Minutes of the Board of Directors meeting held on 28th March 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 Richard Connett, Director of Performance & Trust Secretary	RCo
	Mr Richard Paterson, Associate Chief Executive – Finance	RP
	Mr Robert Craig, Chief Operating Officer	RCr
	Mrs Jenny Hill, Senior Independent Director	JH
	Ms Kate Owen, Non-Executive Director	KO
	Mr Neil Lerner, Non-Executive Director	ML
	Mr Richard Hunting, Non-Executive Director	RH
	Mr Nicholas Coleman, Non-Executive Director	NC
	Dr Caroline Shuldham, Director of Nursing & Clinical Governance	CS
By Invitation:	Mr Nick Hunt, Director of Service Development	NH
	Ms Jo Thomas, Director of Communications & Public Affairs	JT
	Ms Joanna Axon, Director of Capital Projects & Development	JA
	Mrs Carol Johnson, Director of Human Resources	CJ
	Mr Piers McCleery, Director of Planning & Strategy	PM
	Mr David Shrimpton, Private Patients Managing Director	DH
	Dr Anne Hall, Director of Infection Prevention & Control	AH
	Ms Carol Gadd, Clinical Services Manager/Modern Matron	CG
In Attendance:	Mr Anthony Lumley, Corporate Governance Manager (minutes)	
	Ms Katherine Denney, Head of Marketing Communications & Web Editor	
Apologies:	Pr Sir Anthony Newman Taylor, Non-Executive Director	ANT
	Pr Timothy Evans, Medical Director	TE

2012/14 <u>ANNOUNCEMENTS</u>

SRF called for a moment of silence to show the Board's respect for Lord Newton of Braintree, former Chairman of the Royal Brompton & Harefield NHS Foundation Trust (RBHFT) who had passed away recently. BB announced that the funeral was being held in St Peter's in Coggleshall on 12 April at 2.00 pm.

2012/15 <u>MINUTES OF THE PREVIOUS MEETING HELD ON 25 JANUARY 2012</u>

The minutes of the meeting were approved.

2012/16 <u>REPORT FROM THE CHIEF EXECUTIVE</u>

BB gave verbal updates on the following items:

Judicial Review: Safe and Sustainable

BB reported on the Court of Appeal hearing on 19 and 20 March 2012. BB said that the Trust's legal team still thinks there are reasonable prospects of a ruling in favour of the Trust. The team is coming to the Trust today to be given a tour of the wards, and then after this, will meet with Trust staff.

BB said the Trust's counsel does not expect to hear back from the court until late in April 2012.

BB concluded this part of his report: the JCPCT had sent the Trust a finance template which effectively asked that plans are submitted which would commit the Trust to the continued provision of capital and staffing for delivery of paediatric services when this had not been identified as one of the proposed options in the consultation. BB invited PM, who is currently working on a draft response with NH and RP, to give further detail. PM said the letter accompanying the template included a set of hypotheses based on a reapportionment of tariff. The Trust has drafted a reply based on paediatric services being a core part of its services, but given the capital commitments this entails, for example the Cystic Fibrosis project costed at £5.5m, it will be necessary to revisit the business cases. BB proposed that the draft response be checked with the Trust's legal team before despatch.

Academic Health Science Partnership (AHSP)
BB reported that he had recently attended a meeting under the chairmanship of Lord Darzi. The AHSP is currently expanding to involve other bodies based in North West London (NWL). There is currently debate about the naming the AHSP. Imperial College (IC) want to ensure its trademark rights are maintained if it is named after IC. They have suggested it should be called IC Health Partners or IC London Health Partners. BB said this reflected the tensions amongst the partners and is indicative of distrust in some quarters.

NL asked that now the Health and Social Care Bill had received Royal Assent would any of the changes made to the Bill when it had passed through the House of Lords have any significant effect on the Trust?

BB replied that he would prepare a briefing for the Board. For now he had noted that the NHS Commissioning Board would be in charge of commissioners, but that there would not be a boss for the NHS in a structural sense as Strategic Health Authorities would cease to exist under the new regime. He noted that the role of specialised commissioning would increase, Monitor would become the regulator for the whole of the health sector and that Health Education England would have an important role in respect of medical education.

