A lifetime of specialist care

Royal Brompton & Harefield NHS
NHS Foundation Trust

Minutes of the Board of Directors meeting held on 29 April 2015 in the Board Room, Royal Brompton Hospital, commencing at 10:00am

Present:	Sir Robert Finch, Chairman	SRF
	Mr Neil Lerner, Deputy Chairman & Non-Executive Director	NL
	Mr Robert Bell, Chief Executive	BB
	Pr Timothy Evans, Medical Director & Deputy Chief Executive	TE
	Mr Robert Craig, Chief Operating Officer	RCr
	Mr Richard Paterson, Associate Chief Executive - Finance	RP
	Mr Nicholas Hunt, Director of Service Development	NH
	Ms Joy Godden, Interim Director of Nursing & Clinical Governance	JG
	Mr Richard Hunting, Non-Executive Director	RH
	Mr Andrew Vallance-Owen, Non-Executive Director	AVO
	Ms Kate Owen, Non-Executive Director	KO
	Mrs Lesley-Anne Alexander, Non-Executive Director	LAA
	Mr Richard Jones, Non-Executive Director	RJ
	Mr Philip Dodd, Non-Executive Director	PD
	Pr Kim Fox, Professor of Clinical Cardiology	KF
	Mr Richard Connett, Director of Performance & Trust Secretary	RCo
By Invitation:	Ms Carol Johnson, Director of Human Resources	CJ
	Mr Piers McCleery, Director of Planning and Strategy	PM
	Ms Jo Thomas, Director of Communications & Public Affairs	JT
	Ms Joanna Smith, Chief Information Officer	JS
	Mr David Shrimpton, Managing Director Private Patients	DS
	Ms Jan McGuinness, Director of Patient Experience and Transformation	JM
In Attendance:	Mr Anthony Lumley, Corporate Governance Manager (minutes)	AL
	Ms Gill Raikes, CE Royal Brompton & Harefield Hospitals Charity	GR
Apologies:	None.	

2015/25 <u>DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING</u>
None.

SRF welcomed Jan McGuinness to the Trust following her appointment as Director of Patient Experience and Transformation. Invited by the Chairman to describe her background JM said she that she had previously worked at the Bupa Cromwell Hospital for three years, but that most of her experience was gained in Canada. Her focus had been on managing programmes of change and she hoped to bring that experience to bear in carrying out her new role at the Trust.

2015/26 <u>MINUTES OF THE PREVIOUS MEETING HELD ON 1 APRIL 2015</u>
The minutes were approved subject to the following amendments:

Page 4, item 2015/16, first para., third sentence: replace 'NL' with 'RP'.
Page 6, item 2015/18, last para., second sentence: replace 'father' with 'further'.

Page 7, item 2015/18, second para., third sentence: insert 'out' between 'buying' and 'the Trust's over performance'.

2015/27 REPORT FROM THE CHIEF EXECUTIVE

BB gave an oral report.

Finances

BB said NHS England (NHSE) had recently met with representatives of the Project Diamond and Shelford Group Trusts. The Trust had been advised on 22nd April 2015 that NHS England would pay a total £13.1m Project Diamond allocation for 2014/15, and that the new HRG4+ tariff would be introduced from 1 April 2016. In addition, Payment by Results (PBR) for specialist commissioning was being replaced from 1 April 2015 by a 'block' contract with NHS England. This was a major change but it was not currently known if it would continue into 2016/17. The quantum in total was slightly better than the expected outturn of specialist income for 2014/15, but made no allowance for growth in demand. The NHSE draft contract for 2015/16 had as yet not been received. The old system of price and volume, CQUINs and performance targets was now somewhat moot with its replacement by a block reimbursement system. Not all the Trusts had accepted the new contract – the large teaching Trusts perceived a disadvantage as they have A&E departments where demand management is problematic. BB said the new system switched the burden of risk from the commissioner to the provider. He handed over firstly, to RP to brief the Board on the latest details of the financial settlement and secondly to RP and NH to brief the Board on the new funding methods for 2015-2016.

