Royal Brompton & Harefield NHS
NHS Foundation Trust

Minutes of the Board of Directors meeting held on 30th November 2011 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, Trust Secretary & Head of Performance	RCo
	Mr Richard Paterson, Associate Chief Executive – Finance	RP
	Mr Robert Craig, Chief Operating Officer	RCr
	Mr Nicholas Coleman, Non-Executive Director	NC
	Pr Timothy Evans, Medical Director	TE
	Mrs Jenny Hill, Senior Independent Director	JH
	Mr Richard Hunting, Non-Executive Director	RH
	Ms Kate Owen, Non-Executive Director	KO
	Mr Neil Lerner, Non-Executive Director	ML
	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	JT
	Mr David Shrimpton, Private Patients Managing Director	DS
	Ms Joanna Axon, Director of Capital Projects & Development	JA
	Dr Anne Hall, Director of Infection Prevention & Control	AH
In Attendance:	Mr Anthony Lumley, Corporate Governance Manager (minutes)	
	Ms Katherine Denney, Web Editor	
	Ms Christine Denmark, Marketing & Communications Manager	
	Ms Jessie Mangold, Head of Media Relations	
Apologies:	Pr Sir Anthony Newman Taylor, Non-Executive Director	ANT

2011/92 MINUTES OF THE PREVIOUS MEETING HELD ON 26 OCTOBER 2011

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

Minute 2011/79, Page 6, 2nd para.:

- after "NC commented that October (M7) was always a critical month." add "…in that it was almost the last opportunity for financial interventions to be made and still have material impact on the full year financial results. He therefore asked what the Finance Committee had concluded from their recent meeting in this respect. NL, chairman of the Finance Committee, assured the board that on the basis of the Trust's performance to date they had concluded that the financial target should still be achievable – though of course this was based on YTD results and unforeseen things could still occur in the future".

2011/93 REPORT FROM THE CHAIRMAN IN RELATION TO THE JUDICIAL REVIEW OUTCOME

SRF reported that on 7 November 2011 Mr Justice Owen had found in the Trust's favour and had concluded that the consultation on the Safe and

Sustainable review of children's heart surgery was unlawful and "must therefore be quashed" on the grounds of being unfair and in particular on the assessment of research within RBHFT. The JCPCT had immediately issued a statement saying it had been vindicated apart from a technicality. SRF said he did not feel this was an accurate and fair interpretation of the Judge's ruling. The JCPCT has decided to seek leave to appeal and, led by Sir Neil McKay, had done so. Only if leave is granted will the Court of Appeal hear the substance of the appeal. SRF said the Trust cannot intervene at the moment, but if an appeal is allowed we would be given sight of the papers and could consider an appeal with cross notice.

In the meantime the Trust had received a letter from Jeremy Glyde, the Safe and Sustainable Programme Director, inviting a resubmission of information for the rescoring of research. The Trust's position remains that the approach of the JCPCT to research is wrong and this will be stated and notice given on a number of issues to Sir Neil McKay this Friday (2 December 2011). SRF said if the JCPCT's appeal is ultimately successful the Board will be notified should the Trust wish to consider seeking leave to appeal that judgement.

BB added some information to SRF's update. It is known that a request to the Court of Appeal has been submitted. The Trust has requested to see the information filed by the JCPCT. Effectively the Trust is a bystander during these procedural deliberations. The submission on Friday 2 December 2011 will include a letter which will then be shared with Board members.

BB reported that four charities (Cystic Fibrosis Trust, Muscular Dystrophy Campaign, Asthma UK, and the Primary Ciliary Dyskinesia Family Support Group) have written to the JCPCT asking for assurance that the proposed changes to paediatric cardiac surgery services will not be detrimental to paediatric respiratory patients. By referring to Section 242 of the NHS Act 2006 which placed a duty on NHS bodies to consult with the public in service planning and in the development of proposals for changes, the charities are questioning if the JCPCT is consulting with all the relevant people. So if the JCPCT's appeal is not upheld, the charities are intimating that any re run of the consultation must include consideration of the collateral impact on paediatric respiratory medicine services.

