A lifetime of specialist care

Royal Brompton & Harefield NHS
NHS Foundation Trust

Minutes of the Board of Directors meeting held on 27 January 2016 in the Boardroom, Royal Brompton Hospital, commencing at 2.00pm

Present:	Sir Robert Finch, Chairman	SRF
	Mr Robert Bell, Chief Executive	BB
	Mr Richard Paterson, Associate Chief Executive - Finance	RP
	Dr Richard Grocott-Mason, Interim 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	JG
	Mr Neil Lerner, Deputy Chairman & Non-Executive Director	NL
	Dr Andrew Vallance-Owen, Non-Executive Director	AVO
	Mr Luc Bardin, Non-Executive Director	LB
	Mr Philip Dodd, Non-Executive Director	PD
	Ms Kate Owen, Non-Executive Director	KO
	Mrs Lesley-Anne Alexander, Non-Executive Director	LAA
	Mr Richard Jones, Non-Executive Director	RJ
	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
	Ms Jan McGuinness, Director of Patient Experience and Transformation	JM
	Ms Joanna Smith, Chief Information Officer	JS
	Ms Jo Thomas, Director of Communications and Public Affairs	JT
	Mr Piers McCleery, Director of Planning and Strategy	PMc
	Ms Joanna Smith, Chief Information Officer	JS
In Attendance:	Mr Anthony Lumley, Corporate Governance Manager (minutes)	AL
	Ms Gill Raikes, CE Royal Brompton & Harefield Hospitals Charity	GR

2016/01 DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING

None.

2016/02 MINUTES OF THE PREVIOUS MEETING HELD ON 25 NOVEMBER 2016

The minutes were approved.

2016/03 NOMINATIONS AND REMUNERATION COMMITTEE OF THE TRUST BOARD

The Board confirmed the appointment of Dr Richard Grocott-Mason (RGM) as the Interim Medical Director and Senior Responsible Officer (SRO) and as such a member of the Trust Board. SRF welcomed RGM.

2016/04 REPORT FROM THE CHIEF EXECUTIVE

BB gave an oral report on the following matters.

Care Quality Commission (CQC) Inspection

The CQC had confirmed the dates of a full inspection of the Trust; June 14th – 17th

2016. He had asked Joy Godden (JG) Director of Nursing to lead the management process. There would be regular briefings for the Board via the Risk and Safety Committee (RSC) and through AVO, chairman of the RSC. AVO asked how the Non-Executive board members (NEDs) would be involved. BB said a month or two before the inspection the Trust would go through the drill of what could be expected from the inspectors. JG, in response to a query from LAA on the scheduling, said she had begun work on the timetable. KO offered to help acting as a shadow inspector.

Biomedical Research Centres (BRCs) Designation
A new round of designations for BRCs by the National Institute for Health Research (NIHR) had begun. These would be centres rather than units. The Trust would be submitting PQQs to the NIHR bid for BRCs for cardiovascular and respiratory by 15th February 2016.

Appointments
BB said that following RGM's appointment as the new Interim Medical Director and responsible Officer, the Trust was proceeding with the appointment of a substantive Medical Director. The first stage was to identify a search company. KO, SRF and himself would be the selectors and then other Board members would be invited on to the selection panel. Simultaneously, the recruitment of a Director of Research would commence.

LAA asked if the Action Tracker was up to date. AL confirmed that it was and all those actions previously recorded in the calendar year of 2015 were complete.

2016/05 CLINICAL QUALITY REPORT FOR MONTH 9: DECEMBER 2015

RCo introduced the report. He updated the Board on the meeting he had attended – the National Cancer Breach Allocation Summit held on 10th December 2015. A consultation on the way in which breach allocations are reported is now expected: shadow reporting had been put in place until the end of 2015/16 and was included in this report.

