Minutes of the Board of Directors meeting held on 25th April 2012 in the Boardroom, Royal Brompton Hospital, commencing at 2.00 pm

Present:	Sir Robert Finch, Chairman	SRF
	Mr Robert Bell, Chief Executive	BB
	Pr Timothy Evans, Medical Director	TE
	Mr Richard Connett, Director of Performance & Trust Secretary	RCo
	Mr Richard Paterson, Associate Chief Executive – Finance	RP
	Mr Robert Craig, Chief Operating Officer	RCr
	Mrs Jenny Hill, Senior Independent Director	JH
	Ms Kate Owen, Non-Executive Director	KO
	Mr Neil Lerner, Non-Executive Director	ML
	Pr Sir Anthony Newman Taylor, Non-Executive Director	ANT
	Mr Richard Hunting, Non-Executive Director	RH
	Mr Nicholas Coleman, Non-Executive Director	NC
By Invitation:	Ms Jo Thomas, Director of Communications & Public Affairs	JT
	Ms Joanna Axon, Director of Capital Projects & Development	JA
	Mrs Carol Johnson, Director of Human Resources	CJ
	Mr Piers McCleery, Director of Planning & Strategy	PM
	Mr David Shrimpton, Private Patients Managing Director	DH
	Dr Anne Hall, Director of Infection Prevention & Control	AH
In Attendance:	Mr Richard Goodman, Director of Pharmacy	RG
	Mr Anthony Lumley, Corporate Governance Manager (minutes)	
	Ms Katherine Denney, Head of Marketing Communications & Web Editor?	
	Ms Christine Denmark, Marketing & Communications Manager	
	Mr Stephen Pike, Performance Analyst	
	Melanie Reid, Tissue Governance Manager	
	Aydan Billal, Service Development Manager	
	Andrea Kelleher, Consultant Anaesthetist	
	Rod Morgan, Chief Accountant	
Observer:	James Brunt, Chief Executive, Devon & Exeter NHS Trust	
Apologies:	Dr Caroline Shuldham, Director of Nursing & Clinical Governance	CS

2012/27 MINUTES OF THE PREVIOUS MEETING HELD ON 28 MARCH 2012

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

- Page 11, item 2012/24, fourth para., first sentence: delete ‘strategic board level risks from the outside world’ and replace with ‘broad strategy discussions’.

Following a suggestion from NC it was agreed that the minutes should include an action tracker in the same format as that used for the Audit Committee and Risk and Safety Committee.

Action: Action Tracker to be included in next set of minutes.

2012/28 REPORT FROM THE CHIEF EXECUTIVE

BB gave verbal updates on the following items:

Judicial Review: Safe and Sustainable: Decision of Appeal Court

BB reported that the decision of the Court of Appeal on 19 April 2012 reversed the prior Judicial Review decision. BB expressed his disappointment with the outcome and described it as a serious defeat. It was important to understand what the judgement says. The Court of Appeal had been convinced by the arguments of the Joint Committee of Primary Care Trust's (JCPCT) barrister. The JCPCT testified they have not made a final decision, are open minded and have not precluded 3 sites in the consultation. The Trust has maintained all along that the Judicial Review would not solve the problem of children's cardiac surgery. The Trust had set out to expose an unfair process.

BB read out a comment received from a parent. The parent had stated that the Trust's legal challenge had shown that the JCPCT had not considered its obligations under Section 242 of the NHS Act 2006 and consulted on the impact on respiratory services and had shown that they had not been open minded. The parent went on to say that the statements issued by Sir Neil McKay, Chair of the JCPCT and Sir Roger Boyle had referred, in terms, to giving consideration to a three-centre option in London and so he felt the Trust had actually improved the prospects of keeping Paediatric Congenital Cardiac Services (PCCS) and, by calling for a Judicial Review, had achieved very much. BB said he agreed with this analysis. The Board had been sent notes of a meeting he had with Ruth Carnall, Chief Executive of NHS London, and Sir Neil McKay, on 17 April 2012 at their request. He had been asked what he was going to do when the ruling went against the Trust. BB said he had replied that he would ask the Board but he would be recommending that they wait for the final decision by the JCPCT on where children's heart surgery is to be offered in England on 4 July 2012. At that point there would be options to be considered, but BB said he would not elaborate further as this involved some issues which should be held in reserve for a private session of the Board. His view was that salami slicing of paediatric cardiac surgery does not work and it endangers other services. The national review of congenital heart disease had already concluded that splitting children and adults services was not a good idea.

