Minutes of the Board of Directors meeting held on 27th November 2013 in the Concert Hall, Harefield Hospital, commencing at 10.30am

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
	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
	Mr Andrew Vallance-Owen, Non-Executive Director	AVO
By Invitation:	Ms Carol Johnson, Director of Human Resources	CJ
	Mr Nick Hunt, Director of Service Development	NH
	Mr Piers McCleery, Director of Planning & Strategy	PM
	Mr David Shrimpton, Private Patients Managing Director	DS
	Ms Joanna Axon, Director of Capital Projects & Development	JA
In Attendance:	Mr Anthony Lumley, Corporate Governance Manager (minutes)	AL
	Ms Gill Raikes, Chief Executive, The Royal Brompton & Harefield Hospitals Charity	GR
Apologies:	Mr Neil Lerner, Deputy Chairman & Non-Executive Director	NL
	Mr Richard Connett, Director of Performance & Trust Secretary	RCo

2013/91 DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING

None.

2013/92 MINUTES OF THE PREVIOUS MEETING HELD ON 30 OCTOBER 2013

The minutes were approved subject to the following amendments:

- Page 2, item 2013/80, second para., first bullet, 2nd sentence: after 'On the' insert 'Clinicians Group the' before 'Trust's nominee'. .

2013/93 REPORT FROM THE CHIEF EXECUTIVE

BB noted that he had circulated a written summary of his report.

Government's Response to the Francis Report

BB said that last week, the Government issued their response to the Francis Report. The Government accepted all but nine of the Francis recommendations. The Trust was currently analysing the government response to evaluate key implications that may be specific to our Trust. CS was also analysing a subsequent guidance that was issued by the Chief Nursing Officer and the National Quality Board on nursing staffing guidance to make the right decisions about nursing, midwifery and care staffing

capacity and capability. A review report would be prepared for the Board in due course.

The overriding message of Francis and the Government's response was about "listening to the patient, speaking the truth and acting with compassion". BB said these were values and rules that had long been held and practised by the Trust. They were the same values that led the Trust to achieve a positive outcome in the quest for standing up to the "Safe and Sustainable" proposals on behalf of the patient community that the Trust serves. The upshot from the media event accompanying the announcement was an opening up of an industry of consultants and lawyers offering their interpretations.

AVO said that while it was necessary not to be complacent there was a great deal of good practice in the NHS. Even at Midd Staffordshire Hospital parts of their service were excellent. The Trust needs to assure itself that everything it does is ok, be positive but acknowledge there is a lot to learn from. BB said there had been a negative impact on staff morale. The day following the announcement the Secretary of State (SoS) had said that the NHS does 'harm'. The Trust's nurses would have read this.

LAA agreed with AVO that it would be dangerous to be complacent. She also felt it was dangerous to see it as a media event but agreed about the effect on morale. At Mid Staffs the Board's main failing had been complacency.

Chelsea Development

BB said public consultation events by the Royal Borough of Kensington & Chelsea (RBK&C) about the development of the Supplementary Planning Document (SPD) were now in full swing. Later that day he would be attending the first such event at St. Luke's Church, Sydney Street, London SW3. RBK&C had produced a brochure/pamphlet concerning our proposed development plans sent to Board members by email on 26 November 2013 and tabled here. There would also be consultations with other groups of people who wish to meet the Trust outside the public events. He was hopeful this would be a positive process but challengers with vested interests had already emerged and the Trust should not underestimate the potency of these challenges. Generally, these groups had ideas of their own about what the Trust should do with its estate. It was not likely to be 'plain sailing' for the Trust's application.

AVO noted that there had been positive coverage in the media. BB agreed and said the NHS press had also generally been positive.

Asked by LAA who were the challengers BB said they were:
- Royal Marsden Hospital (RMH) who would probably object to the Trust's plan to sell Block E (Fulham Road Wing).

- Some of the Royal Brompton & Harefield Hospitals Charity's Board members had alternative ideas which would be voiced at a meeting of the Charity BB was attending on 28 November 2013.
- Another group had proposed that Block D (Dovehouse Street) should be residential while another proposed it became a staff residence.
- Another proposal was for Blocks E & F (Dudmaston Mews) to become retirement homes.