RJ said he noted that this would place emphasis on specialist Trusts treating within twenty days of referral which seemed sensible. He observed that only 20% of the patients who had breached the 62 day target in the last quarter had their treatment in the Trust in less than twenty days and asked why had the Trust not taken steps to address this and should any representations be made now. RGM said that to be able to operate within twenty days of receiving a referral was extremely challenging. It was not clear from the reported data whether the delays were because of the requirement for further diagnostics, or ensuring the patient was fit and appropriate for surgery. He assured the Board that the teams were working very hard to achieve the target across the whole pathway. He added that the review commissioned by Pr Tim Evans was currently being updated. AVO said that an update would also be reviewed by the RSC.RGM said he expected that this review would provide some more data on the reasons why surgery does not always occur within the 62 days, and identify some further actions that we can implement. He had also asked the care group to try and benchmark the Trust's performance against other centres who provided surgery for lung cancer.

PD said this issue came up at every Board meeting. It was difficult ignoring numbers that did not make sense nor take account of what the Trust was doing. He asked if the message could be made more clearly. RGM said this could be looked at fully when the review was published. He added that the service the Trust provided was

very good; surgical outcomes were very good but the Trust constantly got a 'black mark'. This could be demoralising for the clinical teams who were all working hard. RGM reminded the Board that the 62 day target covered all cancer pathways, and as the Weekly Dashboard included in the report illustrated, many Trusts were not meeting the target. There was no data on individual cancer group pathways.

RJ said he was encouraged as it was now recognised that much of the target had been out of our control. He hoped the Trust did not miss the chance to feedback any views before the new procedure was set in stone. JG said that it was important to understand the context of our service in relation to the wider cancer target, and that our focus should be on delivering the best surgical care for these patients and to continue to work with partner organisations to improve their pathway as a whole.

NL asked if the things TE had put in place had bedded down so that what was seen now was fair. RGM said the review would help provide these answers. NL said this was satisfactory.

RCo noted the planned inspection by the CQC for 14th – 17th June 2016. He highlighted that, of the 238 Trusts inspected to date, only 4 had been rated outstanding.

LAA asked why the outcome for the patient affected by radiation was missing from the report. JG explained that the investigation was still in progress. A note would be added to the minutes. *[Secretarial note: this incident was reported because the patient received 1.7 times the expected radiation dose (the reporting trigger being 1.5). No immediate harm was generated by this dose level, and in addition, the patient was assessed for the increased risk of developing a fatal cancer within their lifetime from this additional exposure. In this case, the increased risk was assessed as being 0.01% which is considered to be low. To provide context, the recommended exposure to trigger a Duty of Candour response is 20mSr, and in this case, the patient exposure was 3.3mSr.*]

2016/06 <u>FINANCIAL PERFORMANCE REPORT FOR MONTH 09: DECEMBER 2015</u>

RP presented the M09 report which summarised the financial performance of the Trust to 31st December 2015.

The Board noted that, while the Trust was just outside plan (Year-to-date) and a break even position in Q4 was needed to stay within forecast for the whole year, there was some assurance that a final reported result which was in line with plan was achievable.

KO asked whether if it was the process of managing performance against the NHSE block contract that was demanding or if it was the contract itself which was creating the challenge. RP said it was difficult to live within the constraints imposed by the block contract. If the number of devices was exceeded the cost was not recovered.

AVO asked if it was possible to set out expectations for the next financial year. RP said that he would be dealing with this later in the meeting. Turning to the balance sheet, this disclosed cash ahead of plan and capital spend behind plan. Planning delays at Harefield Hospital (HH) meant delays in receipts of charitable donations. BB said the Trust had clear expectations but achieving them was another issue. RP added that the opening of Wimpole Street had slipped to the middle of May.

In response to a question from PD on what caused the timing difference before the Charity reimbursed the Trust, RP said this simply reflected how the accounting worked – expenditure was incurred before the reimbursement so that, for example, due to the delay in starting work at HH the Trust's related charitable income would not come through until the next financial year. Charitable donations for capital items went through the I&E account owing to the accounting rules that had to be followed.

RJ asked if any of the financial risks had moved or had been amended since the last update. RP said the Trust periodically reviewed the Risk Register and had very recently engaged in this exercise. However, apart from downgrading the risk of a change of regulation on VAT recovery and a rewording of the top risk (failure to maintain adequate liquidity), there had been no substantive changes.

2016/07 IT UPDATE

Joanna Smith (JS), Chief Information Officer, presented the report. She notified the Board of a correction. In the second paragraph the date (when the Board had last received an update) should have been end of April 2015 and not 2014.