BB further reported that a staff forum had been held on Monday 23 April. He characterised the attitude of staff present as sober, non despondent and resolute. There was a hope and a belief that the Trust will continue to stand up for patients and families.

TE said he completely reinforced BB's view of the meeting. He was congruent with the parent's view that this had been a worth while exercise.

JH asked what the Trust plans would be? BB replied that his assumption would be that paediatric cardiac surgery would be decommissioned as the expected outcome. If that were to be the case, the JCPCT had done its work, and it had no Executive powers. Only specialist commissioners, specifically the London Specialised Commissioning Group (LSCG), had the power to determine how and when to implement i.e. when and from whom to commission specialised services. The Trust's current struggle with the JCPCT is now over. Two other entities were bigger players in the future of paediatrics: the LSCG and Monitor. It would be up to the Royal Brompton and Harefield NHS Foundation Trust (RBHFT) to decide whether the service would be sustainable or not without PCCS. Monitor will regulate and arbitrate. Neither Monitor nor LSCG could order the Trust to transfer services to another trust. RBHFT's staff work for the Trust not the NHS. In summary, BB said there was a long journey still ahead. He would continue to act in the interests of the Trust and patients.

SRF said Sir Neil McKay's press statement said there would a number of discussions about the clustering of services. This was exactly what the Trust had suggested should happen in NWL and it was central to the discussions with Imperial College Healthcare Trust (ICHT). BB concurred and said that at his meeting with Sir Neil McKay it appeared he wanted a quick close as the aftermath will be protracted. SRF concluded that there was some way to go.

NHS North West London (NWL) Reconfiguration Programme

BB reported that NHS NWL were working towards accelerating the reconfiguration programme before the public consultation starts on 26 June 2012, and they were looking for a written commitment to the process from RBHFT.

BB asked RCo to read out a letter received from Anne Rainsberry, Deputy Chief Executive of NHS London who had written to the Trust asking for confirmation by Friday 27 April that the Trust would send a letter of support by 1 June which would include the following requirements: state that the Trust supports the decision to launch consultation and that the Trust had reviewed the Pre-Consultation Business Case (PCBC); contain a reference to supporting the consultation process; and commit the Trust to post-consultation decision-making. NHS NWL had provided a draft letter covering these points. RCo suggested that the PCBC should come to the Board in May and the Trust could indicate that it does support the need for consultation but reserve judgement on the outcome.

BB said he had asked RCo to consult with the Trust's lawyers because of what happened before. JH said the Board could only support the process up to a point. TE added that 2 of the Trust's senior clinical members were on the review body.

The Board agreed to support the consultation process.

Action: include PCBC on Board Agenda 30 May 2012.

2012/29 AHSP TRANSITIONAL PARTNERSHIP – DRAFT MoU

BB reported that he had received a more up to date Memorandum of Understanding (MoU) since the Board papers had been sent out but there was nothing significantly different in them. His recommendation was that the Trust should participate and support the name of 'Imperial College Health Partners'. The cost of the subscription was £30k. The AHSP was still being led in the interim by Lord Darzi. BB was involved in the Panel to shortlist candidates for the Managing Director position.

JH asked if BB could distinguish between an Academic Health Science Centre (AHSC) and an AHS Network (AHSN)? BB said there were 5 AHSCs in the country with different models, approved by the Department of Health (DH). AHSNs had been formulated from an idea about innovation by Sir Ian Carruthers. BB said he has heard a number of definitions of what they are. The model for an Academic Health Science Partnership (AHSP) was very clear in the document, but this was neither a delivery centre nor a network. JH had attended a London-wide workforce planning meeting where the view had been aired that a AHSN could be used as a planning mechanism for services. TE said the existing AHSC would look different from the AHS networks. The latter had been less academically distinguished. SRF said the key thing was the identity of the Chief Executive; he also questionted whether there would there be too many partners. TE agreed and said the success of the new AHSP would be determined by how it would interact with NWL reconfiguration (and could even become the vehicle for its delivery), and to what extent the partners could be bought into the agenda of a collaborative model. BB said that as an AHSP Board member he would be resistant to the body becoming a power manager of reconfiguration or research and infrastructure. It was not about replicating university partnerships. He agreed with SRF that the Chief Executive's identity was critical. In response to a question from KO on whether other partners could derail it, BB said he did not see the AHSP going very far, very easily, and it would all shape up ultimately around money.

