A lifetime of specialist care

Royal Brompton & Harefield NHS
NHS Foundation Trust

Minutes of the Board of Directors meeting held on 26th October 2016 in the Board Room, Royal Brompton Hospital, commencing at 2.00pm

Present:	Mr Neil Lerner, Acting Chairman & Non-Executive Director	NL
	Mr Robert Bell, Chief Executive	BB
	Mr Richard Paterson, Associate Chief Executive - Finance	RP
	Dr Richard Grocott-Mason, Medical Director/Senior Responsible Officer	RGM
	Mr Robert Craig, Chief Operating Officer	RCr
	Mr Nicholas Hunt, Director of Service Development	NH
	Ms Joy Godden, Director of Nursing and Clinical Governance	JG
	Dr Andrew Vallance-Owen, Non-Executive Director	AVO
	Mr Luc Bardin, Non-Executive Director	LB
	Mr Philip Dodd, Non-Executive Director	PDd
	Ms Kate Owen, Non-Executive Director	KO
	Mrs Lesley-Anne Alexander, Non-Executive Director	LAA
	Pr Kim Fox, Professor of Clinical Cardiology	KF
	Mr Richard Jones, Non-Executive Director	RJ
By Invitation:	Mr Richard Connett, Director of Performance & Trust Secretary	RCo
	Mr David Shrimpton, Director Private Patients	DS
	Ms Jo Thomas, Director of Communications & Public Affairs	JT
	Ms Carol Johnson, Director of Human Resources	CJ
	Ms Jan McGuinness, Director of Patient Experience and Transformation	JMcG
In Attendance:	Mr Anthony Lumley, Corporate Governance Manager (minutes)	AL
	Ms Gill Raikes, CE Royal Brompton & Harefield Hospitals Charity	GR
Observers:	Ms Yvonne Moulds, Partner Pricewaterhouse Coopers LLP (PwC)	
	Mr Peter Reading, Specialist Board Leadership Pricewaterhouse Coopers LLP (PwC)	
Apologies:	None	

2016/78 DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING

None.

NL introduced and welcomed Yvonne Moulds and Peter Reading who were attending this meeting as observers on behalf of PwC whom the Trust had commissioned to carry out the Well Led Board Review.

2016/79 MINUTES OF THE PREVIOUS MEETING HELD ON 28th SEPTEMBER 2016

The minutes were approved.

Board Action Tracking

BD16/45 Collaboration with Chelsea and Westminster NHS Foundation Trust (C&W): a) Update Report to be submitted to the Board in three to four months' time.

In response to a request from the Chairman for an update (and given that it was not due to be reported on again to the Board till January 2017) RCr said that the work with C&W

was continuing and he could update on two things: firstly, discussions had been initiated with Imperial College Healthcare NHS Trust (ICHT) following the three (Royal Brompton & Harefield NHS FT, C&W, ICHT) Chief Executives' meeting in early September 2016; and secondly, that the consultancy work commissioned from 'Attain' was under way. RCr agreed to confirm the status of the report with Piers McCleery, Director of Planning and Strategy, and suggested that the Board receive an oral report at the next meeting (30 November 2016), with a full report – including representation from C&W – in January 2017.

Action: amend Notes in Action Tracker for BD/45 adding comments above.

BD 16/70 Update on progress of ECMO resubmission.

RGM said NHS England's (NHSE) Quality Surveillance Group had completed the peer review on the 11 October 2016 having spent one day at Guy's and St Thomas' NHS Foundation Trust (St Thomas' hospital because they provided a supporting service to the Trust) and one day at the Royal Brompton and Harefield NHS Foundation Trust (RB&HFT). They had noted significant improvements and changes compared to their findings from the review in May 2016. However, on the same day the advert to procure ECMO services had appeared on the internet. RGM said the written report from NHSE should be received within four to six weeks. He also noted a market engagement event for VV ECMO which was scheduled for 7th November 2016.

2016/80 REPORT FROM THE CHIEF EXECUTIVE

BB gave a verbal report on the following items:

BB reported that there had been an exchange of correspondence with NHSE on their Congenital Heart Disease (CHD) proposals. The Trust had decided to hold back from launching a Judicial Review (JR) on the advice of Counsel. The Trust intends to work collaboratively with NHSE throughout the consultation process. However, on the advice of Counsel the Trust had written to NHSE before the end of September, notifying them of its concerns with their proposals. BB characterised the written response from the lead commissioner as 'sweet and sour'. On the one hand they acknowledged the Trust's position but on the other had they had asked the Trust for detailed information and impact assessments on the knock on effect on services with a response deadline of 7 November 2016. The Trust would be providing the information requested and would also be responding to the comments in their letter.

