Royal Brompton & Harefield NHS
NHS Foundation Trust

Minutes of the Board of Directors meeting held on 26th September 2012 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
	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 Carol Johnson, Director of Human Resources	CJ
	Mr David Shrimpton, Private Patients Managing Director	DH
	Mr Nick Hunt, Director of Service Development	NH
	Mr Richard Goodman, Director of Pharmacy & Medicines Management	RG
In Attendance:	Mr Anthony Lumley, Corporate Governance Manager (minutes)	
	Ms Pat Cattini, Matron/Lead Nurse Infection Prevention	
Apologies:	Mr Neil Lerner, Non-Executive Director	NL

2012/73 MINUTES OF THE PREVIOUS MEETING HELD ON 25 JULY 2012

The minutes of the meeting were approved.

2012/74 MATTERS ARISING

Actions from minutes

The Board reviewed the Action Tracking log.

BD 12/17 Key Performance Indicators. NC confirmed that the comment was correct and the Board now had the opportunity to choose targets other than those mandated for compliance reasons.

BD/17 Radiation Safety Incidents. NC confirmed that the Risk and Safety Committee (RSC) had received a report from Michael Rubens, Consultant Radiologist.

BD/47 Approval of Annual Report & Accounts. RCo explained that this action had been left as yellow as it would be carried out later. However, the Monitor Bulletin for September 2012 had stated that the consultation on the Operating Manual is about to be published so this represented an opportunity to address the action shortly.

2012/75 REPORT FROM THE CHIEF EXECUTIVE

BB gave verbal updates on the following items:

Letter from West Middlesex University Hospital NHS Trust

BB reported that he had received a letter from the Chief Executive of West Middlesex University Hospital NHS Trust (WMUH). WMUH had determined that their journey to be a Foundation Trust (FT) was not 'doable'. WMUH have retained KPMG to assess the options and WMUH had written to ask if the Trust would enter into a partnership. It could be surmised that the same letter had been sent to other Trusts. BB asked Board members for their views. It is thought that this letter is likely to have been sent to other FTs. SRF asked if there were any synergies? BB replied that it would be a collaboration between a general hospital and a specialist hospital but the location of WMUH in Isleworth in the borough of Hounslow counted against it. A more suitable partnership would be one with another 'like' hospital. WMUH had underlying structural issues. Its new building had been funded by a Private Finance Initiative and this partly led to speculation as to why it had not been able to achieve FT status. WMUH was being supported by the NHS Trust Development Authority which helps Trusts become FTs or enter partnerships.

RCr said the Royal Brompton & Harefield NHS Foundation Trust (RBHFT) provides a fortnightly cardiology clinic at WMUH. He did not feel that the Trust was in a position to help them across the range of services they provide. RH, KO, and JH all expressed a view that the Trust should not consider a partnership. CS agreed as did NC who noted that there was no spare acreage at WMUH which counted against a relationship.

BB said that the words 'merger' or 'takeover' were not included in the letter.

It was agreed that the Board had no appetite to consider a partnership with WMUH.

Joint Committee of Primary Care Trusts (JCPCT) decision on Cardiac Surgery

BB reported that he had attended a meeting of the implementation group led by the London Specialised Commissioning Group (LSCG) in August and a further meeting on 25 September 2012. At the latter meeting he had put forward the Trust's position on the JCPCT decision and there had been a healthy debate. In attendance were Sue McClellan, Chief Operating Officer of LSCG, Dr Andy Mitchell, now Regional Medical Director for London in the NHS Commissioning Board (NHSCB), Ann Radmore, Chief Executive of NHS South West London and the executive directors of Great Ormond Street Hospital (GOSH) and Guy's and St Thomas' (GST). The group was still aiming for decommissioning of paediatric cardiac surgery at RBHFT by April 2014. The group had acknowledged that a definition of paediatric cardiac surgery per se does not exist in commissioning terms. They had therefore set up a project team to determine which codes make up the service. It was reported that it had already run into difficulties as some of the procedure codes apply to both children and adults. However, the group thought that they could conclude this work by Spring 2013 so they can give

contract notification which had originally been stated to be 12 months, but which had been stated at more recent meetings to be 6 months.

BB said the Trust's lawyers had written to the group asking for clarification on employment law and TUPE. A letter received on 25 September from the group had stated it was the Trust's responsibility and the Trust's liability.

