Royal Brompton & Harefield NHS
NHS Foundation Trust

Minutes of the Board of Directors meeting held on 25th September 2013 in the Concert Hall, Harefield Hospital, commencing at 10.30 am

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
	Pr Kim Fox, Prof of Clinical Cardiology	KF
	Mrs Jenny Hill, Senior Independent Director	JH
	Mr Neil Lerner, Deputy Chairman & Non-Executive Director	NL
	Mr Richard Paterson, Associate Chief Executive - Finance	RP
	Dr Caroline Shuldham, Director of Nursing & Clinical Governance	CS
	Mr Richard Hunting, Non-Executive Director	RH
	Ms Kate Owen, Non-Executive Director	KO
	Mrs Lesley-Anne Alexander, Non-Executive Director	LAA
	Dr Andrew Vallance-Owen, Non-Executive Director	AVO
	Mr Richard Connett, Director of Performance & Trust Secretary	RCo
By Invitation:	Ms Joanna Axon, Director of Capital Projects and Development	JA
	Mr Richard Goodman, Director of Pharmacy	RG
	Ms Carol Johnson, Director of Human Resources	CJ
	Ms Jo Thomas, Director of Communications & Public Affairs	JT
	Mr Nick Hunt, Director of Service Development	NH
	Mr Piers McCleery, Director of Planning & Strategy	PM
In Attendance:	Mr Anthony Lumley, Corporate Governance Manager (minutes)	AL

2013/66 WELCOME

On behalf of the Board, the Governors and staff of the Trust, SRF expressed huge thanks to Jenny Hill whose last Board meeting this was. JH had carried out a long tour of duty as a Non-Executive Director, latterly as the Senior Independent Director. On a personal note SRF added that JH had been a major source of advice for him.

2013/67 DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING

SRF declared an interest in relation to Report of the Chief Executive - Offsite Private Patients Outpatients Facilities (Agenda Item 2013/70). TE also declared an interest in the same item.

2013/68 CHANGING THE WAY WE THINK ABOUT OTHERS – BARBARA'S STORY

CS introduced a recording of Barbara's story, a film made by Guy's and St Thomas' NHS Foundation Trust and sent to Dr Kelleher at the Trust. Viewings had been arranged for staff in both sites as the film was seen as a way of looking at how some patients experienced care provided by the NHS. The film followed a patient with dementia through an outpatient appointment. Ostensibly about raising interest in dementia, CS felt the film was translatable to general experience in an acute Trust.

There followed a discussion and comments were made by Board members.

JH asked what were the key improvements suggested by staff to the facilitators and what was being done to embed these? CS said staff comments had not been collated yet but an example is that a team had chosen to do a good deed of the day and keep a record. It was about changing the climate and thinking.

SRF said lessons from the film clearly applied not just to patients with dementia and he had noted that it was also about the importance of courtesy. In reply to a question from SRF about what practical steps could now be taken CS said these would become more apparent over time.

2013/69 MINUTES OF THE PREVIOUS MEETINGS HELD ON 24 JULY 2013

The minutes of the meetings were approved.

2013/70 REPORT FROM THE CHIEF EXECUTIVE

BB gave verbal updates on the following items.

Redevelopment of Chelsea Campus

BB said the first step of this process was obtaining planning consent to reach a position where the Trust understands the capital values of the estate (on the Chelsea campus) and what are the calibrated visions for developing the Royal Brompton Hospital (RBH) and Harefield Hospital (HH) sites. Discussions with the Royal Borough of Kensington and Chelsea (RBKC) had led to the signing of a Planning Performance Agreement (PPA) to produce a supplementary Planning Document (SPD) The aim is to optimise the value of the estate. The SPD had been suggested by RBKC and the process should be completed by the second quarter of 2014. This was being led by RBKC and paid for by the Trust. Local consultation would be part of this. BB added that once SPD was passed, the Trust will be able to submit detailed planning applications for the estate. The Trust will only be a developer of the RBH estate. Our advisors hoped that the Trust would have planning consents by spring 2015. The Trust would be paying RBKC £200k for the PPA and the level of application fees for planning consent was expected to be around £8m. This covered the retention of a miscellany of planners, architects, estate planners and consultants on trees and heritage. The intention was to optimise values and recover costs through disposal of the estate. The project would be run and managed by EC Harris who would assign a full time project manager. It would be managed as a delivery project (i.e. with the expectation that it will be realised). Questions about what kind of hospital would at this stage be aspirational as the focus was on planning consents.