In response to a question from KO on the likely timescale of the appeal process, SRF said he thought the Court of Appeal will consider leave to appeal in March 2012, but it could be as late as October next year when the actual hearing takes place. i.e. this is not a short term issue and this is potentially disturbing for the Trust's patients. The Court of Appeal could decide to bring matters forward. BB added that in a letter he had seen from Sir Neil McKay, he had said that if the JCPCT is successful on appeal, they expect to make a final decision shortly after the judgment is handed down around April or May 2012. If the JCPCT is unsuccessful on appeal they will

be obliged to hold a further public consultation and expect to make a final decision in the autumn of 2012.

In response to a question from NL on what were the views of the Trust's counsel, SRF said they believed the Trust's case had not been diminished in any way at all. BB said Mr Justice Owen, a senior judge, in his ruling had stated that he felt the prospects for an appeal were poor.

JH asked on a point of governance whether a formal minute should be made that the Board approves the next stage of the process? SRF said that the appeal would be noted and communicated when made by the JCPCT and that the Board would be appraised if a cross notice were to be considered. BB said that the Board was on record as having decided to contest the matter and therefore a new resolution is not required constitutionally.

NC asked if the real issue is whether an accommodation can be reached. SRF said that this would need to be formed round the proposal being developed by Sir Liam Donaldson which involved three services and one hub. BB said in his view, Sir Liam's proposals will not be progressed. Also the political leaders do not appear to want to engage because they have delegated decision making to the JCPCT.

RH commented that the current impasse mirrors previous battles and the view from the centre, over the last 25 years, that specialist trusts should not exist. SRF concluded that the members of the public have indicated their support for the Trust. BB referred to a mobilisation of support and letters from overseas such as from the Karolinska Institute in Stockholm. In the absence of leadership from the government the priority must continue to be protecting the interests of patients.

2011/94 REPORT FROM THE CHIEF EXECUTIVE

BB gave verbal updates on the following items:

Academic Health Science Partnership (AHSP)

BB noted that he had sent Board members a copy of Lord Darzi's Academic Health Sciences Review on the AHSP, minutes of the first meeting of potential partners, and other related notes. Lord Darzi was appreciative of RBHFT's involvement, and this had been echoed by Imperial College Healthcare Trust (ICHT). Lord Darzi had also asked for management support and to this end, Piers McCleery, Director of Planning and Strategy will be helping and relieved of some of his RBHFT executive duties.

SRF asked about the implications of the Royal Marsden (RM) not joining the AHSP? BB replied that the RM was basing its strategic plans around the development of the London Cancer Alliance. BB noted that CS had been tasked with devoting more executive director time to the London Cancer Alliance and that development of this initiative may impact upon plans at RM.

SRF said that following his meeting with Leszek Borysiewicz, Vice-Chancellor of the University of Cambridge reported at the last Board meeting, he had received a letter from him on 28 November. The Vice-Chancellor had said he had met with the chairman and chief executive of Papworth Hospital NHS FT and they were loath to delay the move of Papworth Hospital to align with RBHFT plans. SRF said this effectively brings discussions with Cambridge to an end.

TE was invited by the SRF to comment on the AHSP. TE said the Trust continues to have productive engaged conversations with ICHT on existing service dispositions and joining up other services such as the aortic dissection service . He also attends monthly meetings with colleagues from the RM. The RM's focus both clinically and in respect of governance and research is focused on its site south of river in Sutton. It is possible that if St George's Hospital, with whom the RM often look to partner, look north of the river for future development, this may affect thinking at the RM.

NC mentioned 'en passant' that announcing Imperial partners in April could break the dam. BB replied that it would help but it would not break the dam as it was not about paediatric cardiac surgery but about a broader agenda.

JH asked about the status of the Institute of Cancer Research in relation to this, as it is part of the University of London as well as an independent charity, linked to the RM through research. TE said the Institute have had constructive discussions on scientific collaboration with Imperial College.

