A lifetime of specialist care

Royal Brompton & Harefield NHS
NHS Foundation Trust

Minutes of the Board of Directors meeting held on 30 March 2016 in the Concert Hall, Harefield Hospital, commencing at 10.30am

Present:	Mr Neil Lerner, Deputy Chairman & Non-Executive Director	NL
	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
	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 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 Tim Callaghan, Deputy Director of Finance	TC
	Mr John Pearcey, Cancer and Thoracic Surgery Service Manager	JP
In Attendance:	Mr Anthony Lumley, Corporate Governance Manager (minutes)	AL
	Ms Gill Raikes, CE Royal Brompton & Harefield Hospitals Charity	GR
Apologies:	Sir Robert Finch, Chairman	SRF

2016/15 DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING

None.

2016/16 MINUTES OF THE PREVIOUS MEETING HELD ON 27th JANUARY 2016

The minutes were approved.

2016/17 REPORT FROM THE CHIEF EXECUTIVE

BB reported that Trust staff were well into planning and preparation for the inspection by the Care Quality Commission (CQC) on 14-17 June 2016 and were presently responding to an extensive data and information request which RCo was coordinating. RCo said that he expected to assemble in the region of 400 documents and that the CQC had asked for Board papers (Part I and Part II), Risk and Safety Committee minutes, and Audit Committee minutes from the last six months.

2016/18 DRAFT OPERATIONAL PLAN 2016/17

RP reported on the significant differences between the Draft Operating Plan (DOP) which had been submitted in February 2016 and the Draft Final Operational Plan (FOP). The condition of the release of Sustainability and Transformation Fund (STP) monies had been contingent on a control total deficit of £2.3m but this was before final tariffs had been published and while NHSE 2016/17 contract proposals had yet to be finalised.

The Trust's view was that this control total could not be achieved and therefore the DOP was submitted with a deficit of £8.8m to Monitor (now NHS Improvement – NHSI) with compelling reasoning. NHSI wrote back recently with a marginally improved control total (a deficit of £3.7m). However, in other respects their position was uncompromising. NHSI's letter had been sent to all Trusts of which, about a third had rejected their control totals while those that had done so had included numerous caveats.

The Trust had continued refining the Plan and some improvements not yet seen by the Board had been reflected in it but it remained a work in progress. Moreover, NHS England (NHSE) had informed the Trust that the margin on locally priced ICDs/high cost devices of c. £3m would be eliminated.

RP said progress to date could be characterised as one step forward and two steps back. The step forward was the continuation of work on cost management with an upside on income (albeit with increasing contingencies) but the environment was one of planning under stress. As of today with only two full calendar days remaining in the current financial year, the Trust was still waiting to hear from NHSE on the 2016/17 contract and yet the Trust was expected to submit the FOP by 11th April when it was inconceivable we will have reached agreement with NHSE (and the contract deadline was 31st March 2016).

RP recommended that the Trust proceeded to pull together what it can based on what is concretely known by the middle of the week commencing 4th April and that a Finance Committee be held on Wednesday 6th or Thursday 7th to review and approve so that the FOP submission would be made by Friday 8th. The Board agreed to this procedural proposal.

RP said the budgeted deficit for the FOP of £15m (which reflected what was known at 23rd March) was based on the assumption that 151 Sydney Street would be sold and realise £20m. A £15m deficit would all else being equal reduce cash by £15m adjusted for depreciation and this effect on cash flow had to be considered in the light of NHSE having a history outside the block contract of being a poor payer.

AVO asked if it was known whether the Trust was coming off a block contract as from midnight on 31st March. NH said this was unknown but if this happened the cap would be removed. In order to address the gap between NHSE's national budget for specialised commissioning and the budgets of the specialist providers it was expected that there would be a transitional arrangement. RP added that the contract assumption in the FOP would be on a cost and volume basis.