In summary BB said that many of the groups appeared to believe that because they saw the Trust as part of the NHS it should simply give some of its assets away, despite the fact that any proceeds were required for re-investment.

AVO said that the more (and more disparate in nature) the proposals were, the better the Trust's plans would look. SRF agreed and said if the Trust is not allowed to sell off parts of its estates the Royal Borough would not have a new hospital for the 21st century.

KF asked if each block would be part of a separate application and, if so, how would the Trust handle it if some are rejected and some are accepted? BB said the Trust would consider this in private. He added that planning was a 2-stage process: the SPD followed by detailed planning applications for the estate. Those who acquired Trust assets would be subject to planning processes of their own. The Trust would not complete the second stage until there were planning consents for all the properties to be sold.

Private Outpatient Facilities

BB reported that the Trust was currently in the final stages of negotiating a lease for new premises on Wimpole Street to expand the outpatient clinics space for Private Patients (PP). A lease agreement was expected to be completed by the beginning of 2014 and a phasing in period of 3-6 months was currently anticipated.

SRF said he had visited Wimpole Street to look at the facilities. They seemed most appropriate.

BB concluded his report by reminded the Board that the SoS would be visiting the Trust on 5 December 2013. This was an opportunity to show how the Trust does not reflect what has been happening in some parts of the NHS. SRF said it was essential that the SoS hears all the right messages and the briefing for staff was clear.

2013/94 NHS ENGLAND (NHSE) NEW CONGENITAL HEART DISEASE REVIEW

RCr said the paper was provided for members' information. He had 2 additional comments: firstly, that the review was thus far long on process and short on substance. Secondly, the review was working on standards, for children, for DGHs (as was done in the Safe and Sustainable (S&S) review), and for adults. NHSE would bring these strands together to consult in the new year. He also noted that the broad scope had implications for the

Trust's neighbours. For example, specialist obstetrics had been included in the scope which is a service provided by Chelsea and Westminster Hospital NHS Foundation Trust (C&W).

SRF asked what the 'hidden agenda' was? RCr said the review's Programme Board maintained that they want to engage as much as they can and to avoid an argument over 'winners and losers' when the final specification is published in the summer of 2014. The service standards would be aspirational and it would be up to NHSE's specialist commissioners to assess how to use them in commissioning decisions.

SRF asked if Great Ormond Street Hospital and Guy's and St Thomas' Hospital were involved? RCr said they also had representation on the informal 'engagement' groups. SRF asked if the Trust had a good interface with the bodies involved? RCr said, as he had previously stated to the Board, that the Trust was seeking to engage as much as possible, but could give no guarantees about its influence. TE said that some of the leadership roles had gone to some organisations that may not be sympathetic. The Trust's clinicians were scarred by previous experience. He could only give cautious assurance about engagement but he felt that the Trust would meet the standards when these were published.

BB said that the 'hidden agenda' was for fewer centres to deliver CHD services and this would tacitly be admitted by the leaders of the review. The issue now was the process to achieve that result. He was not aware of an agenda specific to RBH but some of those involved still held similar views to those involved in S&S. RC concurred and said that the review team's presentation to the Provider Group showed they were clearly struck by the fact that there were currently as many as 25 centres delivering Adult CHD surgical services. That was more concerning to them than the number of paediatric centres.

2013/95 <u>CLINICAL QUALITY REPORT FOR MONTH 7: OCTOBER 2013</u>

Presenting the report on RCo's behalf, RCr highlighted the following:

- Monitor's Compliance Framework: all requirements had been met, but the 62-Day Cancer target was subject to the 2 breach repatriation requests described in the report being agreed in discussion with the 2 Trusts concerned. RCr cautioned that this performance was only for the first month of the current quarter (Q3 – October to December 2013).
- Care Quality Commission (CQC): the Trust had been alerted to an inspection expected at Harefield Hospital (HH) before the end of the financial year.
- Clinical Outcomes: Hospital Standardised Mortality Rates (HSMR): this was 116.45 which was above the national benchmark, but falling back towards the expected rate.
- Incidents - Safety SI's (Serious Incidents): one SI – a Grade 3 pressure sore, occipital region reported in October 2013.

