Minutes of the Board of Directors meeting held on 27th March 2013 in the Concert Hall, Harefield Hospital, commencing at 10 am

Present:	Sir Robert Finch, Chairman	SRF
	Mrs Jenny Hill, Senior Independent Director	JH
	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 Neil Lerner, Non-Executive Director	NL
	Ms Kate Owen, Non-Executive Director	KO
	Mrs Lesley-Anne Alexander, Non-Executive Director	LA
	Dr Andrew Vallence-Owen, Non-Executive Director	AVO
	Mr Richard Connett, Director of Performance & Trust Secretary	RCo
By Invitation:	Pr Kim Fox, Prof of Clinical Cardiology	KF
	Ms Carol Johnson, Director of Human Resources	CJ
	Ms Joanna Axon, Director of Capital Projects & Development	JA
	Ms Jo Thomas, Director of Communications & Public Affairs	JT
	Mr Piers McCleery, Director of Planning & Strategy	PM
	Mr David Shrimpton, Private Patients Managing Director	DS
	Mr Richard Goodman, Director of Pharmacy & Medicines Management	RG
	Ms Joanna Smith, Chief Information Officer	JS
In Attendance:	Mr Anthony Lumley, Corporate Governance Manager (minutes)	
Apologies:	Mr Richard Hunting, Non-Executive Director	RH

2013/15 MINUTES OF THE PREVIOUS MEETING HELD ON 30 JANUARY 2013

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

- Page 3, item 2013/3, second para. first sentence: replace ‘adequate’ with ‘appropriate’.

2013/16 REPORT FROM THE CHIEF EXECUTIVE

BB gave verbal updates on the following items:

Safe and Sustainable (S&S).

BB reported on a number of matters in relation to the S&S review and the implications for the Trust.

a) the Leeds Children’s Charity, who had won the judicial review of the decision to close paediatric heart surgery at the Leeds Infirmary, would be hearing a judgement today (27 March 2013) in the High Court as to whether the consultation should be quashed and about potential remedies.

b) A meeting was held with Terry Hanafin, former Chief Executive at Essex Strategic Health Authority and currently Chairman of the Steering Group for the Implementation of the JCPCT decision. The meeting had been organised by Sue McClellan, Chief Operating Officer London Specialised Commissioning Group (LSCG) and with Dr Andy Mitchell, Regional Medical Director for London in the NHS Commissioning Board (NHS CB) in attendance. Representatives from Great Ormond Street Hospital (GOSH) and Guy's and St Thomas' (GST) were also present. Terry Hanafin had said the primary focus is on finding a good solution for London. He noted that closing Royal Brompton Hospital's (RBH) Paediatric Cardiac service would have consequences and that the solution for London would need to take these into account. His views were endorsed by Sue McClellan and Dr Andy Mitchell. This was encouraging and showed support for the Trust's view that there should be a three centre network solution.

c) Memorandum of Understanding (MoU) with Chelsea & Westminster NHS Foundation Trust (C&W): this has been signed and relates to exploration of the feasibility of co-locating children's services.

d) Independent Reconfiguration Panel (IRP): this was scheduled to report to the Secretary of State for Health (Jeremy Hunt MP) this week but he had requested the IRP to extend its mandate to 30 April 2013 in view of the Leeds Children's Charity's court action.

e) Appointments and other matters: the Trust now has five Consultant Grade Paediatric Congenital Surgeons in post. Royal Brompton & Harefield NHS Foundation Trust (RBHFT) is one of only two centres who have at least four consultant grade surgeons. Letters of support for the Trust had been sent to Lord Ribeiro, Chairman of the IRP from Harvard University, the Johns Hopkins School of Medicine (Baltimore, USA), the College of Medicine (University of Cincinnati) and several European centres. These attest to the Trust's role on the world stage and refer to the international standard for large volume centre being between 250-350 - S&S had recommended the closure of RBH which does in excess of 400 cases.

