Minutes of the Board of Directors meeting held on 25th July 2012 in the Board Room, Royal Brompton Hospital, commencing at 2 pm

Present:	Sir Robert Finch, Chairman	SRF
	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 Nicholas Coleman, Non-Executive Director	NC
	Mrs Jenny Hill, Senior Independent Director	JH
	Mr Richard Hunting, Non-Executive Director	RH
	Ms Kate Owen, Non-Executive Director	KO
	Mr Richard Connett, Director of Performance & Trust Secretary	RCo
By Invitation:	Ms Jo Thomas, Director of Communications & Public Affairs	JT
	Ms Joanna Axon, Director of Capital Projects & Development	JA
	Ms Carol Johnson, Director of Human Resources	CJ
	Mr Piers McCleery, Director of Planning & Strategy	PM
	Mr David Shrimpton, Private Patients Managing Director	DH
	Mr Nick Hunt, Director of Service Development	NH
	Dr Anne Hall, Director of Infection Prevention & Control	AH
	Mr Richard Goodman, Director of Pharmacy & Medicines Management	RG
In Attendance:	Ms Sue Peterson, Named Nurse, Safeguarding Children	SP
	Ms Tracey Foster, Trust Safeguarding Children & Young People Nurse Advisor	
	Mr Anthony Lumley, Corporate Governance Manager (minutes)	
	Ms Pat Cattini, Matron/Lead Nurse Infection Prevention	
Apologies:	Mr Neil Lerner, Non-Executive Director	NL

2012/54 MINUTES OF THE PREVIOUS MEETING HELD ON 30 MAY 2012

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

- Page 7, item 2012/46, second para., second sentence replace ‘CS’ with ‘CJ’.

2012/55 MATTERS ARISING

Actions from minutes

The Chairman reviewed the Action Tracking log and all the elements are complete or followed up on this agenda.

2012/56 REPORT FROM THE CHIEF EXECUTIVE

BB gave verbal updates on the following items:

Safe and Sustainable

BB reported that he had attended the meeting on 4 July 2012 when the JCPCT announced the decision to de-commission paediatric cardiac surgery at the Royal Brompton hospital site (RBH). No one from the public

was allowed to ask questions during the 6 hours meeting except for a 20 minute period at the start when issues they raised were logged so the Panel could take note of them when reaching their decision. No timeframes had been given for implementation but it was likely the implementation framework would take effect in the 2014-15 fiscal year. A precursor was the process of implementation already being led by the London Specialised Commissioning Group (LSCG). Sue McClellan, Chief Operating Officer of LSCG had already approached him and a meeting would take place in the week commencing 30 July with Guy's & St Thomas' (GST) and Great Ormond Street Hospital (GOSH) represented. Dr Andy Mitchell, Chief Medical Officer of NHS London (NHSL) and Professor Deidre Kelly, Professor of Paediatric Hepatology at Birmingham Children's Hospital, would be the leaders of the implementation processes in London and nationally respectively.

BB said that in his view, having looked at this in detail and taking into account the direct consequences for patients, families and staff, this was a very bad decision. As the Trust's Chief Executive he could not recommend that the Board accept the decision. He was content to discuss how the Board should respond to this in the open part of the Board meeting, or defer discussion until the private Part II session, this was for the Chairman to decide. The consequences of the decision were: the knock on impact on other services and in particular respiratory medicine and Adult Heart Congenital Disease; the legal position of the Trust as an employer in the light of services being de-commissioned (Kemp Little LLP were in attendance to give legal advice); and the financial consequences, loss of income and costs incurred as a result of the knock on impact. He could not propose that the decision be accepted as is.

These points would not be ones Ruth Carnall, Chief Executive of NHS London, and Sir Neil McKay would wish him to have made. However BB said he was obliged to consider patient safety and sustainability issues and be meticulous and forensic and not superficial in his examination of the issues.

SRF invited comments from Board members and firstly asked the Trust's Medical Director about the implications. TE said he had little to add but the implications were profound, in particular the knock on effects. The manner, speed and extent of how the decision is implemented would be crucial in terms of the impact on the Trust in its current form. In reply to a question from SRF on whether this meant tertiary centres would become a thing of the past TE said in a general sense that was not true. This week a letter had been published which endorsed the specialist services model for orthopaedics hospitals. He noted that this model was also endorsed by Professor Ara Darzi. However, the nature of the Trust's work, and its unique vertical model of care were threatened. He also noted that there were only 2 other centres, Papworth and Liverpool Heart and Chest Hospital which provided similar specialist services, but that they lacked the vertical integration with paediatrics. A certain form could be maintained but it would

be different from the existing form and safety would be a paramount consideration. Difficult Asthma and Cystic Fibrosis services depended on a strong paediatric department and the knock on effect on adult services would be profound.