The Board approved the MoU.

2012/30 CLINICAL QUALITY REPORT FOR MONTH 12: MARCH 2012

RCo said that the focus of this report was the monthly update against Key Performance Indicators (KPI's). A more extensive redesign of the Clinical Quality Report for M1 of 2012/13 would be presented to the Board in May. He highlighted the following from Month 12:

- MSSA/E Coli: monitoring of these indicators would be devolved to the Infection Control Committee as there were currently no targets and these measures do not form part of the Compliance Framework.
- Cancer, 62 days to first treatment: since the report was written, 3 repatriations had been agreed. Therefore the target was met.

- Compliance target, *Clostridium difficile* was not met with 13 cases against an annual threshold of 7. RCo invited AH to give an update. AH said, as reported at the last Board, the new DH guidance, effective from 1 April 2012, introduced the reporting of all cases where the antigen and toxin are found to be present, whereas up until the end of March 2012, Trusts had only reported clinically significant cases. Between 1 April 2011 and 31 March 2012 there had been 41 such cases, with 16 reported to the Health Protection Agency. Of these, 3 had been deemed to be non attributable to the Trust. If the new DH guidance was applied to this same period the Trust would have had around 6-13 more cases. RCo said DH's target for 2012/3 remains 7. Monitor's Compliance Framework includes a 'de minimis' of 12 for 2012/13.

NL said the introduction of a de minimis does not change AH's suggestion that the Trust will comfortably exceed the target. KO asked if this meant that all Trusts were likely to exceed their targets. RCo said this was not the case, as those with high thresholds (e.g. 200) might still pass their indicator. It only applied to Trusts with low numbers. JH commented that the Trust has a low rate of cases and TE confirmed that it was about 0.5 per cent. BB counselled caution as the issue was about compliance with a target, not simply about the clinical or safety implications.

RCo said that the new guidance implies that in some cases of loose stool, patients should not be tested for *Clostridium difficile*. The Trust's clinicians' view that this was not a safe approach, and that the Trust should not follow this part of the guidance. AH said it was often difficult to establish which patients have *Clostridium difficile* and which do not. She therefore advised care about the use of laxatives. The aim must be to reduce the number of patients with diarrhoea and she was hopeful this could be achieved.

Non-Executive Directors expressed their bafflement with the proposed new guidance. ANT said the Trust should pursue this issue to see if sense can be made. BB said the Board should be mindful that in 6 months the Trust could breach the target.

RCr said that the Board should note the advice not to comply with DH guidance on testing. In reply to a question from NL, AH said that under the new regime, the Trust would be reporting cases that did not actually show clinical signs of *Clostridium difficile* infection and therefore a breach of the DH target was inevitable.

RCo continued his summary of the report. There had been 1 outbreak of Norovirus and 1 Grade 3 pressure ulcer. For cancelled operations, he reported that the year-to-date position was 1.3% against elective admissions and the Trust had, therefore, underachieved against the Care Quality Commission target of 0.8%.

Commenting on this issue, RCr said the number of cancellations in February and March and the recent rate of increase at Harefield was a concern, and had

(rightly) been raised by a Governor attending the last Board meeting. It appeared that cancellations at Harefield had become a 'fact of life' rather than the exception to be avoided. The rise reflected a constellation of issues. He had asked his Management Team to produce an action plan, there would be regular monitoring of data and performance on a weekly basis. The following could be not be used as excuses but would provide some context:

- Pre-admission: ensuring patients were kept monitored after they had been to a pre-admission clinic but before admission to hospital
- Surgical rotas: ensuring no 'elective' theatre lists on the day following an on-call period
- More flexible allocation of theatre time.
- Anaesthetic practice: ensuring prompt preparation and turnaround of patients to reduce the risk of theatre overruns.