RP said, as reported to the Board on 1 April 2015, that the Trust had received a "best and final" offer from NHS England: however, this had been superseded on 22 April with an offer of a further £2m of Project Diamond funding for 2014/15 : if this was agreed by the Trust total Project Diamond funding of £13m would be provided. This compared with the Trust's original 2014/5 budget of £8.6m for Project Diamond and, later, the expectation that the Trust would only receive £4.3m. The Trust had also had an undertaking that tariff version HRG4+ would be introduced from April 2016. The block contract for 2015/16 was £224m. The Trust had accepted the offer subject to 'lift and shift' provisions where, for example, commissioning had moved from the Clinical Commissioning Groups (CCGs) to NHSE and funding needed to follow: this caveat had been accepted by Paul Baumann, NHSE Director of Finance. RP said the Shelford Group Trusts had refused the offer of block contract as they could not control demand. They therefore had defaulted to 'Default Tariff Rollover' (DTR). There also remained a risk that Monitor, which still had to make a decision on the 2015/16 tariff, might either re-consult on the 2015/16 tariff or refer the position to the Competition and Markets Authority. In either case this would be a lengthy process.

Monitor's Board was not due to meet till the end of May and there would probably need to be agreement from the then ruling Government. Responding to NL's question on whether the consultation could be as long or short as the Trust would like it to be, RP said the Trust could object on the grounds that it already had a deal**.**

BB said there would be a lack of clarity for three to six months. NL said he questioned the wisdom of leaving the setting of tariff in the hands of the regulator and not the paymaster. BB said Trusts who had not accepted the block contract were in a risky position. RJ asked if the Trust's acceptance of the block contract was subject to acceptance of the NHSE contract. RP said that was correct. BB said Monitor had not been sighted on the offers. RP said Monitor would still have a role in relation to CCGs and, for 2016/17, HRG4+.

NH said that qualifications had been agreed with respect to the block contract. These included that the Trust would be reimbursed for any spending on new services specified by NICE guidance during 2015/16 or any material shift in market share. The CCG default tariff amounted to £40-50m. BB said the same principles should apply, if there was any substantial change in market share. NHSE had apparently written to CCGs and told them not to pay for CQUINs. NHSE local teams appeared to be unsighted of this.

BB said in summary the position was the Trust was at the positive end of the spectrum while being conscious of financial risk in 2015/16. Even if the detail is not known, at least the Trust has an idea of what it will be paid. The Trust would have to manage high-cost issues such as drugs and cardiac devices – these were now Trust risks. The Trust's clinicians and operations managers would have to shift how they work and this managerial change would be difficult. However, BB assured the Board that the executive team would be on top of this issue. SRF asked if this meant that NHSE were likely to repeat the block contract in 2016/17. In response BB said he had always argued for block contacts for elective specialist hospitals – the more the Trust had control of throughputs and inputs the better. However, the impact on the primary angioplasty service at Harefield Hospital (HH) needed diligence. In principal the Trust was in a better place. In 1999 in Alberta he had headed a commission on reimbursement models and there had been shift from line-by-line tariff to 'block'. BB said he suspected that in 2016/17, although there would be a tariff, there would not be a return to the line-by-line reimbursement model. NHSE would be looking to reduce bureaucracy which counted against a return to the older model.

AVO said the cost of the NHS purchaser / provider model had been staggering. BB said more changes were happening now (for example devolution of NHS funding to local authorities in Manchester) and would continue, begging the question 'What is NHSE's role?'. TE said there would be an impact on job planning. His memory of working under block arrangements was that when there was no money towards the end of the

financial year, operations would be halted and the provider would just wait till April to start again. Today's staff were not used to working like that. Caps on the numbers of procedures would need to considered as well as a focus on partner organisations, for example from Scotland and Wales being outside the block contract. This was a mind-set shift, restricting what can be done and was also rationing but, with Private Patients (PP) and referrals from the devolved nations, there would be opportunities. TE concluded that clinical staff would be using clinical judgment.

RCr said that the Management Committee had recently looked at high cost drugs. Expenditure on drugs was approaching £40m a year, well over 10% of the Trust's annual turnover. With a fixed budget, there would need to be a different rigour about what would be prescribed and patient eligibility. The Chairman of the Medicines Management Board (and Director of the Lung Division) was looking both at which medications should be prescribed and at what volume, so the discipline was developing that had not been required before.

BB said that all the divisions had been sighted of the change to the block contract. He had not heard from anyone who had said they could not do it. Therefore at the very least the Trust's new clinical leaders were aligned and it was an opportunity. It was assumed we are running an efficient place and this would allow the Trust to look at certain areas, and consider the current practice of certain individuals. New financial systems with case costing capabilities would now become very relevant.

