A lifetime of specialist care

Royal Brompton & Harefield NHS
NHS Foundation Trust

**Minutes of the Board of Directors meeting held on 28 October 2015 in the board room, Royal Brompton Hospital, commencing at 2pm**

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| Present: | Sir Robert Finch, chairman | SRF |
| | Mr Robert Bell, chief executive | BB |
| | Pr Timothy Evans, medical director and deputy chief executive | TE |
| | Mr Richard Paterson, associate chief executive - finance | RP |
| | 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 and 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 and Trust secretary | RCo |
| By Invitation: | Ms Jo Thomas, director of communications and public affairs | JT |
| | 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 |
| In Attendance: | Mr Anthony Lumley, corporate governance manager (minutes) | AL |
| | Ms Gill Raikes, CE Royal Brompton & Harefield Hospitals Charity | GR |

2015/76 <u>DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING</u>
None.

2015/77 <u>MINUTES OF THE PREVIOUS MEETING HELD ON 30 SEPTEMBER 2015</u>
The minutes were approved.

2015/78 <u>REPORT FROM THE CHIEF EXECUTIVE</u>
BB gave an oral report. He outlined four concerns that together would present a confluence of challenges and adversities for the Trust and its strategic direction over the next twelve months.

**Finance**

BB reported on the mounting financial squeeze of funding in the NHS and the incessant if not continuous need for revenue generation and income diversification strategies. The Trust had a deficit budget and was on track to achieve the planned deficit at the end of year. The Trust was subject to a huge amount of scrutiny, interference and pressure from other sources,

especially from Monitor, the regulator for Foundation Trusts (FTs), acting beyond its regulatory role. BB tabled a letter sent by Monitor on 26 October 2015. While Monitor acknowledged that the results to date were in line with the plan the subtext was that it still wanted more costs cut. BB said this was indicative of the environment in which the Trust had to operate – the Regulator was seeking to direct our actions when this was not a Regulator's role but that of the Trust's management team. Monitor required the Trust to respond by the 6 November and confirm that it was applying its controls on management consultancy and its agency 'rules'. BB said the Trust was planning a fact based and robust response demonstrating that it was tracking performance to achieve results. The Trust was not at risk of special measures but BB emphasised that this was not a natural environment and hence caution was required.

NL asked about the status of the Monitor 'rules'. BB said it was guidance for FTs. For NHS Trusts, who had received the same letter, they were rules. RP added that they were also rules for FTs who were recipients of distressed funding or in special measures. There was, however, a veiled threat that if the Trust did not comply and it did not save money, it would be held to account. PD asked if the management consultancy cap was generic. RP said the capital projects were excluded by Monitor but the Trust would address them in its response.

AVO said much depended on the Autumn Statement and the Spending Review (SR) to be presented by the Chancellor on 25 November 2015. BB said going forward he was not optimistic and there were no signals that there would be any relief. If anything it was likely the Department of Health would state that the £8bn 'increase' would be ring-fenced. KO concurred and noted that the partial 'U-turn' by the government on tax credits would have to be paid for. BB said every week he heard of another health organisation that was performing worse than expected or was being placed into special measures. He suspected that the picture was even worse than that which was being reported in the media. This underlined the imperative to generate revenues from outside the NHS. There were opportunities in the private sector to compensate although the Trust would not see any benefit until later fiscal years.

LB said he understood and accepted this position and noted that the Trust existed in a complex environment with a deficit budget and a need to generate other sources of revenue. He asked about how the Trust covered this in its planning process. BB said there was a plan for the next twelve months and two years beyond that. The Trust was seeking to exploit revenues abroad and add revenues from other private patient (PP) services. When the Monitor team had conducted the performance review in the summer this was the plan that was put before them and which they had examined in depth. They had responded 'go do it'. Costs would be managed without recourse to slash and burn. The direction of travel was to generate external sources of income in the UK and abroad: one avenue

was the opening of the PP outpatient/ diagnostic facility at Wimpole Street on 1 April 2016; another, the management contract opportunity in Kuwait.

RP said he expected there to be a requirement for a detailed forward plan over multiple years but the green light from Monitor was still awaited and was unlikely to be forthcoming until after the SR in the autumn. BB added that this stasis on budget planning also had an impact on redevelopment, capital plans and renewals. There should be no expectation that the problem would go away. There would be no going back to 'normal' - normal was what existed now. LB said he recognised the various strands the Trust had to balance but said that, when it came to the time when the tariff arrangements were known, he as a newcomer would welcome a discussion about money from the non-executive standpoint.