RH said he appreciated that all the Trust's efforts would be focused on obtaining planning consents but the Trust must be thinking about what it needs to build as a parallel exercise. BB said the Trust should not get ahead of itself or raise its ambitions beyond its financial capabilities. Over the next period, in meetings and discussions, the Trust should learn about

what are other modern hospitals are like and not become too absorbed about who has what space.

LAA asked, given that the design of a new hospital should be the priority, what was the thinking around consulting with staff and patients on their views on the principles? BB said stakeholder engagements with staff and patients would be part of the SPD this autumn led by RBKC. Then, when the Trust submits a planning application it will run its own stakeholder events to look at planning priorities.

JH asked if other strategies would be constrained by the new build such as the IT strategy and the whether the Board should test the IT enablement strategy in parallel with this process? BB said IT enablement was in parallel to this process and clinical leadership would be engaged in the possibilities of technology.

AVO asked what were the lines of business strategies for Private Patients (PP) that would have a bearing on design and build? BB said if private healthcare and other issues such as location of paediatric services were resolved in a timely manner then they would have a bearing. This meant all the strategies were moving together and not separately (as might be the perception).

NL noted the interaction between planning consent discussions and certainty regarding proceeds of disposal. The amount the Trust will receive would be uncertain until the sale of all the non hospital use lands had been completed. However the more the Trust understood the nature of consents that it could obtain, the more certainty there would be. He asked where in the timescale it could expect to find out what the proceeds are likely to be and factor these into the plans for the redevelopment of the hospital? In response BB said that over the last 2 years the Trust had been involved in exercises around hospital design against a background of not knowing what was expected from sales. The planning gain issue had a policy level set at 50%, although the Trust had looked at models including 50%, 20% and lower. The SPD is premised on a goal of 0% affordable housing as the Trust is working with RBKC to put forward a case that it is a public hospital and all the money realised will be put into a public hospital. What kind of consent achieved will emerge through the SPD. BB reminded the Board of the time factors: spring 2014 – completion of SPD; spring 2015 – planning consent obtained. In that year the Trust will gain a more precise understanding. This will result in an informed view on proceeds. BB added that depending on the amount of planning gain there could be a variation of up to £100m in the amount that could be reinvested back into hospital facilities.

NL queried the nature of the engagement during the period from Spring 2014 to Spring 2015 with those responsible for planning models of future service provision. BB said the Trust should develop these aspects in line with the planning consent strategy. NL said he was pleased to see that the

team was currently focussed entirely on planning consent issues. BB said on-going projects for development such as ICU at HH and the campaign for hybrid theatre at RBH were likely to happen sometime before the rebuild of RBH.

SRF said the Property Committee had looked in detail at how does the Trust get to where it wants to be in by the spring of 2014 including the question of which consultants to involve. A report assessing the direction and what has been achieved to date would be presented to the Board in late 2013 or early 2014.

NL said he was confident that the £8/9m in fees would comfortably be recovered in the planning gain. BB said this was public money and the Trust was open and accountable. The issue was under control.