NHS North West London (NWL) Reconfiguration Programme
BB said that he and TE had attended a private meeting on 13 March 2012 with Anne Rainsberry, Deputy Chief Executive of NHS London, Dr Mark Spencer, Medical Director for NHS NWL and Daniel Elkeles, Director of Strategy for NHS NWL and the programme director. They want the Trust to publicly state by June 2012 that it is moving to White City as they viewed this as central to all the plans for transforming healthcare in NWL. BB said he was also asked whether RBHFT would consider operating a consolidated paediatric centre for NWL in partnership with St Mary's Hospital and Chelsea and Westminster NHS Foundation Trust. BB said he

had posed a question back to them of how this would sit with the JCPCT process. Anne Rainsberry had said she would say to JCPCT there were now a new set of conditions that have affected London.

BB added that a retreat session for the board would be held on 2 May 2012, hosted by KPMG. He and TE had left the meeting with the NWL programme team with a view that the Trust should get on with what it has to do.

Review of National Transplantation
BB reported that on 16 March 2012 the Trust had attended a presentation/discussion lasting 4 hours before a panel convened by the National Specialised Commissioning Team (NSCT). The Trust's team had acquitted itself very well. Debate had been challenging, but he felt afterwards that it would be difficult for the commissioners to decommission the Trust's transplant services.

The NSCT had probed BB about a possible move of the Trust's Royal Brompton Hospital (RBH) site to Addenbrooke's Hospital in Cambridge. BB had responded by stating that the issue had now passed because Papworth Hospital had decided to follow its own route with a PFI (Private Finance Initiative) funded project, and had no vision for a shared centre. RBHFT now has a different strategic proposition.

NHS Confederation
BB said the Trust were subscribers to the FTN (Foundation Trust Network) which is part of the NHS Confederation (NHSC). As of 1 April 2012, the FTN will become an independent lobby.

As an FT the Trust will clearly continue as a member of the FTN. But BB sought the views of the Board as to whether the Trust should continue membership of the NHS Confederation (NHSC).

RH asked concerning the cost, which was given at £4.9k. NL pointed out that this excluded staff time and that the FTN had visibility but NHSC did not.

KO asked what the Trust would lose by not being a member of NHSC?

BB said the Board has to consider whether the Trust wants the NHSC as a friend. The CEO of NHSC, Mr Farrar, has demonstrated that he is more independently minded and NHSC had taken on an NHS leadership role.

SRF said there was no compelling reason why the Trust should not continue its membership, and the Board agreed to do so.

SRF added 2 updates to BB's report from matters arising out of the minutes of last meeting.

a) Discussions with Imperial College Healthcare NHS Trust (ICHT) were continuing on joining respiratory, paediatric, cardiology and transplantation services. Together with PM, he would be meeting with ICHT on 29 March 2012.

b) Under Section 242 of the Health and Social Care Act 2006, the Royal Borough of Kensington & Chelsea (RBKC) has the power to call for a review of the Safe and Sustainable consultation in order to review the knock on effects for paediatric respiratory services. The request for such a review would be led by the Leader of RBKC, Sir Merrick Cockell.

2012/17 CLINICAL QUALITY REPORT FOR MONTH 11: FEBRUARY 2012

Before RCo introduced his report, NL asked for clarity on Section 1.4 Health Care Acquired Infections (HCAI). Noting that the Trust does not have targets for some of these, he asked what the triggers were for HCAIs. RCo said MSSA and E Coli are not reported to Monitor, but data is submitted to the Health Protection Agency and they placed it in the public domain. It would be possible, with the help of AH, to set a target for MSSA as data has been collected for more than 1 year. However, E Coli data has been collected for less than 1 year, so setting the baseline would have to precede any target setting. NL said if the Board is presented with information it has to be for a reason. BB acknowledged that seeing what is the context and looking at how information is presented is fair, but questioned whether managing by a target was a useful thing. He accepted though that this would be worth having a Board debate on. He added that there should be things tracked that were being tracked nationally and the Clinical Quality Report included information in this vein. NC concurred with this and said the report is a compendium and the Trust should never set performance targets merely for the sake of having them.

