Minutes of the Board of Directors meeting held on 30th May 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 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 Nicholas Coleman, Non-Executive Director	NC
	Mrs Jenny Hill, Senior Independent Director	JH
	Mr Richard Hunting, Non-Executive Director	RH
	Mr Neil Lerner, Non-Executive Director	ML
	Ms Kate Owen, Non-Executive Director	KO
	Mr Richard Connett, Director of Performance & Trust Secretary	RCo
By Invitation:	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
	Nick Hunt, Director of Service Development	NH
In Attendance:	Mr Anthony Lumley, Corporate Governance Manager (minutes)	
	Ms Jessie Mangold, Head of Media Relations	
	Ms Pat Cattini, Matron/Lead Nurse Infection Prevention	
Apologies:	Pr Sir Anthony Newman Taylor, Non-Executive Director	ANT

2012/40 MINUTES OF THE PREVIOUS MEETING HELD ON 25 APRIL 2012

The minutes of the meeting were approved.

2012/41 MATTERS ARISING

Actions from minutes

The Chairman reviewed the Action Tracking log and all the elements are complete or followed up on this agenda.

2012/42 REPORT FROM THE CHIEF EXECUTIVE

BB gave verbal updates on the following items:

Judicial Review: Safe and Sustainable: Decision of Appeal Court

BB reported that he had met with Sue McLellen (SM), Chief Operating Officer of the London Specialised Commissioning Group (LSCG) on 29 May 2012 to discuss the impact of the potential withdrawal of Paediatric Congenital Cardiac Services (PCCS) on Paediatric Respiratory Services (PRS). An engagement exercise was being run by LSCG . They had asked for the Trust's help to identify the audience. In the interim the Trust's counsel had advised, with regard to s.242 of the NHS Act 2006, that if the commissioner (i.e. the LSCG) has been involved in a decision to alter the

range of services that decision must be scrutinised by the relevant Overview and Scrutiny Committee (OSC). LSCG is the commissioning member of the JCPCT. The Trust therefore wrote to the LSCG asking if they intended to consult rather than just engage. At the meeting on 29 May, BB was informed that the LSCG would reply to the Trust's letter shortly. At the same meeting the Trust was told that 5000 patients would be affected and was asked to provide names and help with the mail out of the questionnaire. The LSCG said they would use this material to inform the JCPCT's decision making.

BB said a letter had been received this day (30 May 2012) from SM in which she had stated that the responsibility for consulting and due regard for the impact on services lies with the JCPCT and this was the issue raised by the Trust in the Judicial Review. The LSCG was coordinating the initial engagement process to inform the next steps. The letter went on to state that should the Trust's PCCS be decommissioned more work was needed along lines the Trust had suggested. The LSCG said they thought it was not clear that the OSC should scrutinise the process and that the consultation by the JCPCT had been adequate. BB said it was evident that the LSCG had been given a slightly different interpretation by their legal team of the implications of s.242. BB concluded that if PCCS were decommissioned, the Trust would need to decide whether to mount another legal challenge.

SRF asked if the LSCG were going to consult with the Board? BB said it was not a consultation but an engagement to assess the impact. The 'trick' that was being utilised by the LSCG was to ask the Trust to agree to the Pollit Review recommendations which essentially assumed the Trust would become a general hospital by continuing with PRS but not specialist services. In response to a follow-up comment made by SRF on whether the Trust should then ask its Medical Director to conduct an impact assessment, TE said the impact had been discussed and noted at previous Board meetings. It had been stated that the Trust would not wish to practise other than in areas of specialist paediatrics.

BB reconfirmed, in response to a request for clarification made by NL, that the authority to implement the recommendations rests with the LSCG and not the JCPCT. He added that there were 2 other review processes in progress – the London-wide tertiary paediatric review, and the National Commissioning Board review of paediatrics. The LSCG have said that they hope that all of the processes would be aligned.

