A lifetime of specialist care

Royal Brompton & Harefield NHS
NHS Foundation Trust

Minutes of the Board of Directors meeting held on 28th September 2016 in the Concert Hall, Harefield Hospital, commencing at 10 30 am

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
	Ms Jan McGuinness, Director of Patient Experience and Transformation	JM
	Mr David Shrimpton, Director Private Patients	DS
	Ms Jo Thomas, Director of Communications & Public Affairs	JT
	Ms Carol Johnson, Director of Human Resources	CJ
	Mr Piers McCleery, Director of Planning and Strategy	PMc
	Ms Jan McGuinness, Director of Patient Experience and Transformation	JM
In Attendance:	Mr Anthony Lumley, Corporate Governance Manager (minutes)	AL
	Ms Gill Raikes, CE Royal Brompton & Harefield Hospitals Charity	GR
	Mr Alistair Martin, Head of Stakeholder Engagement and Campaigns	AM
Observers:	Ms Laura Middleton, Director Pricewaterhouse Coopers LLP (PwC)	
	Ms Sally Bassett, Director Pricewaterhouse Coopers LLP (PwC)	
Apologies:	None.	

2016/68 DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING

None.

NL introduced Laura Middleton and Sally Bassett from PwC who would be conducting the Well Led Board Review and were attending this meeting as observers.

2016/69 MINUTES OF THE PREVIOUS MEETING HELD ON 27th JULY 2016

The minutes were approved.

Matters Arising

- Page 5, Financial Performance Report. RJ asked if NHS Improvement (NHSI) had responded to the submission of the pay bill analysis they had requested from

the Trust. RP said NHSI had acknowledged receipt of the information but no more than that.

Board Action Tracking

BD16/45 Collaboration with Chelsea and Westminster NHS FT. PMc said the feasibility study from the external consultancy had been completed. This had concluded that a collaboration around paediatric critical care would be clinically beneficial and financially affordable. The next stage would be the completion of a more detailed implementation plan and financial plan. This would start in the week commencing 3rd October 2016 and would take about six to eight weeks and the output of which would be outline clinical governance and corporate governance models. NL noted that progress had been made. RCr said the Board would recall that this was building on an existing collaboration.

NL said that an update should be scheduled for the meeting of the Trust Board to be held in January 2017.

BD 16/61 Cancer Services Review Action Plan. Following a suggestion from RJ it was agreed that the action plan would be circulated to members of the Board who are not members of the Risk and Safety Committee (RSC) following its review at RSC on 17th October 2016.

2016/70 REPORT FROM THE CHIEF EXECUTIVE

BB gave a verbal report on the following items:

77 Wimpole Street

BB said that today (28th September) was the official opening of the Trust's new outpatient facility for private patients at 77 Wimpole Street.

Congenital Heart Disease (CHD) Proposals

BB reported that he was reasonably confident that there would be no decommissioning of the Trust's CHD services in 2017. However, the threat had not gone away. This news had been communicated to staff in forums held at both sites earlier in September. The national consultation process was expected to commence in December 2016 and run to March 2017 and the Trust would participate and respond.

Care Quality Commission: July 2016 Warning Notice

BB said that on 8th September 2016 the Trust was informed by the Care Quality Commission (CQC) that they were withdrawing the Warning Notice that was issued in July 2016. They had indicated that they had identified a number of areas where the CQC could have set out their 'evidence more clearly'. BB added that he believed that the robust response by the Trust to the initial notice, prepared by JG and RGM, had led to its withdrawal.

LAA asked which areas had the notice applied to. BB said the inspector had observed that the four lifts could all be used for patients, transport and goods and this had an impact on infection control. Since 1st September only one lift could now be used for goods and linen. JG added that CQC's warning had been out of context and disproportionate. AVO said he had seen the paperwork and he commended JG

and RGM for their response. By withdrawing the notice CQC had acknowledged problems with their processes.

BB said it was not known exactly when the report from the inspection in June 2016 would be received. Generally the CQC had submitted reports around six months after the site inspections so the Trust could anticipate its arrival sometime from October to December 2016. He confirmed that the Trust would receive a draft report first and could comment. He added that NHSI were being kept informed.

NIHR (National Institute for Health Research): Biomedical Research Centre (BRC) Application

BB said the Trust in partnership with Imperial College London (ICL) had not been successful in the application for a combined Cardiovascular / Respiratory BRC designation. With the effective demise from 1st April 2017 of the on-going funding for the Trust's two NIHR Biomedical Research Units, the Trust now faced an economic shortfall in research funding of approximately £4m a year. BB gave the Board further information on the national allocation of funding which had seen a redistribution of funding from the capital (and in particular away from ICL) to the regions. BB said he thought that this reflected a wish on the part of NIHR that the Imperial College 'family', which included the Trust and other Trusts, which had lost out in the round such as RMH and ICHT, should strive for further consolidation. He added that the feedback from the failed application was that the research was not impressive, not value for money and there was not much linkage identified between cardiovascular and respiratory research.