AVO said he agreed that it was an opportunity to tackle issues. He asked if the strategy was still to continue to plan for a deficit. BB confirmed that the Trust's objective was to return to a sustainable financial position at the earliest possible opportunity. He said the Trust was already subsidising other organisations with no financial return, for example Imperial College London (ICL) and the Academic Health Science Network. KF said he also agreed that the new arrangement was an opportunity. He asked, if it was the case that the block contract was based on historical line-by-line, how do you change from what was done in the past. NH said £224m was a marginally better outturn than last year, but the Trust would be faced with choices – for example, between transplants or coronary artery bypass grafts (CABG). This meant the Trust was not required to stick to specific service lines but it was required to stick to the money. BB said the Trust should review what it does in relation to services which currently did not make money. LAA said it was within the power of the Board to solve this problem.

Chelsea Redevelopment

BB said that NHSE's London office, led by Anne Rainsberry, had now launched a review process concerning the future plans for estate development in Chelsea inclusive of the Royal Marsden Hospital (RMH). To the extent that NHSE would be exploring the prospect of central capital funding for any shared facility development with RMH, a traditional NHS sequential process of Strategic Outline Case (SOC), Outline Business Case

and Full Business Case (FBC) with funding application would be followed. This was an extensive and time and resource intensive process that is likely to require several months for completion even for the SOC phase. In the meantime, The Royal Borough of Kensington & Chelsea had now halted any SPD process until the NHS England review is completed. RP was leading the Trust's team on the NHSE review steering group.

BB said he and RP had met with John Moynihan (JM) on 17 April 2015. JM had presented a revised vision for the Chelsea estate, rebuilding the Trust's Sydney Street campus by digging four floors underground, connecting RBH, RMH, and ICR with an S-shaped underground road and 'expropriating' the NHLI building. The proposal by JM was costed at £900m and he had said, when pressed on how this would be financed, that he recognised that the sale of properties would not realise enough funds and that a PFI scheme could be utilised. BB said he had made it clear a PFI was off the table. JM then mentioned the Medical Research Council or ICL as possible funders.

In summary BB said this was an NHSE-led process. As such, the prospect of moving forward with any substantial redevelopment of the Chelsea estate was in abeyance pending the conclusion of the review process. In the meantime the Trust had received some serious enquiries into purchasing parts of the Trust's estate.

Invited by BB to comment on the NHSE process, RP said that since the review process began in December 2014 there had been only one meeting in April 2015 with another planned for 30 April (Tim Callaghan would be representing the Trust on the Finance Working Group and Rob Wilson would be the Clinical Group lead for the Trust). RP said that to issue a FBC could take months if not years. The intention was that the final case would be submitted to the Treasury for funding. The prospects of this being forthcoming were in his view very slim. He suggested that the Trust should proceed to the SOC then at that point decide whether to go on or stop. PD asked if the default position BB had set out previously – prioritising respiratory patients, intensive care, and PP – was on hold or continuing. BB said this was a profound question. The priorities had not changed. The NHSE process would not put a stop to the Trust advancing phased redevelopment. to create a wing for respiratory patients, the HH implementation plan and the Wimpole Street PP inpatient project were all carrying on. He added that overseas opportunities currently under consideration also had a better than 50% prospect of success. SRF proposed a Board seminar be held to look at redevelopment and the impact on RBH and HH sites. Part of it was wrapped up with RMH who, whatever the Trust does to the Chelsea Campus, still wanted to rebuild the Fulham Wing as an extension of their site. SRF said patients must come first. Meetings would be held with Cadogan, ICL and others. It was agreed that a Board seminar would be held to discuss these issues.

KF said JM had also met with Dermot Kelleher, Dean of the Faculty of Medicine at ICL and himself. If it was assumed JM represented the Chelsea

residents, KF said he thought it was a desire to stop any new build affecting the light on Dovehouse Street which was driving his proposals**.**

2015/28 CLINICAL QUALITY REPORT FOR MONTH 12: MARCH 2015

Introducing the report RCo said the highlights were:
Monitor Risk Assessment Framework

- *Clostridium difficile*: Only one lapse of care had been identified by NHSE during 2014/15. This meant only one case counted against Monitor's de minimis threshold of twelve. The target was therefore met for Q4.
- RTT (Referral to Treatment Time) targets, all met
- Cancer access targets; the 14 day and both 31 day targets were met. 62 day urgent GP referral to 1st Treatment target, Q4 performance was 77.78% against a threshold of 85%. Therefore this target was not met.