RCr went on to note that cardiac surgery patients were now often less than 30% of Intensive Care patients at any one time, increasing pressure for surgical capacity. Lung transplant and acute cardiology numbers in ITU were much larger than they used to be.

Finally, RCr reported that the figures for 1 April to 23 April 2012 showed some improvement with 10 cancellations reported for the period. TE said he agreed with RCr's analysis. The Trust did not have the flexibility at Harefield to accommodate comfortably all the demands being placed on the service.

JH asked if this was calibrated with the risk register? TE said he was confident the risk management of it was right. It informed strategy rather than risk. NC said this had also come under the spotlight of the Risk and Safety Committee (RSC). The RSC was pleased to see that RCr was looking at broader cultural issues rather than just procedural ones.

2012/31 <u>FINANCIAL PERFORMANCE REPORT FOR MONTH 12: MARCH 2012</u>

RP said this was an abbreviated report because the annual close had significantly affected M12 figures. RP highlighted that in M12:

- The Income and Expenditure (I&E) outturn for the month was characterised by a number of positives and negatives and one-off items, many of which were not wholly attributable to M12, which resulted in an overall deficit of £4.4m building on the baseline surplus for the month of £0.3m.
- This translated into a provisional figure of a £1.8m surplus for the year (compared to Plan of £3m surplus). This was subject to audit but he anticipated that this was close to the final figure.
- Capital: Liquidity and cash remained strong, none of the Working Capital Facility had been used, and Capex was slightly behind plan.
- Taking all this into account means the Trust has maintained its Monitor Financial Risk Rating (FRR) of 3, per Plan, for 2011/12 as a whole.

NC asked if March had been the busiest month for activity why Project Diamond (PD) funding had not been included in the figures? RP replied that it was correct to describe M12 as the busiest month and PD was included in the figures. RCr said March was often a busy month in spell terms.

However, M12 activity was almost exactly the same as in 2010/11 and given that, one would have hoped for a bigger surplus. NC asked if the Trust is raising the bar with the amount of activity it can deal with? RCr replied that this was correct and that Acorn Ward at Harefield was a good example of expanding capacity to meet demand.

The Board NOTED the report.

2012/32 STATUS OF 2012/13 BUDGET

Introducing the report, RP said it was an update of the draft budget presented to the March 2012 Board meeting and remained work in progress. A final budget would be presented to the Board in May for approval as part of the Annual Plan. He reported a movement from a deficit of £2.1m reported in March, to £1.7m as disclosed by the Board paper. RP referred the Board to Appendix B which showed the development of this change. Pay and non-pay contingencies had each increased by £1m with further cost pressures of £0.7m, £200k of which represented redevelopment fees which would have to be expensed. Service developments contributed an additional £1.2m, together with a further £2.1m in cost improvement plans (CIPs) had improved the position by £3.3m . There had been no change made to underlying NHS revenues, pending the outcome of discussions with NWL on 2012/13 commissioning arrangements.

RP reminded the Board that later in the meeting he would be proposing that in its Q4 return to Monitor it states that the Trust anticipates it will achieve a minimum FRR of 3 over the next 12 months. The Trust plans to budget a £3m surplus (1% of revenue) as expected by Monitor so the current gap to that plan was £4.7m. Three further elements would be put in place to bridge this:

- firstly, further FSP measures which the Trust would aim to introduce;
- secondly, NHS income could be higher than as reflected in this draft of the 2012/13 budget. NH was due to meet with NHS NWL on 26 April and believed that there could be some progress. He did though caution that there may be additional penalty provisions to be taken into account;
- thirdly, by recognition of Project Diamond (PD) funding in the final budget. He reminded the Board that PD income had been awarded to specialist Trusts in London in each of the last 5 years in recognition of inadequate tariffs for certain of the more complex procedures that they performed. RP said that he attends PD Director of Finance meetings as a result of which he was confident that there will also be PD funding in 2012/13 even though the NHS has not committed to providing it, consistent with recent years. The Trust may receive less than it did in 2011/12 (which itself reflected a declining trend) but he did believe it would be made available. From 2013/14 Monitor would be taking over setting of tariffs from DH. Monitor had commissioned a study of PD tariff setting and seems sympathetic to the position of PD Trusts.

