A lifetime of specialist care

Royal Brompton & Harefield NHS
NHS Foundation Trust

Minutes of the Board of Directors meeting held on 25 November 2015 in the Concert Hall, Harefield Hospital, commencing at 10:30am

Present:	Sir Robert Finch, chairman	SRF
	Mr Robert Bell, chief executive	BB
	Pr Timothy Evans, medical director and deputy chief executive	TE
	Mr Richard Paterson, associate chief executive - finance	RP
	Mr Robert Craig, chief operating officer	RCr
	Mr Nicholas Hunt, director of service development	NH
	Ms Joy Godden, director of nursing	JG
	Mr Neil Lerner, deputy chairman and non-executive director	NL
	Dr Andrew Vallance-Owen, non-executive director	AVO
	Mr Luc Bardin, non-executive director	LB
	Mr Philip Dodd, non-executive director	PD
	Ms Kate Owen, non-executive director	KO
	Mrs Lesley-Anne Alexander, non-executive director	LAA
	Mr Richard Jones, non-executive director	RJ
	Pr Kim Fox, professor of clinical cardiology	KF
	Mr Richard Connett, director of performance and Trust secretary	RCo
By Invitation:	Ms Carol Johnson, director of human resources	CJ
	Ms Jan McGuinness, director of patient experience and transformation	JM
	Ms Joanna Smith, chief information officer	JS
	Mr Steve Williams, head of procurement	SW
	Mr Chris Japhtha, senior contracts manager	CJ
In Attendance:	Mr Anthony Lumley, corporate governance manager (minutes)	AL
	Ms Gill Raikes, CE Royal Brompton & Harefield Hospitals Charity	GR

2015/87 DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING

None.

SRF led a tribute to Professor Tim Evans (TE), whose last Board meeting this was. TE had been the Trust's Medical Director for eleven years, a period marked by moments of turbulence but through which he had always been a tower of strength. Highlighting TE's achievements SRF said he had brought order to the delivery of specialist clinical care in heart and lung disorders; been a passionate advocate of quality and patient care; been prodigious in his own work on, and for, research and as evidenced by the paper on this meeting's agenda (see minute 2015/94); had a major role on national and international fora and bodies on all aspects of medicine; appointed first as Academic Registrar and then Academic Vice President of the Royal College, and then to the post of Lead Fellow for the Future Hospitals Commission. SRF added that, to cap all this (and in his view no better person could

have been chosen), TE had been seconded to the Department of Health (DoH) as Director of Clinical Excellence.

SRF proposed, and the Board unanimously endorsed, a resolution of thanks on behalf of the Board, the Governors, the hospital, the staff and above all its patients for an extraordinary job superbly done. SRF also led the Board in wishing TE well and expressed the wish that he would keep a weather eye open for the Royal Brompton and Harefield NHS Foundation Trust (RB&HFT).

2015/88 MINUTES OF THE PREVIOUS MEETING HELD ON 28 OCTOBER 2015

The minutes were approved.

Matters arising

- Page 12 (Action Tracker)

NL asked if there was an update on the two actions which had gaps under 'Board agreed/completed' and noted that the I&T update was due to come to the Board. SRF said the I&T update would be presented at the next board meeting (27 January 2016). JG explained that the other action, providing contextual information for the Nurse Safe Staffing report, would be addressed later in this meeting (see 2015/92 Ward Nurse Staffing Review).

2015/89 REPORT FROM THE CHIEF EXECUTIVE

BB gave an oral report.

Report - Driving Innovation in the NHS: The Future of Specialist Provision in England

BB said he had circulated this paper to the Board before the meeting. Its publication today was timely with the Autumn Statement and the Spending Review (SR) announcements also being made on 25 November 2015 and the aim was to make the media aware of the place of specialist hospitals.

SRF asked whether the report's publication marked a moment when the NHS concept of 'bigger is best' and that specialist Trusts should be absorbed within the contours of larger hospitals had been superseded and the threat to RB&HFT had diminished. BB said the idea that standalone specialist Trusts should be taken over was less prominent; the emphasis was more on where specialist services might be spread too thinly across district general hospitals and teaching hospitals. Some of the units within these Trusts were now consequently under threat. The very positive change was that eleven years ago the Trust was actively campaigning to prevent the closure of Harefield Hospital (HH) and here it was today - concrete proof that this challenge had been overcome. He added that a lot of the reason for that was about what the Trust had done. The Trust had been founded with this view that there needed to be a voice about the value of specialist hospitals. In the same time span Professor Tim Briggs was now in the Department of Health (DoH), and with TE about to take up his post there, that department would now have two leaders (the other being Lord Carter) from specialist Trusts. In response to a supplementary question from SRF

about what the report says for us BB said it re-affirmed the Trust's mission and its values.