Care Quality Commission (CQC). The Draft Intelligent Monitoring (IM) report for May 2015 was received on 22 April and the Trust has raised some questions about the report with the CQC. The draft IM report was discussed at the Risk and Safety Committee (RSC) meeting on 28 April 2015.

AVO said that the RSC had assessed progress against the action plan with regards to the review of the lung cancer pathway and had concluded that the Trust was doing all that it could. He noted the appointment of a new consultant in Respiratory Medicine with expertise in Lung Cancer and Pleural Disease, ratification of which was on the Board agenda.

TE said the Trust was spending time with the referring hospitals and, as recommended by NHSE's cancer lead, engaging as fully as it could with the referring organisations.

BB said this was relevant to the reimbursement model and under the 2015/16 compensation system this would not be merely a performance issue. There was a regular problem of late referrals from West Hertfordshire NHS Trust (Watford General Hospital) who showed no responsiveness. BB said that the Trust had not been able to find an intermediary able to help with this and might have to review whether this service could continue in the future.

The Board noted the report.

2015/29 FINANCIAL PERFORMANCE REPORT FOR MONTH 12 AND 2014/15 OUTCOME

RP said the Month 12 report was much shorter than for other months as the Finance team had been focused on annual reporting. He reported the following performance in M12:
- I&E account: the reported surplus for M12 was £3.7m against a planned surplus of £1.1m. When one-off/year-end adjustments were taken out there was an underlying deficit of £150k although that did not include Project

Diamond funding (budget £0.7m). The year end result was a deficit of £3.3m. This was behind plan and was principally as a result of: £2.3m planned surplus, £4m property impairment, £3m delay in charitable donations and £4.5m Project Diamond surplus over plan. The underlying shortfall was £2.5m, less than 1% of revenues.

- Cash: balance sheet. £10m RCF was drawn down in full in March. Net cash was zero. However, on 1 April 2015 the Trust received £6.3m of over-performance money and £9m Project Diamond was due. Overall the cash position, therefore, was promising.
- Capital expenditure: this had been reforecast at £28m in the Autumn of last year, and thanks to the leadership of RCr, had landed spot on.
- Provisions: these were reasonably conservative. Though not huge some protection had been included for any 'bad news' in 2015/16.
- CoSRR (Monitor Continuity of Service Risk Rating): A rating of 4 was achieved for 2014/15.

SRF congratulated RP and his staff for the end of year result as well as the operations team.

The Board noted the report.

2015/30 <u>WARD NURSE ESTABLISHMENT REVIEW</u>

JG highlighted that these reviews came out of the Francis report with the aim of providing assurance for the Board that ward nursing establishments were safe. This report covered four areas:

- Activity: Safer Nursing Care Tool Audit of activity undertaken every six months which provides a baseline staffing recommendation which was validated by senior nurse and matrons. The audit had shown that staffing levels were adjusted over time and also confirmed that in some areas, activity and case-mix had intensified and therefore converting some temporary staffing expenditure into established posts was appropriate (for example in AICU).
- Patient safety: the Safety Thermometer audit occurred on one day each month and covered four areas; pressure ulcers, falls within the last 72 hours, urinary catheter use and related infection and venous thromboembolism (VTE) risks and events. The results were reviewed by each ward every month.
- Patient feedback: Friends and Family Test (FFT) and the Inpatient Survey. The latter survey was a national survey which allowed the Trust to benchmark against other Trusts. The Royal Brompton and Harefield NHS Foundation Trust (RB&HFT) did very well on the two questions relevant to the establishment review (Always or nearly always enough nurses on duty and It took staff more than 5 minutes to answer the call bell) in comparison with other Trusts.
- Staff Feedback: the Trust again did very well on the two relevant questions in comparison with other Trusts (Work pressure felt by staff and % feeling satisfied with the quality of work and patient care that they are able to deliver)

JG concluded that she could assure the Board that the ward staffing levels were sufficient to provide safe and effective care reflecting the high quality of care provided by the staff the Trust had.