RP concluded by recommending that the Trust includes in the 2012/13 budget the same transitional funding it received in 2011/12 (£6.7m) less a

contingency of £2.0m in case funding is reduced and to cover possible additional penalties due to a tighter commissioning regime. These changes would be reflected in the final budget to be approved at the May Board meeting.

Noting that CIPs were going well, JH asked how can the Trust be comfortable that they had been about service redesign and not cutting into the muscle and fabric of the Trust? RCr assured the Board that patient safety was one of the considerations in developing every CIP. NL said all Board members had received a copy of the Monitor publication *'Delivering Sustainable CIPs'* which had been reviewed by the Finance Committee in March 2012. BB concurred with RCr and cited numbers of staff appointed or replaced in the last 12 months: 406 medical staff, 301 nurses and 279 other staff. This demonstrated that the Trust was not cutting into muscle and illustrated a trajectory of growth.

NC asked how much contingency was incorporated in the budget? RP said it comprised £4.0m for unbudgeted costs, £2.4m against NHS income as a placeholder, and a proposed £2.0m against PD funding which gives a total of £8.4m. NC then asked that given the Trust had undershot its budget for 2011/12 was the contingency as conservative as last year? RP said this was the case and that it was a prudent budget. He added that budget holders were being tasked with tight budget objectives.

The Board NOTED the report.

2012/33 CONTROLLED DRUGS GOVERNANCE AND ACTIVITY OCT-DEC 2011

RG said his team would be reviewing procedures over the next 12 months. NL thanked RG for the improved presentation of the report.

The Board NOTED the report.

2012/34 Q4 MONITOR DECLARATIONS 2011/2

(i) GOVERNANCE & QUALITY DECLARATIONS

RCo reported that an investigation by the Health and Safety Executive (HSE) into the January 2011 spillage in the RBH Containment Level 3 Laboratory was on-going. HSE had written to the Trust with further questions on 23 April 2012 and the Trust would reply shortly.

The recommendation is that the Board should declare that all of the targets in the Compliance Framework have been met, apart from the *Clostridium difficile* objective, which has not been met. This meant that the Trust could not sign Declaration 1, and should instead sign Declaration 2:

'For one or more targets the Board cannot make Declaration 1 and has provided relevant details on worksheet "Targets and Indicators" in this return. The Board confirms that all other targets and indicators have been met over the period (after application of thresholds) and that sufficient plans

are in place to ensure that all known targets and indicator which that will come into force during 2011-12 will also be met'.

The 'Targets and Indicators' cell on the Q4 worksheet would then be completed and this, together with the exception report, will be sent to Monitor via the Monitoring and Regulatory System (MARS) portal.

Action: submit Declaration 2, complete Q4 worksheet and send to Monitor via the MARS portal.

RCo drew to members' attention his recommendation that the Board should make Declaration 1 for the Q4 Quality Declaration. The Board approved submitting Declaration 1:

'The board is satisfied that, to the best of its knowledge and using its own processes and having regard to Monitor's Quality Governance Framework (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), its NHS foundation trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.'

These declarations would then be submitted to Monitor, via the MARS portal, by the Director of Performance & Trust Secretary acting with delegated authority from the Board.

Action: submit Declaration 1 for the Q4 Quality Declaration and send to Monitor via the MARS portal.

(ii) FINANCIAL RISK RATING

RP reminded the Board, that each quarter it is required to make a Declaration to the effect that 'the Board anticipates that the Trust will continue to maintain at least an Financial Risk Rating (FRR) of 3 over the next 12 months'. He was comfortable with recommending that the Board should approve the Declaration.

The Board agreed to make a declaration of FRR3 as at 31 March 2012.

Action: submit Declaration to Monitor stating Board anticipates FRR3 will be maintained over the next 12 months.

2012/35 ANNUAL PLAN 2012/13 TEMPLATE

Paper G was presented by PM. He described the purpose of it as being to provide the Board with a copy of the main section of the strategy template in order to provide Board members with an initial view of the particular topics Monitor has prioritised for attention this year.