North West London (NWL)
Led by Anne Rainsberry, Deputy Chief Executive of NHS London**,** a new reconfiguration programme for the NWL sector has been launched with a new Board, with members named including BB. RP had attended a meeting for BB and in his capacity as Associate Chief Executive. The programme will be comprised of 6 work streams: clinical, out of hospital care, communications, finance, workforce, and estates. BB said that while the RBHFT, being a foundation trust, could stand to one side, he felt that on balance the Trust should participate. NH will coordinate trust involvement. RP said he had noted how ambitious the programme is. There will be a JCPCT, a pre-consultation business case and consultation. With the involvement of PCTs, CCGs (Clinical Commissioning Groups), and Providers in the process he thought that there was potential for there to be conflicts of interest.

Industrial action - Wednesday 30 November
BB reported that contingency plans for today's action had been led by RCg. RCg said 80 members of staff were on strike out of around 3000 staff in total, the principal groups taking action being radiographers and physiotherapists. Routine chest x-rays and CT scans had been cancelled and there was no rehab service at the Royal Brompton Hospital (RBH). Some outpatient clinics were affected and about 30-40 catheter laboratory

procedures had also been cancelled, as had around 10-15 cases in theatre. The Director of Human Resources had insured an additional 40 staff places were provided for children in temporary day care facilities set up at both sites. About 20 to 30 staff had taken annual leave to look after dependents. BB said that it was business as usual to an extent.

NL asked if an estimate of the loss of income could be given? RCg said that every month a clinical governance day is held. The effect on income would be no worse than one of these governance days. He estimated the loss on a governance day as less than 5% of the monthly income. BB said the real cost was irritation and inconvenience to patients. The impact of a snowy day would have been worse.

Sunday Times article

BB reported on an article published in the Sunday Times which had reported details about a patient who had asked for a carer to spend time with her in hospital. BB expressed frustration with the way in which the circumstances had been manipulated to make a story.

RH made a suggestion that the article be referred to the Press Council. This suggestion was discussed but it was felt that, given the other challenges facing the Trust, it was not a good time to follow this course of action.

2011/95 CLINICAL QUALITY REPORT FOR MONTH 7: OCTOBER 2011

RCo highlighted the following from the Clinical Quality Report for Month 7:

- two Serious Incidents (SI's): a Grade 3 pressure sore in paediatrics and an unexpected death of a paediatric patient at St George's following attendance at RBH;
- *Clostridium difficile*: 2 cases, bringing the YTD figure up to 10. The Monitor Executive had met on 16 November 2011 and, taking exceptional circumstances into account, had agreed to maintain an amber green rating for governance. Monitor had since required the Trust to commission a self certification review from a Monitor approved list of reviewers. KPMG have been selected from this list and will undertake the review during December / early January 2012. The report will be presented to the next Trust Board meeting on 25th January 2012.
- RCo and Dr Anne Hall, will prepare a detailed report concerning *Clostridium difficile* performance for the January Board where the Q3 declaration will also be made.

At this point the Chairman invited Board members to comment or put questions to RCo. NC said he welcomed the work RCo would undertake with AH for presentation in January.

AH was invited to comment. She said diagnosis of *Clostridium difficile* was not easy. The Department of Health had issued guidance about the advisability of changing testing regimes in 2009. This would mean no longer using the single test for toxin but looking at alternative means using a two stage test to look for the toxin gene as well. The two stage test identifies a larger number of cases. This was undoubtedly a good thing for patient

safety. The Trust introduced the new test in October 2010. Since April 2011, only those patients with clinical disease have triggered reports to the HPA. In short, a better test is now used, but this has contributed to the Trust breaching the target set by the DH. This had happened to other Trusts who had adopted the more sensitive testing method.

SRF welcomed AH's involvement. He recommended that AH and RCo should consult with NC as Chair of the Risk and Safety Committee and TE as Chair of Governance & Quality.