NL said the report highlighted the need to work smarter but the report had not mentioned money. Noting that Simon Stevens (SS) Chief Executive of NHS England (NHSE) talked a good deal about networks in his forward view, AVO asked what that meant for the Trust. BB said that many of the eighteen standalone specialist Trusts referred to in the report were central to the new structures and might be associated with Vanguards or Accountable Care Organisations (ACOs) in the future. For instance, the national Accountable Clinical Network for Cancer (ACNC) had been formed and was comprised of networks led by UCLH, The Christie and the Royal Marsden Hospital (RMH). There was no Vanguard for Cardiac as yet. This was where more generic collaboration came in such as that between the Trust and Liverpool Heart and Chest NHS FT. BB said Vanguards would get money but specialist collectives such as the one he described would not be funded and if anything the Trust would pay for it itself. The precursor of this agenda was the 2008 collaboration with Great Ormond Street Hospital (GOSH). BB added that the Trust was now more networked: with Chelsea and Westminster Hospital and also Southampton General Hospital and Oxford University Hospitals; and the Trust was about to become part of the Academic Health Science Centre of Imperial College London (ICL). BB added that there was no government funding for networks.

PD said he thought that the underlying theme was a warning against short termism in the face of fiscal constraints. He asked what were the next steps. BB replied that he did not see any evidence that commissioners would put in place reimbursement systems aligned with costs and that although the drivers for orthopaedics and cardiovascular services were different, the fiscal challenge was the same.

Announcement of additional funding of £3.8bn for the NHS (24 November 2015)

BB said that on 23 November 2015 he was invited along with other senior NHS executives to 10 Downing Street for a briefing by the Prime Minister and Simon Stevens (SS) in the run up to the Autumn Statement. The reality was that the additional funding (announced on 24 November a day ahead of the SR and Autumn Statement) meant very little to our Trust. This was not new money but part of the £8bn by 2020 as previously promised. The difference here was the timing. Originally it was expected the £8bn would be phased over five years but now half of the amount was to be injected in the first year. This reflected the strong influence of SS who had persuaded the government that the promise of £22bn efficiency savings could not be achieved if the additional funding was not front loaded. The PM had set out three priorities:

- The government was supportive of the national health service. They had made commitments and the NHS, unlike other public services had had not faced cuts. The priorities were integration (ACOs and Vanguards) and devolution. The Cities and Local Government Devolution Bill (the

Devolution Bill) was going through Parliament. Manchester was an area where powers were expected to be devolved. This would impact FTs which would become part of a new devolved Health Service. The government expected to see savings as a result of this policy.

- Seven day working: all services should be available every day of the week. BB said this was not a concern for the Trust as it had already taken steps to achieve this. The government's target was GPs and A&Es. The PM had said this would be funded.
- Innovation and technology: the UK was leading the world on techniques and methods. A proclamation was expected during the Autumn Statement about a dementia research institute.

BB said that, in summary, this was not extra money and all should be divested of the notion that capital monies would be made available to realise the shared vision with RMH. The NHSE sponsored project had not been considered by the Board of NHS England nor the Treasury, nor the Government.

BB said that impending industrial action by Junior Doctors was likely to go ahead and if it did it would have an impact.

NL asked how NHSE would use the front loading to invest in change rather than simply funding the deficits. BB said he thought it was all about which image the government wanted to convey. The deficit for the acute sector was currently £1.8bn and was therefore likely to be £3.6 to 4bn at the end of March 2016. As this was a 'bad news story' how this would be countered was in the government's mind. Celebrating and promoting Vanguards and ACOs was part of their answer. NL said the truth was the £4bn deficit was happening and would happen again. BB said this reflected the 'game of politics'. AVO said he agreed but, in his position, he was aware that the government had signalled that some of the change could be realised by reducing capital and that they were also looking at novel ways to raise capital. BB said the sourcing of the additional funding to be allocated now was from within the £8bn envelope, so funding for other things such as public health and medical education was likely to be reduced.