The implementation group had agreed to draft a letter to parents to provide comfort and assurance and stating it would be 'business as usual'. A transitional steering group was set up to meet monthly with medical directors ,including TE. BB said his impression from the meeting was that there was no plan, it was a moving feast, and complicated. The Trust's position is that the implementation group should only devolve what needs to be devolved and therefore the Trust is interested to know what it is that will be devolved. BB said there were now good working relationships with the commissioners but he was less positive about the other FTs who seemed less keen on collaboration. BB said he continued to make the group aware of the risks to recruitment and retention and the serious risks to children's respiratory medicine. The decision to decommission children's heart surgery was not a rational one and the Trust could not accept it as it is and would work to find a rational solution.

BB reported that the independent panel to look at the knock on effect on Respiratory and other services had been established with Professor Peter Hutton of University Hospital Birmingham in the Chair. Professor Hutton had selected his team and work had commenced with the aim to report in December 2012. TE added he would be speaking to Dr Mitchell later today who was already aware of the Hutton report. At the implementation group meeting on 25 September Dr Mitchell had said that the way forward was through networks and he appeared to accept the Trust's view that London is 'different'.

BB concluded his report stating that the Secretary of State had received 3 referrals of the decision to decommission children's heart surgery at Leeds General Infirmary. He had informed the implementation group that Hillingdon Council was also likely to make a referral. The attitude of the commissioners had been dismissive of these initiatives. The Leeds Charity announced it was seeking leave for a Judicial Review on 4 October 2012. Judgement was expected in March 2013.

2012/76 <u>CLINICAL QUALITY REPORT FOR MONTH 5: AUGUST 2012</u>

RCo highlighted the following from Month 5:

- *Clostridium difficile*: 11 cases at M5 against the de minimus target of 12. The forecast therefore was that at the end Q2 the target would not be met. RCo reported that he would liaise with Monitor to seek to hold the Trust's Governance rating as Amber/Green rather be escalated to red. The failure against the *Clostridium difficile* target was predicted in the Annual Plan so there should be no need for a self certification review this time.

- Cancer 31 day: 2 breaches to date with adjusted performance of 95.1%. There had been no breaches in September so the forecast was that this compliance target would be met.
- Cancer 62 day: was met with 2 repatriations and performance of 87.5%
- Care Quality Commission (CQC): he would be meeting with the compliance inspector on 27 September 2012 and he anticipated that the Improvement Action to be closed.

RCo tabled an updated Serious Incident (SIs) report with 6 SIs for the months of August and September 2012.

For the NHS Standard Contract commissioners have their own Quality Dashboard with KPIs and Quality Metrics For cancelled operations 15 reported in Q1 had been removed as it was found that Royal Brompton Hospital (RBH) had been reporting additional cases that did not meet the required definition. For 18 weeks the performance of 85% meant a failure to meet the patient target at speciality level. This would result in financial penalty - a 2.5% deduction of income measured at M5.

RCo drew the attention of the Board to the Quarter 1 (Q1) CQUIN Report. This outlined performance against the 8 indicators for 2012/13. The expectation for Q1 is that baselines will be set and plans agreed. CQUIN payment for Q1 will be dependant on commissioners being satisfied with these baseline and plans.

JH asked CS if the presence of pressure sores in the SI report showed an increasing trend, or was an unfortunate coincidence, and she asked whether these were reported to any other committees? CS replied that there was more vigilance and with the tissue viability nurses there had been an increase in reporting. There was an Action Plan to improve assessment of patients, use of specialist equipment and management of pressure ulcers by nurses. It was treated as an operational issue, however she was prepared to consider formal reporting.

NC said, in his capacity as Chair of RSC, he had to consider if the report showed that things were acceptable. He asked how the 15 cancellations had been identified? RCo replied that the senior nurse in Heart at RBH had seen the increased numbers and had decided to investigate. Personnel had changed and the problem had occurred during handover. NC asked what did the 2.5% penalty equate to in monetary terms. RCo said it was £38,000 for M1 – M3 for NHS North West London.

Action: consider formal reporting of pressure sores to a committee.