SRF said that the judgments on the Leeds Children's Charity's case had been in two parts: firstly, on information about a score for quality that should have been supplied to the Leeds Infirmary. That had already gone in favour of the Charity on 7 March 2013. The hearing today was about whether the whole consultation should be dropped. The Trust's legal advisors were asked whether the Trust should bring a similar action. He and BB had been informed that no action was needed at this stage.

JH asked, if the outcome of the IRP's review of S&S was favourable and if the MoU with C&W proceeds, what the Trust's vision for paediatric would be? BB said this was a seminal point – it addressed not just paediatrics but the future of Trust's role. The Trust, increasingly, was a key player in a system of care which was not just London based. This was multi factorial and not easy to illustrate. While it was London based

the Trust held a unique situation on the global stage. He added that the Trust and the other two London based providers of specialist paediatric heart surgery ware all different: one is a specialist children's' hospital (GOSH) one provides general services for both Adults and Children (GST) with some specialties, and our Trust provides specialist heart and lung care throughout life. The three centres each offered a different but complementary model of care and it did not make sense to break this up.

NHS Provider Licence

BB urged all Board members to familiarise themselves with the terms of the Provider Licence (which replaced the Foundation Trust Terms of Authorisation) received on 26 March 2013 from Monitor and effective from 1st April 2013. This changed the nature of the NHS. The Trust and private sector companies can now be licenced under the same regime. The Trust will now be subject to the 'continuity of services' regime. The NHS CB, effective from 1 April 2013, will not 'own' the Trust. This ran counter to the thrust of the JCPCT's actions through S&S in which they had suggested ownership of the Trust's services. BB tabled an illustrative picture of the NHS which demonstrated the complexities of the new landscape. He concluded his report by stating that the Trust to date had not had sight of contracts on commissioning intentions and he also proposed that RCo circulate the Licence to all the Board. This was agreed.

Action: RCo to circulate Licence to all Board members.

2013/17 CLINICAL QUALITY REPORT FOR MONTH 11: FEBRUARY 2013

Presenting the report RCo said the presentation and content of it was now actively under review in light of the Francis Report into the failings at Mid Staffordshire NHS Foundation Trust. He highlighted the following from Month 11.

- Monitor's Compliance Framework:
  - *Clostridium difficile*: 18 cases year-to-date (YTD). 13 of these had occurred in the first 6 months, and 5 cases in the 5 months since then.
  - 18 Weeks Admitted: performance of 86.5% which was a fail on the target. This was predicted in the Annual Plan which meant Monitor was cognisant of this.
  - Cancer pathways: 62 days' wait to first treatment. There had been 2 breaches and repatriation letters were still outstanding.

NL asked how the boundaries for Monitor's ratings between Red (Not Met) and Amber Red (Not Met) were defined/set? RCo said that as the report covered the second month of the fourth quarter, the governance rating is a forecast. BB added that the predicted failures were significant because failure over three consecutive quarters would result in escalation by Monitor. NL said this information was helpful.

- Care Quality Commission (CQC): In response to the Francis Report the government has said it is committed to introducing a simple system of hospital ratings to be overseen by a new Chief Inspector of Hospitals to be appointed by the CQC. Hospitals will be given a single overarching rating as either Outstanding, Good, Requiring Improvement or Poor.
    - Safety SI's (Serious Incidents): 3 in January 2013 (pressure ulcer, chest drain insertion, and fractured femur suffered by patient receiving palliative care); 1 in February 2013 (sleep apnoea/patient required tube but subsequent cardiac arrest).
    - Radiation Safety Incident: 1 reported (radiopharmaceutical misadministration in Nuclear Medicine).

NHS Standard Contract (Commissioners):

- Mixed Sex: no breaches in January 2013, 2 in February.

National Friends and Family Test (FFT):

- RCo reported that it was highly probable that the FFT would be included in the new CQC hospital rating. The Trust has a net promoter score of 82%. The Secretary of State in his comments on 26 March 2013 on the Francis Report had indicated that the CQC rating would be for individual departments/wards rather than for the Trust as a whole. The FFT section of the Clinical Quality Report showed that the Trust currently had two wards that were doing exceptionally well as recorded in FTT responses.