Responding to further comments from Non-Executive Board members RP further clarified that:

- The FOP did not reflect the elimination of the £3m margin on devices. However, a reference to further risks alluded to the discussions on this and it was known that it was a threat. There had though been an NHS income upside as well so the level for net tariff movement was unchanged.
- Cash would be sustained during 2016/17 provided 151 Sydney Street was sold for a minimum of £20m. After that loans would have to be repaid and the cash problem would become serious. NH added that there was no immediate problem as NHSE would be paying us next month.
- As a result of negotiations the tenants of this property and also Chelsea Farmers Market had been given flexibility by being given six to twelve months' notice.
- To date RP was not aware that any of the Trusts who had accepted their control totals with conditions had been challenged on those conditions. There was no apparent advantage in accepting with conditions as opposed to not accepting because a failure to achieve the control total meant the S&T funding would not be received. His assessment was that the Trust could not craft a credible plan with conditions as this would have to be based on 'heroic' assumptions.

Noting that for 2016/17 FSPs and service improvements had been thoroughly examined to see if this could reduce the shortfall, the Board discussed whether further measures such as reductions on head count and back office (and also sharing back office with other Trusts) needed to be taken to reduce the deficit including clinical and non-clinical spend.

AVO was of the view that actions had to be taken for 2016/17 as selling properties to fund deficits could not continue and he had noted that other Trusts were reducing staff. KF said he had observed that the long term game plan of the NHS was to encourage the sale of property and therefore the sequential sale of land/property and use of the proceeds to provide cash was their preference rather than the sale of a specific asset for new build (in our case the sale of Chelsea Farmers Market to build on the car park).

RP reminded the Board that under contract the Trust was obliged to deliver services when the margin was wafer thin and in his view the Trust was already close to being as lean as it could be. A further reduction in clinical payroll costs which amounted to 80% of the total staff pay bill would only lead to a loss of income.

As to selling property, RP said his view was that there was no overarching game plan yet in place. He informed the Board that a letter was being sent later that day to Jonathan Fielden, Director of Specialised Commissioning (NHSE) which would be jointly signed by the Trust and other specialist Trusts ostensibly in the same position as RB&HFT. These were Great Ormond Street Hospital, UCLH (National Hospital for Neurology and Neurosurgery), the Royal National Orthopaedic Hospital and Moorfields Eye Hospital. The letter set out the arguments and pressures these Trusts faced and from our perspective it was hoped that when HRG4+ was finally planned and delivered, these issues would have been included in its design.

BB said the outcome of the plan as set in the report would most likely lead to an external audit review by NHSI which would consider if the Trust had reduced enough staff and sold enough assets. In some respects this was the Trust inviting this to happen and as a consequence of meetings with NHSI which, while amicable,

revealed a lack of empathy on their part in relation to the Trust's situation. He added that as the Trust's Chief Executive he could not propose reducing the scope and quantity of service. The imperative was to deliver the business plan as the Trust had demonstrably done for 2015/16. By proposing to maintain quality and the range of service in the plan the Trust was exposing the issue of underfunding.

The Board then discussed Wimpole Street and Kuwait and heard from BB and RP that in relation to the former the risks were as stated in the plan and the project was moving forward; and in relation to the latter that recent progress had been made towards acquiring a tax exemption certificate and the expectation of signing of the contract by July 2016. Both assured the Board that the assumptions were balanced and the risks were made clear in the FOP. RCr added that the capacity numbers for Wimpole Street were conservative initially but were set to improve significantly after 2016/17. KF was concerned that the benefits may not be realised and questioned whether the inpatient capacity would be there. BB reminded members that the plan showed Wimpole Street would not make money in 2016/17, and probably not until the second quarter of 2017/18 but if the challenge to provide the beds could be met, the capacity for future income growth was there.