LB asked for further explanation of devolution and how it could change the practice of government. BB summarised the historical background of the NHS. The structure had evolved in a number of ways since 1948. Twenty years ago the NHS devolved to the nations (England, Scotland, Wales and Northern Ireland) and all were distinctly different. For example, in Scotland there were no hospital boards but authorities which were and part of local government. In England quasi-independent Foundation Trusts (FTs) had developed. Under the Devolution Bill – in England only – services would not be national. Services would be devolved to local government who would be in charge of the funding allocations. The Bill will enable what happened in Manchester to happen throughout England. In London local authorities (LAs) had already been making bids (BB added that he believed one from Hillingdon Council was being considered). RB&HFT was connected with two

LAs and that how this would work out was uncertain. The Devolution Bill was proceeding through the Parliamentary stages very quickly and would most likely be enacted in 2016.

LAA said that although local care was generally a good thing it might not be so good for specialist services such as at RBHFT and in ophthalmology [for the RNIB].

LB asked about the impact on specialist national / international services. BB said this underlined the importance of messaging and promoting the report on specialist provision. SRF said this signalled the end of the 'bottom up' governance favoured by former Prime Minister Tony Blair and his Health Secretary, Alan Milburn. The 'top down' governance now in vogue could lead independent FTs to diminish and disappear. BB concurred and said there would be fundamental changes to what the Trust would be and that it would be important for it to stay connected to its roots. LAA said she noted BB's views but re-emphasised that devolution was not all bad. There was a huge body of research which showed that combining health and social care would deliver a return on investment and free money for specialist services that were not devolved. The real issue was would NHSE ever give up control and how much authority do they really have.

Acknowledging the fairness and reasonableness of a comment made by LB that the Board should be asking him how they could help, BB said his rationale for reporting this item was to inform the Board so it understood what was going on and would not rely on the media for information on this subject as it was generally not the best source. He suggested that the Board could continue to discuss the Devolution Bill and what it could mean for the Trust as it went through Parliament over the next six months. He added that there was a risk of assets being transferred to local authorities and that Board members could help by being informed and prepared. SRF proposed that Devolution be the topic of a future Board Seminar, at an appropriate time.

PD said at the last Board meeting (28 October 2015) BB had said he was meeting with Cally Palmer (CP), Chief Executive from RMH and asked about the outcome. BB said they had discussed three issues:

- NHSE's process: they had both agreed this was not going anywhere and they had agreed to write jointly to Anne Rainsberry (AR), NHSE's Regional Director for London, about this. However, this agreed action had been superseded by events and a joint meeting with AR had been scheduled for 4 December 2015.
- CP had agreed to write a letter in support of RB&HFTs objection to Crossrail 2's plan for a station entrance on the Chelsea Farmers Market and this subject would be discussed at the next meeting of the Redevelopment Advisory Steering Group to be held on 9 December 2015.
- RB&HFT's previous offer for a Board-to-board seminar to look at the future and a possible merger: BB said he had not heard anything further

from CP. SRF reported that RMH's Chairman, Ian Molson (IM), had informed him that he had written to the Royal Borough of Kensington and Chelsea. SRF said he then wrote to IM thanking him for Crossrail 2 support and that the Trust welcomed CP's commitment that she would make no objections to the creation of a new facility next to the Sydney Wing. SRF added that, last week, he had raised the question of the Board-to-Board meeting with IM suggesting that five board members from each Trust attend. To date he had not received a response.

2015/90 CLINICAL QUALITY REPORT FOR MONTH 7: OCTOBER 2015

RCo said the significant highlights of the report were:

Monitor Risk Assessment Framework:

- *Clostridium Difficile*: 3 cases in M7, 19 Year to date (YTD). The most recent review of 9 cases had concluded that none were due to lapse in care which left 10 awaiting review.
- 18 Weeks Referral to Treatment (RTT) Incomplete: for M7 the target had been met at 92.1% (threshold being 92%).
- Cancer 62-day wait for cancer first treatment: performance was not met (41.67% against the threshold of 85%).

To steer Board members through the complexity of reporting on the cancer wait indicator, and to inform them of potential changes in reporting, RCo went through the two main sections of the Clinical Quality Report (Monitor/Provider Licence and NHS Standard Contract) relating to the 62 day cancer target in detail.