SRF asked if the Trust could do anything better to lower the cases of reported *Clostridium difficile*? CS said the Trust should focus on what it can do about it and would continue with its policy of zero tolerance. Antimicrobial prescribing, effective hand hygiene, laxative reduction were all measures that might help and also carrying out Root Cause Analysis (RCAs) of any issues. RCo said that he had written to NHS London to place on record that the Trust continues to dispute the *Clostridium difficile* objective set by the Department of Health (DH) and to request clarification of the process by which this can be progressed. BB added that the Trust had now been dealing with this issue for three years (since the baseline was reduced by the Department of Health [between 2010/11 and 2011/12]Originally the Trust had approached the Department of Health (but had not received a reply and had then went to the regulator, Monitor. Monitor had changed their target to a *de minimus* which showed that they understood the problem.

NL welcomed these comments and said that his question to the Board in January had been about whether the testing for *Clostridium difficile* was appropriate and he had not been suggesting the testing was inadequate.

AVO asked if it was known whether other London based Trusts were in breach? BB said other Trust with lower thresholds were indeed in breach. Part of the problem was that the indicator was applied to Trusts where the reporting the incidence of *Clostridium difficile* did not appear to make much sense – for example Moorfields Eye Hospital. TE agreed. He supported CS's statement about zero tolerance - one further breach would be one too

many. If the Trust continued to monitor performance against its own metric he was comfortable with that. He added that it is difficult to apply the guidelines 'appropriately'. The Trust does work to a protocol and on this it does not compromise.

BB reiterated that the Trust does not have a systemic infection control problem.

NL asked what would be the financial impact of the Trust declaring it had not met the 18 week referral to treatment time target for admitted patients. RCo said a significant provision had been made. He confirmed that this was the first year that NHS NWL had raised this issue.

NL asked how the Trust would implement the Waiting list initiative (the remedial action plan) and set about improving the performance? RCg said the plan remained to be back in compliance from 1 April 2013. In November 2012 NHS NWL had asked the Trust to project the trajectory of patients. This had been done and the Trust had been successful in getting some additional resources to help deliver the plan. NL then asked if NHS NWL would accept the 90% and whether RCg was comfortable with the Trust being slightly below the target currently? RCg said he was comfortable with the current outturn.

NL noted that a report from CS in a later paper included some negative patient comments and asked that some negative comments be included in future FFT reports to ensure balance. This was agreed. NL said that while the net reporting score was also very good he wondered how it compared to comparative hospitals who had scored higher. Being able to see this would allow the Trust to see how it could improve further. CS said this was the first time the FTT had been carried out. The DH planned to make the findings public from July 2013.

2013/18 <u>FINANCIAL PERFORMANCE REPORT FOR MONTH 11: FEBRUARY 2013</u>

Introducing his report RP highlighted the following performance in M11:

- This had been a disappointing month yielding a £1.7m deficit against a planned surplus of £0.5. Performance year-to-date was a surplus of £0.2m which was off plan by £2.0m.
- The poor M11 result had been caused by a number of things: PICU agency costs, redevelopment costs, shortfall in private patient income, refurbishment of ICU at Harefield Hospital (HH), low rate of discharges leading to a bottleneck at HH, and capacity issues at RBH.
- Looking forward to M12 the planned surplus for M12 was £0.9m: while predicting performance can be hazardous RP anticipated there would be an improvement over M11. Positive factors included additional permanent staff in PICU which would continue into the next year and the completion of ICU refurbishment at Harefield. This meant the planned surplus of £3.2m could still be achieved.
- Project Diamond (PD) funding of £9.2m had been received on 1 March.