The Board NOTED the report.

2012/36 AUDIT COMMITTEE

(i) MINUTES OF THE MEETING HELD ON 7 FEBRUARY 2012

The Board NOTED the minutes.

(ii) REPORT FROM THE MEETING HELD ON 24 APRIL 2012

NL reported that the Audit Committee (AC) had been introduced to the new counter fraud team; received 3 Internal Audit reports; considered the annual review of AC effectiveness which the committee hoped would encompass the review of Board effectiveness; and made minor changes to the Terms of Reference.

SRF asked if he had any concerns about the financial performance? NL said he had no concerns about the information presented to the AC. The debate with the auditors will be about how conservative rather than how aggressive the figures are.

2012/37 RISK AND SAFETY COMMITTEE (RSC)

(i) MINUTES OF THE MEETING HELD ON 7 FEBRUARY 2012

The Board NOTED the minutes.

(ii) REPORT FROM THE MEETING HELD ON 24 APRIL 2012

NC reported that the RSC had been active in reviewing the regular business of the Trust. Its activities had included:

- Serious Incidents (SIs): The RSC had reviewed all SIs since the last meeting and also took a helicopter view of 15 that had occurred over the last year or so. There were a number of issues discussed in relation to specific SIs. On the broader view, the meeting concluded that there may be material patterns across the 15 SIs (for example in the supervision of training and/or in information flows).
- Transplant reviews: There were 2 of these. First, the RSC discussed the difficulties the trust was having closing-out the internal review of heart transplantation following NSCT's intervention. This was a good example of the Trust's appetite for risk as tabled at the last Board meeting. Second the committee was updated on the national transplantation review.
- New alerts: the Trust, and the RSC, welcomed any sensible external assessments of its clinical performance. Two such new and important alerts were discussed at length in the RSC. The first was a Dr Foster alert suggesting that the Trust's mortality rates in acute myocardial infarction were higher than average. Drilling-down into the data, understanding if it is really the case, and if so what should be done about it, was work in progress in the Trust. The second was some data analysis by the Society of Cardiothoracic Surgeons (SCTS) suggesting that the Trust ranked poorly on mortality in some types of cardiac surgery. Again understanding this data and what it means is also work in progress. The key messages from the RSC on these alerts were: firstly, there was no evidence of hubris and when the alerts come in they are

taken as seriously as possible; and secondly, these alerts would be published in a month's time and would be in the public domain.

TE said the Dr Foster alert was due to inaccuracy of data and allocation of coding groups. A full report on myocardial infarction was being prepared for the Governance and Quality Committee (G&Q) meeting in May. The STCS data was of particular concern. He had spoken to Ben Bridgewater, STCS audit lead, who had introduced new data monitoring systems. This issue would also be reported to the G&Q in May.

ANT said he agreed with TE. The mortality rates were not within the limits of chance and there was wide variation. Careful interpretation was needed. TE added that certain diagnostic categories spanned 12-20 deaths with 1600 operations which meant a survival rate of 98%.

2012/38 ANY OTHER BUSINESS:

1. Recommendation of advisory appointment committee: the Chairman had agreed to take this additional item of business as a matter of urgency. The Board were presented with a ratification form for appointment by NC. NC reported that this was an unusual post inasmuch as it was for a part-time Consultant in Liaison Psychiatry. There had been a strong list of candidates and 3 had been shortlisted. The panel had spent some time after the interviews in a substantive debate on the relative merits of 2 of the candidates.

   The Board ratified the appointment of the following consultant:

   James Wooley as a Consultant in Liaison Psychiatry

2. SRF informed the Board that interviews for ANT's replacement as a NED would be held in 2/3 weeks time.

3. SRF asked if the Board would receive a presentation on the Health and Social Care Act and its implications. BB said that, while he agreed that education was needed, a specific presentation was not necessary as the subject would be considered at the seminar on 2 May hosted by KPMG.

2012/38 QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions from members of the public.

DATE OF NEXT MEETING

Wednesday 30th May 2012 at 10.30 am in the Concert Hall, Harefield Hospital.