Minutes of the Board of Directors meeting held on 28th November 2012 in the Concert Hall, Harefield Hospital, commencing at 10.30 am

Present:	Mrs Jenny Hill, Senior Independent Director (Chairman)	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
	Mr Richard Hunting, Non-Executive Director	RH
By Invitation:	Ms Jo Thomas, Director of Communications & Public Affairs	JT
	Ms Carol Johnson, Director of Human Resources	CJ
	Mr Nick Hunt, Director of Service Development	NH
	Ms Joanna Axon, Director of Capital Projects & Development	JA
	Mr David Shrimpton, Private Patients Managing Director	DS
	Mr Piers McCleery, Director of Planning & Strategy	PM
In Attendance:	Mr Anthony Lumley, Corporate Governance Manager (minutes)	
	Ms Shareen Chatfield, Head of Media Relations	
	Ms Katherine Denney, Head of Marketing Communications & Web Editor	
	Ms Christine Denmark, Marketing & Communications Manager	
Apologies:	Sir Robert Finch, Chairman	SRF
	Mr Nicholas Coleman, Non-Executive Director	NC
	Mr Richard Connett, Director of Performance & Trust Secretary	RCo

2012/99 MINUTES OF THE PREVIOUS MEETING HELD ON 24 OCTOBER 2012

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

- Page 4, item 2012/90, third para. Delete third and fourth sentences and replace with: ‘NHS NWL had said every patient must be asked and initially this was to be in a way that enabled the patient to be identified. Now the Trust still has to approach all patients to get a 15% response rate and show that this sample is representative of the total patient mix. Demographic data has to be collected to enable this.’

Matters Arising other than those on the agenda or the Action Tracker

- Page 8, AOB b). JH said that as agreed at the last meeting, Gill Raikes would be giving a talk on the new charity and progress so far at 1pm before the next Board meeting on 30 January 2013.

- Page 9, Questions from Members of the Public. RCr confirmed that, with NH, he would be getting some information from Estates about The mansion and forwarding it to Mr Chapman (see Item 2012/109 below).

2012/100 REPORT FROM THE CHIEF EXECUTIVE

BB gave verbal updates on the following items:

Update on discussions with Chelsea & Westminster Hospital NHS Foundation Trust (C&W)

BB reported that the discussions with C&W were progressing and had been very constructive. There was a clear alignment if Royal Brompton & Harefield NHS Foundation Trust (RBHFT) remained in Chelsea. Both Trusts were already collaborating successfully in many areas. C&W provide a number of services that complement RBHFT's and utilise our specialist teams. Equally the Trust has a number of specialist services which call upon the expertise of C&W's consultants. The urgent matter to be considered was paediatric services.

BB said he had met with C&W's Chief Executive on Monday 26 November 2012. They had agreed that a framework would be needed so the Trusts' Boards can meet and discuss the issues in January 2013. A meeting is planned for 21 January 2013 which meant that he would be able to report back to the RBHFT Board at its meeting on 30 January 2013.

In the meantime there had been other joint meetings - Medical Director to Medical Director and Service Teams to Service Teams. BB said that, to date, nothing had occurred to halt the discussions. The way to approach the collaboration would be to create special purpose vehicle, populate it with initiatives and then work out how to work together rather than considering any type of merger agreement. He added that his impression was that C&W were interested in clinical collaboration and the likely enhancement of their services as a result of an association with the Trust.

Imperial College Health Partnership (ICHP)

BB referred Board members to the two documents he had sent them which provided an update on the application by ICHP to become a designated Academic Health Science Network (AHSN) and included the draft AHSN business plan. BB said he was not aware that ICHP had appointed a Managing Director yet but he believed this was imminent. ICHP now has a corporate identity for its official letterhead.

PM confirmed the timescale: the final meeting with designation panel would take place in December 2012.

JH asked what the impact of the Trust's involvement in an AHSN would be? BB said that AHSNs were new 'creatures' and had not come out of an organic 'bottom up' process. He was inquisitive about their long-term future and it was more likely that in a few years' time, with a future government in place, they could be replaced by something else. He added that JH's question was very apropros when seen in the context of the discussions with C&W. He had been asked by C&W if the framework should be within the AHSN? BB said he had replied that it shouldn't. The officials involved in the designation process were all from the National Health Service

Commissioning Board (NHSCB) or the DH and its management was very characteristic of how the NHS approaches such initiatives. In summary BB said that AHSNs were the currently relevant development, and it was right to go along with it.