SRF asked if the LSCG was considering 3 sites and 1 service. BB said the option of 3 sites was being considered but not as 1 service. He added that the 2 concurrent processes he had described affected the configuration of services north and south of the River Thames respectively. NL commented that this painted a picture (as Board members had previously described in other Board meetings) of an 'Alice in Wonderland' scenario where reviews would take place of all congenital services after the national review of paediatric cardiac services.

NC asked if the JCPCT would be announcing its decision on 4 July? BB confirmed that the decision would be announced on that day. The LSCG would then take into account what the JCPCT had decided when implementing the recommendations. The LSCG had satisfied itself that it had consulted appropriately, i.e. on the issue of consultation.

SRF suggested that the Trust should ask for a legal analysis of where it now stands and consider whether it feels the JCPCT had acted lawfully. BB said the key issue for the Board is does it have any spirit to continue in a challenge mode and asked the Board to consider guiding him.

NL asked if the Trust should have a discussion in advance of the decision? BB replied that Trust's counsel were bound to say the Trust's position should be 'we don't agree' with the JCPCT and they should have consulted with the OSC on the effects of service change. The Secretary of State had already referred the OSC question to the Independent Reconfiguration Panel. CS asked if the OSC could approach the LSCG to ask for its input to be considered? BB said the OSC is entitled to write to the Secretary of State. RP asked if the Trust could ask for the results of the engagement exercise as the results would have a major effect on what the Trust could do next? BB replied that the LSCG had been reluctant even to share the Terms of Reference. BB added that he agreed that the Trust should ask the LSCG to share the results but that this should be subject to advice from the Trust's counsel.

SRF asked if the Trust had seen the draft questions in the questionnaire and what had happened in relation to them? He also asked if the Trust should run its own independent exercise? BB said he did not know what would be in the questionnaire. A sounding of the Trust's 5000 patients was possible but his preference was to respond when the Trust's legal team had given him an action plan.

NL said he felt there was an appetite for continued challenge which meant the Trust should proceed with its robust stance. However, if the Trust continued to operate in a combative mode this could make future relationships difficult. If paediatric cardiac surgery is excluded any steps to fight become central to operations. SRF asked what legal advice had been given and what were the chances of winning? JH said she did not see this as a binary question but the issue should be debated and discussed as a board and Board members should be better informed about the consequences. RH said that personally he does have the spirit to keep fighting but hoped that it could be done in the least aggressive manner possible. NL said the Trust's lawyers may suggest other less aggressive ways to continue the debate.

NC outlined 3 potential outcomes and positions: firstly, the Trust should reserve its decision so there would be nothing to prejudice the outcome; secondly, if the legality of the decision was beyond doubt then the Trust

should accept it; and thirdly, if the decision was not legal and not in the interests of the citizens of the country the Trust should have the spirit to challenge (but not through the courts but by challenge or negotiation).

RCr said there were 2 steps: first what happens after the decision on 4 July is known, and second what the Trust does before them. The JCPCT and Safe & Sustainable Review need to know that the Board might challenge their decision. He felt the Trust should continue to use its external advisors (i.e. legal and other counsel) over the next few weeks to maintain pressure on the JCPCT, LSCG and other relevant parties.

KO asked if consultation offered additional options, was there any sense that there could be a face-saving outcome? BB replied that the Trust had obtained documents from February 2012 used by the JCPCT. These revealed that the JCPCT had been consulting on a different series of proposals (including 5 new options 3 of which propose 3 London centres), from those first published in July 2011. It was clear that there were Trusts outside London which would never have the volume of cases the JCPCT had set as their minimum criteria. The range used was 1200-1500 for London. Divided by 3 centres this gave 400-500. Therefore London passed the test whatever configuration was chosen. The issue now was what could be done to redistribute work outside London so each centre achieves at least 400 cases a year. He concluded by stating that the impression he got from their meeting on 29 May was that SM was only doing the engagement exercise because she had been asked to do so.