SRF asked if the Trust was going it alone on its IT strategy or learning from other Trusts. JS said the Trust was unusual in having the depth and breadth of a strategic plan that is invested in and supported. There were other Trusts who have already invested in some areas as we had done or planned to do but this was in pockets of development and not, apparently, as part of an overarching strategy and plan. The challenge was to maintain the momentum. She added that a full Lorenzo EPR might have been desirable or preferable but that would have been a multi-million pound project. SRF asked if there was a commercial opportunity (patient records) for selling RB&HFT's expertise. JS said the Clinical Data Warehouse provided some opportunity for revenue and she and PMc were aware of this and were actively looking for situations to exploit it. Beyond that the Trust had more work to do before it could set itself up as a centre of excellence.

RJ said he noted that the I&T Committee had representation of all users. He asked if those Executive Directors involved could provide a view or give their impression. JG said she was excited by the programme and there had been good clinical engagement.

KO said that she noted that a major aspect of the work being done as part of the Digital Care Transformation Programme was behavioural. She asked if JS felt she was getting support within the organisation. JS confirmed that support from senior management and colleagues was excellent and that her biggest challenge was supporting her own staff through the change process in order to deliver innovation and new services at the pace and style required. She added that the HR team were being supportive and that there was more to be done as many of her team had become quite institutionalised. KO asked whether low score in maturity levels referred to in the paper were a concern. JS explained this was primarily one area of I&T and the one most affected by the previous issue.

AVO said he had experience of data collection in other private hospitals and asked if they were ostensibly the same systems. JS said aside from their billing function they were clinically the same system. BB said the medical records were not the same. A fully fledged electronic patient management system would be unaffordable in our Trust and this underlined the importance of the structured approach being taken.

RGM said the roll out of Electronic Prescribing had been very successful at both sites in general with only some parts of RBH (Sydney Wing) to be done. RCr confirmed this would be finished by the summer (2016).

LAA said she had seen at first hand the excitement of staff on the ward at HH when the new electronic Medicines and Prescribing system – Medchart - was launched.

The Board noted the report.

2016/08 2016/17 OPERATIONAL PLANNING

RP gave an oral report. A blizzard of planning instructions and guidance had been received in the last ten days. The Trust was required to produce two plans: firstly, a draft 2016/17 Operational Plan by 8th February 2016 (with a final version on 11 April); and, secondly, a five year Sustainability & Transformation Plan (STP) by June 2016. The latter would be 'place based' and, in theory, encompass the local health economy including all providers and commissioners (primary care, community care and CCGs). These planning requirements had been first discussed at the Finance Committee meeting on Monday 25th January. RP gave more detail of the two plans and the issues were then discussed by Board members.

Operational Plan 2016/17

Trusts had been instructed to optimise results for the current year and strongly urged to report that they expected at the very least to achieve their planned outturn for 2015/16 and, if possible, to do better. The total planned deficit for all providers (FTs and NHS Trusts) was £1.8bn but this was now forecast to increase to £2.5bn subject to accounting changes being proposed by Monitor and the TDA. Planning guidance now signalled that any deterioration over the £1.8bn aggregate deficit would be deducted from 2016/17 funding. RP said, as had had reported in his M09 summary (see Minute 2016/06), that RB&HFT's expected outcome was within £1m of plan. This was important as an inaccurate estimate of the outturn (as a result of a subsequent major variance) would be deemed a failure of governance. The Trust had been allocated a control total - basically a synonym for the expected 'result' - of a £2.3m deficit for 2016/17 and the Trust was also required to state that it would be achieved**.** If the Trust did not make this statement then it would forfeit the STP funding (provisional allocation of £4.8m). If the Trust did confirm it but the result was not achieved, it would not be paid the STP amount - in other words it was between a rock and a hard place. RP added that as of today (27th January 2016) the Trust had not received any information on 2016/17 tariff, contracts or whether the block arrangement with NHS England would continue. We had run figures on the best outcomes (which included receipt of the STP funding of £4.8m) and the optimal achievable result was a deficit of £10m (£7.7m worse than the control total of £2.3m). This took account of the withdrawal from 1st April 2016 of the previously expected benefits of both HRG4+ funding and specific top-ups for respiratory and cardiac services, both of which had been 'kicked down the road' to at least 2017/18. RP suggested that further work was needed to enable a more substantive judgment to be made and, to that end, a further meeting of the Finance Committee would be convened.