The Chairman instructed the G&QC then Risk & Safety Committee (RSC) to review: (a) the Trust's policy of not setting clinical performance indicators and targets - instead reporting clinical performance to the Board using externally set indicators and targets; and (b) what the Trust's preferred set of clinical performance indicators could look like.

JH said that Single Sex Accommodation and the Senior Information Risk Owner reports could have been presented as separate reports and said there was a need to rationalise agenda items. RCr said that the Single Sex Accommodation report was included because the formal annual declaration was due. The report should be seen in the context of the Trust's reporting requirements. BB concurred and said while it was important to have good governance and management, the Trust does have to show compliance. CS commented that there is continuous pressure to show that the Board has seen things which are reported externally. JH asked if there should be a separate section for a compliance report. RCo explained that his intention was to present the Exception Reports, beginning with SIs and then follow the same hierarchy as given in the key performance tables in Section 1 of the paper, which included the essential parts for compliance on page 1.

RCo highlighted the compliance target for Cancer 62 days to first treatment (see p6), comparing the Trust's update position with figures presented on the DH's "Open Exeter" website. The Department of Health (DH) do not take into account 're-allocation' of breaches to referring hospitals where they had delayed the referral. The full report was included for the Board to ensure full transparency (this is one of the indicators under review by external auditors as part of their review of data quality for indicators supporting the Quality Report). The report including breach reallocations has been shared with Monitor who are content. RCo said that, based on figures since January 2012, the Trust might breach the 62-day cancer target of 79% in Q4. Diagnostic information on 6 patients was awaited. If breached, this would score 1.0 against the Compliance Framework and when added to the 1.0 scored against the *Clostridium difficile* objective, this would mean that the Governance rating for the Trust would move from amber/green to amber/red. This should be considered when the Board is required to make the Q4 Governance Declaration for Monitor in April.

NC said the main consideration of the 62-day cancer target was whether the Trust was doing the best for these patients. Replying to a request from NL to explain 'Open Exeter', RCo said it is a nationally hosted information system. As with the 31-day pathway, the 62-day pathway starts at other hospitals elsewhere in the country. The pathway start information is uploaded by the referring hospital with RBHFT closing the pathway after treatment. The problem arises from the Trust having to declare performance at the end of the quarter to Monitor when other hospitals can modify data after the Monitor reporting period is closed. Hence the need for this data validation report to the Board. NL asked if other Trusts had no provision for breach repatriation in their systems. RCo answered that the IT system is a national system used by all trusts and it does not have this functionality.

RCo highlighted the 4 SIs and the single Radiation Safety Incident. SRF asked CS if 4 was more than usual and NL also asked if she could say how serious each one was. CS said the second incident reported in January 2012 reflected that there had been cancellations along the way. She felt this raised serious concerns.

NC added his views and explained the issues as they appeared to him in his capacity as Chair of RSC. The Trust tends to have 10/12 Serious Incidents (SIs) a year. These are the most serious. What the RSC does on behalf on Board, is to review each incident and look for 4 things: firstly has it been investigated properly; secondly look at the root causes; thirdly whether recommendations are being discharged; and fourthly have the recommendations been bedded in and have therefore had the desired effect. NC said he could give the Board assurance that the Trust is diligent in investigation. The committee would also be seeking independent assurance later in the year on whether recommendations are having the desired effect.

JH said was really saddened by the first SI reported in February (which had occurred during December 2011) and wondered if the Board should be stating

that it finds this unacceptable. She noted that over 8 months, there had been 3 cancelled operations. She asked if the report could have set out some more vibrant learning points and if it could be noted that the Board wants to be satisfied appropriate lessons had being learnt? RCr said a frank discussion had been held at the Operations group, and that the report of the investigation was still awaited. NL said he was assured by NC's comments on the role that the RSC fulfils but this was the worst incident in the Trust he had ever read.

SRF asked NC (Chairman of the RSC) to brief the Board on the outcome of the RSC's review of root causes of the Dec 11 serious incidents and actions being taken to prevent recurrence.