AVO thanked JG for her report. He had noted that Pressure Ulcers was one of the Quality Priorities and improving the management of them was very much in hand. PD said the RSC had noted that the FFT response rate was low in comparison with the national average. JG said it was low but the Trust was hitting the 30% target. Collecting responses was an onerous activity and should be viewed in the wider context of patient feedback. NL said performance was poor relative to other Trusts. RJ said he had noted that the tone of the feedback was excellent. He asked if the recent uptick in VTE was a concern. JG said it was not a concern as yet but it was being closely monitored through monthly reports and trends would be considered. RP said that the feedback on FFT performance was not poor, in fact it was excellent – it was the response rate that was low.

The report was noted.

2015/31 IT UPDATE

JS gave a presentation which provided a recap on how things were in 2013, the I&T Strategy and 3 Year Plan approved in March 2014, progress so far, and what is planned in 2015/2016.

SRF asked how had medical and nursing staff reacted to the programmes. JS said they were very supportive. Cliff Morgan, Clinical Director, Critical Care and Anaesthesia was the bridge into the clinical community. There was good clinical representation on the I&T Committee and a team of three full-time nurses had been assigned to the Digital Care Transformation programme. There were great levels of enthusiasm. The challenge was to get sufficient engagement, recognising that clinical staff are very busy and had different priorities, without slowing down the programme.

NL thanked JS and said that every time he heard her present he became more confident.

KF said the cost of achieving our aspirations could be followed by high costs of maintaining it and asked if JS could reassure the Board that this would not be too much. JS said there was still more to be done to get where we want to be (for example more work is needed on telephony, Imaging solutions and patient engagement) and therefore more cost will need to be incurred over the coming few years, but once completed she was hopeful that through reducing complexity and standardising where possible, the on-going operational costs would be kept more or less flat.

NL asked if maintenance costs could be expected to decline. JS said that whilst the major new investments had an impact now there was an opportunity to standardise and therefore save money. It was about accepting that an 80-85% fit was good enough, versus wanting to achieve

90-95% fit which would result in a large number of similar systems such as the Trust had today.

SRF thanked her for the presentation. It was agreed that an update should be given to the Board in six months' time.

2015/32 2015/16 DRAFT I & E AND CAPITAL EXPENDITURE BUDGETS

Introducing the report, RP said that these budgets would be reflected in the Final Operational Plan (Paper E) and submitted to Monitor by 14 May. The I&E budget, which reflected the block contract arrangements referred to above, showed an improvement of £1.5m from that presented at the 1 April Board meeting. This was mainly due to additional work on the operational side to drive down projected costs. Contingencies of £1m each had been included for Pay and Non-Pay although larger contingencies would have been preferable. There was no Project Diamond income in the budget. EBITDA showed a deterioration from 5.8% (budget 2014/15) to 2.6% (budget 2015/16). The budget depended heavily on cost control rather than the past years' reliance on growth to achieve additional margin, an approach which could not work under block contract arrangements.

NL asked what impact additional cost pressures would have on the budget. RCr said some progress had been made on paring back some of the proposed cost pressures. There was, however, some risk as they were linked to the amount of activity delivered and the requirements of a block contract. It was still a challenging budget, albeit delivering a deficit. In this and subsequent years, longer-term cost savings would be developed further.

RP continued his summary of the report: The 2-Year Capital Investment (CAPEX) Programme still showed, despite paring back the total budget from £49m to £35m, a funding deficit of £10m. The Board would recall that on 1 April it was reported that the Trust had asked the ITFF for £10m for 2015/16 and £10m for 2016/17 to fund the balance of the (pared down) CAPEX programme for these two years. Barclays' agreement to further ITFF borrowing was required: this had been forthcoming and ITFF notified. A formal loan contract would not be signed until after the General Election on 7 May but, assuming it went ahead, this should give the Trust breathing space for at least 12 months.

RP stressed that the Trust had 'dodged a bullet' for now but it needed to take advantage of this breathing space to:

- Expand and change the balance of private patient business
- Reach a better understanding with the Charity
- See the positive impact on results of HRG 4+ (recognising that the details were still unknown)
- See what, if any, additional support will be provided to the NHS by the next government.

Headline savings expected from the NHS over the next five years amounted to £22bn. On a pro rata basis this would require the Trust to make savings of a further 20% over that period which was simply not achievable.

RJ asked if Barclays' consent had included onerous conditions. RP said it did not.