- NHS Standard Contract: 18 RTT by National Speciality – Incomplete Pathways: the 92% target had been missed at the 'other' national specialty level (89.16%). 18 Weeks 'Admitted' and 'Non-admitted' pathways were compliant across all specialties.

SRF asked if the Trust was confident that the threshold of 12 cases of *Clostridium difficile* would be accepted by the Department of Health (DoH)? RCr said RCo was not confident this would be agreed.

RH said he would welcome TE's comments on HSMR. TE clarified that the procedures and diagnoses that had contributed to the score came from within acute cardiology at HH and specifically from primary angioplasty. The rise in HSMR had started in April 2012. Analysis of all deaths had showed that cardiac arrests out of hospital were now coming to HH which was right in one key respect as, occasionally, a patient's life was saved. He added that, in spite of this second consecutive monthly fall, the Trust should not be complacent and he could not give reassurance it would not rise again. TE also pointed out that Papworth Hospital NHS Foundation Trust and Leeds Teaching Hospitals NHS Trust had expressed concern about this data. It had emerged that the clinical codes used in the Trust to identify palliative care were not those used by the Dr Foster HSMR analysis, and this adversely influenced the reported figures. It was noted that the HSMR figures contributed to the Trust being rated in band 3 by CQC in their recent 'Intelligent Monitoring' Report (band 1 being the highest risk and band 6 the lowest risk). RH welcomed TE's comments. Invited by the Chair to comment in his role as chair of the Risk & Safety Committee, AVO said coding of palliative care was hugely controversial. It appeared many Trusts had effectively 'upped' their codes in order to reduce their HSMR score. The Trust must be transparent and correct in its processes, but clearly argue its position with the CQC.

BB said it was indeed clear that the CQC had used this regime to place the Trust in a ranking of 3. Country wide there was discontent with respect to this CQC process and he and some other Trust CEOs had stated their concern. He agreed with AVO that the Trust must challenge CQC and voice its concern about the system it was using. The timing of the publication of the report had been unhelpful as it had been released to the press with no advance opportunity to comment. It was right to challenge what the Trust perceived as ineffective processes. AVO concurred and said he was concerned that too much attention was given to stark data on mortality published by Dr Foster. There was no focus on the 95% of patients who do not die and their (often positive) experience of care.

LAA asked for clarification of a complaint summary suggesting that an 'open' heart procedure would be less painful than a minimally invasive one. CS and TE agreed that this appeared incorrect and CS offered to check the summary after the meeting. (Secretarial note: CS has clarified since that because of the degree of internal manipulation with minimally invasive surgery it can be more painful).

The Board noted the report.

2013/96 FINANCIAL PERFORMANCE REPORT FOR MONTH 7: OCTOBER 2013

Introducing his report RP highlighted the following:

- M07 had been a good month. As October had more normal working days than any other month the Trust had budgeted for additional revenues but did even better, exceeding plan both for NHS and PP. M07 had recorded a surplus of £1.3m against a planned surplus of £1.1m. The Trust had a surplus Year to Date of £2.7m against plan of £1.4m. The plan for the whole year was £2.3m. All divisions were meeting or exceeding plan on a YTD basis.
- One off items: firstly, following a VAT audit on the period January 2010 – March 2011 the Trust had been notified that it had under-declared VAT to the sum of £400k. A provision of £0.5m had been set up in M7 to cover this plus any interest or penalties incurred. Secondly, the release of £500k from the provision which was set up in March 2013 against the risk of non-payment of PCT legacy debts by successor bodies. This had proved to be more than required as the great majority of PCT debts had subsequently been collected. The net effect of these two movements to the Trust's I&E was zero.
- Balance sheet – cash. This had held up quite well but NHSE and the Clinical Commissioning Groups were still very slow payers. The Trust had just received £2m from NHSE but had had to agree this was 'on account' and not for over-performance. However, RP said he was hopeful that the outcome of a meeting with NHSE shortly would lead to further receipts. The new Working Capital Facility was in place. The Trust's balance sheet could be described as 'conservative'.
- Continuity of Service (CoS): The Trust did not have to make a declaration against the new CoS rating for M07 as CoS is declared quarterly but if it had had to, it would have been a 4, the best available.
- Project Diamond (PD): RP said he was now more confident this was forthcoming as he had read in minutes from NHSE that they were anticipating a £600m surplus.
- Looking ahead, RP said he was not unduly concerned about the outturn of 2013/14. However, the Trust had to start planning for 2014/15. A recent straw poll of Trust finance directors had revealed that 50% would be planning a deficit for next year. There was some talk about Monitor putting to the DoH that 4% efficiency was too much after last year which meant there was a slight possibility this would change for the better.