BB said any death was concerning. He advised that Board members should avoid being political or emotional. The Trust's operational staff needed to be assured that the Board understood all the circumstances around the SIs reported to it. Incidents might involve many clinical issues, not all of which come out in root cause analysis. The incidents had not been well reported. He assured the Board that they are taken seriously. KO said she noted what could be learnt from it, about the impact of cancelled operations. BB said personally he was more concerned about the 6 complaint letters he had received about cancelled operations which had all occurred at HH.

It was agreed that NC will brief the Board on the outcome of the RSC's review of root causes of the December 2011 SI and actions being taken to prevent re-occurrence.

RCo said that the Care Quality Commission (CQC) would look at our investigation of the Radiation Safety Incident. NC wondered whether, as radiation incidents had doubled in 2011/12 compared to 2010/11, the Trust therefore had an emerging radiation safety problem? It was agreed that the RSC would be provided with a summary of last year's incidents and this years so a comparison could be made. RCr suggested asking the Radiation Protection Committees to review the trend of incidents. It was agreed that the RSC would review the year-on-year increase from 3 to 7.

RCo highlighted 3 items which were all about compliance and were for Board oversight: Section 3 Senior Information Risk Owner (SIRO) Report 2011/12, Section 4 Single Sex Accommodation Declaration of Compliance 31 March 2012, and Section 5 Equality Objectives.

JH said she had noted the rapid 'spike' in deep wound infections at RBH and asked if any assurance could be given that this was being addressed. CS said a lot of work continues and the Trust will keep monitoring.

SRF invited AH to give an update on *Clostridium difficile*. AH said, en passant, that the Trust has very low incidence of E Coli bacteraemia compared to other organisations. Also, MSSA infections were low compared to other London Trusts. Turning to *Clostridium difficile*, during 2011/12 the Trust has followed national guidance for reporting of *Clostridium difficile*. Currently this means that

only clinically significant cases are reported. The new recommendations (published 6th March 2012 - effective from 1st April 2012) now advise the reporting of all cases where the antigen and toxin are found to be present in the patient. AH said that so far in 2011/12 there had been 31 cases in which both the antigen and toxin found and possibly 3 more in March.

The new guidance also recommends that in some cases of loose stool, patients should not be tested for *Clostridium difficile*. AH said that in her professional opinion strict adherence to the new guidance could have an adverse effect on patient care.

NL asked if the target would be changed to reflect the new guidance? CS said it is not known what the DH is planning to do yet about the target in relation to the new guidance. RH asked if other Trusts were in a similar position? AH said there was great consternation amongst other Trusts. It was agreed to bring this issue back for further discussion at the next Board meeting in April.

Modern Matron's Report

CG highlighted the substantial progress made on hand hygiene compliance over Q3 and Q4 from 60%-80%. The RSC had supported a new compliance target of 90% effective from 1 October 2012. In relation to Hand Hygiene there were some issues with new staff. In response to a question from SRF on what would be done to address this, CS said all staff will be reminded that the Board values this and takes it very seriously. NC clarified that the RSC had endorsed a 90% hand hygiene target and had not invented it.

2012/18 <u>FINANCIAL PERFORMANCE REPORT FOR MONTH 11: JANUARY 2012</u>

Presenting the report, RP highlighted that in M11:

- The Income and Expenditure (I&E) outturn for the month was disappointing. The Trust had fallen short on plan on NHS Clinical Income, Private Patients (PP) income, Pay and Non Pay costs. Against a planned budget surplus of £0.7m, there had been a deficit of £0.5m.
- However, the Trust had received Project Diamond (PD) funding for complex procedures via NHS London. This had transformed the MTD (Month to Date) and YTD (Year to Date) figures. In addition to recognising £6.1m of the 2011/12 allocation in M11, the Trust has a balance of PD of £0.6m which was received in March 2012.
- The Trust can expect to finish the year flat on an underlying basis, but PD monies and property revaluation would mean achieving a surplus. The Trust will therefore maintain its Financial Risk Rating (FRR) of 3.
- To help the Board gain a better understanding of variance, the report had been reformatted and set out financial performance by division rather than specialty.
- Balance sheet. Even without PD liquidity was comfortable.
- Capital expenditure, the actual for the year was running behind plan. However, this was within the envelope Monitor expects.