- Monitor: each patient was numerated as 0.5 and shared by the two providers. Under Monitor's protocol the breach was wholly reallocated back to the referring Trust when the breach reallocation request from our Trust's CE was agreed by the referring trust. This was reconciled after Open Exeter publication and then reported to the Board. The data presented in the Clinical Quality report was reviewed by Deloitte LLP, the Trust's external auditors, to ensure that the Board was correctly informed.
- NHS Contract (Commissioners): no breach reallocation 19 people were treated during M7 so the table showed 9.5, each patient counting as 0.5 at the treating Trust (RBHFT), and 0.5 at the referring trust.

In both sections adjusted performance for M7 (Q3 to date) was 42.1% because no breach reallocation requests have yet been agreed.

RCo set out the discussions in progress between regulators and commissioners about the most appropriate way to measure waiting-times for Cancer patients. There was currently no agreement and the discussions were continuing.

RCo then gave further details of the national 'summit' to be convened by Monitor on 10 December 2015, at which the Trust has been invited to present. The Christie Hospital, RMH and Guy's and St Thomas' NHSFT had also been invited. RB&HFT would be represented by Andrew Menzies-Gow,

Director of the Lung Division, Niall McGonigle, Consultant Thoracic Surgeon at HH, John Pearcey, Cancer Manager and RCo.

While SRF thought the proposed new reporting arrangement might appear crude, NL said he thought it would be better than where we are now. In response to questions from RJ, RCo said that where breaches were reallocated to referring trusts, he hoped this would be done on the basis of the national protocol rather than requiring the writing of letters as at present.

RCr described the twists and turns of the external reporting requirements, which RCo had set out, as 'Kafka-esque' and, as Board members had previously acknowledged, sometimes a distraction from the experience of patients awaiting diagnosis and treatment. In that regard, he reported that the Lung Division had reviewed the referrals of patients with cancer received since April 2015. Assessing waiting-times was not straightforward, as patients' conditions and readiness for surgery on referral varied widely. However, an assessment with NHS England suggested that 16 of the 85 patients accepted for surgery (across both hospitals) since April had suffered an unnecessary delay in the Trust prior to their operation. The data underpinning this assessment was becoming more consistent and accessible and would be in routine use in future.

LAA welcomed this understanding, and encouraged the Trust to remain open in acknowledging its own shortcomings. She sought assurance that the 16 patients would be raised at the forthcoming 'summit' meeting and that we should be open about any who had died (although it was noted that all of these patients had still undergone surgery, and so their prognosis was not necessarily poor; a greater concern were those patients who were considered inoperable on referral).

TE sought to provide assurance in two ways: firstly, it would definitely be raised at the meeting and the Trust's staff would openly present the current position; and secondly, he had asked Drs Pallav Shah and Sanjay Popat to revisit their original report in January 2016 and provide a frank assessment of the Trust's progress. On a separate matter, he added that if the Junior Doctors' industrial action went ahead, cancer operations would be prioritised. PD asked why there were only comments against 3 of the 11 patients in the table of breaches from specified referring Trusts.

LB said he supported LAA's comments on 'people' (i.e. the patients). He asked how the risk of legal liability could be averted. BB said that, in spite of the reporting flaws for which the Trust was not culpable, the Trust did what needed to be done in order to comply. The Board was more focused on what could be done to bring down the numbers of patients who breach the target. BB added that TE and his team were very determined to ensure patients were treated when needed, and there were improvements in the cycle of when a patient was seen. Liability did come up and there were complaints relating to harm/death though he was not aware of any litigation relating to the cancer targets. (TE confirmed this was correct).

AVO (in response to PD) said the Risk and Safety Committee had full discussions of cancer performance and it was agreed that this would be the appropriate committee to look at the details of individual patients cases.

The Board noted the report.

2015/91 FINANCIAL PERFORMANCE REPORT FOR MONTH 07: OCTOBER 2015

RP reported the following performance for M07:

- I&E account: the Trust had planned for a surplus of £1.5m. The actual position was a deficit of £1.2m, £2.7m worse than plan. The principal cause was capital donations being £2.1 adverse due to the timing of the receipt (most having been received in prior months). Year to date (YTD), the plan had been for a deficit of £7.0m but the actual position was a deficit of £7.7m, which was £0.7m worse than plan. Of that £700k, £500k was due to a shortfall in capital donations. Revenue (total of NHS clinical income and Private Patient income) was ahead of plan, but costs (Pay and Non Pay) were adverse to plan**.** EBITDA (Earnings before Interest, Taxes, Depreciation and Amortization), was also behind plan (£0.8 adverse YTD). This indicator was a more focused assessment of the strength of the Trust's underlying financial performance as it was under our control. RP added that, overall, I&E performance was slightly disappointing but was not a major concern given typical monthly fluctuations.
- FSP (Financial Stability Plan) and CIPs (Cost Improvement Programmes): the Trust was delivering 80% of planned savings. The current forecast was to achieve 90% of planned savings by end of year. In particular there had been some traction on procurement savings and the Board would hear of this separately (see minute 2015/93).
- Balance sheet: cash was below plan primarily as a result of the £5m drawdown of the ITFF loans planned for October 2015 now taking place in November.
- Balance sheet: capex was £2m behind plan. Immediately following the last Board meeting the report to Monitor on expected capex outturn for 2015/16 was amended as the ability to fall within Monitor's 15% tolerance was on the cusp. The principal cause of the shortfall had been the delay in obtaining planning permission at Harefield Hospital although the pre-conditions had now been satisfied.

In response to a query from SRF on whether he had anything to report about the how the budget for 2016/17 would be set, RP said he could not give any indications until the Trust had visibility on the tariff (not expected until mid-January 2016) and more information on specialist top ups. News on the latter was better – there was some indicative comfort for the Trust as the cardiac and respiratory top ups had been introduced. However, as this money would be taken from the overall funding pot, all Trusts would get a bit less tariff income while we got a bit more top up. In short, what was being given by the right hand was being taken away by the left – there was

also a new proposal for marginal rates on specialist services paying only 50% to 60% of tariff above an undetermined baseline. RP concluded that, as it was also not known whether a block contract for the Trust would operate again, the picture overall was extremely confused. NH said he had recently attended a meeting with NHSE which confirmed that the Trust would know better following the tariff publication to be followed by the standard two week consultation period. There was a general expectation that next year would be another 'fudge' and the whole issue of settled tariff delayed until 2017/18. He concurred with RP's analysis though in relation to top ups a modicum of optimism could be allowed.

KO asked to what extent the shortfall in charity donations was due to delays. RP confirmed this was indeed a timing issue but he added that the Trust did not receive this income until the related capital expenditure had been incurred. That said, given some of the capex delays the Trust was unlikely to achieve all the planned capital donations by 31 March 2016 but this would be caught up next year.

PD asked if the timetable for the opening of the PP outpatient / diagnostic facility at Wimpole Street was unchanged. RP said it was on track to open in April next year but the costs associated with its setup would have some impact this year. Even when open for business there would be some months needed to ramp up operations to full activity.

AVO asked if the project to realise income streams in the Middle East was progressing as planned. BB said the Trust's Private Patients Manager and Director of Planning and Strategy were in Kuwait now and the Trust was moving forward with the plan that a three year management contract of between £95-98m would likely be delivered in the next fiscal year.

The Board noted the report.

2015/92 <u>WARD NURSE STAFFING REVIEW</u>

JG introduced a report that provided background and detail to the high level nurse fill rate data provided in the monthly performance reports. The key area of enquiry related to the apparently lower fill rates for non-registered nurses on both sites. The report confirmed that the actual numbers involved were relatively small, and that absence was unlikely to be filled like for like in this staff group. Section 4 of the report set out the areas to probe. The table illustrated that in a comparison of planned versus actual hours the Trust was actually using more than expected. She added that the ratio of registered to non-registered was high and that the levels of agency nurse hours was relatively low at 10% of the overall nursing hours. Finally the analysis of planned verses actual hours for each area demonstrated that while some were higher and some lower there were no standout areas of concern. Moreover, staff moved between areas at short notice to meet additional short term requirements. JG said that, in summary, staffing levels were safe in this Trust but that this was a baseline, and that we are focussed on delivering high quality care.

SRF asked if she was confident that staffing levels were safe and the Trust would be able to recruit those needed broadly in line with the government's interdiction of 9%. JG said she was confident about safety levels but that the growing recruitment pressures were a concern, and that a broad strategy for recruitment had been developed.

NL commended the report. He asked if a snap shot could be given of the immediate impact of the new agency rate 'caps' which came into force on 23 November. JG acknowledged that this could be a problem for us. RCr said that while it was too early to measure the impact, an additional constraint which had commenced in October 2015 on the use of 'off-framework' agency nursing staff, could have an effect. To a large extent, rarer, higher-skilled nursing staff were with 'off-framework' (unapproved) agencies which generally paid better rates. The Trust had to use some of these to maintain safe levels of care. The Trust now had to report all instances when the financial 'cap' was exceeded or 'off-framework agencies used. RCr added that the rules did not strictly apply to RB&HFT. However, the language governing the new arrangements was strongly worded to encourage compliance and threatened regulatory intervention for material 'breaches'.