Following a question from NL RP assured the Board that there was nothing untoward about the proposed accounting for 2015/16.

BB said the Trust's mission, in the face of this challenge from NHS Improvement (NHS Trust Development/Monitor), was to deliver safe and sustainable services for

patients. He concurred with RP's analysis that the likely outcome of whichever of the two courses the Trust took was that it would lose the STP funding. At the Finance Committee the priority would be to determine what needed to be done to achieve the right budget. He added that the Trust was also being asked to achieve double the amount of cost efficiencies. RP said that this assumed income was assumed successful PP initiatives in Kuwait and at Wimpole Street.

KF agreed that the aim was not to compromise patient care against a backdrop of the government looking to restrict the amount of care provided. He asked if the control total was activity related. RP said he did not know but the Trust was not unique in the level of challenge it faced. He acknowledged the validity of the point that care may have to be apportioned. The government projected £22bn of savings over five years which was about 20% of the NHS budget and a third of the provider budget. This was equivalent to saving a further £120m at our Trust over the next five years. In the face of these funding exigencies, the government had three choices: firstly, let the system run out of cash and see providers go to the wall in growing numbers; secondly, pay and fund the system adequately; or thirdly, direct the NHS to reduce its offering.

RP confirmed that for tariff the headline figures was an increase of 1.1% but service line detail had not been provided. NH also confirmed that activity projections had not yet been provided by NHSE or by other NHS commissioners.

The Board debated whether it would better to align the Trust's position and response with that of others. The Board noted that other Trusts were looking at different efficiency factors. Some of them expected deficits ten times higher (£100m) than that of the Trust which would affect how they responded. It also appeared that some Trusts were likely to accept the offer while others would take a holistic approach and take a logical stand (which RP himself believed was the best approach). BB advised that an aligned response would not work. RP added his view that if the Trust said 'no' with convincing reasoning Monitor might respect us for it.

BB reminded the Board that the Trust was currently rated as 2* by Monitor (Financial Stability Risk Rating – FSRR) which showed that the Trust was viewed as a credible organisation, in spite of the first ever expected deficit being recorded in our history. The guiding principle was to preserve that perspective next year and to demonstrate, even if the planning figures were perverse, that the Trust could deliver what it committed to deliver.

NEDs agreed that ultimately the front line had to be protected and this was the instruction from the Board to the Finance Committee. The Board agreed that the narrative of the submission should include the instances of 'success' that the Board had agreed in its earlier private meeting should be highlighted in its stakeholder engagement.

The Board agreed that the Finance Committee be delegated authority to sign off the submission in which the Trust would signal whether it agreed to the control total or not.

Action: submit draft 2016/17 Operational Plan by 8th February 2016 (RP)

Five Year STP

The Trust awaited definite instructions. The 'health footprint' was open to definition though it had already been indicated that the first of the five years had to be consistent with the budget as set out in the Operational Plan 2016/17. The Finance Committee had already heard that a 'do nothing' approach would lead to a £50m deficit by 2021/22. Alternatively, if everything that could be done on efficiencies was done, the resulting benefits received and revenue diversification achieved, a break-even position could be projected (50% internal efficiencies, 50% revenue diversification) but this assumed all the cards fell the right way up. It was agreed that the presentation the Finance Committee received would be circulated to all Board members.

Action: circulate five year projection presentation to all Board members (PMc)

2016/09 Q3 MONITOR DECLARATIONS 2015/16: (i) GOVERNANCE DECLARATION (ii) FINANCIAL SUSTAINABILITY RISK RATING (FSRR)

RCo presented the paper and highlighted the addition of a new statement on capital expenditure.

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

For finance:

a) That the Trust will continue to maintain a financial sustainability risk rating of at least 3 over the next 12 months should be declared 'not confirmed'.

b) That the Board anticipates that the Trust's capital expenditure for the remainder of the financial year will not materially differ from the amended forecast in the financial return should be declared 'not confirmed'.

For governance:

That the board is satisfied that plans in place are sufficient to ensure: on-going compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards should be declared 'not confirmed'.