NL thanked RP and his team for the new report. Divisional reporting had emphasised the difference in margins between the Heart and Lung

Divisions. He asked if capital being behind plan, and whether such a large capex spend could be managed. RP said a year ago there had been substantial capital overruns. The new and tighter controls since introduced represented a substantial improvement.

RCr acknowledged that the point made by NL was pertinent. The backlog investment in estates management had been better managed since mid-year 2011/2, and there had been investment in people and processes. Reviewing governance processes had led to some delays in implementing projects, but he did not envisage these delays being repeated in 2012/13. NC congratulated the executive team.

The Board NOTED the report.

2012/19 STANDING FINANCIAL INSTRUCTIONS (SFIs) UPDATE

RP presented the report. He noted that the Board should review SFIs annually though, for understandable reasons, the last review had occurred in June 2010. The report listed the proposed changes. Following a comprehensive review by a number of executives, a full version of revised SFIs with tracked changes was available to any Board member for inspection. He highlighted 2 changes: firstly a section had been rewritten to reflect the new and improved procedures for capital budgeting, reporting requirements and the remit of the Capital Working Group (CWG); and secondly, the annex on Non Pay expenditure had been revised in particular to take account of e-procurement developments. If approved, a programme would be established to communicate the changes to Trust Directors and employees.

NL said the Audit Committee would undertake the task of reviewing the SFIs during 2012/13.

The Board approved the changes to SFIs subject to a review by Neil Lerner to be carried out after the meeting (secretarial note: Mr Lerner suggested a small number of further amendments which, following executive consideration, were also adopted in the final version of the SFIs).

2012/20 EDUCATION UPDATE

The Board noted Paper D.

2012/21 2012/13 I & E BUDGET SUMMARY

RP presented Paper E. The 2012/13 budget is still work in progress and an updated and improved version would come to the next Board meeting. The document in final form would be approved by the Board at its May meeting and subsequently submitted to Monitor as part of the 2012/13 Annual Plan.

RP guided Board members through the Budget Setting Summary explaining each column in turn. He highlighted:

Column G: Savings target of £10m. The Trust had achieved £5m to date.
Column H: This included a 'placeholder' (i.e. a working estimate of an item to be confirmed in due course) of £2,469k.

SRF asked NL to comment on the Monitor paper received by the Finance Committee on savings plan. NL said all Board members had received a copy of this paper. He was comfortable that the principles in that paper were reflected in preparing this budget.

NL asked if the PP revenue uplift of c£0.6m in column E was sufficiently ambitious. He commented that developing the ventilator-weaning service could enhance income. DS said he would be looking to expand PP, if capacity were there, with patients coming from the Middle East where there is currently high demand. Any change would be reflected in the next version of the draft budget.

RH asked if most of the PP patients for the weaning service suffered from COPD (chronic obstructive pulmonary disease). BB said that quite often these patients had other medical conditions than COPD, such as failure of the diaphragm. NL commented on the planned increase in activity. DS added that increasing PP activity had been a challenge affected by the general economic situation, the political upheaval in north Africa and the Middle East, Greece and Cyprus. RP explained that the plan for PP is actually slightly more ambitious than indicated and is £1.5m more than 11/12 outturn.

Noting that overall NHS income was coming down, NL asked if this adequately reflected pressures the Trust is under. NH agreed that this did reflect the position of the Trust. Commissioners such as NHS NW London were putting in claims from prior years such as one for anti-coagulation that dates back to 2005. They will also be challenging Trusts through new performance measures which could lead to fines if not met, for example charging £100k per data set per month for not recording the NHS number in 95% of cases.

NL asked if it would be possible to capitalise all fees and in particular those incurred in relation to the redevelopment of the Royal Brompton. RP answered that it would not be possible to capitalise fees incurred before a site is identified and selected definitively. However, he agreed that it would be advisable to reflect £100k of expenditure on planning and design fees in the budget to reflect the period of 2012/13 prior to such a decision being made.