BB said the Board could not be expected to support delivery of an unsafe service. An approach that focuses on a superficial narrow issue had serious deep rooted impacts. His intention was to set out a proposal for the Board's response in Part II. In law it was morally and ethically the provider not the commissioner who was primarily responsible and accountable for the delivery of safe services.

SRF said the decision was bad for the hospital and the patients, staff and communities the Trust serves. BB said the Trust stood for the interests of the patients it serves and not vested interests. Others in the public domain had sought to undermine this position.

JH said that the institution should be defended, but there needed to be an awareness of where we sit in the wider NHS, and recognition of the force for change embodied in the new commissioning arrangements. The Trust would have to implement this decision and engage with partners. The NHS cared less about hospitals and more about high quality care. The Trust could fight the decision but it would not win. A longer 'game' should be played which would not be about survival of the hospital as property.

RH said he looked forward to hearing the details of BB's proposal in Part II. He felt that some aspects could be diverted to this part of the meeting.

RCr said if the Trust accepts the decision where would it stop. The Board should be clear about what kind of organisation it wants the Trust to be.

SRF wondered whether this would be the first step in decline, or did the Board think that such an institution should be protected? RCr concurred and said patients were referred to Royal Brompton & Harefield NHS Foundation Trust (RBHFT) for a reason and that should be protected.

KO said it would be more sensible to discuss BB's proposal in Part II. CS said she had been thinking on these issues carefully and felt that the Trust should continue providing a cradle to old age heart service.

NC said staff and patients deserved a clear statement of intent from the Board. Other service reviews would be coming and the Trust needed to look to the future and consider where the Trust fits in the new model of healthcare. The Trust should be part of a solution for the NHS rather than resist too strongly. He added that he supported further discussion in Part II.

SRF opened the discussion to members of the public. Ken Appel said his experience on the Abdominal Aortic Aneurysm Steering Group had led him to believe that this decision was set in stone. Patient safety was the

provider's responsibility but it was the Government's responsibility to ensure that providers were able to exercise that. He asked if this should then be put to the Cabinet Office to make them aware of the destructive nature of the proposals? SRF said he was sceptical about it being on the Government's agenda.

David Potter said that the patients and public he had spoken to were desperately disappointed which he characterised as 'crazy vandalism'. He would be loath to see any reduction in the services provided by the Trust but as other decisions had adversely affected RBHFT he felt it was right and proper for the Board to discuss its position in Part II.

SRF concluded this part of the discussion by stating that the consequences were enormous and would mean that the Trust would cease to exist in its present form. He noted that the staff and supporters at Harefield Hospital (HH) were strong and he expected them to come alongside the Board in a strong manner to face what would be a colossal battle. This battle could be political and recently Andy Slaughter MP had spoken in Parliament in support of the Trust.

2012/57 CLINICAL QUALITY REPORT FOR MONTH 3: JUNE 2012

RCo reported that all of the Compliance Framework targets set by Monitor had been met in M3. This included *Clostridium difficile* with 6 cases year-to-date against the de minimus target of 12. The Care Quality Commission (CQC) had carried out an unannounced inspection of HH on 20 June 2012. The draft report had declared the Trust to be fully compliant. RCo said that the first part of his report was concerned largely with compliance metrics. The remainder was taken up by Priorities for Quality Improvement and CQUIN. He reminded the Board that the Priority for Quality Improvement metrics are those chosen by the Trust and that the process for selecting metrics for 2013/14 would be starting soon. He noted that this was an opportunity for the Board to choose targets other than those mandated for compliance reasons. CQUIN performance for 2011/12 had been 100%, so all of the CQUIN income had been received. Priorities for Quality Improvement figures were for Q4 of 2011/12. The next Clinical Quality Report would contain information on Q1 of 2012/13. The topics for the indicators were selected by patients, carers, staff, FT members and Governors via a voting system.

SRF asked why the Trust appeared to be hitting the target for *Clostridium difficile* when last year the Board had declared the target as not met. RCo said that previously the target had been set on a trajectory of 2 for each quarter so if this had still been in place there would have 6 counted against 2 and therefore reported as failed. SRF asked how other Foundation Trusts (FTs) were fairing? RCo replied that 5 Trusts in London had targets of less than 20 for the year and all of them were already in breach. SRF said he hoped this meant that the message may be getting through to the Department of Health (DH) that the *Clostridium difficile* target was very challenging.

SRF said this was a satisfying report. NC said the Risk and Safety Committee (RSC) had also considered the report on 24 July 2012 and was content.