KF asked how long Monitor would tolerate the Trust's deficit before they escalated. BB said, if a Trust had a planned deficit which had been endorsed by Monitor, they would not intervene (unless it went off plan). The FT sector was seeing increased intervention by Monitor not only because of deficits but also because of CQC inspections which in many cases were giving poor ratings and bad quality assessments.

NL asked if the Trust had received the same letter as other FTs. BB said it was an individual letter.

NL said the Trust could not address questions about the medium term future until it heard about the tariff. NH said NHS officially had stated it would be issued on 19 January 2015. However, what form it took was clearly linked to the Autumn Statement. There would be a two to three week consultation period and contracts would be expected to be signed by 31 March 2016. HRG4+ would be introduced and the damage to the cardiac chapter seemed to have been mended, but the indications were at this stage that after factoring in efficiency requirements the Trust might lose between £10m and £20m NHS income for 2016/17. NL commented that this did at least give a basis on which to plan. NH said the Association of UK University Hospitals had cancelled a meeting which had been scheduled for today to discuss tariff. BB said there should be no expectation that tariff would be an improvement on this year, indeed it could be worse.

**Staff Morale**

BB said there was increasing low morale and staff were worried about wage issues and the imposition of new working conditions by the Secretary of State for Health. BB observed that there was a gap between the world staff live in and the actions being taken by the State who were bent on imposing new working conditions, renegotiating contracts and imposing caps on the use of staff – all adding to the challenge and uncertainty. Junior doctors at the Trust had sought support from the Trust in the confrontation with the Secretary of State for Health.

BB said that the mood of staff was confused, uncertain and disturbed and that Staff did not blame the organisation but had an expectation that the Trust would help to solve the problems for them. The problem was systemic. Another issue impacting on the Trust was seven day working and each month the Secretary of State appeared focused on a new issue. BB said this was politics, not management, and he felt that it was almost inevitable there would be a blow out of some kind. He hoped the Trust's junior doctors did not go on strike as if they did the hospital would be affected. With industrial disturbances of this nature there were always winners and losers and no middle ground. In response to a question from PD about contingency plans, BB said that operational contingency plans were in place and that the message to staff had to be handled carefully. There should be no signal that we have given in or lost purpose and corporately the Trust should reaffirm that what the staff were doing what was right. The leadership group should not shy away from breaking some eggs, supporting appropriate compensation and not adhering to agency caps where these would adversely impact patient care. BB said he was seeking the Board's support for a position which demonstrated that the leadership was determined to do what was right in order to care for the patients and if rules had to be broken then they would be.

PD said there were three issues: a deficit and no money to give to staff to ease the pain; agency cap rules and waiting list problems. It was about where you take the pain but there was no win wherever was selected to take the pain. BB said the objective was not to compromise on care.

LAA asked if there was an internal communications plan to address this that could that could tap into the positive mood captured in the staff friends and family test. BB agreed that was a very accurate assessment and that this would be part of the plan. BB added that the focus should be on how the Trust was continuing to deliver excellence, taking the key messages from patient groups.

There was unanimous support from the Non-executive board members for the position proposed by BB.

**NHS Structural and Organisational Changes**

BB drew the attention of the Board to the myriad of initiatives in recent months, including Vanguards and Accountable Care Organisations and reassured the Board that the Trust was not missing out of anything. If there was anything meaningful, this would be brought to their attention.

BB said he was meeting with the Chief Executive of the Royal Marsden Hospital (RMH) on 29 October 2015 who had recently been made 'Cancer Tsar' for the whole country. He would be asking her for more information on what this entailed and how it impacted on the joint working of both Trusts.

**Redevelopment**

BB reported on planning blight in Chelsea and an unsteady property market that would impact the Trust's development and rebuilding plans for example, Crossrail 2 and the protracted NHS process between ourselves and RMH. The Trust's priority of rebuilding was now almost off the rails. Recent developments had undermined the Trust's position in a critical way. Combined with the three other issues he had set out above, this increased the gap between intention and reality. BB concluded that even taking forward a moderated vision would be a big challenge.