2012/77 <u>FINANCIAL PERFORMANCE REPORT FOR MONTH 05: AUGUST 2012</u>

Introducing his report RP said that M05 was the best month financially the Trust had achieved year-to-date (YTD). He highlighted the following:

- Activity was below plan but there was a favourable case mix.
- Private Patient (PP) income was below plan but respectable

- Pay costs were close to, and non-pay costs slightly above, plan. Additional related income compensates for these additional non-pay costs.
- Performance YTD was a surplus of £0.7m, £1.1m ahead of plan. The Trust was c.£3m ahead of plan for NHS Income but c.£2m behind plan for PP income.
- The Trust was on track for maintaining a Financial Risk Rating of 3 for Q2.
- Balance Sheet: there was a strong cash position, ahead of plan. Project Diamond funding, which was expected later in the year, would provide an extra boost.
- There were minimal borrowings. Capex was behind plan but it was within the acceptable range for Monitor.
- Assuming the Trust achieves plan for the year as a whole, the attention would turn to 2013/14 which would be a challenge in both income and cash terms.

SRF asked why the Trust was not doing better in PP? DS said the insurance market was relatively weak. The Middle East market had dried up in London but was expected to come back. Insurance companies were clamping down on costs for some complex devices. SRF asked about long term trends in PP. BB replied that it was a market of choice and elective treatment was the basis of most care. The conditions still exist and the demand for cardiac and complex respiratory services would not disappear. Looking at the market over the last few decades, there had been a surge in the 1980's, decline in the 1990's but a recovery later that decade. He felt that the market would come back. SRF said that when the Trust makes a decision about what kind of hospitals it needs, the future size of the PP facility must be a consideration.

2012/78 <u>RESEARCH UPDATE</u>

TE introduced the report and said it was a routine paper and for information, and was a regular review of activity. He drew the Board's attention to the increase in recruitment of patients into National Institute of Health Research (NIHR) studies. This had led to a higher ranking. The Trust was in the middle range of all Trusts and ranked eighth when compared to specialist Trusts. The Trust was meeting the metrics of delivery and should meet the metrics set out in the report without too much difficulty.

SRF asked to what extent paediatric issues had degraded research? TE said that paediatrics was a small part of the portfolio but it did have a significant impact on the Trust's research reputation. He noted that researchers as a group represented mobile talent And he thought it likely impact would be significant. Loss of the paediatric service would place the Trust more in line with Papworth Hospital and the Liverpool Heart and Chest Hospital (LHCH).

KO asked if commercial funding had gone down everywhere or was it cyclical? TE said there was some cyclical funding with phase II studies, but he thought overall funding was going down generally.

JH asked if more information on outputs could be included in the updates. TE said they were included in the annual report but agreed they could also be put in the updates.

BB said it was a source of regret that none of the non-executive directors had been encouraged to attend the first annual meeting of the ICMS initiative in Liverpool. TE commented that it is an independent body and not part of the Research & Development team.

Action: include information on outputs in the Research Updates for the Board.

2012/79 LEARNING DISABILITIES ANNUAL REPORT 2011/12

CS said that Monitor's Compliance Framework included an indicator covering access to healthcare for people with a Learning Disability (LD).The report was an update on performance relating to the 6 standards for the indicator. The Trust was compliant with all of them.

RH asked how significant a number of patients with a LD does the Trust currently have? CS said compliance was not about numbers but for the Trust, although it varied, the total was small.

JH asked if people with a LD find access to the Trust's facilities difficult? Was the Trust good enough at meeting and greeting? CS said the Trust still had work to do in this area. However, the Trust was aware of individual patients once they had been registered and from then on could anticipate their needs. SRF asked if patients are asked about what they need? CS confirmed this did happen.

The Board noted the report.

2012/80 MODERN MATRONS REPORT JANUARY 2011-JULY 2012

PC highlighted 3 subjects from the report and answered questions from Board members on each one in turn. Firstly, soft facilities services were under new contract, but the Matrons did not feel the contractor was responding to their concerns. Noting that the situation was not acceptable, NC asked if she needed help to effect improvements? PC said there were problems at both sites. RCg said pressure to improve was being applied. BB said issues with the contractor should be coming through the operating structure and not discussed by the Board. RCg said there were real challenges with the contact and the risks should not be news for the Board. The contract was output based. If they were not meeting their responsibilities then the contractor would need to review the resources allocated to the contract. The tender had been for a contract not just with the Trust but also with the Royal Marsden, Chelsea & Westminster (C&W) and the Institute for Cancer Research. However this had been the framework agreement and each organisation had a separate bilateral contract with ISS Mediclean.

JH noted that while multiple contracts delivered savings, they might in themselves be an issue due to the adverse impact on quality.

BB said the Trust should be dealing with the contractor through the direct channels of authority and there should be a constitutional route through which the reports were brought back to the Board. The Matrons Report was about issues of safety and satisfaction. How the Trust's management deals with them was not a direct matter for the Board.