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 Table 3) which have not already been reported.

Action: Upload declarations to the MARS portal before noon Friday 29th January 2016 to ensure compliance with Monitors' reporting requirements.

2016/10 RECOMMENDATIONS OF ADVISORY APPOINTMENTS COMMITTEE

The Board were presented with five ratification forms for the appointment of consultant medical staff. The first related to the appointment of a Consultant Intensivist in Cardiorespiratory Intensive Care and had been chaired by LAA who presented the recommendation for appointment. The second, third, fourth and fifth forms were all presented by NL and were for: a Consultant in Cardiothoracic Anaesthesia; a Consultant Physician with an expertise in Pulmonary Hypertension; and for the appointment of two Consultants in Anaesthetics at HH.

The Trust Board ratified the appointments of:
- Dr Victoria Sheward as a Consultant in Intensivist in Cardiorespiratory Intensive Care;
- Dr Aikaterini Vlachou as a Consultant in Cardiothoracic Anaesthesia;
- Dr Laura Price as a Consultant Physician with an expertise in Pulmonary Hypertension;
- Dr Ales Hodek as a Consultant in Anaesthetics at HH; and
- Dr Sarka Moravcova as a Consultant in Anaesthetics at HH.

2016/11 PROPOSED SALE OF 151 SYDNEY STREET

RP introduced the report in which the proposed sale of 151 Sydney Street was set out. The Board was being asked to recommend this for approval by the Council of Governors as under the Trust's constitution all real estate transactions must be approved by the Governors. RP drew attention to one of the risks of a sale – a buyer could use its subsequent position to hold the Trust to ransom over its plans to sell Chelsea Farmers Market (CFM). The Trust could mitigate this by selling a long lease of 151 with covenants rather than a freehold interest (the Trust had asked two agents to pitch for the selling mandate).

KO asked if it would be a better approach to sell 151 Sydney Street with CFM together. RP said CFM was blighted (safeguarded) and therefore the aim was to have Crossrail 2 sign an (unconditional) contract agreeing that when Government funds were available (estimate 2020) they would buy CFM at full redevelopment value.

The Board agreed that it would recommend to the Council of Governors that it approves the sale of 151 Sydney Street once the necessary terms had been agreed with the probable buyer.

2016/12 MRI SCANNERS

RP said the paper set out that the Trust needed to replace three aging MRI Scanners at the RBH site and the proposal was that new scanners were leased under seven year operating leases. RP added that they would be recognised as a rental expense over a period which meant that the lenders (ITFF and Barclays) approval was not required but this would be 'above the line' for EBITDA, in other words this would reduce EBITDA which is one of Monitor's financial metrics. RP further added that a new lease accounting standard from 2019 meant all leases would then be on the balance sheet.

RCr confirmed that if the development of a new respiratory wing happened then the scanners would have to be moved but this could be done.

The Board approved the replacement of the Trust's MRI Scanners.

2016/13 PROPOSED MARS (MUTUALLY AGREED RESIGNATION SCHEME) SCHEME

RP said this was the fifth year invitations inviting applications had been sent to staff. Employees applied for MARS terms and, if they were agreed by the Trust on operational and other considerations, asked to sign a Settlement Agreement. The annual scheme needed to be Treasury approved, a task delegated to Monitor. This year the Trust only expected a handful of successful applicants. Last year some thirty had applied and ten were approved. This year, to date, only fourteen Trust employees had applied.

(LB left the meeting).

2016/14 QUESTIONS FROM MEMBERS OF THE PUBLIC

Ken Appel said he had looked on the internet at Trusts that had failed (rated inadequate) their CQC inspection and were under special measures and he had seen nothing that pertains to here. BB said the CQC would undoubtedly find something to focus their attention on, especially facilities, and there will be a challenge. However, he assured the Board that the Trust would be ready.

KA asked if consultants monitored the time factor in diagnosing cancer waits. RCr said they did and there was enormous scrutiny. Whole clinical teams reviewed the patient lists once a week.

KA asked if it was likely improvement works to the lakes at HH would commence. NH confirmed that improvement works had been done.

NEXT MEETING Wednesday 30th March 2016 at 10.30am, Concert Hall, Harefield Hospital