In summary, BB said the Trust still anticipated the formal NHSE led consultation to begin in December 2016 and this would continue through to the Spring of 2017. This meant there could be no decision to decommission services by 1st April 2017. BB said that 2018 would be complicated by other issues, but there was no immediate threat to CHD services.

2016/81 CLINICAL QUALITY REPORT FOR MONTH 6: SEPTEMBER 2016

NL drew the Board's attention to the poster display in the Board room which showcased two impressive winners of the Quality Improvement prize. JG had volunteered to say something about these. JG said the winning team's entry had focused on exercise for patients and demonstrated that small changes could result in big improvements. The runner up project had focused on the allocation of roles for staff at the beginning of each

shift. This would mean that in the event of a cardiac arrest staff already know their role, which saves valuable time should a cardiac arrest occur.

NL asked how the prize winners were recognised (in terms of being rewarded). JG said money was allocated to support the projects going forward. Aside from minor gifts given to staff it was about the prestige of the work going through and the knowledge of staff that their work was recognised and lauded by their colleagues. NL asked if this could be referred to in next year's Annual Review (on 2016/17). JT confirmed that it would be.

Introducing the Clinical Quality Report, NL said this would be the last time it was presented in the old format. A draft new version had been included for information. This still required work but the Board were invited to make comments now. More detailed comments could be directed to RCo. NL commended RCo for the work he had put into this.

RCo tabled an updated cancelled operations page (replacing page 19 of the report) and a 62 day Cancer Urgent GP referral page (replacing page 14 of the report) which included bullet points with details of outcomes where there had been successful curative treatments. NL asked if the trend of cancelled operations could be made clearer. This was agreed.

Invited by NL to give high level comments the Board discussed the new format. Both KO and LAA agreed that the draft was an improvement and AVO confirmed that the Risk and Safety Committee had also discussed the new format and was satisfied with the summary of topics although it was felt this could be shortened. KO was concerned that the Board had agreed that more 'colour' was needed in the form of an overview at the beginning of the report and this was still absent. LAA was equally concerned that there was still insufficient focus on patients and outcomes and that the majority of the indicators in the appendix were about staff, cost and complaints. She said the tabled paper on cases and outcomes was better. The Friends and Family Test (FFT) section from the old style report was an example of the kind of information to be included in the new format. RCo said that the Board was no longer required (by NHSI) to confirm performance against the indicators, so it was the right time to reconsider the format of the report. He also confirmed that he had discussed this with JMc inclusion of patient experience information and had been advised that this should not be done in isolation, but in context. JG said it was important to get it right – the more information NEDs could give Executives the better.

PDd noted that in the section on 18-week Referral-to-Treatment (RTT) that there was no commentary with an explanation of why or what was being done in the light of the missed target. RCr referred to the bullet-points in section 2.7.6, and commented further on the trajectory for RTT performance, indicating that the Trust's current position was within the 1% tolerance of the target. Achieving the target would depend heavily on the success of work now in progress with NHSE and with Imperial College Healthcare Trust (ICHT) whereby ICHT would deal with some of the excess demand on RB&HFT. PDd suggested adding a bullet point that said where we are and what was being done about it. This was agreed.

In response to a question from LAA on whether other Trusts were including more commentary, RCo said he had looked at other Trust's reports and most reported on regulator targets; none had an equivalent of the Trust's proposed new format.

RCo said the new format had retained trajectory information about 18 week and 62 Day Cancer. The old style report completed the first half of the financial year and went right up to the final date of the Risk Assessment Framework (30th September 2016) . He pointed out that the Single Oversight Framework (SOF) came into operation on 1st October 2016 and that NHSI would be publishing reports against the indicators covered by the SOF.

NL asked why on the Performance against STF Fund Trajectory graph for 62 Day Cancer the solid line went to a dotted line. RCo answered that this was because the data for the final month was provisional because it had not yet been published.

It was agreed that RCo would take a revised mock-up of the clinical quality report, based on October data, to a small group and that LAA and AVO would be the NED representatives.

AVO said that all Board members had now been sent the action plan from the cancer services review. This would be kept under review.

LAA said she was surprised to see positive comments under the categories of patient 'extremely unlikely' or 'unlikely' to recommend the Trust in the FFT section. JG said that sometimes patients were dissatisfied with one aspect of their experience while remaining positive about the rest. This highlighted again the difficulty in seeing reports on mandated indicators in isolation. NL asked if the template was produced by Picker and they chose the comments. JMc said that was correct. AVO added that the RSC received a year end Patient Experience report. RJ suggested that there should be more frequency in reporting this than annually to get the 'colour' other Board members sought and that if this report was submitted as part of the new Clinical Quality Report twice a year that would be more appropriate. This was agreed.

Action: RCo to produce new Clinical Quality Report, based on October data, to be discussed with LAA and AVO. Twice a year the report will include the Patient Experience Summary Report.