RJ agreed that this was a helpful report. He suggested that it was repeated quarterly. He noted that planned verses actual hours showed that more staff hours were being filled than planned and this presumably was an overspend. He asked what was the cause of this overstaffing. JG said that this was usually triggered by the variability of patient acuity and the mechanism for booking additional staff was tightly managed – the use of these staff was only sanctioned when moving staff across clinical areas could not be achieved.

AVO also commended the report which had raised the right questions. He had been hearing outside about minimum standards but RB&HFT was not a minimum standard organisation.

The Board noted the report.

2015/93 PROCUREMENT PRESENTATION

RP explained that this item was included on the agenda for the following reasons: firstly, as it was recommended by the Audit Committee who had noted that a presentation on this topic had not been received for some years; secondly, as a discussion would be timely following the publication of the interim report, Review of Operational Productivity in NHS Providers by Lord Carter (and with the final report due to be released shortly); and thirdly, Monitor's and our own internal focus on procurement and cost savings. He introduced Steve Williams (SW) and Chris Japhtha (CJ) who then delivered the presentation. The Chairman and Non-Executive Directors asked them questions and received the following replies (with comments added by Directors):

- what efforts were being made across hospitals: the LPP (the London Procurement Partnership) helped deliver and manage that – for example the national cardiothoracic framework (NCF). The first stage was about as much as possible, stage two about leveraging. At local level, through the LPP, the Trust was trying to get requirements and doing that with SFM (soft facilities management, 'soft' being services such as catering, cleaning, security, mailroom, and health and safety, as opposed to 'hard facilities' typically building fabric, electricals and fire).

- noting that good collaboration with clinicians was behind recent procurement activity at the Trust, how were decisions being made: citing the example of the medical devices contract SW said this was the biggest single commodity expenditure of the Trust's. The optimal level of engagement was achieved through the NCF. The LPP were then asked to model reductions. Divisional directors cascaded options to sub specialties and mandated them to make decisions on options. RCr added that this was part of the Trust's FSP. If the procurement mechanism showed that a saving, of for example £0.25m, could be made and the clinicians then chose not to follow it, they would have to justify that decision and find another way of delivering the same value. TE concurred and said that SW and CJ were invited to clinical directors' meetings and the decision making was indeed clinically led.

- with 30% of stents in London being put in at this Trust, was the Trust doing a lot of angioplasty, or were more stents being inserted in each patient suggesting that clinicians' practice needed to be reviewed: TE said, in his new position at DoH, he would be looking at that and cardiology was one of the top five areas that would be examined. BB said that seven years ago the figure was 50% and as it was now 30%, so things had 'improved'.

- taking all commodities into consideration what was the sweet spot and maximum potential savings if these were applied to all categories. SW said that he thought that somewhere between 5% and 10% of the £50m suitable for competitive tendering could be saved.

On behalf of the Board SRF thanked SW and CJ for their presentation.

2015/94 <u>RESEARCH STRATEGY REVIEW</u>

Introducing the report TE said as outgoing Director of Research this paper had been produced to provide a review of progress against the 2012-15 Strategy's goals. The Research Management Committee believed the Trust had done well against the targets and thought that a strategy should be developed for 2016-20. It was an appropriate moment to think about the themes of a future strategy as the competition for the next BRU designation was due to be announced on 26 November 2015 and the Spending Review should indicate how much money was available. A short report by the Translational Review Group (October 2015) had been included in this paper. This had recommended that the Trust re-apply for two separate

BRUs. Annex 3 of the Research Strategy Review encapsulated what it was hoped could be achieved if these applications were successful.

SRF asked TE if he agreed that research and innovation was crucial to the Trust. TE said this was absolutely true and that the Trust was seen as a leader in bed to bench research, which was of equal importance to bench to bedside research.