NC commented that the pay and non-pay contingencies ought to be larger. When the report comes back in April he would like to find assurance, that in the CIP programmes, there would be no negative impact on patient safety. RCr agreed that this would be covered in the next version of the report.

RP noted that the budget currently disclosed a deficit of £2.1m: as Monitor expected a 1% return on revenue (some £3m) this meant that the budget was c.£5m short, equivalent to the current shortfall in CIPs.

RP reminded the Board that the draft budget presented in April may still not reflect the final position.

2012/22 2012/13 I & E CAPITAL EXPENDITURE BUDGET

RCr presented the report noting the donation from the charity, and the proposed £3m allocation from Project Diamond monies. He drew the attention of members to the Service and Estates Development figures. Formal approval of these figures by the Capital Working Group is subject to acceptance of the business cases for each scheme.

Replying to a comment from KO on current backlog maintenance costs, RCr referred to the reference in the report to a three-year backlog plan designed to reduce risks.

NC asked if the £3m PD allocation to capital funding is under spent would the difference go into the I&E account? RP said this could not happen as it is a cash item.

Subject to confirmation of the estimated Service and Estates Development costs, the Board approved the 2012/3 programme.

2012/23 AUDIT COMMITTEE

(i) MINUTES OF THE MEETING HELD ON 19 OCTOBER 2011

The Board NOTED the minutes.

(ii) REPORT FROM THE MEETING HELD ON 7 FEBRUARY 2012

NL reported that the Audit Committee had received a presentation from CJ on the Trust's Appraisal System and the improvement in uptake. CJ will report to the committee again in 12 months time. The Trust's internal auditors, KPMG, had reviewed progress against the audit plan which was found to be on track. KPMG had also reported on their progress with validating recommendations outstanding from the previous audit regime.

The committee had also reconsidered its terms of reference. Slight refinements are proposed, but these are not sufficiently substantive to require review by the Governors.

Note: The main change is to replace 'Statement of Internal Control' with 'Annual Governance Statement 'in order to meet Annual Reporting requirements set by Monitor.

NL suggested that in future minutes of the most recent meeting should be circulated in draft form and this was agreed.

2012/24 RISK AND SAFETY COMMITTEE (RSC)

(i) MINUTES OF THE MEETING HELD ON 19 OCTOBER 2011

The Board NOTED the minutes.

(ii) REPORT FROM THE MEETING HELD ON 7 FEBRUARY 2012 and (iii) TRUST RISK REPORT

In addition to the update on SIs which he had been given during the discussion of the Clinical Quality Report, NC reported that the RSC had been active in reviewing the regular business of the Trust. Its activities had included:

- Safety Climate work: a review of the results of this Trust's first Safety Climate Survey. The RSC will be reviewing the next survey results in early 2013. The lesson was that if the safety culture is good the Trust will be safer whatever the procedures and processes are, but if the safety culture is bad no amount of procedures or processes will prevent SIs. Hence the importance of concentrating on safety culture.
- Risk Management [item 2012/24 (iii)]: The committee had reviewed the outcome of the work to refresh the Risk Register (RR) processes and had concluded that theses should now yield the highest priority risks and so can supersede the Board Assurance Framework (BAF). This would also result in regular risk reports to the Board focusing on the greatest risks to the Trust. The first such report had been included in this agenda. NC asked the Board to note: actions must be taken to reduce these risks (referring to page 3) so the blobs can be moved out of the red, or these risk events would surely happen; this was about risks management and not about assurance on other matters; this would be a long-wavelength process. Other risks may suddenly emerge which this process would not pick up which would have to be addressed by the board additionally.

Noting that a lot of progress had been made, KO felt that broad strategy discussions should be included. NC replied that the Risk Register was a bottom up process and there would be no BAF. CS added that there was a reference in the Risk Register to external reviews, but that this area would benefit from more thought. She pointed out that on page 1 of the Trust Risk Report there is a Trust Board Statement on Risk. NC said the Board were being asked to approve this statement.

NL drew attention to the amber risk on page 2 of the Trust Risk Report, number 10 Loss of Clinical Services which covered KO's earlier point about risks in the outside world.