NHS England – Review of Congenital Heart Disease Services

BB said the Safe & Sustainable (S&S) process that was focused on the reconfiguration of Paediatric Cardiac Surgery was over. In July 2013 NHS England informed the Secretary of State that they will now embark on a new process which will focus on Congenital Heart Disease Services for both Adults and Children as a new exercise to replace the defunct S&S process. The Trust's position had always been that it supported this broader focus on congenital heart disease. BB added that beyond this nothing concrete had happened except a statement on NHS England's website that they will be open and consultative. BB invited RCr to update the Board as he chairs the Trust's group that monitors this issue.

RCr said little had happened since the end of July but noted two points: firstly, Prof Sir Malcolm Grant, Chair of NHS England, had said an implementable solution would be delivered within a year; and secondly he had said NHS England want to develop a proposition for debate by autumn of this year. In order to set about this processes had been put in place. A Clinical Advisory Group chaired by Sir Michael Rawlins (former Chair of NICE) would be working alongside Bruce Keogh, NHS England's Medical Director. However, it was unclear how this structure would work. RCr said he would be keeping a weather eye on the issue.

SRF asked if the Trust was sufficiently protected from the dangers and could ensure it would not be excluded from meeting groups as had happened during S&S? RCr said he could not guarantee that the Trust would be included. However he believed there was some recognition on the part of NHS England of the issues and faults of the S&S process. Malcolm Grant's letter had emphasised the need to do engagement and involvement in a better way. RCr added that the Trust would continue to seek involvement in the new processes. For instance, the Trust had nominated a paediatric cardiologist to chair a new Congenital Heart Disease Group under a Children's Clinical Strategy Group for NHS England (London).

NL said he was surprised at the timescale in MG's letter which appeared neither practical nor in the government's interest. RCr and BB agreed, and referred to a commitment made at the time of the Secretary of State's announcement in June 2013, which appeared to tie NHS England to a 12-month timetable. RCr added that NHS England had stated that they are committed to a single service commissioned nationally, and that it does not want 'winners and losers'.

KO asked if the Trust should be more active in its participation? BB agreed and said the Trust must ensure it is not acting as outsiders. He felt that there is more awareness now that the Trust will robustly defend its services. TE concurred with this summary. The Trust had been actively recruiting paediatric consultants. Two senior appointment would shortly be made and the candidates were well known and from overseas.

AVO said some Board members know and encounter the people involved quite often and asked if Board members could have briefs to support them in these discussions, so the Trust could make effective use of Board members' time? BB welcomed this contribution.

Collaboration with Chelsea and Westminster Hospital NHS Foundation Trust (C&W) on Paediatrics

BB said this issue was linked to the Review of Congenital Heart Disease Services. As previously reported the Trust had been examining the feasibility of joining its paediatric services with those of C&W. In spite of a high degree of engagement at Board, medical and management levels the Trust had been frustrated by the slow speed of C&W's involvement. A meeting between the Trust and C&W Executives had taken place on 19 September 2013. Agreement was reached to proceed subject to C&W completing an internal planning exercise by the end of quarter one of 2014 to determine the feasibility of locating such a centre on its hospital premises. BB added that the timing of this was linked to the SPD process as described in the first item in his report (which was due to be complete at the same time).

RP said he concurred with BB's summary. The ball was in C&W's court.

KO asked BB if he was optimistic about progress being made? BB said he was and it could be done. His advice to C&W had been that they adopt the SPD process the Trust was pursuing.

NL asked who from C&W was leading the project? BB said Tony Bell, Chief Executive Officer of C&W had assigned it to his Chief Financial Officer. BB added that at the recent meeting he had made (a number of) points which had been well received by C&W. In previous meetings with C&W it had been apparent they had a number of other organisational objectives which competing for management time with the proposed collaboration with the Trust. It now appeared that this issue of prioritisation might be sorting itself

out and C&W were working to a timescale that should be acceptable to RB&HFT's Board.

SRF noted that C&W were showing a willingness to do something and there was also a lack of suspicion between the Trusts. RP agreed and added that Tony Bell liked the concept. He also agreed with BB that C&W now believe they can make a decision in isolation of other C&W priorities.