LAA said she had been unable to work out in the report the profitability (percentage) from Private Patient (PP) income. RP said PP and NHS costs were conflated in the finance report and the data underlying it. Separately, the Trust did have a service line reporting (SLR) system. However, this was only prepared on quarterly basis and it was behind monthly reporting. For example, SLR data for Q2 would not be reported until early December. The Trust currently did not have the systems that could provide integrated

reporting of SLR data with that for the finance report but this was intended in the future. In the meantime, he agreed to share Q2 SLR data with LAA outside the meeting.

KF said these were outstanding figures but noted two outliers - respiratory medicine at HH (positive) and cardiac surgery at RBH (negative). He asked what was the problem in cardiac surgery and what was being done? TE outlined some of the work that had been done at HH in which cardiac surgery was an important part, and outlined the changing provider landscape and pressures on the Trust from outside. He assured the Board that he believed the HH service was now as efficient and streamlined as it could be, but wished to guard against complacency. The improvements seen at HH could now equally be applied to RBH.

BB said that there had been some staffing issues and endorsed TE's description. BB believed a change of attitude was needed at RBH as it had been assumed that patients would come simply because of its history and reputation but this was demonstrably no longer the case. TE agreed and said the Trust should work more closely with referring DGHs on their referrals. He added that the problems described did not apply to thoracic, adult, and paediatric surgery, all of which were working well. RCr said that the changes described at HH had occurred at the same time as a change in the complement of surgeons. Therefore the timing at RBH was appropriate, given the recent appointments there. KF acknowledged that there had been a transformation at HH. BB said there was still more work to at both sites and any difficulties would have to be reported to the Board. He emphasised that, at RBH, there were some surgeons who had already adapted and therefore had not been affected by the downturn.

Invited to comment on the financial position RCr said the various teams deserved recognition for the good performance. He added that even in the RBH heart division targets were being met because areas other than adult cardiac surgery were doing well.

BB said the present underlying position was good but there was a challenge. Monitor may comment that the Trust was not meeting its savings target (Cost Improvement Plan - CIP). RP said he had quarterly calls with Monitor, and one was scheduled for the next day (28 November 2013). CIP was behind target despite the fact that the Trust's financial performance for the year as a whole was ahead of plan. He had previously stressed to Monitor that the Trust managed the whole of the I&E account and not just the CIP elements thereof. That said, the CIP was currently short of target by c.50%. However, this was in part due to activity levels ahead of plan which had led to additional costs, in particular pay costs. These points would be put to Monitor.

The Board noted the report.

2013/97 RESEARCH UPDATE

TE presented the report and said the highlights were increased self awareness and grants were satisfactory. This was the second year of the strategy and it was on target. However, he described 4 significant challenges:

- Research productivity - genetics. In 5 years genetics research will be as important as cardiac research.
- Heavy investment in IT.
- Imperial College London (ICL) have started to recognise colleagues in less traditional areas. E.g. Adjunct Professor programme. Darryl Shore and Rob Wilson had been made Adjunct Professors. This was a huge advance but further recognition was needed.
- Research funding: attention should be given to where the funding of research was heading. The traditional grant model was unlikely to continue forever. A centre for community based cardio-vascular research was possibly needed. As the Trust moved towards BRU replacement or replacement of BRU funding it was likely RB&HFT would be excluded from applying.