The Board noted the negative impact this would have on staff morale and that the consequences were not simply financial given that the Trust had been putting a lot more, in terms of energy and resources, into research than it got back. It also noted and took some assurance from the impending appointment of a new Director of Research and Education and that the person interested in the role was aware of this latest development, and that this would enable an opportunity to refocus the organisation's research endeavours and priorities in alternative directions and aim for better returns from projects.

In response to a question from PDd on what the immediate short term financial effect would be RP said it was important to keep research facilities operational which underlined the need to find the funding. £3m of the £4m which would be lost went towards keeping the two existing BRU facilities 'on the road'. He had raised the issue informally with Gill Raikes, Chief Executive of Royal Brompton and Harefield Hospitals Charity (the Charity) and had established that there was a basis for a discussion for the Charity to potentially help bridge the funding gap until new sources of research funding had been identified. BB added that the service would not be economic for the next two years. The current NIHR BRU grants amounted to just 1% of Trust turnover. None-the-less, this made income diversification strategies more important than ever.

PDd asked if the ECMO threat (as described by BB at the last Board meeting in July 2016) was still current. The Board heard that the Trust would resubmit a bid and that this would entail firstly a repeat of the peer review conducted in the Spring (in which the Trust had done well) and which was seen as necessary in the light of the personnel changes and in order to establish that the service was still robust and safe and sustainable during the anticipated winter surge. RGM confirmed in response to a

supplementary question from PDd that verbal feedback from this review could be expected in time for the next meeting of the Trust Board which was scheduled for 26th October 2016.

Action: Board to be updated on progress of ECMO resubmission at the Board meeting on 26th October 2016 (RGM).

2016/71 CLINICAL QUALITY REPORT FOR MONTH 5: AUGUST 2016

Presenting the report RCo said that in doing so he was responding to questions raised by a Board member. In relation to 62 Day cancer target the Trust had been collecting data about day 38 referrals for the last eighteen months and had therefore had been able to agree with NHS Improvement that the national breach allocation policy could be applied by the Trust from 1st April this year. The 1st October 2016 date contained in the report was the date when the rest of system was expected to catch up and have arrangements in place.

RCo reported that the trajectory for the 18 week referral to treatment time target had been met for M5, although he noted that data continued to be validated following the change to the patient administration system in July 2016. He added that this validation work would contain elements both positive and negative to performance against the target.

NL asked, given the STF trajectory target for the 18 week referral to treatment time target was more challenging for the rest of the year, what the prognosis was for the rest of the year and also asked how much the penalties were. RCr said penalties of £50,000 per month were applied for being >1% away from the trajectory, but could be 'reclaimed' if the position recovered. The action plan jointly managed by the Trust and NHS England was designed to maintain the trajectory to the end of the year, and the figures would improve in the coming months. RCr said that at this stage he was reasonably confident, but not yet assured, that the year-end target would be met, as elements of the plan were out with the Trust's control. He also noted the implementation of the Lorenzo PAS (the Trust's new patient administration system), saying that more work was being done and it would be another month at least before processes were aligned with reporting requirements, and would take longer to become fully embedded. In the meantime, the impact of data flows and validation through Lorenzo might skew 'snapshot' figures in either direction.

RJ noted that the detail for a referral to the Trust on Day 38 appeared to show that the referring Trust had not completed the diagnostic tests and asked who paid for these. NH confirmed that no additional costs (in this case for diagnostics) would be borne by us. RGM cautioned that the cancer pathway was too complex and did not lend itself well to being compartmentalised as the current reporting encouraged. This could lead to apportioning blame which was not constructive.

The Board noted that going forward the Trust would still be required to meet the performance requirements set out in the NHS Constitution (Department of Health) and that these informed the NHS Standard Contract (NHSE) and the SOF (NHSI).

It also noted that the introduction of the SOF was a welcome development given that it brought together the metrics contained in the RAF (Monitor), the Accountability Framework (NHS TDA) and some of the metrics used by CQC.

NL congratulated RCr on the apparent improvement in cancelled operations performance.

LAA said she continued to have concerns about the description of incidents. Comments were generalised and this report appeared to be moving back to numerical reporting with less on the human aspect and the outcomes for patients. AVO and KO agreed that more patient centred information in the Board report could provide greater assurance. NL highlighted that this was also the case with the reporting of nurse staffing – while it could not be contested that the levels were safe the rational was not clear. JG acknowledged the concerns but commented that there should be a clear understanding of what summaries were needed and how it might differ from the information that the RSC considered.