- Balance sheet: cash and liquidity at the end of M11 was reasonable and would be boosted by the PD receipt. Capital spend was at the lower end of the 75% to 125% of planned spend that Monitor expects the Trust to achieve.
- A draft budget for 2013/14 would be presented at the next Board meeting. This would be a demanding year for the fourth time in succession. Both cost and income would be under pressure.

NL said he echoed everything RP had said. He noted that PD income was in excess of what the Trust had budgeted. RP confirmed that the budget had been conservative. The year ahead appeared more challenging than at the same time last year.

BB noted that PD was not in excess of what the Trust had asked for. The Trust had always insisted it should be receiving more.

The Board noted the report.

2013/19 RESEARCH UPDATE

TE said the report highlighted the Trust's successes: recruitment of patients into research studies, grant income, and governance associated with delivering research. The Trust is a major recipient of funding from the National Institute for Health Research (NIHR). The report also included an update on the 2012-15 Research Strategy. TE reported that that there had been satisfactory progress against the plan which had been agreed by the Board in 2012. In terms of outputs, 313 articles had been published over the last recorded 12 month period. He contrasted this output with the 170 papers published by the Collaboration for Leadership in Applied Health Research Centre based at C&W which had published 170 papers over the last 4 years.

SRF asked if work with Imperial College (IC) was progressing well? TE said it was and a strategic away day had been held recently. The requirements set by the NIHR were being met and developed. SRF noted that at the recent opening of the sleep centre Sir Mervyn King, outgoing Governor of the Bank of England, had praised the Trust highlighting its national and international standing.

KF endorsed TE's comments and the collaboration between IC and the Trust is outstanding and is a model for others Trusts.

BB said the emphasis on IC meant the importance of the tripartite partnership between the Trust, the Liverpool Heart and Chest Hospital (LHCH) and IC known as the Institute of Cardiovascular Medicine and Science (ICMS) could be overlooked. Both Richard Hunting and KF sat on the ICMS Board. A very positive meeting had been held on Friday 22 March 2013. BB suggested that maybe internally more people needed to be made aware of this. JH concurred and said as well as involving industry in partnerships the Trust's existing collaborative work with IC, the partnership

with Liverpool and IC through the ICMS triangulated the outputs. KF commented that the ICMS collaboration was not the same as the research collaboration between the Trust and IC. But together in terms of clinical workload it was almost certainly the largest in Europe. This was manifested in publications, research projects. In the ICMS, IC'S position is that of the academic partner. KF said it was quite right to explore ties with industry.

SRF suggested Liverpool's CE was invited to give a presentation to the Board. KF suggested that he present to the Board on the subject of the ICMS collaboration and this was agreed.

AVO said that as a new member of the Board had been very impressed with the report. He noted that during his various discussions with and meetings at the Department of Health he had not had the impression that DH officials were area of the Trust's contribution in this area. He suggested the Trust's profile could be better. SRF proposed that JT could lead work in this area.

Action:

- **KF present to a future Board meeting on the subject of ICMS collaboration.**
- **JT to update the Board on profile-building work with DH.**

2013/20 MID STAFFORDSHIRE NHS FT PUBLIC INQUIRY 2013 REPORT (THE FRANCIS REPORT)

Introducing the report CS said it had been written before the announcement on 26 March 2013 by the Secretary of State but she believed that his comments had no major impact on this report's content. In the report she has set out the themes of the recommendations from the Francis Report that she felt applied immediately to the Trust. CS said she did not think it was necessary to establish an internal Francis Report Steering Group and that it was better to cascade the message down to individual managers but the Board was invited to comment on whether this was the right response. In her view RBHFT is clearly not 'a Mid Staffs' but that did not mean the issues would not be taken seriously by the Trust. David Nicholson, NHS Chief Executive, had written a letter to all Trusts and suggested that the Francis Report be discussed at a public Board meeting and in teams.

SRF said the report would go through the Risk and Safety Committee (RSC) overseen by AVO is his new position as Chair of that committee. He suggested that the Board's action today should be to note the report and note that it will come back in due course. CS commented that she thought that would be the best course.