Reporting on the second issue, PC said Hand Hygiene had seen some improvement and the Trust was at a good level compared to other organisations. In response to a question from SRF about how the improvement had come about, PT said it had been addressed through senior nurses but said something stronger was needed to improve it further. CS added that the Trust had started rating and publishing areas but conceded more work was needed. JH asked what the areas were? CS said they spread across different disciplines.

PC said the third topic was *Clostridium difficile*. This was now one of the biggest challenges. Practical actions taken in relation to *Clostridium difficile* were antibiotic stewardship and better use of laxatives. There was a move to look at antimicrobial stewardship and the introduction of an algorithm for diagnosis. PC added that there had been 2 more cases in September. Her team were aware that RCo was reporting to the Department of Health (DH) the Trust's ongoing concern over an inappropriately low target

NC asked if compliance with the metric was changing clinical practice? PC said this was the central issue. If the DH guidance was followed, there are patients who might be assessed as not needing to be tested. This may help achieving the target, however it risked compromising patient care as some patients for who may be clinically assessed as not having to be tested (because there is an alternative explanation for their loose stool), may in fact be positive. If there was no testing there is a risk of missing positive cases. PC added that as the Trust does not want to compromise patient safety her team are likely to test and therefore miss the target.

NC asked if this meant that a side effect had been to change the nature of anti-biotic treatment? CS said this was not what was being said. PC said that some antibiotics were more likely to be associated with *Clostridium difficile* but there were others that can be safely used instead. Some Trusts had instigated a moratorium on the higher risk antibiotic usage unless prescribing is approved by a consultant microbiologist. The Trust should encourage antimicrobial stewardship to reduce prescribing of antimicrobials which are known to be associated with *Clostridium difficile*, and also reduce usage of laxative.

SRF asked if comparisons were made with other hospitals or organisations? PC said she did communicate with other Trusts. For instance the LHCH had

told her they were struggling. She added that within her team there was a feeling that currently in the DH there wasn't the support. CS said in conclusion that RBHFT does manage its patients well.

The Board noted the report.

2012/81 CONTROLLED DRUGS GOVERNANCE AND ACTIVITY APRIL 2012-JUNE 2012

RG presented the report which was for information and followed the usual format of reporting each quarter in the year this one being for Q1 of 2012/13. He was happy to report that of 41 incidents recorded to date none were graded amber or red.

The Board noted the report.

2012/82 RECOMMENDATIONS OF ADVISORY APPOINTMENTS COMMITTEE

The Board were presented with 3 ratification forms for the appointment of consultant medical staff by KO for a Consultant Interventional Cardiologist, by RH for a Consultant in Respiratory Medicine with a special interest in Severe Asthma and Exercise Physiology, and by JH for a Consultant in Histopathology, specialising in Thoracic Pathology.

KO said in her case a candidate had been selected on a majority decision. To an extent the panel had had to weigh up people who were well known against those who were less well known. JH said that while over time improvements such as psychometric testing had been introduced, she wondered if it would be helpful to review the Trust's consultants' recruitment process? BB said the tradition in the Trust was to pre-screen the shortlist. The Trust continually learnt from practice and had looked at panel compositions and improved the process. However, the process had to follow statutory requirements. What could be looked at was how job descriptions were defined and described and how candidates were pre-screened. TE said the recruitment process had been thoroughly overhauled and was very thorough. The appointment process did vary between posts and divisions but the issue was about what do the panellists think the (Trust's) mission is. Any discussions on the mission should happen well before an appointment is made. There were site differences to be considered and appointing a locum first could be advantageous if the other candidates did not have the practical skill set. TE added, and asked that it be recorded for the record, that the Trust had recruited an excellent candidate. In response to a query from SRF on whether the Board should receive a paper in the New Year, TE said a paper was not the right thing to do but it would be helpful for the Management Committee to look at each appointment in more detail. CJ agreed with this view. BB said the Trust should look at the memberships of the panels. CJ also noted that locums were often on the Trust's books for 3-4 years and suggested that the policy on the use of locums should be looked at with a view to agreeing that tenure in locum posts should be for a maximum of one year.

KO noted that the concerns would be raised but added that a very good candidate had been appointed. SRF concluded that the Board were content to ratify the appointment.

RH reported that the panel he had chaired had interviewed just one candidate for the position of Consultant in Respiratory Medicine and had agreed to appoint.