Visit by Robert Francis QC to Harefield Scharwtz Rounds
BB said Robert Francis QC, author of the report into the care provided by Mid Staffordshire NHS Foundation Trust, had visited HH and had observed a Schwartz Round. It appeared he had been very impressed and subsequently he had written a complementary letter to the Trust.

Invited by BB to give more detail CS described the background to Schwartz Rounds and what they entailed. They had been introduced from the US in a pilot by the King's Fund (KF). Rounds provide staff with the opportunity to examine the psychological, social and emotional aspects of healthcare. Since then the Point of Care Foundation has been established to continue this work and it was in his capacity as a Trustee of the Foundation that Robert Francis had made his visit.

Schwartz Rounds are about the experience of care and about how staff feel. The Trust had a good relationship with the KF in relation to the Rounds. In his letter Mr Francis had referred to an 'uplifting experience' and the 'courage and candour (of the staff)' and had noted the emphasis on emotional content. CS said it had been decided not to let the audience know RF was attending though the presenters had been told that he was.

In response to a question from SRF who had asked if the Rounds were case studies around individual patients, CS said they were not about the successes and failure of care but about how much staff felt about the care. The experience was more exploratory rather than 'how do we mend this?'. BB said it was about creating a 'culture' where it was good to talk and allowing staff to feel it's perfectly normal to feel good or bad.

CS said the National Institute for Health Research (NIHR) had made a call for research applications in response to the Francis Inquiry. Schwartz Rounds were one of the possible areas for study identified. A team led by Kings College Nursing Research Unit had led the application to evaluate Schwartz Rounds: staff from the Trust including John Pepper, Consultant Cardiac Surgeon, and CS had collaborated in this.

LAA asked if patients were present at Schwartz Rounds? CS said in only one instance had a patient been included who was also the mother of a patient. This changed the nature of the discussion and generally the Rounds are for staff only so they can discuss the challenges for them.

BB proposed that NEDs are invited to attend Schwartz Rounds. SRF also expressed a wish to attend. It was agreed this should happen and dates will be circulated.

Offsite Private Patients (PP) Outpatients Facilities

BB said the Trust was currently engaged in discussions to expand its PP outpatients facilities by leasing new clinical space in the West End in proximity of Harley Street. Between 20 to 30 consultants had made pledges to take up space.

KO asked if this would be brought back to the Board to discuss? SRF said the Finance Committee had been examining financial projections in depth.

2013/70 INSTITUTE OF CARDIOVASCULAR MEDICINE & SCIENCE COLLABORATION (ICMS) UPDATE

KF gave a verbal update on the ICMS, a not for profit company involving the Liverpool Heart & Chest Hospital (LHCH) and the Royal Brompton & Harefield Hospital NHS Foundation Trust (RB&HFT) with Imperial College (IC) as the academic partner. A written report would be presented to the Board when a full business plan has been prepared. The ICMS is now 2 years old and will be holding its second meeting in October 2013. Currently there are 21 PhDs, 16 from this Trust and 5 from LHCH. Professor Peter Weissberg, Medical Director from British Heart Foundation would be coming to the meeting to present a prize for the best PhD. KF added that the ICMS had started with international mentors; these are now part time employees of IC based at RBH they would be given Trust honorary contracts and will be attending the forthcoming meeting.

KF said academically the ICMS had exceeded in what it set out to achieve though, to date, not enough use had been made of the huge joint clinical base. However, the partnership had improved RBH's position in the world. The world's leading cardiology centre was now in Europe. The MSC course in nursing, run out of RBH, was a good example of collaborative work. Also genetics was developing as a collaborative project. Each Trust had contributed £50k. £70K was left but the intention was to present a business plan in the spring of 2014 where further funding is likely to be requested.

NL asked if it would be correct to summarize the joint venture as having shown that extracting synergies was more challenging than putting the mechanics of a joint venture into place? KF said this was correct. BB said the symbolic value of the partnership enabled the Trust to claim it had national reach and was not isolated. As this joint venture would be a test bed for future exercises it was important to learn from the experience.