SRF summarised the position and steps that the Board could agree on:
- No formal action until 4 July when the JCPCT's decision is known.
- Work with the LSCG on the engagement exercise.
- Continue to receive legal advice and maintain pressure on the JCPCT.
- Prepare responses, but take no steps until/unless the Board agrees.

2012/43 CLINICAL QUALITY REPORT FOR MONTH 1: APRIL 2012

RCo said that the M1 report had been reformatted in order to bring the compliance framework to the fore by having this on the first page. This also included the Governance rating (currently amber/green) for the quarter given to the Trust by Monitor. The second page now had clinical items which had previously been on page 1. One other change was that the report no longer reported Surgical Site Infection Surveillance Service (SSISS) routinely, but would do so by exception.

- *Clostridium difficile*. There had been 3 reportable cases in April. TE commented that it was helpful to have the exception report and that together with CS, he had commissioned an external review of the Trust Infection Control service, which would include a review of arrangements for testing and reporting Clostridium difficile within its terms of reference. *Cancer target. Since* the report was printed the breach repatriation request made to Luton had been declined.
- 18 weeks Referral to Treatment: the target had been met but with no margin. RCo noted that the Compliance Framework published by

Monitor looked at achievement of this indicator in aggregate across all specialties.

- Outbreak of infection: RCo noted one outbreak of norovirus in paediatrics.
- Cancelled operations: performance was presented in the report measured against the NHS Standard Contract measure of 2% cancelled operations against elective admissions. Although this was not a compliance requirement it had been included to take the Board's concerns into account as expressed at the meeting in March 2012. NL pointed out that as the position reported was 1% then the word 'underachieved' should be changed to 'achieved'. Similarly JH noted that the data in the table showed that the first bullet should read '16 (cancelled) operations at HH and 5 at RBH' and not the other way round as was printed.
- Board statements: RCo recommended that the Board confirm all the statements apart from Statement 11 as 3 targets were known to be at risk, and there was 1 other new target relating to incomplete patient pathways which might also prove to be a risk. RCo recommended that the Trust forecast a governance rating of amber/red in the 2012/13 Annual Plan submission to Monitor. In 2011/12 there had been a discrepancy between the forecast governance risk rating and the actual risk rating during the year and this had led to concerns at Monitor resulting in a requirement for the Trust to undertake a review of its self certification procedures. This was the background to the prudent approach he now recommended. He noted that such a declaration should not be made lightly as it might result in Monitor requiring the Trust to undertake a stage 2 review of the Annual Plan 2012/13. NL asked if was a certainty that up to 2 targets would be failed (thereby causing an amber/red rating). BB said it was definite and cited the refusal of an FT to accept repatriation of a cancer breach as an example.

The Board agreed to forecast a rating of amber/red for 2012/13.

NC asked that Statement 9 be changed from 'audit committee recommendations' to 'recommendations from internal and external audit'.
NL asked what Appendix C4 referred to in statement 16? RCo assured him that it is was on the Compliance Framework and the Trust had fulfilled the criteria. PM also confirmed that the Trust had fulfilled the criteria.

Action: RCo to amend report with changes to correct errors in the Exception Report on National Contract: Cancelled Operations and change the wording of Statement 9.

2012/44 <u>FINANCIAL PERFORMANCE REPORT FOR MONTH 1: APRIL 2012</u>

Introducing his short report for the first month of 2012/13, RP highlighted that in M1:

- The Income and Expenditure (I&E) outturn was a deficit of £1.4m, which was a disappointing result.