JH said that when major reports such as this are seen by the Trust the organisation had not always been very good at looking back. Previously some principles had been identified but they had hung in the air?

KO referred to Point 75 in the Board report on the recommendation of the Francis Report for role descriptions to be produced for Governors. She asked if the RSC should look at how that might done? SRF said the RSC would take this on board.

NL said he had noted and agreed with the view that a Francis Steering Group was unnecessary but asked if there should be an implementation plan? CS said this had not been developed as yet as it had been necessary to wait for the Secretary of State's statement but this would be looked at over the next two months. It was agreed that CS would present a report to the Board in July and that this would mark the fulfilment of the 'instruction' that the Francis Report be discussed in a public meeting.

BB said he interpreted JH's comments as begging the question 'Is the Trust compliant?'. The Trust has its own standards and values and the issue is about how the Trust is managed on a daily basis. The Trust was constantly in alignment with its core values. The response to the Francis Report is about testing whether the Trust's values are relevant in relation to it. He noted that there had been a tremendous amount of hyperbole that had accompanied the publication of the report and this had manifested itself mainly as an anti-NHS view. It was right that the Board should occasionally show how the Trust was doing against its values. This was not a demonstration of the Trust being defensive but a proper and measured response to the hype and hyperbole around the Francis Report.

LA said that the values focus on doing the best for patients. She cautioned that is might not be best to describe reaction to the report as hype especially in respect of the relatives of the victims of abuse within Mid Staffs Hospital. She asked if whistleblowing reports were seen by the Board? CS said they were. Some reports were looked at by the RSC. The Trust's Whistleblowing Policy had been reviewed and currently there had been no whistleblowing allegations to assess. The minutes of RSC are included in Board papers. SRF added that every paper of the sub committees is available to all Board members on request.

AVO observed RCA processes at Trust are very good. He endorsed what CS had said and he thought it was correct that here will be some pushy implementation by the DoH. He wondered if the NHS was not so good at safety. Using a comparison with the aircraft industry, in that sector if a serious fault was detected, then they instantly grounded all aircraft to be inspected and the faults rectified before they are allowed to become airborne again.

BB said that the duty of candour starts at the top. The Trust had always been open and transparent about its flaws and faults. In response to AVO's analogy he commented that the Trust itself does deal with its safety problems appropriately. BB said the Trust in general had good outcomes which did not happen by chance.

2013/21 STAFF SURVEY RESULTS

CJ was invited to introduce the report. She said the aim of the report was to highlight the most significant and negative responses in the 2012 survey and to demonstrate how RBHFT compared with other specialist Trusts.

NL commended the report which was a balanced one. The Trust was one of only 8 organisations who had scored over 90% in relation to the question about whether staff felt happy with the care provided if a friend or relative should need treatment. The Trust's score of 93% mirrored overall findings that staff engagement was high.

CJ highlighted two charts which showed the Trust was below the national average. Firstly, the percentage of staff appraised in the last 12 months (65% against the average of 82%). The aim is to address this target both in terms of quantity and quality. Secondly, the percentage of staff who believed that the Trust provided equal opportunities for career progression or promotion (82% against 88%). The aim is to look at secondments and project work. KO said she was unsure whether this meant equal opportunities for progression (in the sense of opportunities of support for BME groups) or opportunities for progression for all? CJ said it was the latter.

NL said it would be useful to know what the average was for all acute specialist Trusts though admittedly it was a moot point about what might be learnt from that. However, he proposed that a report on Appraisals be presented to the Board. This was agreed (for October 2013).

KO noted that the report focused on inputs rather than outcomes. She asked if there was any feedback on the quality of appraisals? CJ acknowledged this was a pertinent question. Staff were engaged and their views sought on other occasions than the appraisal during the year, through team briefings for example. KO thought it should be asked in the survey but said she drew some encouragement from the response.