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

BB reported that the Independent Reconfiguration Panel (IRP), directed by the Secretary of State to review the JCPCT's decision on the designation of children's heart centres in England, had indicated that it wants to visit the Trust in early January 2013. BB assured the Board that the Trust would be prepared. He added that the work of the independent panel set up by Professor Peter Hutton was progressing though he is not privy to the detail. Professor Hutton would be consulting his expert panel in December 2012 and in January 2013 the Board would be able to read the resulting report. The IRP is aware of its existence and will receive the report as a separate submission from that of the Trust.

2012/101 CLINICAL QUALITY REPORT FOR MONTH 7: OCTOBER 2012

Presenting the report on RCo's behalf, RCr highlighted the following from Month 7:

- Monitor's Compliance Framework:
  - *Clostridium difficile*: although year-to-date (YTD) the target was not met there had been no further breaches in October. Monitor's Executive Committee had met and had decided to override the automatic 'red' governance rating and instead hold it at 'amber green'. Monitor had told the Trust that it was unlikely that the override would be applied again should a similar situation arise in 2013/14. This had implications for whether the Trust revised its strategy for handling C Diff infections, or reports that it is not possible to reduce the number any further.
  - Cancer pathways: 62 days' wait to first treatment. Four breaches (out of 13 cases) in October. The expectation was that these numbers would even out over a quarter. There was nothing to suggest that the Trust's processes were inadequate in the four relevant cases.
- NHS Standard contract:
  - 18 weeks: performance was still below the threshold of 90% for cardiac surgery especially on the Harefield Hospital (HH) site. A remedial action plan had recently started with expanded capacity for HH waiting list patients using on-site and off-site capacity.
  - Mixed-sex accommodation: After a long period of no breaches there had been a total of 11 breaches in M6 and M7. They had occurred in delays from the step-down from the high dependency area to open ward level. The Clinical team were looking at ways to prevent further breaches but ongoing pressures on bed-capacity and the tight target timescales meant that there were no ready answers to hand.

NL said that he understood reporting on *Clostridium difficile* was as good as it could be and did not think it was considered possible to do more to bring performance within the range of identified targets. RCr said this was essentially correct as the Trust did not believe it had an infection control problem, but the Trust had to review the relevance of its current regime in the light of changes in guidance. TE said the review of assurance processes by the Royal College of Pathologists (the College) had been constructive and helpful. There was a new policy for attributing cases but it was too early to tell what the impact was. In response to a query from NL on whether this was within the guidelines, CS assured him this was the case. TE added that the Trust was looking at the structure of areas of where infections occur so there was progress. This meant there would be an impact on reported C Diff infections, but it was unlikely it would be at the level of the DH-imposed target.

CS said that, as a result of the College review, internally there had been a separation of the Consultant roles in infection control and microbiology, and the role of Director of Infection Prevention & Control (DIPC) rested with her now. She would therefore be the accountable person overall and report to the Board. The starting point would be that the rate of infection was something that could be improved on. In addition, as part of the restructuring and with further investment in pharmacist support, more frequent anti-microbial prescribing audits would be carried out. NL said this was very helpful and suggested that in her role of DIPC CS could give a talk to the Board sometime in Quarter 1 or Quarter 2 in 2013/14. This was agreed.

JH asked if the Monitor process for setting the governance rating had been binary or had there been negotiation? RCr replied that he understood that the relationship manager assigned to the Trust by Monitor would have presented the Trust's case at Monitor's committee meeting. The manager would have been questioned and challenged. BB said that as previously stated at Board meetings the Trust's position is that it does not believe the organisation has an infection control problem but rather there is a target reporting problem. The target for *Clostridium difficile* was an arbitrary one set by those who do not appear to accept any evidence the Trust presents to contrary. The monitoring regime – Monitor's Compliance Framework – within which Foundation Trusts (FTs) are required to operate is in itself binary. The nature of reporting these statistics was a matter of practice that varied in Trusts. BB said he was confident that CS will be diligent in her role as DIPC. He added that the Trust was definitely in breach of the *Clostridium difficile* target this year but it was not known what the target will be for 2013/14. However, it is expected it will be as low as now if not lower. This was a problem that was evident in large surgical centres throughout the UK.