SRF said that the S&S process had criticised paediatric research and asked if the high level of quality TE referred to applied to all parts? TE said it did though more to some areas, which were world class, and less so to others. In reply to a further question from SRF he said it was the case that the Trust had to create the income itself.

Invited by the Chair to comment of TE's points KF said:
- He agreed that the university model of clinical research may not be sustainable. Over time the Trust would be unlikely to get grants and there was a preference for non clinical research. At the same time the Trust's clinical research was excellent. There were instances where outstanding individual clinicians would never get grants from NIHR. For example: John Cleland, a world class leader in heart failure or Pr Jadwiga Wedzicha and Gavin Donaldson, Reader who had taken their whole team from University College London (UCL) to RBH. In response to a question from SRF on whether the Trust had sufficient capacity to continue with its research ambitions, KF said the Trust was big enough (being about a third of the size of UCL) and it was essential to do it**.** KF added that he agreed with TE that we need to think about how we do it ourselves.
- The adjunct professor programme was a positive move. He agreed that the Trust must put more people up for it. Darryl Shore clearly benefited immensely from being Pr Darryl Shore.
- He agreed that genetics research was a huge advance.

BB said the Board should recognise and acknowledge the merit of having 2 leading academic clinicians as members - KF and TE - who share the same vision and a recognition that the historical model had to shift. This was not a new phenomenon in the world. Trusts will end up with their our own learning and research institutes and no longer be tied to just one university. This challenge had been recognised and was being met by TE and his team. ICL

would still remain an important part of the future. World wide, the key resources in research had come from private donors. SRF asked where he saw the Liverpool Heart and Chest Hospital (LHCH) in this vision? BB said they were a building block to getting to the vision as was University Hospital of South Manchester. LHCH shared this vision. The model could be described as the affiliated hospital model. Trusts could become affiliates of several academic institutions.

2013/98 MATRONS' REPORT: JULY – SEPTEMBER 2013

CS presented the report. The highlights were

- hand hygiene where the electronic monitoring system was up and running and is being evaluated in critical care areas
- Cleaning at HH with good news from HH with scores close to, or above, benchmark levels in high risk areas.
- Intentional rounds in ICU at HH with cost and time savings related to haemofiltration therapy.
- Experienced based co-design with patients. Paula Rogers, Senior Research Nurse in the heart division at Harefield, had been awarded a grant from the Foundation of Nursing Studies to undertake a study of the patient's experience of having a myocardial infarction (heart attack) and of being involved in a research project.

The report had also set out some of the continuing challenges in the Fulham wing.

CS said that in addition to the Champions Award for the lung division at HH referred to in the report, a clinical nurse specialist, Melissa Rochon had won the Nursing Times 2013 award in the infection prevention and control category. This had been mentioned by the SoS in relation to his forthcoming visit to RBH. The Board congratulated Melissa on a fine achievement which recognised her outstanding work.

2013/99 CAPITAL INVESTMENT FORECAST

RCr introduced the paper which had jointly been prepared by RP and himself. The paper asked the Board for approval of re-forecast capital investment for 2013/14 and a view on investment decisions over the next 5 years (i.e. up to and including 2018/19) and an endorsement of the proposed approaches for external sources of funding. The Chief Information Officer was developing an I&T strategy that would come to the Board for review. KO suggested that it would be better if that strategy was seen at the next Board meeting (January 2014) before the Board held its 'retreat' to look at future options. This was agreed.

RP described it as an ambitious programme. If the Trust did not look for outside funding the CoS rating would suffer in the next financial year which meant it would be necessary to secure long-term funding for capital expenditure from early in 2014/15.

SRF said he noted that plans for HH were included but asked for more detail of what it could mean for that site? RCr said in the longer term this meant investing in new services at HH, including new inpatient beds. The current programme entailed replacing and enhancing critical care beds. These beds were currently scattered across the hospital and hard to manage but would be replaced over time in a way that was affordable and achieved volume. Also over the next 3-5 years developments (for both cardiac and respiratory patients) needed to be accommodated.