RH wondered if the Trust had declared non compliance at Q2 in October 2011 whether Monitor would have followed the same course of action. BB said that with hindsight, it would have been better if a breach of the Clostridium difficile objective had been identified as a risk to the Governance Rating in the Annual Plan 2011/12.

RC continued his report on Month 7:

- Cancer 62 day wait target: there had been 2 breaches, with the Trust scoring 77.8% compliance and therefore failing against the target of 79% for month 1 of Q3. As one of these breaches related to a patient referred at day 77 the Trust is seeking repatriation of this breach to the referring Trust.
- Cancer 31 day wait target: 1 breach leading to a score of 94.1% short of the compliance target of 96%.
- Cancelled operations: the YTD position of 1.2% so this indicator is underachieved.
- RCo drew attention to the 188 patients who have breached the 18 weeks Referral to Treatment Admitted Wait target and the report provided on page 10 of the Clinical Quality Report. He noted that this target may need to be flagged as at potential risk of breach when the 2012/13 Annual Plan is composed.

NL asked whether detail of the reasons for cancelled operations could be provided as had previously been the case? RCo replied that this information would be provided in the next Clinical Quality Report.

2011/96 FINANCIAL PERFORMANCE REPORT FOR MONTH 7: OCTOBER 2011

Presenting the report, RP highlighted:

- Income and expenditure statement: after five months close to plan, both Month 6 and now Month 7 had been disappointing. In Month 7, usually a strong month for performance, the Trust had expected to make a surplus of £700k but this was only £100k and this was only after releasing some £400k of surplus debtor reserves.
- On a YTD basis there was a cumulative surplus of a little over £500k against a planned surplus of nearly £2.0m.
- This month's poor result reflects both inpatient activity and income, especially elective activity (10% below plan YTD), although this revenue shortfall is masked by additional revenues and costs of drugs and devices. ITU and HDU bed days and revenues have partially compensated for this shortfall.

- YTD, pay costs remain lower than plan but non-pay costs are running substantially over plan. In addition to over budget costs of drugs and devices, there was a £800k overspend of establishment expenses, £200k of which related to the costs of the Judicial Review. An application to the Court to recover legal costs has been made. Until it is known whether the JCPCT has been granted leave to appeal at which time this matter would need to be reconsidered, the Trust's I&E account would not be credited for the legal costs.
- Balance sheet*:* liquidity and cash were both at adequate levels although cash at 31 October was a shade below the 10 days of OPEX Monitor uses as an early warning indicator. CAPEX is running behind plan but within the range deemed acceptable by Monitor.
- the falling off of results against plan was worrying.

RP said he had attended meetings of the Project Diamond Trusts and there was some optimism that RBHFT may be awarded Project Diamond (PD) monies for 2011/12 as well as for 2012/13. However, the Trust had not seen anything in writing from the NHS so had not recognised any benefit in the figures at this point. Based on the stress test modelling, if the same amount of PD money is received as last year, in Q3 the Trust could convert its FRR to 4 and retain this for the year provided a £6m surplus is achieved. Conversely, should the Trust not receive anything it could lose up to £1.5m for the year as a whole without losing our FRR3 at which point monthly monitoring would presumably recommence.

Looking ahead, in connection with the property redevelopment plans, the Trust needs to develop a sophisticated model of income and cash flows to permit scenario planning. While this was usual practice there is also an obligation to accommodate Monitor's requirements as their approval is required before RBHFT may contract with third parties for any major transaction. RP said he understands that the Monitor process is similar to the financial aspects of FT authorisation for aspiring Trusts so it will be demanding.

The Chairman invited RCg to comment on whether elective activity was the main cause of the worse than expected results. RCg acknowledged October had been disappointing but said that focussing on this to the exclusion of other activities was potentially misleading and no single factor could explain this. A concern was the mix of cardiology work at both sites and the volume of high end electrophysiology work and implantation of devices. Rates of last year were currently not being sustained. In cardiology lower volume and a cheaper mix of activity were anticipated until April 2012. Capacity was another factor; the Trust has had one less operating theatre at RBH since September 2011 and this would continue to January 2012. In summary RCg said cardiology was the main concern. There was no indication in surgery whether it will return to a normal mix or it will continue as current.