RH asked for more details of the actions taken to address 18 weeks and in particular critical care off-site? NL asked if it would it be possible to do this without an adverse financial impact? RCr explained that the pressure arose as there was insufficient capacity at Harefield to meet the demand for our

services within the specified waiting-times – in that sense we were victims of our own success. TE concurred, and said that patients affected were offered the option of treatment off-site, and that their proposed treatment was considered by surgeons and anaesthetists to ensure it was appropriate. RCr went on to explain that the overall financial impact was uncertain and subject to the post-operative demands of the surgery undertaken, but that the assessment carried out suggested there would not be an adverse financial impact. BB concurred. As he understood NL's question to be about whether the costs of the 18-week penalties, which were automatic if there are breaches, would be greater than the cost of the initiatives and therefore the risk of non-compliance was higher than the risk of financial stability, he could assure him that this was not the case. The fines incurred to date were currently well under £100k, but would rise steeply if not brought under control. The action plan should help the Trust attain a decent financial and governance rating position.

BB stated that for all targets the aim was not to have any amber ratings let alone red.

The Board noted the report.

Action: CS to give presentation to Board on her role as DPC in first half of 2013/14.

2012/102 FINANCIAL PERFORMANCE REPORT FOR MONTH 07: OCTOBER 2012

Introducing his report RP highlighted the following performance in M07:

- Overall this was a disappointing result after high hopes as there were more working days (23) in the month. October had yielded a surplus of £0.2m against a planned surplus of £1.4m.
- Patient income was generally to plan but some of that had been generated by high levels of critical care income. Private Patients (PP) had seen the best monthly performance YTD. Because critical care is expensive to run there were high associated pay costs, including the high nurse-to-patient ratio and the requirement for specialised nurses. There was also a balance to be struck between permanent and temporary headcount especially at times of high demand for critical care. Beyond these factors, there was a particular issue in staffing Paediatric Intensive Care Unit (PICU). Non-pay costs were over plan although some of this overrun related to drugs and devices excluded from contract and therefore recovered in income. There had also been negative variances in spend on consumables to re-stock lines which had affected the month's results.
- YTD income was marginally above plan. YTD pay costs were right on plan, and non pay costs above plan. There is a YTD surplus of £0.6m against £1.2m target, so the Trust is £0.6m behind plan.
- Liquidity and cash performance had been respectable. Capex had been below the target that Monitor expects but the Trust expected to make up the shortfall in Q3 and Q4.

RP said he had done some preliminary projections for the outturn for 2012/13 and thought the Trust would achieve approximately the £3m planned surplus before year-end adjustments which can affect the final outturn. He had also looked at 2013/14, assuming the aim of again achieving a surplus £3m being 1% of income as Monitor's minimum expectation of FTs. At this stage, the financial challenge for next year would be between £3m and £21m in terms of costs savings or service developments.

KO asked if the spike in non-pay costs was unusual? RP said on the one hand it was unusual but the Trust had bought a lot of consumable stock in M07. If this performance were repeated in M08 more analysis would be required. In the meantime RCr was tightening non-pay authority levels. NL said that the Finance Committee had spent some time questioning executive directors on this issue.

JH asked if cardiac surgery was changing its nature? (Asked by BB to clarify what specifically she had noticed had changed, JH said she thought the trend was that complex surgery was down but routine surgery was up). TE said this was difficult to know. With RCr he had asked Dr Piers Clifford, Consultant Cardiologist at Buckinghamshire Healthcare NHS Trust and at HH, to examine this issue. There could be no doubt there have been changes, some of which have patterns and some do not. At Royal Brompton Hospital (RBH) site the Trust was doing well. There had been an effect on consultant job planning so the Trust was well aware of the issue. Commenting on JH's observation that complex surgery was down TE said this could happen one year but the next year it would be the other way round. BB said his 'theory' was that there had been greater than 50% change in cardiac surgeons at HH. He cautioned against characterising the issue as being about complex versus general cases but noted instead that there had been changes in personnel and practices.