NL said this highlighted the need to look at how the Trust would survive in future years and suggested a brainstorming session would help shape the strategy. As the imperative was to ensure the Trust was a viable entity going into 2017/18 then this debate should take place within the next two months. It was agreed that a seminar would be convened before the end of May to which (following a suggestion made by AVO) appropriate clinicians would be invited. BB said the focus should be on revenue and income as focusing on cost and expenditure would not bring sufficient value and he reminded the Board that clinicians were already engaged in the process as members of the Management Committee.

BB confirmed that the Trust was not as yet part of a five year Sustainability and Transformation Plan (STP) and was waiting to understand the STP it would be assigned to. RP said the deadline was the end of June so an STP would be put in place. The steer from NHSE was it would be with NHSE and other specialist Trusts.

The Board noted the report and agreed to delegate authority to the Finance Committee to approve the Final Operational Plan for issue to NHSI by the deadline of 11th April 2016.

Action: issue FOP to NHSI by the deadline of 11th April 2016 (RP).

2016/19 <u>CLINICAL QUALITY REPORT FOR MONTH 11: FEBRUARY 2016</u>

NL commended RCo on the high quality of the report, said that he expected that people had read it and invited questions.

LAA said that, the outcomes for patients as a result of Serious Incidents had been omitted and this had occurred again despite her raising this issue previously. If the outcomes were not known then that should be stated. JG said the Risk and Safety Committee (RSC) discussed the outcomes but acknowledged the point.

PD asked for a commentary/explanation on the Cancer 62 Wait Weekly Dashboard (14th March 2016) RCo said that this was a new dashboard published by NHSI and NHSE which showed how the performance of the Trust against this indicator was viewed by the regulator and the main commissioner. A letter from Monitor received

on 24th March 2016 had stated that the anticipated National Cancer Breach Allocation protocol would be introduced during 2016-17. The guidance refers to a target time of 24 days for treatment by specialist centres. In response to a query from NL about what the 'agreed time lines' were as referred to in the Cancer Dashboard RCo said this was in relation to cases not treated within twenty days, [that being the shadow performance metric used during the transitional period between December 2015 and March 2016].

RJ asked a series of questions and the responses in summary were

- JG confirmed that the review of Clostridium difficile cases scheduled for 22nd March 2016 had been rescheduled to May by NHSE but it was hoped that it could be brought forward to April. (NL commented that the new process was working well and he had no reason to believe it was not satisfactory).
- JG gave more information on the infection outbreak in AICU. The outbreak came from an unusual organism which has not been recorded as an outbreak in the UK before, although routine screening for this organism is not in place in other hospitals. A detailed action plan is in place and the Trust was working with Public Health England (PHE) on developing protocols. We have seen more patients with positive screening in the last three months. Patients were predominantly 'colonised' but some had grown the organism in their bloodstream. She added that it was important to remember that these patients are on Critical Care because they were very sick, which makes it more difficult to understand the clinical impact of this organism on this group of patients. JG assured the board that extensive infection control measures were on-going, and the situation was being closely monitored and managed. RGM supported this assessment and said there had been an outbreak in the Far East. It was agreed that the Board would receive an update at its next meeting following a discussion at the RSC first.
- The second radiation incident reported was similar to the first one and they had occurred within fourteen days of each other. NL confirmed that the RSC had looked at it and had been assured there was a process in place. This will be discussed further at the RSC in April, where the annual report is being presented.
- RCr agreed that it was good news that there were no breaches of the pledge to offer another date within 28 days of a cancelled operation and said the Board could draw comfort for the plans in place to reduce the overall number of cancelled operations. The Trust would continue to try and do as much as it could to reduce them. There had been a reduction in theatres, catheter labs and bronchoscopy suite at the Royal Brompton Hospital (RBH) site and there had also been a reduction at HH compared to previous peaks. This remained a quality priority**.** NL proposed a paper come to a future Board meeting and this was agreed**.**
- Responding on behalf of Carol Johnson (CJ), Human Resources Director, JG said actions were in place to address the Trust's standing in the top 20% of Trusts with staff experiencing harassment, bullying or abuse. With CJ she was working together in the next month to look at the very specific working areas where there were problems and it was anticipated that this would be higher on the agenda and a report brought to the Board sometime this year. BB pointed out that the CQC were likely to focus on the indicators in the Learning From Mistakes report when they inspected the Trust in June. He proposed that the report be brought forward to the next board meeting. This was agreed.