2012/58 FINANCIAL PERFORMANCE REPORT FOR MONTH 03: APRIL 2012

Introducing his report for the third month of 2012/13, RP highlighted that in M3:

- The Income and Expenditure (I&E) outturn was a surplus of £0.3m. Although the figure was flattered by the release of a provision of £0.7m this was justified as it was provision against debtors related to contractual disputes with commissioners which had been resolved.
- The Year to Date figure (Q1) was a deficit of £0.7m which included £1.6m of Project Diamond Income (PD). Special factors behind the performance were: an outbreak of norovirus with costs incurred in M1 and M2 with some impact being felt from extra spend on agency nursing; more public holidays than usual; and deterioration in Private Patient (PP) performance in a difficult marketplace.
- Balance sheet: the Trust had recently learnt that PD funding would be provided to the Trust in Q2 when usually it arrived in Q3 or Q4. It was not known when the funds would be released in Q2 or how much but it would improve the cash position and liquidity further.

SRF asked if the fall in PP income reflected a long term downturn or was it a blip. BB replied that this had been discussed at the Finance Committee meeting on 24 July 2012. The private sector was not doing well with the foreign market and the local market affected. The foreign market vacillates but should come back. The local market reflected the downturn in the economy. He was not confident this would come back in the near term. In response to a comment from SRF that this would have a serious impact on PP income, BB said the Trust would have to offer alternative services where the Trust expects the private market to develop.

SRF summarised that the Trust had returned a solid performance.

NC said that on the face of it the figures illustrated where the Trust expects to be at this time of year. He asked if the Finance Committee had any view on the likelihood of achieving Plan over the year. RP confirmed that this had been considered but his report to follow on the Trust's Financial Risk Rating would expand on this subject.

The Board noted the report.

2012/59 EDUCATION UPDATE

RCo gave a verbal update on behalf of Professor Margaret Hodson. The Trust would not lose any Deanery trainees in the next 12 months. There had been 2 visits from the Dean to look at the way the faculty meetings and education committees were working and a quality liaison meeting with the Deans.

SRF thanked Professor Hodson for her update.

2012/60 INFECTION CONTROL – ANNUAL REPORT 2011/12

Introducing the report AH highlighted the absence of MRSA and GRE bacteraemias over the year and low hospital rate of acquired MRSA given the large numbers. This reflected the hard work by the team in maintaining compliance with the hygiene code and the favourable report by the CQC in April 2011 and this year at HH. The only downside was the alteration in testing and reporting for *Clostridium difficile*.

Noting that testing now appeared to be 'sensible' SRF asked if standards could be maintained? AH said she was hopeful infections could be kept as low as possible. The typing of all *Clostridium difficile* had shown that cross infection was not occurring. This showed that the Trust was not giving patients *Clostridium difficile* but rather that it was coming into the hospital with the patients themselves. Work is continuing to reduce the incidence of diarrhoea and hence reduce the requirement for stool samples to be taken and tested.

JH asked if the reference to norovirus in the report referred to a new outbreak or the same outbreak described in the Financial Performance Report and also if it should be included on the Risk Register (RR)? AH said it has been described as the same outbreak which occurred in 2 waves, each wave with a slightly different molecular type of the virus, from March to May 2012. This was the first outbreak in 10 years. In response to KO's comment that as it was recurring it should be higher up the RR, AH said this was not a recurrence but a wave. NC said the RSC had concluded that the infection control procedures were operating as intended.

Referring to a comment from NC that a number of priorities were listed in the report's conclusion, AH said reducing the number of patients in whom *Clostridium difficile* is detected was the number one priority but that she felt that the remaining priorities were all equally important.

The Board noted the report.

2012/61 SAFEGUARDING CHILDREN - ANNUAL REPORT 2011/12

CS introducing Sue Petersen, Named Nurse, Safeguarding Children to the Board. CS said enormous progress had been made with Adult Services engaged with the training and their responsibilities to safeguard the children of adult services. The background to this was that the safeguarding agenda was getting bigger and more work was being generated.

SRF thanked Sue Petersen and Tracey Foster and congratulated them on the progress made.

The Board noted the report.

2012/62 TRUST RISK REPORT

CS presented the report and said that the number of risks had been reduced from the previous version. She drew attention to the text in the Statement that the level of risk deemed acceptable / tolerable is kept under review by the Trust Board.

NC said that the risks could be broader but the aim was to chart the right path between two extremes and the Statement illustrated how this could be done. CS said that in response to a view expressed by the Board the risk of de-commissioning paediatric cardiac surgery had been added to the RR and made the number one risk. Related to it was the risk of failure to maintain effective influence with key external stakeholders (Risk number 5).