2015/79 CLINICAL QUALITY REPORT FOR MONTH 6: SEPTEMBER 2015

RCo said the significant highlights of the report were:

Monitor Risk Assessment Framework:

- 18 Weeks RTT Incomplete: the target had been met for every month of Q2 so the recommendation was that the target be declared met.
- Clostridium dificile; reviews of 9 of the 16 cases awaiting review had been completed by NHS England and no lapses of care had been identified. So the recommendation was that this target be declared met for Q2.
- Cancer 62-day wait for cancer first treatment: performance was not met (69.05%) against the threshold of 85%. RCo said that it was important to be sure that the Trust was doing everything it could and referring centres were doing everything they should before moving on to a discussion of how the target is measured, including breach reallocations. The Trust was continuing to work through the action plan from the review of the lung cancer service at HH commissioned by TE and which was reviewed earlier this month by the Risk and Safety Committee (RSC). RCo highlighted the actions being taken both internal to the Trust and those relating to the referring centres. For the former Dr Jaymin Morjaria, Consultant in Respiratory Medicine with Expertise in Lung Cancer and Pleural Disease had started in post at HH on 1 October 2015 and for the latter Mr Niall McGonigle, Consultant Thoracic Surgeon and John Pearcey, the Trust's Cancer Manager, were showing system leadership by facilitating a meeting between the Trust and clinicians from the referring centres to be held at the end of November 2015. This was the focus before looking at the metrics.

NL asked what would be the benefits of Lorenzo, the new patient administration system (PAS) due to be implemented as part of the Trust's I&T strategy. RCr said it was replacing the very old iSoft PAS system and was supplied by CSC. It was a very different system - the current PAS was little more than a data repository and historic record of what had happened - but the Lorenzo system would be much more dynamic, e.g. in helping the management of referrals into the Trust and patients' journeys on their Referral-to-Treatment (RTT) pathways. AVO said the RSC was looking at the cancer pathways at every meeting, and had agreed that the Trust should set its own, internal target of 100% of patients referred being seen in a timely manner once under our care.

RJ commended the addition of the detail of cancelled operations in the report (those patients not treated within 28 days of cancellation), but noted that the cancellation date was only given in the first three cases and asked that this should be included for each case in future reports as it helped to give context to each breach. LAA said she was grateful and felt that this was much more 'people–centred'. However, she felt that it did not elaborate on why an alternative date was not offered within 28 days. RJ noted the statement under the table on page 20 about penalties for breaches under the NHS contract and asked what the implications were for the Trust. NH confirmed that these penalties were negotiated out at the time of the Trust agreeing the block contract for the current year. This was not true where it was a CCG but relatively speaking this was not a significant factor. RCr said the Trust did still calculate what the impact would be if the penalties were applied as this was an important consideration for the teams. RJ said this highlighted the importance of NH's success in getting this provision removed from the block contract. RJ also said he was concerned to read that "it is beginning to look as if there will no change" in the current Monitor breach allocation policy, given that the Board was assured earlier in the year that it was likely that sense would prevail and the two current measures would be brought together and take into account the dates cases were referred to the Trust. RCo said currently he was not seeing any sign of the bringing together of the performance measures. RJ asked if more pressure could be applied to ensure a sensible meaningful outcome. RCo said that he and NH would be attending the Performance and Contract Executive (PCE) meeting with NHS England next week and would raise the issue there to open up discussion with NHS England as the other main player in the Tripartite (Tripartite consisted of Monitor, the Trust Development Authority and NHS England).

NL said he noted that the problem with cancelled operations seemed to be in cath labs at RBH. He also noted that the graph in the report showing quarterly figures for cancer breach reallocations sought and agreed showed a downward line for those agreed and he asked how long it could be before measures put in place started to kick in and the line move up.

On cancer targets, RCr said there were too many moving parts to give a simple answer. The two newly-appointed consultants, one at each site, would drive this but they would need six months to make an impact. TE said that while it was reasonable that the Trust was less certain about the bits of the pathway without its control, it needed to be intolerant of poor performance where it did have control. He believed challenging internal targets were needed and currently a little over 70% were meeting the threshold and this could be 90%. The Trust should expect to see the consultants achieve this soon, and they had been asked to do re-audits.

On cancellations, RCr said the figures showed that the number of cath lab breaches (a new indicator this year) was dropping as the year progressed, but agreed that the reported position on 28-day re-admissions was

disappointing. It related to a couple of individuals' performance, but the reason for the errors was because processes were not working well. BB said the issue was whether two people's behaviour could be altered. RCr confirmed that the processes were being changed. LAA welcomed the information, as it showed the real impact on patients. NL was concerned that a great deal of weight was being vested in the performance of the Lorenzo system. RCr pointed out that Lorenzo's role related to RTT waiting times, not to cancellations.