AVO noted his concern over the decrease in the number patients referred for cardiac surgery treatment completing their pathway within 18 weeks for cardiac surgery and

asked if this was a function of funding issues. RCr confirmed this and said that if NHSE commissioned sufficient activity, the Trust would meet the target.

AVO congratulated the Trust on achieving a 35% response rate for the Friends and Family Test in February 2016.

The Board noted the report.

Action: update on Serious Incidents to be provided to the Board on 27th April 2016 (JG).

Action: paper on cancelled operations to be included in a future Board meeting (provisionally 25th May 2016) (RCr).

Action: paper on actions to address harassment, bullying and abuse to be included in the Board agenda on 27th April 2016.

2016/20 LUNG CANCER SERVICE PERFORMANCE OVERVIEW 2015/16

John Pearcey (JP), Assistant General Manager Lung Division, presented the report on behalf of Dr Andrew Menzies-Gow, Clinical Director for the Lung Division who had not been able to attend today. He re-emphasised the points made in the executive summary that RB&HFT was the fourth largest centre in England for primary lung cancer resections and the mortality rate (for 30 days and 90 days) was much better than the national average. The overall surgical approach for lung resection at the Trust was also better than the national average, which contributes to better quality of life and improved post-operative outcomes for our patients.

NL asked if the report demonstrated that the regulators were measuring the wrong thing. JP said that waiting times are still an important indicator for the Trust but that the clinical outcomes were also as important to monitor. RGM concurred and said that for lung cancer in the UK it was not the 62 Day target that was the main issue, but the late detection of patients suitable for surgical treatment. Currently only 15% were detected earlier enough for lung cancer surgery as a whole. He added that whilst it was important to operate as early as possible, this alone was not the solution to lung cancer. What the Trust was attempting to do was show it was delivering a good service as it worked towards greater compliance.

Noting the contents of the report the Board acknowledged that the imperative was the outcomes – generally good - despite the complex and unwieldy process surrounding the reporting of the indicator, and that the paper gave a balanced view. Board members were also assured that, overall, the future of the service was very good.

2016/21 FINANCIAL PERFORMANCE REPORT FOR MONTH 11: FEBRUARY 2016

RP presented the M11 report which summarised the financial performance of the Trust to 29th February 2016.

The Board noted that the February headlines were better than budget and that NHSE underperformance had been offset by a compensating adjustment; Year to Date (YTD) the Trust was almost on plan (deficit of £11.7 against £1.5m); the year

outturn (deficit of £10m) was almost spot on; and that cash and liquidity were currently stable.

PD noted that the agency target was a tad over 8% and asked what the consequences were of the Trust breaching NHSI's cap on agency costs. RCr said the use of agency would continue to be higher than the figure assigned by NHSI with pressure in nursing particularly critical care (adult and paediatric). He added that steps had to be taken to improve this but the breaches would continue albeit by not much and not to the extent of the last six to twelve months. NHSI had signalled that the cap would ratchet down from 1st April 2016. Some of the Trust's agreements with agencies addressed this, some did not, and inevitably staff were selective about the agencies they worked for.

LB said he was supportive of achieving the planned deficit for 2015/16 of £10m as this would the Trust leverage in its dealings with NHSI. RP said that we might be reporting £10.3m or £10.4m but certainly not an £11m or £12m deficit.

The Board noted the report.

2016/22 CAPITAL INVESTMENT PROGRAMME 2016/17

RCr presented the paper which he emphasised remained a draft. The programmed totalled £21m with £19m in 2016/17 and £2m into 2017/18. In addition £8.6m had been deferred from 2015/16 to 2016/17 to complete Wimpole Street development and for the Critical Care and Imaging Centre at HH and a further £2m deferred from 2015/16 to 2017/18 to complete the Imaging Centre. The final programme would be submitted alongside the FOP.