SRF asked RCr if he was content that the capital programme for the next two to three years was adequate for our needs. RCr said the intentions were right and the individual projects addressed the needs the Trust had. However, as of 29 April 2015, the Trust still did not have planning consent for HH developments. He reminded the Board that additional ward development was not funded although, if ITFF money was confirmed, a revised case had been prepared which would enhance both PP and NHS capacity at HH.

RP said that the Trust's planned deficit of £10m should be seen in the context of the aggregate deficit forecast for all FTs of £950m, and all providers £1.5bn to £2bn. Monitor's response to the Trust's draft Operating Plan could take some time. The Trust was in a position to declare that it would expect to maintain a CoSSR of 3 for the next twelve months (based on taking 2015/16 as a whole for these purposes as the initial phased budget revealed a substantial deficit in Q1 as a result of low working day numbers and the time needed to put new CIPs into place).

AVO asked if the strategy was to maintain a deficit or return to balance. SRF said, as Chairman, he was committed to get the Trust back to balance and he hoped that HRG4+ would resolve that.

NH said that he and RCo had attended Hillingdon Council's External Services Scrutiny Committee on 28 April 2015. They had asked when the HH planning application was being considered. NH said the response had been that it was on the agenda of the planning committee in the next two weeks. NH added that he was not confident that HRG4+ would help the Trust address the deficit. An unpalatable 'zero sum' game was being played out. RP said he was not as pessimistic as NH and he observed that because the Project Diamond/Shelford Group funding for complex services represented a miniscule proportion of the total NHS budget: a redistribution of this funding would not move the needle for other Trusts in a zero sum game.

BB added that the Trust had an underlying surplus in recent years and no history of deficits. However, he did not think the deficit would be corrected in the short term and indeed this could take years. In terms of the CoSRR metric and the availability of cash, as measures of going concern, there was some comfort but the reimbursement base was broken unless the Trust radically changed its revenue earning capabilities.

AVO suggested that the budget was discussed at the next Board seminar. LAA said she would not want to limit the discussion to finance at the seminar.

The Board approved the submission of the Trust's income, expenditure and capex budgets to Monitor.

2015/33 FINAL OPERATIONAL PLAN (FOP) 2015/16

Introducing the report PM said the FOP made reference to the impact of the one year block contract and the need to use patient level costing and service-line reporting to adjust the mix of activities and manage operational performance. The FOP included a greater focus on PP opportunities in central London and the Middle East. Monitor had asked the Trust if the plan was a refresh, a reconstitution or a recommitment and the Trust had replied that it was essentially a recommitment.

NL asked whether describing the target for the CIPs as 'achievable subject to close management attention' was the best way to phrase it. RCr said the phrase would be revised.

AVO said he was surprised to read that the Trust had been to the Middle East to develop core PP markets. He spent a lot of time in that area for UK Healthcare plc. He asked whether a briefing at the Board seminar was needed. BB said the Board, through the Finance Committee had been diligently briefed. SRF said he would talk with the Chairman of the Finance Committee to ensure that the Board was appraised.

RP said that Monitor had reviewed the Draft Operating Plan submitted by the Trust in April 2015 and had asked for a number of points to be explained in the FOP. Given the scale of the projected deficit it was also likely that a Monitor team would visit the Trust but their finite resources and the number of Trusts projecting deficits meant that this might take some time.

RP also said that template for the FOP including a sustainability statement for the next one, three and five years. He recommended that the Trust provides this confirmation for only one year. Monitor would ask for an explanation of this but having talked to other Trusts RP said he felt the Trust could not do anything else. NL said this was sensible. The Trust could not go on supporting deficits of this scale as eventually it would run out of cash.

It was agreed that the final form of the FOP would be decided by RP. This would be circulated with the next minutes. RP said he would share the final version with his Executive colleagues before it was submitted.

The Board approved the submission of the Final Operational Plan.

2015/34 Q4 MONITOR DECLARATIONS 2014/15: (i) GOVERNANCE DECLARATION (ii) CONTINUITY OF SERVICE (CoSRR) RATING

The Board agreed that the following governance statements should be made:

For Finance, that the board anticipates that the Trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months.

For Governance, the Board agreed that the governance statement that plans were in place to ensure on-going compliance with all existing targets should be declared 'not confirmed' because the 62 day cancer target had not been met for Q4.

Otherwise, that the Board confirms that that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework page 22, Diagram 6) which have not already been reported.

