellent appointment.

The Board ratified the appointment of Silke Schelenz as Consultant in Microbiology and Infection Control.

2014/82 AOB: SUB-COMMITTEES

SRF said the Board was asked to ratify the appointment of PD to the Risk and Safety Committee. This was approved.

2014/83 QUESTIONS FROM MEMBERS OF THE PUBLIC

Helen Edwards asked who appointed the Chairman?

RCo said the process was led by the Council of Governors. The Nominations & Remuneration Committee of the Council of Governors made a recommendation for the full Council to consider. RH said this was not a Board matter and therefore should not be discussed further. BB said that was correct – the Board was not involved in the appointment process of the Chairman.

Michael Gordon said the had noted that the Star Centre had been used for a planning application hearing for a dementia project. This was vigorously opposed by the Harefield village community. He asked if the Trust had made any objections?

BB said this was not a matter for the hospital. Hospital facilities were made available to any external group that pays fees, providing income that was gratefully received, as long as the user was not engaged in something illegal or illicit. There was no formal process or even indirect process in which the Trust would show favouritism or non-favouritism to such a project.

Michael Gordon asked if the proposed industrial action by the health unions would have any impact on the Trust?

BB said the Trust was aware of the action days planned in October 2014. Appropriate internal measures would be taken and there would be continuity of service.

NEXT MEETING Wednesday 22nd October 2014 at 2 pm in the Boardroom, Royal Brompton Hospital