Referring to the Friends and Family Test results, NL said that a comment in the box headed Patients unlikely or extremely unlikely to recommend our Trust seemed out of a place as it was a positive one. JG said that sometimes patients were dissatisfied with one aspect of their experience while remaining positive about the rest and that in this case the comment had been a criticism of the quality of the food which was being looked into.

RJ asked if the successful SMS pilot would be rolled out across the piece. JMc said that with JS they were looking at what this would cost and how best use might be made of existing planned expenditure.

PD asked whether the level of hours filled for unregistered staff in the Nurse Safe Staffing report (lower than registered by a third at the Brompton) was an area of concern. JG explained that the figures needed to be seen as a whole, and that as the numbers of non-registered nurses are relatively small, the percentage rates as shown were unhelpful. She confirmed that the issue of nurse staffing was given careful attention, and that currently the staffing levels were judged as safe. JG also agreed to provide more detailed information for the next Board meeting.

The Board noted the report.

**Action: add note to Nurse Safe Staffing report to provided context for reported hours filled by unregistered staff (JG).**

2015/80 FINANCIAL PERFORMANCE REPORT FOR MONTH 05: SEPTEMBER 2015

RP reported the following performance for M06:

- I&E account - general comments on month: reasonably satisfactory albeit flattered by some one-off items.
- I&E account - year to date (YTD). At the mid-point in the year the Trust had made a deficit of £6.5m, £2m better than plan. The planned deficit for the first half year had been front loaded to take account of the extra public holidays and summer holidays. The principal reason for the improved outturn at the midpoint was that £1.5m of capital donations from the Charity had been received ahead of plan. RP added that the planned depreciation expense was overstated. On an underlying basis, the budget was pretty much on plan. RP thanked RCr and his operational team and the divisional directors for their hard work and diligence.

- New section in the report narrative on FSP (Financial Savings Plan) and CIPs (Cost Improvement Programmes): this was an area Monitor focused on. The Trust was a little behind at half year, 80% of planned savings, the shortfall mostly due to procurement, drugs in particular. The current forecast was to achieve 90% of planned savings by end of year.
- Balance sheet: cash was on plan. There were provisions available for release if results went off track in the second half.

RP said that KF had asked at the Board meeting held in May 2015 how confident he was that the Trust would achieve its planned deficit (£10m) and he had answered that he was about two thirds confident. He was now more confident of achieving the planned underlying deficit after the first half year. The Achilles heel was cash. YTD EBITDA was just £3m so capex still largely depended on third party borrowings and contributions from the Charity. NL said the Trust had benefitted from a strong balance sheet. This had been somewhat eroded and would be difficult to regenerate.

The Board noted the report.

2015/81 AUDIT COMMITTEE (AC)

(i) REPORT FROM MEETING HELD ON 19 OCTOBER 2015

NL thanked Tim Callaghan, Deputy Director of Finance, for the great deal of hard work he had put in to produce these minutes in the short time since the meeting.

RJ asked if the value of assets requirement described by Deloitte in the sector review had led to any alterations. NL said it had not.

(ii) UNCONFIRMED MINUTES FROM THE MEETING HELD ON 19 OCTOBER 2015

The minutes were noted.

2015/82 RISK & SAFETY COMMITTEE (RSC)

(i) REPORT FROM MEETING HELD 19 OCTOBER 2015

AVO said he was grateful to Anne Middleton, Head of Quality and Safety who had produced these minutes in a timely manner just prior to her departure from the Trust. The committee had received a cancer review update and an excellent presentation on pressure ulcer management. It had also reviewed the Matrons report which had been reformatted to concentrate on one area, in this instance nurse leadership. There had been a good discussion.

KO said that she welcomed LAA's suggestion that Non-Executive Directors should attend some mock CQC inspections.

(i) UNCONFIRMED MINUTES FROM THE MEETING HELD ON 19 OCTOBER 2015

The minutes were noted.

2015/83 Q2 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. NL said that confirming that the Trust anticipated that the capital plan would meet the current forecast was challenging. RCr agreed, but said current information was not materially different from what had been forecast. He confirmed a key risk, that there was still no 'start-on-site' for the imaging and critical care development at HH as discharge of planning conditions was still outstanding. These were being pursued with the London Borough of Hillingdon (LBH).

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

For Finance, the Board agreed that:

The governance statement 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'.

That the governance statement 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 'confirmed'.