It was agreed that a mock-up of the Clinical Quality Report that the Board should receive be considered by the RSC at its meeting on 17th October 2016 and then used in the Clinical Quality Report for the Board meeting on 30th November 2016.

Action: mock-up of the Clinical Quality Report to be considered by the RSC on 17th October and the format used in the report presented to the Board at its meeting on 30th November (JG).

2016/72 FINANCIAL PERFORMANCE REPORT FOR MONTH 5: AUGUST 2016

RP presented the M05 report which summarised the financial performance of the Trust to 31st August 2016 and the Board noted the key headlines

- although the month had been on plan the result was 'flattered' because some income had been recognised which should have been reported in the previous month. This had resulted from the introduction of the new PAS system in M04 which had experienced some teething problems.

- Only 82.5% of the potential Sustainability and Transformation (S&T) funding had been recognised in M05 notwithstanding the eventual achievement of the two relevant trajectory metrics which triggered this portion of the S&TF. A timing difference between the finalisation of the finance report and the internal confirmation of trajectory compliance was the cause of this. The S&TF shortfall of £100k would be recognised in M06 but the equivalent M06 S&TF, if earned, could not be recognised until M07.

- FSP (Financial Savings Plan) CIPs (Cost Improvement Programmes) YTD had achieved about 80% of plan, though savings at this level would become more difficult to achieve in the second half of the year.

- Balance sheet - cash: the Trust had agreed with Barclays an extension of the Trust's existing working capital facility to 1 December. Negotiations were in train to renew the facility for two more years from that date. The finance report included a new red risk based on the threatened decommissioning of CHD services and the potentially serious 'hit' to income of nearly £60m if this transpired. Income from Wimpole Street and Kuwait could lead to some upside but these would not in themselves fill the £25m gap in underlying performance.

The Board noted RP's view that the forward view looked bleak - based on an underlying margin of negative 7%, the inability to borrow more and, notwithstanding the programme of income diversification, selling further assets to raise funds (aside from Chelsea Farmers Market as part of the Trust's redevelopment plans) was unlikely.

RP informed that Board that in the last few days the Trust had received instructions from NHSI to prepare two year (2017/18 and 2018/19) budgets and from NHSE to agree contracts, both on the same timetable, by Christmas 2016.

In response to a question from AVO about what more if anything could be done within our own budgets both NL and RP assured the Board that the senior team had been tasked to keep their 'eyes on the ball' during the period since the last Board strategy session (in April 2016) and that the Board would review progress before the end of December 2016; and also that, as in previous years, there had been a very professional drive to manage costs.

Noting that achievement to date of the FSPs was behind plan, PDd asked what the prospects for recovery were. RCr said the target of £3.5m for clinical supplies was especially challenging though the sum was reasonably prudent. National drives to reduce procurement spend meant the context within which the Trust was trying to make savings kept changing. Thus some sector wide initiatives made sense – for example specialised cardiac devices procurement. The Trust was considering alternative schemes to substitute for savings shortfalls.

BB alerted the Board to the potential gap in the business plans for the next two fiscal years of 10% to 12% in NHS income (if CHD was lost the gap would be 30%). He added that in terms of what 'more' could be done that while pointing a sharp knife at cost reduction might yield from 2% to 5% (as had happened over the last six to seven years) to do something that might get us to 10%, for example by hardening the already challenging thresholds, was just not possible. The alternative was recognising that a fundamental re-thinking about the Trust's sources of income was required, what they mean and how they transfer into what could be delivered.

BB said he also fully expected a return to a block grant system of funding albeit probably rebranded with a different name and that the current mode of payment, 'Payment by Results' (PbR), would be abandoned as the perception was that this had not worked. He cautioned that this could happen quite rapidly (by Christmas 2016) and that this would usher in a demanding period when the Board would have to make hard strategic decisions. In his view the real concern was cash. In summary he said that the Board would have to decide whether to sign up to a new block grant system while sourcing alternative income streams. Wimpole Street and Kuwait had been in the plan for the current year but would be extended into 2018/19 while other things would be on the table such as PP inpatient capacity at both RBH and Harefield Hospital (HH), indeed must be, as the Trust would have no choice

The Board noted the report.

2016/73 DOCTORS' REVALIDATION REPORT

Introducing the report RGM highlighted the different aspects of assurance of the Trust's appraisal and revalidation of doctors including a review visit from NHSE, internal quality audit and the quality assurance audit of appraisals. The Statement of Compliance had been circulated separately.