JH said an excellent candidate had been recruited for the post of Consultant in Histopathology specialising in Thoracic Pathology. She said the interviewee had suggested she might need to improve her language skills. This led her to think about what assurance did the Trust have that the candidate's current level would not affect her practice and if the Trust ran English lessons and tested staff's levels of understanding. TE said he thought the candidate already had very good English having worked in both Manchester and the US. The role was not a direct patient facing position and as she had passed the GMC English test the Trust would be challenged if it set a further test to check if she was at the appropriate level.

The Board ratified the appointment of:

- Dr Tito Kabir as Consultant Interventional Cardiologist;
- Dr James Hull as Consultant in Respiratory Medicine with a special interest in Severe Asthma and Exercise Physiology and ;
- Maria Angeles Montero Fernandez as Consultant in Histopathology, specialising in Thoracic Pathology.

2012/83 QUALITY IN THE NEW HEALTH SYSTEM

Presenting the report, RCo said Monitor required the Board to discuss the report *Quality in the new health system – Maintaining and improving quality from April 2013* published by the National Quality Board (NCB). The NQB had been established in 2009 and this report built on the work undertaken during the Next Stage Review following the publication of *High Quality Care for All* by Lord Darzi in 2008. *Quality in the new health system* summarised the roles of CQC, Monitor, the NHS Trust Development Authority, NICE, Professional Regulators, Health Education England and the DH in respect of managing quality in the reconfigured health system. It asks the question of who is responsible when things go wrong - which organisation, according to the particular circumstances, should 'hold the ring'. The timing of the release of this publication was partly to address the issue of quality and partly to anticipate any recommendations that may arise once the Francis Report into the failings at Mid Staffordshire NHS FT was published (now expected in the New Year) although it was recognised that the report may need to be developed further once the recommendations from the Francis Report are known. The Board report also included a briefing paper which RCo then summarised, highlighting the key areas from *Quality in the new health system*.

BB referred Board members to the 'Actions for each organisation' on page 51. In line with the first action, by discussing the report now he and the

Chairman are taking the lead as required. Responsibility for quality is now devolved amongst 8 different bodies (distinct authorities), one of which, the NHSCB, will be further subdivided. Some of the bodies are known to the Trust, others are new. He had noted that only 1 sentence referred to the Secretary of State. There was a continuing assumption (evidenced earlier by PC) that the Secretary of State was the ultimate person anyone can go to and this is clearly no longer the case. BB said that he anticipated a rocky journey ahead.

KO said that this was a case of 'It is what it is … and we are where we are' NC said the issue of quality was on-going and the Trust should be concerned with 2 things: commissioning and financial. The Trust had to work out, with so many bodies it now had an interface with, who it relates to while getting on with patient quality and safety. BB said, more than ever before it was about who is responsible for monitoring quality. Monitor was still the Trust's regulator but it was now no longer just a regulator for FTs, so it was left open about who it was the Trust should relate to. NH added that a lot of this published now was 'place saving' before the Francis report came out.

RH said the Board should be guided by RCo.

BB said it was important for the Board to familiarise itself thoroughly with the report so that when debates on quality take place, this is the context in which they are. He noted that the word NHS only came up 3 times in the document (which highlighted the lack of a clear vision moving forward and clarity of what the NHS stood for). KO said in a sense the report does aid a better understanding of the issues.

JH said the Trust should be very clear about the quality it stands for. There was a danger of the tail wagging the dog. She went on to suggest that the topic might be one for specific debate at a future Board Seminar.

SRF concluded by stating that the Board had read and understood the report and held a discussion and in particular it noted the 'Actions for each organisation'. BB said *Quality in the new health system* should also be disseminated to the Governors and included in the Governors' Council agenda for 10 October 2012. This was agreed.

Action: Include *Quality in the new health system* in the agenda for Governors' Council 10 October 2012.