BB said the Charity could be guided by this. While there wasn't much detail in the proposals some of them could be supported by the Charity and fundraising requirements should be co-ordinated between the 2 bodies. (Note for the minutes: SRF and BB are trustees of the Charity. RH is Chair of the Charity's board). Gill Raikes was invited to respond. She said she would welcome more detail. She added that the Charity was also interested in supporting research but emphasised she would listen to all formal proposals from the Trust.

RH said, speaking in his position as Chair of the Charity's Board of Trustees, that the sheer quantum of what the Trust wanted to achieve was significant. The Charity had started from a fairly low base but recognised that most of the funding for the Trust's capital programme would have to come from elsewhere than the charity. He emphasised that the Charity and the Trust were working together on this.

The Board approved the revised forecast of capital investment for 2013/14; recognised the planning assumptions for 2014/15 and beyond; endorsed the principal of approaching external sources for funding; and further integration with the work of the Charity.

2013/100 <u>GOVERNMENT RESPONSE TO FRANCIS REPORT</u>

SRF noted that the Board paper was full and largely self explanatory but invited CS to add any further comment. CS said that the issue of staffing (and the guidance that would be produced by the government) was the collective responsibility of the Board and not just the Director of Nursing. She added that the Trust had already proactively done a staffing review.

SRF asked if many of the priorities within the government's response were already happening in the Trust. CS said that they were but highlighted that the level of detail that Trust will be required to respond to would be huge. There was a regulatory burden issue. BB said Monitor would be producing guidelines for requirements for 2014.

BB said he felt it was disturbing that there appeared to be a context that could lead to the Trust being told it was not providing adequate staffing. In July 2013 the DoH had publicly disclosed that the Trust had one of the highest quantums of agency use but now all Trusts were being asked to look at quality and whether there are sufficient numbers of staff in place. Previously the Trust had needed the nurses and had brought in nursing

staff as appropriate because the Trust is always guided by doing what is right for patient care.

AVO said the National Institute for Health and Care Excellence had also being asked to look at staffing levels.

CS said she was and unsure where this new initiative may lead. The issue of nursing and staffing levels had been raised before and attempts to address it had been made over many years. In the meantime the Trust would continue to use on one of the better recognised tools which was mentioned in the Appendix of Board report (i.e. regular updates on staffing described under Openness and transparency specifically).

2013/101 RECOMMENDATIONS OF ADVISORY APPOINTMENTS COMMITTEE

KO reported on the appointment of a Consultant Cardiac Surgeon Aortic Surgery. There were 2 candidates - a well regarded locum and an established consultant surgeon from outside. It was decided to offer the post to the external candidate. TE confirmed that further development for the current locum was already underway. The appointment was subject to the person having been observed practising in surgery. TE confirmed this had happened and there were no concerns. The appointment of George Asimakopoulos was ratified by the Board.

2013/103 QUESTIONS FROM MEMBERS OF THE PUBLIC

Mr Kenneth Appel complimented TE for the Research Update and CS for her paper on the Government's Response to the Francis report. He asked the following questions:

- What was the current position of the negotiations with C&W on sharing of a paediatric heart service?

SRF said discussions were continuing and C&W would make up their minds by March 2014. BB added that the Trust was ready to move forward. The Trust was waiting to hear from C&W specifically on whether they can accommodate the space RB&HFT had asked for.

- Cancelled operations: one of the causes listed in the Clinical Quality report was 'capacity' (i.e. lack of). Can this be addressed?

RCr said he had had conversations with KA on this subject and these would continue. He added that any cancellation was not done lightly. He also cautioned about reading too much into the descriptors for cancelled operations but acknowledged the point that when there are cancellations this still should be addressed.

- Complaints: there appeared to be a discrepancy in the number of complaints from NHS compared to PP complaints. CS said this could be explained by the fact that there are many more NHS patients.

NEXT MEETING

Wednesday 29th January 2014 at 2 pm, in the Board Room, Royal Brompton Hospital.