JH said that it would be helpful to know how the percentage (RBHFT - 38%) of staff reporting good communication between senior management and staff broken down by site. CJ said the average for RBH was 38% and Harefield Hospital (HH) 39%.

RP asked if the score for the percentage of staff reporting errors, near misses or incidents (86%) would be a better one if it was higher or lower? TE replied that the more open the culture of an organisation the higher rate of reporting tended to be. This meant that higher is better.

Action: CJ to present report on Appraisals to the Board in October 2013.

2013/22 CONTROLLED DRUGS GOVERNANCE AND ACTIVITY OCTOBER 2012-DECEMBER 2012

The Board noted the report.

2013/23 AUDIT COMMITTEE (AC)

(i) REPORT FROM THE MEETING HELD ON 19 FEBRUARY 2013

NL apologised for the absence of the minutes from the February meeting. He summarised the principle issues arising. The internal Auditor's programme was proceeding according to plan. One important issue was raised by KPMG relating to the process for ensuring that lessons of wider relevance were captured. At the meeting the Committee reviewed Deloitte's audit planning for 2012/13. NL explained that following the external review of Board and Committee effectiveness in 2012 the Committee would be carrying out a self-review of effectiveness in 2013. The result of this review would be shared with the Board in July 2013.

2013/24 RISK & SAFETY COMMITTEE

(i) MINUTES FROM THE MEETING HELD ON 19 FEBRUARY 2013

NL highlighted one comment from Internal Audit review from implementing lessons from SI's. This report had received an Amber rating. The key recommendation related to trends in root cause analysis.

2013/25 TRUST RISK REPORT

CS reported that the RSC had received a risk update at its February meeting. This report was a summary of it. He highlighted the 2 highest risks - Decommissioning of paediatric cardiac surgical services (2835) and Estates health related issues (2894). BB had updated the Board on risk 2835 in his Chief Executive's report (see above).

For risk 2835 NL said he was unsure he understood the movement correctly on the risk matrix illustration. It was unclear whether the travel was either as a result of the controls the Trust had now put in place or was due to external factors. CS agreed to review this item.

2013/26 REGISTER OF DIRECTORS' INTERESTS

The Board confirmed the accuracy of the report.

2013/27 QUESTIONS FROM MEMBERS OF THE PUBLIC

a) Donald Chapman said at the last Board meeting that he had been reassured that the condition of the Harefield Mansion would be monitored. He asked if there was any further progress to report.

JA said a planning report and a structural structural survey had been carried out. The costs of repair were due to be considered by the Capital Working Group alongside other estimates of capital improvements which would also require due consideration. DC said the Mansion was a Grade 2 building which had been allowed to fall into state of decay. It was historically important from the perspective of the history of NHS and Harefield Hospital.

b) Michael Gordon (a RBHFT volunteer) asked three questions. Firstly, why were the public and staff failing to use the alcohol rubs either at the bed side on at the public entrances as part of infection control? Secondly, for the High Speed Two (HS2 – Cross Rail project London/Birmingham) he had noted that the digging up roads will affect emergency ambulance access to HH. He asked what the Trust's view on this was? Thirdly, what was the Trust doing in respect of Nurses' training?

In response to Mr Gordon's first question CS said she would look into this but that the emphasis was now on using the alcohol rubs before entering wards and at the bedside. She added that in response to the question on training the Trust already had a programme for Health Care Assistants. BB added that the Trust stopped monitoring hand hygiene compliance at point of entry as there was no clinical evidence that this was effective. It had been halted as a mandatory practice and there was evidence that the alcoholic liquid was being taken for other reasons than prevention of infection.

SRF said a response to the question on HS2 would be added to the minutes as a secretarial note. (Secretarial note: RCg will liaise with the London Ambulance Service). Mr Gordon asked if the Trust had been sent the plans? RCg said the Trust did not get these but he knew that the various ambulance trusts affected do.

DATE OF NEXT MEETING

Wednesday 24th April 2013 at 2 pm in the Board Room, Royal Brompton Hospital.