- The special factors behind the poor performance and low income were: an outbreak of norovirus which had cost £0.5m in income and additional pay costs of £100k for temporary staff. The expectation was little norovirus impact into M2 but it illustrated the impact an adverse event could have; Private Patients (PP) performance had been unusually weak; and the loss of working days to bank holidays. Also coming up were more bank holidays (including an additional holiday) and the Olympics effect. RP said he was still unsure if the latter would result in the loss of work or simply its deferral but thought it would be a combination of the two. The intention was to wait till the results for M2 were known in 10 to 12 days time before deciding on any operational changes.
- One of the Board Statements in the Monitor submission for 2011/12 Q4 was a confirmation that the Board anticipated the Trust would maintain a financial risk rating (FRR) of at least 3 over the following 12 months. The poor M1 result calls that into question. However, if the Trust breaks even for M2 and M3 the Q1 result in aggregate would be sufficient for an FFR of 3. RP said that in his judgement the Trust will achieve this and he was also still confident (albeit admittedly less confident than before) with the 12 months projection of FRR3.
- Cash and liquidity were more positive. There was no anticipated draw down against the Working Capital Facility in 2012/13 so the Board Statement that it was satisfied that the Trust will remain a going concern over the next 12 months (i.e. to 31 May 2013) was justified.

NL asked if more could be done to improve income and how were pay costs running in the first month of 2012/13. RP said they were consistent with the previous 3 months. In the middle of 2011/12 it had risen due principally to temporary staffing requirements but this was now under control.

The Board noted the report.

2012/45 RESEARCH UPDATE

TE introduced the report and said the purpose of it was to inform the Board of research activities from the period 1 January to 31 March 2012. Included were the achievements and metrics and the annual reports submitted by the Biomedical Research Units (BRUs) to the National Institute for Health Research.

SRF asked if there were any comparator studies with other Trusts? TE said that there were and that the metrics used tended include the numbers of patients recruited to studies, grant income received and new grants awarded. He went on to say that benchmarking against all other trusts was problematic because of the inclusion of Mental Health Trusts which used different drug regimes. He concluded by saying that the best way to measure Trust performance was by year on year comparison with the Trust's own performance.

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The Board noted the report.

2012/46 STAFF SURVEY REPORT 2011/2012

CJ presented the report. When it the Board had received the Staff Survey for 2010/11 it had asked for a comparison with other specialist Trusts. The 2011/12 report gave a very positive result especially in light of PCCS review which was in the minds of staff when the survey was carried out in November 2011. The Trust had scored higher on 16 areas, but lower on 8. Bullying and harassment, which were highlighted as up last year, was now down. However there were some areas that would need more attention. For instance, not enough appraisals had been completed so for 2012/13 the Trust would be aiming for 90%. CJ said she was confident this would be achieved. The appraisal form had been made more user friendly especially for more routine roles. The numbers of staff who had received Health and Safety training needed to improve. While this could be partly explained by the 2 year cycle of provision for all staff, this lower performance was harder to understand. However, CJ assured the Board that it was an area the Trust was on top of.

KO congratulated CJ on the results. She asked what the level of appraisals for consultants was? CJ said doctors was 100% and junior doctors' appraisals came through the Deanery. Some areas needed improving such as facilities, estates, finance and nursing but this was likely to be more to do with a lag factor in recording them and uptake had recently greatly improved at HH.

The Board noted the report.

2012/47 APPROVAL OF ANNUAL REPORT & ACCOUNTS INCLUDING QUALITY REPORT 2011/12

RCo informed the Board that the Annual Report had been reviewed by the Audit Committee (AC) to their satisfaction on 29 May 2012. Members of the AC had contributed some useful comments. The report was due to be uploaded to Monitor by 9 am on 31 May. NL said earlier engagement with

the AC next year would be beneficial. SRF commented that in part, the report should be a tool by which the Trust measures performance during the year. NL concurred but said but said a proper debate on what the Trust could get out of it had not been had. It was agreed that NL will take this on board. SRF asked RP if the report was to his satisfaction. RP confirmed that it was and added that the external auditors were also content.

The Board approved the Annual Report and Accounts.

Action: submit the Annual Report via the MARS portal by the deadline.

Action: NL to look at earlier engagement with AC in drafting of the report and clarifying how the report could be used by the Trust.