Action: Additional commentary on 18w RTT to be included in the Clinical Quality Report (RCr).

Action: Cancelled trend in rolling 12 months graph to be made clearer (RCr).

2016/82 FINANCIAL PERFORMANCE REPORT FOR MONTH 6: SEPTEMBER 2016

RP presented the M06 report which summarised the financial performance of the Trust to 30th September 2016. The Board noted the key headlines and that, setting aside the gain on the sale of 151 Sydney Street, the Trust was on plan (underlying deficit of c. £2m) both in-month and year-to-date). RP was reasonably confident that both achievement of plan for the year and the control total would be achieved: the gain on sale (which included a further £4m to be received by the end of the financial year) would offset the delay in the contribution from Kuwait (£3.5m) now expected to deliver from April 2017. Looking ahead RP cautioned that provisional control totals set by NHS Improvement (NHSI) for 2017/18 and 2018/19 were extremely challenging and this view had been endorsed by the Finance Committee which had looked at the initial figures at its meeting on 25 October 2016.

PDd asked about discernible trends of income above budget. RP said BB had a sense that NHS elective referrals were being somewhat constrained. BB said the general message

from commissioners was a dampening down of activities. At the meetings with NHSE which he and colleagues attended, the Trust was invariably browbeaten by the commissioner with its unrealistic expectations. NH said GPs in Hertfordshire were being told not to send cardiac referrals to Watford Hospital because it was impacting on waiting lists. The STP was a vehicle for reducing and shifting expenditure anywhere except the acute sector. BB said the system would not be correcting itself anytime soon. RP said that in contrast non-elective A&E admissions in particular were going through the roof.

AVO asked if it was still likely that PbR reimbursement system would be superseded by the block grant method. BB said the indications were that the formal block grant could be reinstated.

RJ asked for more detail on the performance of Private Patient (PP) income. RP said there were delays in income from Wimpole Street which was behind plan due to its later than scheduled opening plus some fall off in other PP work. This might be due to extended holidays in Middle East though this had happened before and performance had bounced back so it was not yet a trend.

The Board also discussed the current state of the UK insurance market and, if the size of the 'pie' was in decline, was the Trust losing out on its share of that pie. AVO said the market had been flat for a long time but had not yet declined as big corporates were still buying insurance. DS confirmed that there had been a marginal drop off in the last two months. BB said he had noted that even private hospitals were struggling and recently some of the premium private providers had approached the Trust to see if there was interest in a partnership. AVO said in his role as chair of the Private Healthcare Information Network he was aware of a ramping up with patients being encouraged to stay in NHS beds. NL noted that the continuing slide in the value of the pound in the foreign currency market should be a positive for the Trust (as services would be more affordable for foreign patients).

In response to a question from PDd on why Kuwait was delayed DS said the approval of the contract had now gone through a number of committees. A letter from the Ministry of Finance which would allow passage through the final committee had been received in the last 24 hours. Parliament in Kuwait had been dissolved last week and elections would be held at the end of the week commencing 31 October 2016 but the Ministry of Finance was still positive that the contract would be concluded within the current financial year.

The Board noted the report.

2016/83 AUDIT COMMITTEE (AC)

(i) REPORT FROM MEETING HELD ON 25th OCTOBER 2016

LB summarised the business of the AC at its most recent meeting. It had received a report from CJ on the Human Resources Risk Register (it was agreed this would be circulated to all Board members). The External Auditor had reported on planning to the end of March 2017. Other reports included the standard report on counter fraud. The AC had also received and discussed two reports from the Internal Auditors: firstly, on current activities the committee noted that there were no overdue recommendations and AC members had congratulated the team; and secondly, an audit of the use of social media (rated as Green) the AC noting that this was well managed by the Trust's communications team. Finally JG had reported on nurse revalidation. AC members were struck by the progress made in the face of great complexity.

Action: circulate HR Risk Register to all Board members (CJ).

2016/84 RISK & SAFETY COMMITTEE (RSC)

(i) REPORT FROM MEETING HELD 17th OCTOBER 2016

AVO gave an oral update and highlighted the following: the Trust was working with Public Health England towards the formal closure of the *Candida auris* outbreak which was declared in April 2016. No patient appeared to have died directly because of *Candida auris* (though it was impossible to rule it out as being a contributory cause) while other hospitals were now reporting outbreaks. The committee had also discussed governance arrangements at Wimpole Street. The committee was satisfied by this and also noted that Wimpole Street had been registered by the CQC. The RSC also received the annual report on tissue governance and a risk governance report on estates. The London Fire Brigade had concerns but now deemed them fit for purpose. The committee discussed serious incidents and was assured that the right actions had been taken in relation to a needle being left in situ. Having received a report on falls the RSC asked for a report on progress to come back to them. Finally, the committee had received the Matron's Report, the Safeguarding Annual Report and the Controlled Drugs Annual Report.