Consolidated subsidiaries: Number of subsidiaries included in the finances of this return = 0 (zero).

Action: Upload declarations to the MARS portal before 4pm Friday 30 April 2015 to ensure compliance with Monitor's reporting requirements.

2015/35 RECOMMENDATIONS OF ADVISORY APPOINTMENTS COMMITTEE

The Board was presented with one ratification form for the appointment of a Consultant in Respiratory Medicine with Expertise in Lung Cancer and Pleural Disease. KO said there had been three candidates but one had withdrawn before the interviews. One candidate had already worked one day a week at HH and one day a week at Watford General Hospital. It was felt that the other candidate was better placed to face the challenges of the role. TE said the candidate who had withdrawn was also a strong candidate and had only withdrawn because HH did not have respiratory inpatients.

The Trust Board ratified the appointment of Dr Jaymin Morjaria as a Consultant in Respiratory Medicine with Expertise in Lung Cancer and Pleural Disease.

2015/36 AUDIT COMMITTEE (AC)

(i) REPORT FROM MEETING HELD ON 28 APRIL 2015

NL highlighted three of the presentations the committee had received from the internal auditors:

- Information Governance: this raised some serious issues but the presentation from JS had provided assurance that the IT function was addressing these. He noted that the auditors would check that the plans had been delivered.

- Divisional Governance and Risk Management: this had raised issues that required to be addressed but the committee noted they were partly to do with internal restructuring of risk management which had not had time to bed down.
- Internal Audit Plan 2015/16. This was approved.

NL said the AC had also received the Counter Fraud Annual Report and Work Plan, which were satisfactory, and had also been provided with an update by the external auditors, which was also satisfactory. The Committee had also seen an early draft of the Annual Report and Accounts for 2014/15 and given feedback to RCo.

Asked by SRF to describe relations with the auditors, NL noted that he was somewhat conflicted, but went on to say that the internal auditors were doing a good job and had raised the game on audit in comparison with their predecessors. He said that a key point was whether management thought the internal auditors added value. The external auditors did a fine job and he had no criticisms.

(ii) MINUTES FROM THE MEETING HELD ON 16 FEBRUARY 2015
The minutes were noted.

2015/37 RISK & SAFETY COMMITTEE (RSC)

(i) REPORT FROM MEETING HELD 28 APRIL 2015

AVO said the committee had received a presentation from Doctor Gillian Halley on Hospital to Home and noted the outstanding award winning work that had been done. The committee also reviewed an early draft of the Quality Report 2014/15 and the priorities (Safety culture, admission and discharge, pressure ulcers / falls, the lung cancer pathway, deteriorating patients, safer use of medicines); and received a comprehensive report on serious incidents. Finally, the RSC had noted with some concern the number of never events relating to retained swabs/needles. AVO went on to say that JG was reviewing this.

AVO said Richard Grocott-Mason (Divisional Director Harefield Heart Division) was continuing constructive discussions with Dr Foster on the outlier ratings and how patients should be categorised. TE noted that an external review of acute myocardial infarction patients had also been commissioned. AVO mentioned one adverse incident which had occurred with regards to the Welsh contract, which had resulted in some challenging clinical governance issues.

(i) MINUTES FROM THE MEETING HELD ON 16 FEBRUARY 2015
The minutes were noted.

2015/38 AOB

a) SRF gave thanks and paid tribute to Richard Hunting whose last Board meeting this was and whose term ended on 30 April 2015. RH had joined the Board in 2007 and had been an enormous source of wisdom,

clarity, friendship, and business acumen. The Trust was interviewing suitably strong candidates to replace him but in fact nobody would be able to replace him. SRF added that RH was continuing as Chairman of the Charity and he was partly stepping down from the Board to remove a conflict and so that the Charity could benefit from his independent advice. The Board endorsed these comments.

b) RJ said he hoped he was speaking on behalf of all the Non-Executive Board members in extending is thanks to the Executive team who had done a fantastic job in relation to the financial settlement. They had acted professionally and tenaciously despite provocation. This was endorsed by the all the NEDs present. SRF said for the record he would like the Board to note its gratitude to Tim Callaghan for all his efforts over the past weeks and months. This was noted.

2015/39 QUESTIONS FROM MEMBERS OF THE PUBLIC

None

NEXT MEETING Wednesday 20 May 2015 at 10:30am in the Concert Hall, Harefield Hospital