KF agreed research was essential for this Trust in the sense of world leadership and new techniques and TE had done a remarkable job as head of the Research Committee. With limited resources at its disposal the Trust had expanded the research basis and the number of people involved in research, and had encouraged young people. KF added that TE's role was an important one and he would be missed. He asked about the arrangements for his replacement. BB said that it had been an unusual arrangement to have a combined Medical Director and Director of Research and that going forwards these would be separate appointments. Professor John Pepper would be acting as the new Interim Director of Research whilst a substantive appointment to this post was made. BB added that since 2006 the Trust had subsidised research activity and appointments at Imperial College and that the Trust also had every intention of continuing the mission of the organisation. KF acknowledged the Trust's commitment to research and the support of the Charity.

The Board noted the report.

2015/95 RECOMMENDATIONS OF ADVISORY APPOINTMENTS COMMITTEE

The Board were presented with one ratification form for the appointment of consultant medical staff by AVO for a Consultant in Nuclear Medicine or Radionuclide Radiology. The Board ratified the appointment of Dr Georgia Keramida as Consultant in Nuclear Medicine or Radionuclide Radiology.

2015/96 ANY OTHER BUSINESS

a) NL said the Trust was due to have an external review of governance in 2016. He noted that a self-review had been undertaken since the last external review and asked what the process would be for agreeing the next external review. SRF said that a plan would be drawn up early in the New Year and that RCo should bring a paper to the next Board meeting (27 January 2016), taking into account the need to ensure value for money.
b) BB reported that Dr Richard Grocott-Mason (RGM), the divisional director of the heart division, had been appointed as Interim Medical Director and Responsible Officer. A search to recruit a substantive Medical Director was likely to take several months. RGM would be part of the senior management team for the next six to twelve months. KO said she was very pleased to have him on board. BB noted that RGM's appointment was the first time the Medical Director had come from HH.

(NL left the meeting).

c) Junior Doctors: RCr said the BMA was planning industrial action for medical staff-in-training over three days: Tuesday 1 December (emergency cover only for 24 hours) and 8 and 16 December (no cover from 8am to 5pm). Preparatory work had been done and RCr said the Board could be assured there would be safe services on the 1 December, with senior consultant medical staff available. The level of support that could be provided on the 8 and 16 December was not yet known but he remained confident that cover would be adequate and an appropriate level of safe services provided. The impact of the strikes was likely to be in the form of a reduction in some outpatient services and theatre and cath lab lists. All emergency and urgent patients would be dealt with. TE confirmed that comprehensive plans were in place.
d) RP asked that the Board consider the funding for the proposed replacement of three CMR scanners. A business case for these had been endorsed by the Management Committee but as they were expected to be acquired via finance leases (albeit still under negotiation) this would constitute new debt requiring Board approval. The timing meant that the related paperwork could not be produced for this meeting and the next Board meeting would probably be too late. The Board agreed that the paper/s could be submitted electronically to each member for approval.
e) RP reported that Monitor had asked to attend the next (January) Board meeting. This was agreed and noted.

2015/97 QUESTIONS FROM MEMBERS OF THE PUBLIC

Mike Gordon (MG) asked for an update on redevelopment.

SRF said a proposal for a smaller but none the less very important inpatient lung facility was being prepared and the Royal Borough would be approached for planning consent. A final version of the proposal would be considered by the Board. He added that there was 'good news' to report vis-à-vis HH. The London Borough of Hillingdon had now discharged the conditions attached to the planning permission. RCr said work on the Imaging Centre and adult critical care facility should commence on-site before Christmas 2015.

Kenneth Appel (KA) passed on his best wishes to TE and gave him thanks on behalf of Rebeat that HH was still here today. The threat had been very severe and TE's contribution was crucial. He asked when would the Pavilion at HH be re-opening. NH replied and said it was re-opening on 26 November 2015.

Noting that 20% of hired nurses filled the nurse staffing hours KA asked what was being done to minimise that.

KA also asked if using beds in other departments would help reduce cancelled operations. JG said there was an on-going recruitment programme, albeit in difficult circumstances, to keep staff shortages to a

minimum. RCr said that any cancelled operation was distressing for the patient affected, but he could assure KA that the Trust was using every available bed before cancellation was considered. What was seen was a consequence of demand for the Trust's services and what was a fair aim was to eradicate avoidable cancellations so that only the unavoidable cancellations remained.

KA said he was stepping down from the Infection Control Committee whose workload was prodigious coupled with immense attention to detail. His only criticism was that the sound system for teleconferencing between the two sites was poor.

SRF commended KA for his fantastic passion and on behalf of the Board extended its thanks to him.

NEXT MEETING Wednesday 27 January 2015 at 2pm, Board Room, Royal Brompton Hospital