2013/71 CLINICAL QUALITY REPORT FOR MONTH 5: AUGUST 2013

Presenting the report RCo highlighted the following:

Monitor's Compliance Framework (CF):

- The position at month 2 of Q2 was that all CF targets had been met and the forecast for Q2 2013/14 was a Green governance rating, although RCo noted that this would be dependent upon performance for September this being the final month of Q2.
- There were 2 cases of *Clostridium difficile* in August 2013, 1 of which was attributable to the Trust making 5 in total for the Year to Date (YTD) – on track to remain within the Monitor de minimis of 12 for the year. (NL said he would like on behalf of all of the Board to express his approbation of this and thank all the staff who had worked hard to achieve the reduction which had not been an easy task. Board members concurred with this statement).
- The 62 Day Cancer target had been met. Currently, 7 requests for breach repatriations have been made, 3 of which had been agreed. RCo said the Trust was yet to hear about the other 4 but 3 to date meant the target was just on track.
- Care Quality Commission (CQC): an unannounced inspection of RBH had taken place on 13 and 14 August 2013. A CQC team of 8 had gone round all the wards. On the second day 2 members of their team had interviewed 2 executive directors and 3 NEDs. In particular CQC had looked at whether or not the Trust was well led, which was a significant new area within the inspection regime. One of the CQC team was an 'expert by experience' (that is an inspector who has had first-hand experience of receiving care). The expert had been told by a patient that RBH was 'the best hospital in England'. RCo said it was expected that the final report would shortly be published on CQC's website. He suggested that when this happened copies are sent to all Board members. This was agreed.

Clinical Outcomes

- Hospital Standardised Mortality Rates (HSMR):this was 115.43, which is above the national benchmark for this indicator. TE said this was an area of concern. The key procedure and diagnoses codes making up the score tend to indicate that the drivers for this result might be within cardiac services at HH. TE added that HSMR scoring was dependent on the coding of causes of death and that patients coded as receiving palliative care were excluded from the Dr Foster analysis. He noted that the Trust did not code any patients as receiving palliative care, unlike other organisations. TE said this was a surprising variance in coding practices and the reasons were not clear at the present time. Further exploration was required and a full report would be made to the Risk and Safety Committee when it met in October. TE also said that Prof Sir Mike Richards, the CQC Chief Inspector of Hospitals, had written to him about the metrics for measuring mortality in specialist hospitals and TE had agreed to help with the exploration of this subject at national level.

AV said this statistic was in the public domain and this discussion attested to the openness of the Trust on this question. NL said the Board could be comforted by the way that this issue had been brought to the RSC by the executive proactively.

Incidents:

- Safety SI's (Serious Incidents): 1 SI (a Grade 3 Pressure Ulcer) was reported in July and 1 in August (a deep sternal wound infection following aortic arch replacement surgery).

NHS Standard Contract:

- 18 Weeks 'Admitted' pathways: the 90% target was reported to have been failed at the 'other' national specialty level (88.9%), although there had been an improving trend over the period from April to August.
- 18 RTT by National Speciality – Incomplete Pathways: the 92% target had failed at the 'other' national specialty level (90.66%). RCo said important work to address this through improved validation was in hand.
- Complaints: this section now included more information as requested by Commissioners, specifically details of complaint categories.

Friends and Family Test (FFT)

- The first national benchmarking of FFT data had been published at the end of July covering the quarter one 2013/14 period. Based on the Net Promoter Score (NPS) the Trust had been placed as the 3rd highest in London and 11th in the country.
- Current Month Reporting: the overall NPS for the Trust for August was 87 with a response rate of 20.4% which is more than the required minimum (15%).