RCr added that, as one example, percutaneous valve procedures were now being done in catheter labs instead of open valve surgery in operating theatres, e.g. the Trust now had 'TAVI' and 'Mitraclip' programmes which did not exist until recently. This had affected the way spells of treatment were counted, so that it could appear that the Trust was undertaking fewer interventions and referrals were falling when in reality the opposite was true. JH thanked the Executive Directors for their response which had been very reassuring as the points raised had not been immediately apparent in the Board papers.

The Board noted the report.

2012/103 RESEARCH UPDATE

Introducing the report TE said it addressed the request of Board members at the meeting held on 26 September 2012 that they be appraised of the Trust's research outputs (e.g. papers, patents and impact pm clinical practice guidelines) which had previously only been given in the annual

report. This report had 4 sections. The first was about outputs in general, the second concerned new awards (which the Trust had been very successful in obtaining), the third about recruitment of patients into research surveys (which had also been a success in the reporting period), and the fourth about National Institute for Health Research (NIHR) performance metrics for the delivery of research studies. The last subject was analogous to *Clostridium difficile* in that the performance of the Trust is good but when it is reported to NIHR it does not appear so good on paper.

RP said he had noticed that there had been a lot of comment in the press recently after a large pharmaceuticals company had said UK performance on research was very poor and they were therefore considering moving away. He asked if this was a risk for the Trust. TE said he believed that in terms of the effect on 'UK PLC' the exit of Big Pharma from the UK was a done deal and the chances of the country continuing at the forefront were nil. However, these kinds of studies were not the ones the Trust took part in. Where RBHFT could improve was in small scale research projects which typically were unique, high-value contracts (e.g. one of the Trust's was for £1m), small numbers and niche. Paradoxically therefore the Trust should be able to buck the trend RP had described.

In response to a question from JH, TE confirmed that if any consultant has some research published under the Trust's banner they are also automatically registered on the Imperial research publications database. The aim is to get every relevant consultant on it. JH noted that this would help recruitment.

KO asked what percentage of the consultants were doing research? TE replied that it was about 30.

In response to RP's questions earlier BB recounted his experience from a DH committee on which NHS executives, civil servants and Big Pharma representatives had sat in equal numbers. Global Big Pharmas had all written off the UK. This background detail partly explained why the NIHR had set a target of a 70-day turnaround from receipt of a valid R&D application to first patient visit and it also reflected a promise from the Prime Minister to the pharmaceuticals industry that the UK could still be a player. BB agreed with TE that the UK's position at the forefront of medical research could not be regained. In relation to the 70-day target, the Trust would be penalised if it failed to meet the target. However Angela Cooper, Associate Director of Research was currently in dialogue with NIHR and there appeared to be some understanding on the latter's part of differences in reporting.

The Board noted the report.

2012/104 SAFEGUARDING ADULTS: ANNUAL REPORT 2011/12

CS presented the report on behalf of Ana Paz (AP), the Trust's Lead Social Worker and Safeguarding Adults lead who had been unable to attend.

CS described how safeguarding alerts can be raised from outside as well as internally. In 2011/12 the Trust had one external alert which related to a patient with a grade 3 pressure ulcer. The response to the case demonstrated the implementation of the multi-agency safeguarding adults and pressure ulcer protocol designed by the Partnership Board. Pressure ulcers were included in this agreement as they can be an indication of neglect.

JH asked if the Risk and Safety Committee looked at safeguarding adults incidents? CS acknowledged that this should be addressed.

The Board noted the report.

2012/105 RECOMMENDATIONS OF ADVISORY APPOINTMENTS COMMITTEE

On NC's behalf BB presented the Board with 1 ratification form for the appointment of a Consultant Cardiac Surgeon at RBH with an interest in Endoscopic Techniques.

BB reported that it had been agreed that the selected candidate would benefit from further development and training. The candidate had agreed to these terms. She would begin her contract on 1 April 2013 after the training. BB said there had been a challenging debate at the committee. The appointee was a locum well-known in the Trust. One other candidate was very worthy but had no experience in the UK. It was agreed to contact this person as there may be other work suitable work opportunities at the Trust in future he could be considered for.