2012/48 APPROVAL OF THE ANNUAL PLAN INCLUDING 2012/13 BUDGET

In the absence of PM, RP presented the paper. PM sent his apologies for some minor errors in the report which would be corrected.

RP drew the Board's attention to the Income & Expenditure Headline View. This projected a surplus in 2012/13 of £3.2m. His recommendation was that the Annual Plan be approved prior to its submission by 9 am the next day (31 May 2012). NL said the Audit Committee had not looked at this plan. RP said he was content with the final report and that it had previously been distributed in draft to board members for comment and discussed by the Management Committee.

NL asked if the redevelopment should have been included in the financial demands on the Trust? RP said it would not be a major item of expenditure over the 3 years covered by the Plan although estimated costs of planning and design were included. NL accepted this response.

NL also asked whether the charitable fund restructuring should be reflected in the Plan. He was advised that the contribution from the Charity was determined by extrapolation as the new Charity Board's views could not be identified before its first meeting. NL also commented that there was no mention of Imperial College (IC) in the list of Operational Priorities. Referring to point 2 'exploring with ICHT the scope for integrating common services', BB said there was no major change in the Trust's relationship with IC and added that cooperation with IC was highlighted in the main document. NL again confirmed that this response had given him the assurance he required.

The Board noted and approved the budget and Three Year Plan.

Action: submit the Annual Plan via the MARS portal by the deadline.

2012/49 RESPONSIBLE OFFICER ANNUAL REPORT

TE said that this report was presented in response to a request from the AC in February 2012 for an update to be given to the Board. Since then 2

updates (ORSATs – operational readiness self assessment tools) had been submitted to NHS London and the report set out the progress made on revalidation.

TE said that the changes in revalidation, which was an evolving process, had not had a negative impact on the Trust. The Trust was now required to revalidate by 31 March 2013. More had emerged about quality assurance processes. The Trust was more than compliant. It was also auditing actual outcome. He commended colleagues in the HR department for their help in securing resources from the national monitoring body, NHS RST.

SRF asked how the Trust proposed to meet the IT challenge as it was stated in the report that IT systems were still a cause for concern? TE replied that Dr Cliff Morgan (Clinical Director, Critical Care and Anaesthesia) had become the new chair of the Clinical Services Board. Getting that level of granularity was a challenge for any Trust but he remained confident this would come right. Enormous progress had been made since the last report to the Board in June 2011.

NC felt the report was terrific and congratulated TE. He asked when a table would be produced to meet the proposal for a 'Traffic Light System' and what would it take for a consultant to get a red light? TE said if a red came at end of an appraisal it should not come as a surprise but rather as confirmation of previous issues. Reds would be reported to the GMC. It was more about following a process which would allow greens to be awarded. The system itself would be introduced in July 2012 with a pilot for 20 appraisals. He assured the Board that he expected that any red light which occurred would simply confirm previous issues identified through formal process, rather than come as a surprise.

JH expressed concern about the weight of responsibility covered by TE's portfolio. TE said this was continuing to evolve, and that it was becoming evident that it would include the 100 – 110 junior doctors who are not Deanery trainees. Approximately 75-100 non Deanery trainees name RBHFT as their designated body. TE suspected the Trust would want to take on responsibility for this growing group and that this would add to the burden of the Ro. He noted that the borders of the role of Responsible Officer were still to be defined, more would be know about the full extent and impact of this in a year's time.

NL asked about the timescale for the KPMG audit of readiness. TE replied that KPMG had suggested a 2 part audit. NL said that this was not a resource issue.

2012/50 RECOMMENDATIONS OF ADVISORY APPOINTMENTS COMMITTEE

The Board were presented with 3 ratification forms for the appointment of consultant medical staff by JH, RH and NL for a Consultant in Critical Care Medicine, a Consultant Cardiologist with a special interest in

Echocardiography, and a Consultant in Adult Cardiothoracic Anaesthesia respectively.