SRF asked RP if any modelling had been done on the implication of Risk number 1? RP said this would require more granular information and an evidential base to assess a range of outcomes and that this work was underway.

NC highlighted 3 things in relation to the approach to risk and what could be managed: firstly, a much improved process of identifying risks had been instigated; secondly, the list of actions for Risks 1 and 5 was not complete and this was only the first stage. (CS added that actions in relation to paediatrics had not been discussed by the Board to date); and thirdly, some strategic risks large and long range had not been included mainly because they were, as yet, difficult to recognise and describe.

KO said the report had set out a much more helpful process and was much better. It allowed the Board to look at what it knows about and may help it concentrate on what might come up.

The Board noted the report.

2012/63 CONTROLLED DRUGS GOVERNANCE AND ACTIVITY APRIL 2011-MARCH 2012

NC said it was pleasing to note that there were no amber or red incidents. RP noted that the report still had the 'draft' watermark. RG said this was an error and confirmed that it was the final report.

The Board noted the report.

2012/64 MONITOR DECLARATIONS 2012/13 – Q1

(i) GOVERNANCE & QUALITY DECLARATIONS

RCo reported that the quarterly Quality Declaration was no longer required and had been replaced by a new Board statement process to cover the provision of exception reports with the wording " … no matters arising in the quarter requiring an exception report … which have not already been reported". Monitor had been provided with an exception report regarding an investigation by the Health & Safety Executive (HSE).

RH asked for a recap of the HSE investigation. RCr said it was in relation to an incident in the Containment Level 3 (CL3) Laboratory in 2011. RCo added that it had been reported in more depth to the RSC. RCr said that it had been some time since the HSE began their investigation which was still ongoing. NC said the RSC had drawn a distinction between patient safety / staff issues and financial / reputational issues. It was satisfied that none of the former applied.

RCo said the recommendation is that the Board should declare that all of the targets in the Compliance Framework have been met. This meant that the Trust could sign the following statement:

'The board is satisfied that plans in place are sufficient to ensure: ongoing 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.'

'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.'

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

(ii) FINANCIAL RISK RATING

RP reported that the Trust's Q1 performance had been sufficient to report to Monitor an FRR rating of 3 for the quarter.

RP reminded the Board, that each quarter it is also required to make a Declaration to the effect that 'the Board anticipates the Trust will continue to maintain a Financial Risk Rating (FRR) of at least 3 over the next 12 months'. Despite a slow start to the year, he had no serious concerns of FRR 3 not being maintained for the current financial year. He cautioned that making this assertion into 2013/14 would become harder each quarter as the Trust is challenged to achieve a further 4% Financial Savings Plan as the implementation of the Safe and Sustainable decision approaches.

NC asked about likely performance for the rest of 2012/13. RP reported that better performance from Q2 to Q4 was anticipated in the Trust's Plan as per the M3 financial report and that the Trust is budgeting a surplus for the year as a whole. The Finance Committee was in accord with that view.

The Board agreed that the Director of Performance & Trust Secretary, acting with delegated authority from the Board, could report an FRR of 3 for the quarter to 30 June 2012 and declare that the Board anticipates the Trust will maintain an FRR of at least 3 over the next 12 months.

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

2012/65 AUDIT COMMITTEE (AC)

(i) REPORT FROM THE MEETING HELD ON 24 JULY 2012

In the absence of NL, NC gave a verbal report. The committee had noted that good progress had been made on implementing outstanding recommendations and the Internal Audit programme was proceeding according to plan with no significant concerns identified.

2012/66 RISK AND SAFETY COMMITTEE (RSC)

(i) REPORT FROM THE MEETING HELD ON 24 JULY 2012

NC reported that the RSC's overall conclusion, having observed all sources of assurance, was that the processes to manage patient safety and risk were working as intended. When something was identified as incorrect or not good enough it was being investigated promptly and steps taken.

The Board had asked the RSC to look into the Root Cause Analysis (RCA) of a Serious Incident in late 2011 when a patient died after several cancelled operations. Several causes were found, most of them being loopholes and flaws in patient pathways. All had been fixed. Although the fixes were temporary, in due course they would be embedded fully.

NC concluded his report by referring to the departure of Professor Sir Anthony Newman Taylor as reducing the ability of the RSC to give assurance as the Board no longer had a Non Executive Director with clinical experience. SRF said he was well aware of this and it was being followed up with the Governors. NC said in the interim if a significant issue came before the RSC, they would ask for a suitably skilled person to attend.