*[Secretarial note: On the day following this meeting (29 October 2015) the Capital Working Group received an oral report on the expected impact of planning delays currently experienced in relation to the HH campus developments described above. RCr and RP subsequently advised other Board members that, in the light of this additional information, it was not appropriate to make the above statement which should instead be flagged as 'not confirmed'. The Non-Executive Directors confirmed their agreement in writing and the Finance declaration to Monitor was changed subsequent to the Board meeting to:*

*'The governance statement 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, the Board agreed that the governance statement that plans were in place to ensure on-going compliance with all existing targets should be declared 'not confirmed' because the 62 day cancer target had not been met for Q2.

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 30th October 2015 to ensure compliance with Monitors' reporting requirements.**

2015/84 RB&HFT ANNUAL APPRAISAL AND REVALIDATION REPORT

KO said the work behind this paper had been intensive. The review of the appraisal process had shown that it was much better than last year and the Trust should be pleased with what it had done.

It was agreed that TE would convey the Board's thanks to Siobhan Carr, Trust Appraisal Lead, and Nick Brosnahan, Medical Revalidation Manager.

The Board noted the RB&HFT Appraisal and Revalidation Report

2015/85 ANY OTHER BUSINESS

The Board was presented with one ratification form for the appointment of a Consultant in Radiology at Harefield Hospital. RJ said out of five applicants, three had been invited to interview, although one had subsequently withdrawn. The appointee was a locum working within the Trust and was recommended for appointment subject to a Personal Development Plan (PDP) which would help to widen experience here and elsewhere. TE said he was confident the PDP would be helpful.

The Trust Board ratified the appointment of Dr Evangelos Skondras as a Consultant in Radiology at Harefield Hospital.

KF said there was deep concern in the NIHR that there were not enough female applicants for consultant roles. He asked if he could be assured that the Trust was actively seeking out female candidates. TE said he could not provide that reassurance. RJ said that women had been shortlisted for the last three positions and NL said he had chaired panels which had recommended the appointment of female candidates.

KF said that in the context of the BRU application due in 2017 it was essential to have a system of governance in place to ensure that women are encouraged to apply and are able to take the posts up. In higher education many institutions were signed up the Athena SWAN charter dedicated to promote gender equality. An institution must be seen to have appropriate systems in place such as maternity cover to tackle unequal representation of women. KO suggested that the Trust tap into Imperial College London's expertise. KF reiterated that a silver award under Athena SWAN was a requirement of every university. If the NHLI did not have this award, the Trust would not be able to apply for a BRU. SRF said the Trust encouraged suitable applications from both men and women. CJ said the Trust had an Equality and Diversity Policy which ensured appropriate standards were in place. BB said the Trust's recruitment practices and policies, while they could always be improved, were exemplary.

It was agreed that CJ, KF and KO would discuss the matter further.

KF said there were cases of PhDs appointed by the Trust where appropriate maternity cover had not been implemented. TE said this was not the case with substantive NHS appointments.

2015/86 QUESTIONS FROM MEMBERS OF THE PUBLIC

KA asked the following questions:

- would the newly appointed radiologist be practicing intervention and would this enable an expansion into triple AAA.

TE said respiratory and medical intervention were in the job description but not triple AAA.

- how the Division of Respiratory Medicine planned to interact with the Trusts around the HH site with the aim of improving the care provided to those with lung cancer, up to and including exploring the possibility of joint consultant appointments.

It was agreed that TE would write to KA. *(Secretarial note: TE wrote to KA on 28 October 2015)*

- were developments going ahead at Harefield Hospital.

RCr said this consisted of separate elements. As described above, the Trust was waiting for LBH to discharge its 15 conditions on the planning consent awarded for an Imaging Centre and 6-bed expansion of critical care. If work commenced on site during November 2015, the facilities could be operational by September 2016. The Trust's plans also included the expansion of Level 1 (both private and NHS) capacity to be commissioned in 2017 (subject to planning consent). BB expanded on longer term developments. The Trust was in talks with an outfit company that wanted to join forces with the Trust at HH and build a private hospital, with a learning centre and a re-hab centre. He was optimistic about the future and believed this could be a good thing for HH.

- as the main cause of troubles around the deficit was tariff could the Trust identify a certain type of work for which it was grossly underpaid and present it to the commissioner to be considered in the review of tariff.

SRF said this was done the whole time, led by NH. BB commended KA for his vigour and support for the Trust.

NEXT MEETING Wednesday 25 November 2015 at 10.30am, Concert Hall, Harefield Hospital