RJ asked about the 37 doctors not meeting the Trust's minimal revalidation requirements and what that signified. RGM said revalidation took place over a five year cycle and included annual appraisals and 360 feedback (performance-appraisal data collected from 'all around' an employee typically from colleagues and sometimes, customers, or in the case of a hospital, patients). Sometimes the dates, set by the GMC had not coincided with internal Trust processes. Some doctors had not been in the Trust long enough to collect data which meant for example, not all 360s had been collected. This was more challenging for doctors from Europe.

AVO said he noted a low number of appraisal portfolios had been scoped and asked whether this covered the whole of their practice including Private Practice (PP). RGM said while he was pretty confident that PP work was being picked up in appraisals.

At the request of NL, RGM went through each of the ten statements in the Statement of Compliance and detailed where the Board would find assurance. The Board confirmed each statement and agreed it could be signed. NL asked RGM to ensure the Statement of Compliance was included with the revalidation report next time.

KO said an enormous amount of effort and good will had gone into this programme and each year quality changes were made. She commended Nick Brosnahan, former Medical Revalidation Manager and Siobhan Carr, Trust Appraisal lead for the fantastic job done. NL added his personal thanks to KO and RGM.

2016/74 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 in Respiratory Medicine with Expertise in Severe Asthma and had been chaired by LAA who presented the recommendation for appointment. The second, third, fourth and fifth forms were all presented by RJ and were for: a Consultant in Anaesthesia; a Consultant in Anaesthesia and Critical Care; and for the appointment of two Consultants in Critical Care Medicine.

The Trust Board ratified the appointments of:

- Dr Alexandra Nanzer-Kelly as a Consultant in Respiratory Medicine with Expertise in Severe Asthma;
- Dr Fancesca Caliandro as a Consultant in Anaesthesia;
- Dr Orina Kviatkovske as a Consultant in Anaesthesia and Critical Care;
- Dr Clara Hernandez Caballero as a Consultant in Critical Care Medicine; and
- Dr Alex Rosenberg as a Consultant in Critical Care Medicine.

2016/75 PROPOSED SALE OF 151 SYDNEY STREET TO CHARITY

RP introduced the paper and said that the various agreements set out in it had been rigorously examined by the Trust and its lawyers. The Redevelopment Advisory Steering Group (an ad hoc committee of executives and NEDs) had endorsed this transaction at its most recent meeting and recommended it to the Board. In order to proceed, the sale had to be formally approved by the Council of Governors. The Board was informed that 16 out of 20 Governors had given their views and all were in agreement. As a simple majority was all that was required the Council had formally given its approval.

BB said that the sale was not only essential for the Trust to meet the control total stipulation. For the overall allocation to the NHS for 2016/17 the Treasury had stipulated that the sale of surplus NHS assets was a requirement. The Trust would therefore be acting in line with a national strategic direction.

On behalf of the Board NL thanked RJ, GR, and RP who all had worked enormously hard on this project.

2016/76 PROPOSED KUWAIT HOSPITAL MANAGEMENT CONTRACT – BOARD SELF CERTIFICATION

NL asked if all four of the Trust's named consultants had seen the references to them in the Self-Certification. RP confirmed that they all had and that three had written to confirm their agreement (the fourth had not replied).

The Board considered the Board Certification (numbered 1 to 17 in the report). Taking into account earlier presentations and documentation received, the Board authorised the Acting Chairman to approve this Certification. The Board also approved the project risk register and its view that the Accounting Officer's obligations had been duly assessed and fulfilled.

2016/77 AOB

a) RP gave a brief update on the DoH commitment that Trusts consider the sale of surplus lands to provide funds for affordable housing. Sir Robert Naylor*, Chief Executive of University College London Hospitals NHS FT and property and estates adviser to the DoH had informed him that the Trust was in the department's sights and had visited on three recent occasions. They had asked for commercially sensitive information on RBH's plans for Chelsea Farmers Market being used in negotiations with Royal Borough of Kensington and Chelsea. In response, the Trust had said it would provide this information subject to confirmation from DoH that it had no intention of delaying or disrupting our redevelopment planning, and that they would sign a Non-Disclosure Agreement to control against the leakage of this data to other parties. To date these conditions had not been accepted. RP asked, given the current impasse, that the Trust endorse or otherwise maintaining the position adopted to date. The Board agreed that this should continue to be the position of the Trust. NL asked that the Board be kept informed of any developments.

   *[* Note to the minutes: Sir Robert Naylor retired from his post at UCLH on 30th September 2016]*

b) PDd thanked JG who had led him on a walk round of the wards.

NEXT MEETING Wednesday 26th October 2016 at 2.00pm, Boardroom, Royal Brompton Hospital