JH asked if it was right that poor figures were caused by sub-specialities. RCg said it depended on the sub-specialities.

RCg said clinical income for October was on target but most variance was on pay spend. RP commented that clinical income was indeed on plan, the figures were flattered by the over budget levels of high cost drugs and devices. NL asked if they were flattered by reserves, which is also a factor as bad debt reserves are released to revenues? RCg agreed but reminded colleagues that provision had been made for other reserves. NL asked how much surplus the Trust had in reserve for release in the rest of the year? RP estimated that there was approximately £0.5m and confirmed that the balance of the provision would cover any bad debts.

The Board NOTED the report.

2011/97 REPORT FROM THE CHAIR OF THE FINANCE COMMITTEE

NL reported that income was below plan as RP had described in his report to the Board and that more work needed to be done to understand the escalation of non-pay costs. The committee had noted that if the trend were to continue achievement of the plan would be challenging. The committee would be looking at re-projections when it meets on 19 December 2011.

2011/98 REGISTER OF DIRECTORS' INTERESTS

RCo presented Paper C. This had been updated to include RP since his appointment as Associate Chief Executive – Finance. The Board confirmed that, subject to the inclusion of an amendment that NL will forward to RCo, the register is an accurate record.

2011/99 QUESTIONS FROM MEMBERS OF THE PUBLIC

Ken Appel (KA) thanked the Chairman and all the Executive Directors for their work during what had been a dramatic period. He asked the following questions:

a) Could the lack of car parking space at Harefield Hospital (HH) for the League of Friends volunteers be relieved by lowering the curb?
b) TE at the last Board meeting had commented on the gap between those who do research and those who do not. As one of the 5 NICE domains is research couldn't this be encapsulated in the work plans of medical staff?
c) Cancer waits: KA said he was appalled by the results in red and wondered what could be done to remedy the situation?
d) Could more be done to advertise for referrals from practitioners and to provide services at Harefield for patients currently referred to Watford.

Replies:

a) NH said that he meets with the League of Friends monthly and he is aware of the problems caused when non volunteers use the volunteers' car park. The Trust recently appointed a new Site Services Supervisor who had been asked to look into the problem.
b) TE replied that he had been referring to the difficulties consultants have in initiating research given their case load. The capacity for staff to

deliver over and above their normal duties is extremely limited. All consultants must collaborate with research.

- Waiting times for cancer. RCo assured KA that the Trust does take this very seriously. The Trust provides surgery for patients with lung cancer, many of whom are referred to the Trust after they have already breached the 62 day target. He reassured KA that the time between the Trust receiving the referral and performing the surgery is very short and that the Trust was working with those who refer patients in order to see what could be done to reduce the amount of time elapsed before the referral to RBHFT is made.
- RCg said HH's biggest issue is having enough capacity to manage referrals. If a message went out saying GPs could refer double the numbers, HH would not be able to do the work, although he noted that ward/catheter laboratory capacity at HH will be increased in 2012. RCg assured KA that the Trust is alive to this issue.

2011/100 ANY OTHER BUSINESS

JH reported on the work of the Board Evaluation Working Party which had met on Monday 28th November 2011. The Working Party is comprised of 2 NEDs (JH and KO) and 2 Executive Directors (RCg and CS) and facilitated by RCo.

A brief had been prepared for prospective suppliers. Once a supplier had been identified JH proposed that the Chair of Nominations and Remunerations Committee, the Chairman of the Trust Board and The Chief Executive and the Governors be informed. The Nominations and Remunerations Committee would then be asked to approve the appointment. This process was agreed.

DATE OF NEXT MEETING

Wednesday 25th January 2012 at 10.30 am in the Boardroom, Royal Brompton Hospital.