KO noted that the debate over the recruitment process (i.e. known 'internal' v external candidates) had come up to the Board on a number of occasions and asked what had been done about it? BB said there had not been a systematic restructuring but there was now an understanding in the departments that the process was not about 'anointing' favoured candidates. BB added an assurance to the Board that the Trust was not appointing below acceptable standards and was getting candidates who were amongst the best-qualified in the world.

NL said that the more often the Trust appoints its own locums it would become more difficult to get 'external' consultants to apply. BB said he understood this point. However, the Trust often appointed Locums in part to assess their suitability. They can relatively easily move on whereas substantive consultant appointments are permanent.

JH said this discussion provided evidence that the ratification of appointments was not automatic and was always discussed by the Board. BB said that the Trust insisted that consultant posts are Board appointments.

The Board ratified the appointment of:

- Ms Rashmi Yadav as Consultant Cardiac Surgeon with interest in Endoscopic Techniques.

2012/106 COUNTER FRAUD AND CORRUPTION POLICY AND RESPONSE PLAN

Presenting the Policy, RP highlighted that it included 2 useful and practical things: firstly what a member of staff does if he or she suspect frauds and secondly how to go about reporting it.

Noting that this was an overarching new policy, JH said there were some typing errors in the Protocol. Subject to the correction of these errors, the Board approved the Counter Fraud and Corruption Policy.

Action: Policy to be amended and published.

2012/107 AUDIT COMMITTEE (AC)

(i) MINUTES FROM THE MEETING HELD ON 24 JULY 2012 (ii) MINUTES FROM THE MEETING HELD ON 23 OCTOBER 2012

The Board noted the minutes.

2012/108 RISK AND SAFETY COMMITTEE (RSC)

(i) MINUTES FROM THE MEETING HELD ON 24 JULY 2012 and (ii) MINUTES FROM THE MEETING HELD ON 23 OCTOBER 2012

The Board noted the minutes.

2012/109 QUESTIONS FROM MEMBERS OF THE PUBLIC

Donald Chapman asked about the mansion and for a more detailed update than that given under Matters Arising.

In reply RCr explained that the intention had indeed been to send information to Mr Chapman. As this had not yet occurred he said he would now ensure it is passed on. JA confirmed that a report had been completed in the summer 2012. Asked by JH if he accepted this response, Mr Chapman confirmed it was satisfactory but he looked forward to finally receiving the report.

Ken Appel (KA) asked the following questions:

a) He noted that during the step-down there was one team to find accommodation and then the signing-off was delegated. He wondered if this was a contributing factor for the mixed-sex accommodation breaches?
b) With regard to the Cancer 62-day target were there clinical reasons why it had not been met or other reasons?
c) Could BB expand on a comment about a greater than 50% change in cardiac surgeons at HH?

Replies:

a) RCr said that the decision on transferring patients was taken jointly within a clinical team. The challenge was about having the right beds in the right place at the right time in the context of a 4-hour 'window' to

move a patient once it had been decided to do so. He acknowledged that the Trust had struggled with this in recent months and the priority was to get back to what was done in the months before the summer (i.e. to return to a managed situation in which there were no breaches). KA commented that the timing of the 4-hour limit could be controlled by the Trust. RCr replied that anecdotally it was known that some Trusts might 'game' this target, but this was not RBHFT's practice.

b) RCr said that the target essentially required definitive treatment within 2 months of a GP referral for further investigation. The pathway was often complicated, requiring a mix of tests (often at different hospitals) before a diagnosis could be confirmed; and then treatment options to be assessed, discussed and agreed with the patient. The Trust's compliance target was set at 79% as it had been recognised that it was impossible to meet the 62-day wait target for all lung cancer patients because of the complexity of the treatment pathway. It was RCr's understanding that the reported times were not caused by administrative delays for these patients, but were about the clinical assessment, condition and treatments they required.

c) TE said that of the 5 cardiac surgeons who had left the Trust, 1 had retired, 3 had been promoted to prestigious appointments abroad and the 5th had been dismissed.

DATE OF NEXT MEETING

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