RH noted that that the NPS from the national figures for HH was much higher than that recorded for RBH. CS said the difference could partly be ascribed to the number of responses collected (i.e. in general more had been collected at RBH than HH) – the more responses collected the lower the score. In other words smaller numbers may not have picked up the very small number of patients who were dissatisfied. She added that there was currently a lively debate in health journals about what these score were and were not telling us.

NL suggested the Board receive a commentary on what the Trust had done to address issues raised in the 'negative' comments (i.e. those remarks quoted under the section 'Patients' comments when asked: What would have improved your stay?'). It was agreed that such details would be included in future FFT reports.

LAA noted that one of these comments was from a Rowan Ward patient but that ward had not been in the Ward Score table. RCo said this was because

those wards where less than 5 comment forms were collected were not listed and this applied to Rowan Ward.

The Board noted the report.

2013/72 FINANCIAL PERFORMANCE REPORT FOR MONTH 5: AUGUST 2013

Introducing his report RP highlighted the following:

Summary Income & Expenditure

- M5 had seen a disappointing deficit of £1m against a planned surplus of £0.2m. Activity had been close to plan for both NHS and PP but the less complex mix of cases had resulted in revenue shortfalls against plan. However, this had followed a M4 surplus of £1.4m. The Trust had a surplus Year to Date of £1.0m against plan of £0.4m. This was a slightly better position than at the same time last year.
- The Trust was very marginally profitable and costs in the short term are fixed: accordingly monthly results are sensitive to revenue fluctuations. The Trust was keeping its head above water financially but was not creating any surplus to invest. RP said it was best not to look at one month in isolation and the Trust's IT systems did not enable an assessment of financial performance in real time.

Balance Sheet

- Cash was under pressure (while liquidity was still strong) because of difficulties in collecting cash from Clinical Commissioning Groups (CCGs) and NHS England. This was attributable to a combination of a lack of funds and a lack of understanding on the part of CCGs of how the system works. RP added that RB&HFT was not the only Trust currently facing cash flow issues. He and other DoFs had recently met with Paul Baumann, Chief Financial Officer of NHS England, and had been forceful in saying that the lack of receipts was unsatisfactory. Paul Baumann had given some comfort and reassurance that it would be sorted out. NHS England had also said it would shortly start to pay the Trust for over-performance in the early months of the financial year.
- Looking ahead, there would be continuing pressures on cash. RP cited the £8m projected consultancy costs for the redevelopment of Chelsea Campus over the next two years, IT investment needs, ICU investment at Harefield Hospital and other capital projects. He would be working with RCr, who chairs the Capital Working Group, on how these investments will be funded.
- The Trust's Working Capital Facility (WCF) of £22m would expire at the end of September 2013. The Trust was negotiating with the bank for a new facility at a lower level as it was desirable to have one to assist the Trust through the ups and downs occasioned by the new commissioning landscape .

RP said that while the balance sheet was conservative the Trust was exposed in relation to budgeted Project Diamond (PD) funding. As in prior

years, the Trust did not know when it will come or whether the amount would be the same as last year. He noted that Paul Baumann was conscious that major providers who benefit from PD funding are under other funding pressures which should mitigate the risk that PD funding is reduced or even terminated.

RP concluded his report saying that from 1 October 2013 Monitor's Financial Risk Rating scoring system is replaced by its Continuity of Service rating under the new Risk Assessment Framework. The Trust's shadow CoS rating is 4 (the highest level) which he expected to be maintained for the rest of the financial year.

JH said the sale of the Heart Science Centre (HSC) may not be in the best interests of the Trust. RP said that a further reason for the future cash position coming under pressure was because the HSC was now not to be sold.

KO asked if commissioners' inability to pay was a result of the lack of funds or a lack of understanding considering that a lack of funds would be more concerning? RP said some CCGs claim they do not have enough money. He noted that when CCGs were established their geographical coverage differed to PCTs and as a result certain CCGs were now claiming to be underfunded. Others had been trying unilaterally to change contracts which, legally, they cannot do without due process. AVO commented that this was happening across the country and RB&HFT was not the only Trust to be affected. BB said that whatever the cause the future would not be as promising as it was before. The inconsistencies of behaviour described would in all likelihood continue. In response the Trust should do what it had always done – take a firm and consistent business like stance.