2012/84 <u>RBHFT CONSTITUTION, REVIEW TO COMPLY WITH HEALTH AND SOCIAL CARE ACT 2012 CHANGES - EFFECTIVE 1 OCTOBER 2012</u>

RCo updated the Board on changes to the Trust's constitution resulting from the Health and Social Care Act 2012. Monitor has retained the duty to approve the constitution. Following the publication of Commencement Order 2 and the model Constitution published by Monitor in August, the

following changes had been incorporated by DAC Beachcroft LLP into the Trust's constitution in order to ensure compliance from 1 October 2012:

- Change of name from Governors' Council to Council of Governors.
- Definition of the Principal Purpose of the Trust (provision of goods and services for the NHS) and the interrelationship between income from the Principal Purpose and Non Principle Purpose activities.
- Annual Report and forward plans to include information on the impact that income received by the Trust from Non Principal Purpose Activities has had on the Principal Purpose.
- The Trust is required to report what it has done to ensure that its membership is representative of those eligible.
- Any increase of 5% or more of the proportion of total income earned from non-NHS activities in any financial year must be approved by more than half of the members of the Council of Governors

The Board was being asked to confirm the constitution as it was now amended and approve and note its terms.

KO reported that NL had asked that the issue of Governors holding NEDs to account be raised at this meeting. SRF said he felt that as long as there was a healthy relationship between NEDs and Governors then the matter was academic. NC said he felt that this new duty was absurd. Not only were there practical issues but the principle was wrong and dangerous. RP said that NL's recommendation had been that the Trust should write to the Secretary of State and make this point. BB said the Government had introduced the legislation and Monitor had now issued consultation on its implementation. The response should therefore be to Monitor's consultation. In response to a query from JH about whether the Trust should write to the Foundation Trust Network (FTN) and the NHS Confederation to ask for their views, SRF said that he felt this was 'water under the bridge'.

RH proposed that the Trust write to Monitor and not the Secretary of State to voice its concerns about Governors holding NEDs to account. This was agreed.

The Board approved the amended Constitution.

Action: include a note on concerns about Governors holding NEDs to account in the Trust response to the new NHS Provider Licence Consultation Document.

2012/85 THE NEW NHS PROVIDER LICENCE: CONSULTATION DOCUMENT

RP said the intention is to take the Trust's draft response to the Governors' Council meeting on 10 October 2012 and, subject to approval, then send it both to Monitor and to the Foundation Trust Network which is submitting its own response to Monitor. The aim of the paper was to brief members on Monitor's proposed licence conditions and to show suggested Trust responses to Monitor's specific questions set out in their 120 page

consultation document. It was expected that licences for FTs would be issued effective 1 April 2013 and that these would be automatic for FTs.

RP raised two points of concern from Monitor's licensing proposals. Firstly, that Monitor's regulation will become more intense and burdensome. The largely risk-based approach used formerly appeared to be on the wane. SRF commented that this would undermine Board governance. Secondly, in three of Monitor's proposals there was the threat of additional cost for the Trust, in part to fund Monitor's operations and in part to reflect the introduction of a risk pooling scheme to bail out failing providers. RP highlighted Monitor's proposal to create an advisory panel to consider questions brought by governors. SRF said a minor adjustment should be made to the suggested response in the light of NL's point made previously.

BB said that licences will only be issued when providers have agreed which Commissioner Required Services (CRS) they will deliver. However, all services provided by FTs will initially be designated as CRS. This begged the following questions: first, can paediatric cardiac surgery be decommissioned without affecting the rest of the services; and, secondly, can the Trust's PP activity continue a service that is no longer a CRS.

JH pointed out the wording 'questions brought by Governors' on page 10 and wondered if this could be changed to 'issues brought by governors'? RP said the wording of the legislation was set in stone so commenting on the Act itself would be fruitless.

The Board commended the clarity of the paper and agreed that it should be recommended for consideration by the Governors at their meeting on 10 October 2012.

Action: make an adjustment to the draft response to the new NHS Provider Licence Consultation Document, add the response to the Governors' Council Agenda on 10 October 2012, make any amendments required following that meeting, and finally submit it to Monitor.

2012/86 <u>DRAFT MOTION OF SUPPORT FOR CHELSEA & WESTMINSTER RETAINING MAJOR HOSPITAL STATUS</u>

SRF said this report had been drafted by Piers McCleery, Director of Strategy and Planning. It was agreed that the Trust should give every bit of support it could to C&W to retain its status as a major hospital.

The Board approved the letter to be sent to NHS North West London in which it was stated that the Trust supports C&W retaining its 'Major' hospital status within the North West London Reconfiguration Programme.

Action: send letter of support for C&W to NHS NWL.

2012/87 QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions from the members of the public.

David Potter thanked the Trust for a well organised meeting and commented that he had been able to hear clearly all the discussions. The use of the microphones had helped greatly.

DATE OF NEXT MEETING

Wednesday 24th October 2012 at 2 pm in the Board Room, Royal Brompton Hospital.