NC continued his report:

- Infection Prevention & Control: the committee had spent some time discussed in detail the safety of the water supply in the Fulham Wing. It had concluded that the measures taken to address this were satisfactory but there was a strategic consequence: facilities risks are among the Top Trust Risks. Implicit in the Trust's redevelopment strategy is

controlling these for perhaps a decade while redevelopment takes place. This poses the question: should the Trust seriously consider taking major steps to negate the Fulham Road facilities risks at the same time as progressing the redevelopment project.

RCr said NC had highlighted Fulham Road wing but other areas were part of the debate such as Chelsea Wing and the Sydney Street building. There was a balance to be struck between redeveloping elsewhere and maintaining safe standards in the current buildings at the same time.

He said that capital investment would be needed over the medium term to ensure the safety of existing premises.

NL asked, given the seriousness of the item, whether the Risk Report should be higher on the agenda? SRF said that the report should come to the next meeting, then every other meeting, or more if a major issue comes up. This was agreed.

2012/25 PROPERTY COMMITTEE – TERMS OF REFERENCE UPDATE

In addition to this specific update, SRF reported that he had met with Sir Keith O'Nions, Rector of IC and Sir Richard Sykes, Chairman of ICHT on the move of the RBH site on to the Hammersmith Hospital Campus site.

KO said it was important to have continuity of Non Executive Directors (NEDs) serving as members of the Property Committee. SRF said that currently the NED members of the committee are NL, ANT, and himself. He agreed with KO that as ANT would be stepping down he should be replaced and that his replacement should be drawn from the existing NEDS. SRF asked that any of the existing NEDs interested in taking up this position should come forwards and talk to him about it.

2012/26 QUESTIONS FROM MEMBERS OF THE PUBLIC

John Ross said he had received an invitation to an open day at the Cardiovascular BRU on 9 March. He would have like to have attended, but as only 3 days notice of the event had been given, had been unable to do so. He asked if more notice could be given in future.

In reply BB said that this concern was noted and understood.

David Potter said surgical cancellations at the Harefield Hospital (HH) site were an item of major concern and asked if his concern could be recorded?

In reply RCr said he agreed and noted that there was an additional report within the Clinical Quality Report covering this area and that it was important to ensure that the rate at which patients are admitted is managed so that operations happen when scheduled. He warned that the problems behind the high rate in February at Harefield had persisted into March.

DP said he realised that primary angioplasty admissions require more intensive treatment and take precedence over elective admissions. RCr said that there were particular pressures associated with transplant and acute cardiology admissions at Harefield, and that the opening of Acorn Ward in May 2012 would help to some extent by creating more ward beds which would make it easier to move patients from ITU to a ward area.

Kenneth Appel said he wanted to express his appreciation to the Trust Executive for the way in which it had handled the legal defence of the Trust's position.

He noted that the FTN is a relatively new organisation and said that he has attended some events organised by them. He agreed with BB's recommendation that the Trust should remain a member of the NHS Confederation.

KA said he had heard a patient complaint about the catering at HH. A number of staff agreed the standard could be improved.

KA also commented on 3 other items previously discussed. Firstly, the Modern Matron's Report and the hours of cleaning. The Trust should monitor that carefully so it is up to date. Secondly, the 62 Day cancer target. While in Europe cancer waits are lower he felt the flagging of breaches where patents have simply taken more time to consider treatment was inappropriate. Targets should be there to improve standards. Thirdly, there was nothing more distressing for patients than cancelled operations. The Trust should seek a cultural change to improve on that.

RCr responded and said the catering at HH was provided under contract with ISS. Although ISS would continue to provide catering it was now under a new contract. In his experience staff have mixed views and the range and choice of menu items is being monitored through the new contract. In respect of cleaning, there are undoubtedly some challenges in new contract and these will also be kept under close review.

CS added that work had been done to pilot changes in cleaning techniques. In relation to cancer targets CS said she attended meetings of the London Cancer Alliance and that body is aware of the potentially perverse effect of targets. CS also said that her review of complaints showed how big an issue the problem of cancelled operations was at HH.

DATE OF NEXT MEETING

Wednesday 25 April 2012 at 2.00pm in the Boardroom, Royal Brompton Hospital.