The Board noted the report.

2013/73 CONTROLLED DRUGS AND ACTIVITY APRIL 2013 – JUNE 2013

The Board received this report which was for information only.

2013/74 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 Cardiac Surgeon with Interest in Transplantation and a Consultant in Acquired Cardiac Surgery and Heart and Lung Transplantation, and by RH for the appointment of a Consultant in Cardiac Electrophysiology at Harefield Hospital and a Consultant in Cardiac Electrophysiology at Royal Brompton Hospital.

JH noted the Trust was increasingly attracting international candidates. Whilst this was positive the Trust should provide additional development time and resource to induct such candidates as their qualifications did not always align with UK requirements. For example, Dr Aron Popov the successful cardiac surgery candidate, was a Russian national working in Germany. In order to provide complete assurance a 6 to 12 month

probation and development programme followed by a full appraisal by the Departmental lead had been planned for him.

RH noted that the Trust frequently appointed the locum in post to substantive appointments. While the AAC could be assured of their suitability and competence the vacancy could appear less competitive and therefore less attractive to external candidates. TE said the last Electrophysiologist appointed had not been an internal locum. NL asked if on-site locums were any different from any other locums? TE said there was no difference.

The Board ratified the appointment of:

- Shahzad Raja as Consultant Cardiac Surgeon with Interest in Transplantation;
- Dr Aron Popov as Consultant in Acquired Cardiac Surgery and Heart and Lung Transplantation;
- Dr David Jones as Consultant in Cardiac Electrophysiology at Harefield Hospital and;
- Dr Julian Jarman as Consultant in Cardiac Electrophysiology at Royal Brompton Hospital.

2013/75 AOB

SRF introduced one further item of business. With the departure of JH the Trust was required to appoint another NED. There would be a period when the requisite number of NEDs under Monitor's Code of Governance would not be met and the appropriate reference to this in the Annual Report would be inserted by RCo ('comply or explain'). The process would be that the appointment would be made by the Nominations and Remuneration Committee of the Council of Governors, chaired by Ray Puddifoot, and this would meet shortly.

2013/75 QUESTIONS FROM MEMBERS OF THE PUBLIC

Mr Ross congratulated the Board on grasping the issue of the Mansion. He urged the Board to consider 2 other buildings: Harefield House on the High Street and, Brakespeare Grove on the Ruislip Road. Mr Ross thanked Mr Chapman for his part in raising the issue. RCr thanked Mr Ross for his support but acknowledged that there was a lot of work to be done. In response to questions from Mr Chapman, RCr was able to confirm that the scaffolding was being erected; and that water ingress to the basement was one of the challenges being addressed by the professional team.

Mr Appel said that as a Governor he had made a number of ward visits and invariably he heard marvellous comments from patients about their care. When he did hear complaints they were about the anxiety of not knowing the exact time of procedures.

Mr Gordon asked who was responsible for ward-staffing? He had observed in other hospitals that some wards had no staff present and was concerned to know if there were shortages in HH. BB confirmed that the hospital is

staffed 24 hours a day. He believed Mr Gordon was asking if staff were available where they should be at any one time. RCr said the Trust's staffing models were based on expected levels of clinical activity, drawing heavily on past experience. He acknowledged that the Trust does not always get that quite right and that can lead to some delays. BB stated that he had confidence that the Trust's wards were appropriately staffed to deliver the care expected of them. SRF noted that the CQC inspection of RBH on 13 August 2013 had marked the Trust as compliant on staffing levels.

NEXT MEETING

Wednesday 30th October 2013 at 2.00pm, in the Board Room, Royal Brompton Hospital.