NL said drew the Board's attention to the increase from amber to red for the finance risk in the Risk Register owing to the threat of the decommissioning of the Trust's CHD services.

2016/85 NHS IMPROVEMENT SINGLE OVERSIGHT FRAMEWORK (SOF)

Introducing the report RP said that the background was that adding up all the control totals (both agreed and not agreed) the collective provider deficit for 2016/17 was £580m. This had triggered action by NHSI which had led to the financial 'reset' and would herald a more intrusive interventionist regime. With one overarching concept ('earned autonomy') and five themes (quality of care; finance/ use of resources; operational performance; strategic change; leadership/ improvement capability), providers would be segmented into four categories:

- 1. Maximum autonomy. Currently 35 Trusts were in this category and most were community or mental health Trusts. However, Papworth Hospital and Liverpool Heart and Chest Hospital and Moorfields were in this group.

- 2. Offer of targeted support. This was the largest group (106) which included RB&HFT.

- 3. Mandated support. Around 77 Trusts were in this segment.

- 4. Special measures. 22 Trusts were in this segment. All Trusts in segments 3 and 4 were either in breach or suspected breach of their provider licence.

RP said that looking further ahead he thought the Trust would be challenged on two of the themes: firstly, finance and meeting the control total in future years; and secondly, strategic change which relied heavily on STPs: the Trust has only recently joined the NWL STP grouping and given its specialised nature this was not a natural fit. Two elements of reset were yet to be introduced: cost per weighted activity and potential capital spending controls. The latter was a threat to raid capital budgets for revenue and could happen shortly.

NL informed the Board that RP had agreed to approach his peers at Liverpool Heart and Chest and Papworth to gain an understanding of their approaches to these challenges.

Noting that only three Trusts within the M25 corridor were in segment 1 (Moorfields Eye Hospital and two Mental Health Trusts) AVO asked how the Trust would tackle the value for money challenge given its high pay bill growth. RP said that to date NHSI had only acknowledged the Trust's response to their letter asking for an explanation of apparently excessive pay bill growth. NHSI had indicated that it intended to visit the Trust (as it would be visiting all Trusts with excessive pay growth) to understand why Boards had agreed to pay bills 'they could not afford'. AVO said it should be cost per weighted activity rather than absolute pay.

BB said there was no further news on when the CQC would submit its report on the inspection of the Trust's sites in June 2016.

2016/86 NORTH WEST LONDON SUSTAINABILITY AND TRANSFORMATION PLAN

RP presented the report in which the Board was briefed on the North West London Sustainability and Transformation Plan (NWL STP) grouping. The Trust had only been informed it was now part of this grouping in the last three weeks. The STP had been filed on schedule on Friday 21 October 2016. On the same day the Trust had asked if it could have sight of the final version and was informed that it could not see it until it had been approved by NHSE. RP said the Board should understand that it would in time be asked to approve the plan.

The Board noted RP's concerns about the plan's very ambitious overall savings target (£1.25bn) and that they would be expected to endorse it and the target for specialised commissioning within that (£190m); and further noted the challenging timetable and RP's view that there was a risk around the quality of the fiscal projections and that a lack of capital funding and a lack of management capability (clinical care, social care savings) and the targeted squeeze on specialised services had come with no detail on how those providers concerned could achieve the savings. They also heard that, out the 100 hospital providers who were recently canvassed by the media for their views on STPs, just one had high confidence that their plan was achievable over the next eighteen months – most of the remainder (66%) had either low or no confidence.

BB said he had not heard any alarms as yet and assured the Board that he would be the first to know of them. He clarified that there was no 'virtual' NHS England-led STP currently in operation and that RB&HFT now sat in the one referred to above (and also that The Royal Marsden Hospital was not part of it). AVO said that the move to bar Trusts from seeing plans was nonsensical as two Trusts had already published theirs.

The Board were assured that at least one Executive Director or PMc would be present at meetings with NHSE on this subject.

The Board noted further concerns expressed by Executives: on the one hand, the spending threat in NWL could play into a threat to referral bases and a threat in general to specialised services; and on the other hand that the thinking behind the draft paper on specialised commissioning and specialised services in London appeared to be based on the hypotheses that these were expensive procedures.

In response to a question from NL on how much progress had been made on corporate services consolidation RP said he had seen a recent paper led by ICHT and Chelsea and Westminster NHS FT and both the timing and quantum of savings appeared to be highly ambitious.

LB noted that change would be required and that our eyes would need to be open to risk and to opportunities. The tone of our involvement and commitment had to be positive.

NEXT MEETING Wednesday 30th November 2016 at 10 30am, Concert Hall, Harefield Hospital