JH described the recruitment process for the Consultant in Critical Care Medicine. This had been straightforward. ECMO represented a big step change for people appointed by RBHFT compared to other Trusts.

RH outlined the process for the appointment of a Consultant Cardiologist with a special interest in Echocardiography. This was joint appointment with HH and Wrexham Park. The selected candidate had been outstanding and the committee had no hesitation in recommending this appointment.

NL described the recruitment process for the Consultant in Adult Cardiothoracic Anaesthesia. This had not been as smooth as previous appointments. Process lessons would be leant especially about how names come forward. BB added that the issue in this case was less about the grade more about the need to fill the post.

The Board ratified the appointment of:

- Dr Anthony Bastin as Consultant in Critical Care Medicine;
- Dr Aigul Baltabaeva as Consultant Cardiologist with a Special Interest in Echocardiography and;
- Dr Thomas Pickworth as Consultant in Adult Cardiothoracic Anaesthesia.

2012/51 AUDIT COMMITTEE

(i) REPORT FROM THE MEETING HELD ON 29 MAY 2012

NL reported that the AC had spent the majority of the meeting discussing the Annual Report 2011/12. The committee had also received very helpful reports from KPMG.

2012/52 RISK AND SAFETY COMMITTEE (RSC)

(i) RISK & SAFETY TERMS OF REFERENCE

The Board approved the revised Terms of Reference for the Risk & Safety Committee (RSK). Draft minutes from the meeting held on 24 April 2012 were tabled and were noted by the Board.

2012/53 QUESTIONS FROM MEMBERS OF THE PUBLIC

David Potter asked whether the low numbers of staff who had completed the questionnaire for the Staff Survey meant there was a risk the report's findings could be distorted?

CJ replied that she did not think this was a major concern as the response rate was consistent with last year.

Kenneth Appel asked the following questions:

a) Could anything be done about inappropriate parking in the volunteers' parking bays and could this be improved by monitoring by security staff?

b) On a personal note he informed the Board that his first term as a Governor would come to an end on 31 May 2012 and he noted that he had been elected for a second term commencing on 1 June. The first term had been a steep learning curve and he had concluded that Governors needed more input (from the Trust) to aid their development. Although the schedule for Patient Safety Walkrounds had been publicised there should have been more Walkrounds for one Governor with a Director.
c) Was it possible for a Governor to attend RSC meetings?
d) As there was nothing more onerous (in terms of patient satisfaction) than an increase in cancelled operations what steps would the Trust be taking to tackle this?

Answers:

a) NH said he had asked security to do more monitoring and conceded that the main culprits were Trust staff.
b) RCo replied by giving a brief report on the outcome of the Spring Governors' Council elections. Elections had been held for 11 Governors. The outcome of 8 of these (4 Staff, 3 Public and 1 Patient Carer) would be announced as per plan on 31 May. In the elections for the 3 Patient Governors it became apparent that there was a membership data discrepancy. This affected the election mail out which meant the results in these constituencies could not be declared. It was decided to re-ballot the members and the results would be published at the end of June. SRF confirmed that he had endorsed and authorised this action.
c) BB suggested that this should be raised at the next meeting of the Governors' Council.
d) RCr said cancelled operations, their causes and the actions being taken had been debated in some detail at the last Board meeting (as shown in the Minutes of the meeting held on 25 April 2012). The figures for M1 reported to this meeting showed a pleasing reduction. Never-the-less the underlying pressures still existed and indications were that May (M2) would show a deterioration. He felt that the problem required:
    a. Continuous attention from the relevant teams;
    b. Time for the measures identified (and additional capacity at Harefield) to 'bed in';
    c. Ongoing scrutiny of performance.

<u>DATE OF NEXT MEETING</u>

Wednesday 25th July 2012 at 2.00 pm in the Board Room, Royal Brompton Hospital.