2012/67 PROPERTY COMMITTEE (PC)

(i) REPORT FROM THE MEETING HELD ON 24 JULY 2012

SRF reported that the PC's work continued looking at possible sites and the consultants EC Harris were looking at space requirements on its behalf.

2012/68 RECOMMENDATIONS OF ADVISORY APPOINTMENTS COMMITTEE

The Board were presented with 4 ratification forms for the appointment of consultant medical staff by JH for a Consultant in Paediatric Cardiology with Interest in Paediatric Echocardiography, Consultant Cardiologist with a Special Interest in Cardiac Magnetic Resonance, and two Consultants in Paediatric Intensive Care Medicine.

JH said that all of those appointed had previously been working at the Trust as locums. For one of the locums the panel had agreed to provide a development programme which would be managerial.

SRF asked if the candidates had been briefed on Safe and Sustainable? JH said they had. Their acceptance of the posts demonstrated the commitment of clinical staff.

The Board ratified the appointment of:

- Dr Nitha Naqvi as Consultant in Paediatric Cardiology with Interest in Paediatric Echocardiography;
- Dr Joyce Wong as Consultant Cardiologist with a special interest in Cardiac Magnetic Resonance;
- Dr Ajay Desai as Consultant in Paediatric Intensive Care Medicine and;
- Dr Sandra Gala-Peralta as Consultant in Paediatric Intensive Care Medicine.

2012/69 LONDON CANCER ALLIANCE – MEMORANDUM OF UNDERSTANDING

BB said the Prospectus and Memorandum of Understanding had been reviewed by the Management Committee and all partners are being asked that their Trust Boards to consider the proposals. CS was the Trust's 'eyes and ears' on the ground. RBHFT was currently a signed up member of Imperial College Health Partners. The proposal for the London Cancer Alliance crosses boundaries to include South West London and South East London. He had discussed the proposal with Cally Palmer (CP), Chief Executive of the Royal Marsden NHS Foundation Trust (RM) and CEO project lead for the London Cancer Alliance and had subsequently received a letter from her which had summarised their discussion. He recalled that he had stated that the Trust would not be keen to participate in something that conflicts with the Imperial College alliance. CP's letter contained nothing that provided him with assurance on this issue. BB said he had also raised the issue of cross boundary planning of services around particular disease patterns [cancer] with Cally Palmer, noting the preferential standing given to cancer services and that this had been unacceptable when planning paediatric services and that this was a peculiar point of policy confusion.

BB said that he also stated that the Trust would be very concerned if the commissioner's proposals envisaged reducing lung cancer centres and chose to view RBHFT as 2 centres because the Trust provides the service at both of its sites and he noted that RM is treated as one site, therefore there should be consistency.

CS said the London Cancer Alliance had to date been a closed group which made her role difficult. There appeared to be an intention in respect of thoracic surgery to consolidate all services within each Trust on one site. The Trust had good representation on the Lung Pathway Group but not on the Clinical Group. CS noted that the chief executive group was described as representative and did not include the chief executives of all of the Trusts involved. The Trust had put 2 staff forward to sit on the Clinical Group. CS added that at a Cancer Network meeting she had attended, it was reported that all Trusts had signed up and that the Alliance would start operating in the third week of September. CS asked whether the Board approved RBHFT joining the London Cancer Alliance?

SRF asked what the downside was from joining?

BB said he thought the Trust should join up and deal with the consequences. He noted that the group will influence commissioners.

TE said that the intention was to agree 5 London Thoracic Surgical Groups. He felt the Trust should be proactive. A meeting was being held after this Board between the Trust's thoracic surgeons and Imperial College Healthcare NHS Trust's single thoracic surgeon. He was hopeful that the Trust's 2 nominations on the Clinical Group would be accepted.

CS said that she recommended that the Board sign the Memorandum of Understanding.

The Board approved signing the Memorandum of Understanding.

2012/70 LETTER FROM DR PETER CARTER, CHIEF EXECUTIVE & GENERAL SECRETARY OF THE ROYAL COLLEGE OF NURSING

The Board noted the letter.

2012/71 ANY OTHER BUSINESS:

SRF introduced Gill Raikes, the new Chief Executive of the Royal Brompton & Harefield Hospitals Charity. He welcomed her on the Board's behalf.

2012/53 QUESTIONS FROM MEMBERS OF THE PUBLIC

David Potter wished the Trust well in its deliberations and subsequent actions.

Ken Appel asked for Governors to be represented on the Trust's committees. BB replied that this would be discussed at the Governors' Council meeting on 31 July 2012.

DATE OF NEXT MEETING

Wednesday 26th September 2012 at 10.30 am in the Concert Hall, Harefield Hospital.