LB asked about investment in private facilities at Harefield Hospital. RCr confirmed that total new investment of £5.4m was planned, provisionally split £3.4m in 2016/17 and £2m in 2017/18. Final costs were awaited, but the current expectation was that the new facility would be available in approximately twelve months' time.

AVO asked what was the timeframe for depreciation of the scanners included in the plan. RCr said this was generally 7-10 years – but one of the existing scanners was 14 years old. RP added that some of the scanners would be on seven year operating leases.

The Board noted the report and agreed that submission of the Capital Investment Programme alongside the FOP should be delegated to the Finance Committee.

2016/23 AUDIT COMMITTEE (AC)

(i) REPORT FROM MEETING HELD ON 22 FEBRUARY 2016

NL noted that this continued the good practice of ensuring the full Board had sight of the Audit Committee minutes while recognising that they were still unconfirmed.

(ii) UNCONFIRMED MINUTES FROM THE MEETING HELD ON 22 FEBRUARY 2016

The minutes were noted.

2016/24 RISK & SAFETY COMMITTEE (RSC)

(i) REPORT FROM MEETING HELD 22 FEBRUARY 2016

AVO drew attention to two 'good news' items. As part of its continuing promotion of improvement and excellent initiatives across the Trust, the committee had received a

brilliant presentation on a project to redesign Cystic Fibrosis Outpatients and noted that this had resulted in nine additional patients being reviewed each week. AVO, in the context of the earlier discussion on the 62-day target for definitive treatment, also re-emphasised the Trust's better than predicted survival rates for lung cancer surgery and consistent ranking above average on patient experience in the National Cancer Patient Experience Survey

(ii) UNCONFIRMED MINUTES FROM THE MEETING HELD ON 22 FEBRUARY 2016
The minutes were noted.

2016/25 REGISTER OF DIRECTORS' INTERESTS
The Board confirmed the accuracy of the report.

2016/26 RECOMMENDATIONS OF ADVISORY APPOINTMENTS COMMITTEE
The Board were presented with two ratification forms for the appointment of consultant medical staff. The first related to the appointment of a Consultant Paediatric Cardiologist and Lead in Paediatric Echocardiography and had been chaired by NL who presented the recommendation for appointment. The second was presented by RGM (on behalf of Pr Dudley Pennell who had chaired the Committee as KO was unable to attend at short notice) and was for a Consultant in Paediatric Cardiomyopathy.

The Trust Board ratified the appointments of:
- Dr Giovanni Di Salvo as a Consultant Paediatric Cardiologist and Lead in Paediatric Echocardiography; and
- Dr Inga Voges as a Consultant in in Paediatric Cardiomyopathy.

2016/27 APPROVAL OF BAD DEBT WRITE-OFF
RP said that in accordance with the Trust SFIs (Standing Financial Instructions) the two proposed write-offs over £50k had been recommended by the Finance Committee for approval by the Board. NL said that while in this instance a 'lessons learnt' exercise had not been undertaken, the next time the Finance Committee received a report on write-offs the members would be looking for a detailed 'lessons learnt' report.

The Board approved the write-offs of the two debts over £50k each as set out in the report.

2016/28 AOB

a) RP said that Board members had each been sent a copy of a report from the Trust's lawyers Hempsons in relation to the NHS Surplus Land Collection Return for 2016. Their report had been issued subsequent to the distribution of Board papers for this meeting. The report followed a meeting of the Redevelopment Advisory Steering Group on 21 March at which the requirement for the Trust to complete and submit the return was discussed: it was decided that legal advice should be sought. RP added that the substance of Hempsons' advice as he understood it was that, although the Trust was not legally obliged to complete and submit the return, it would be advisable to do so. RP said the definition of 'surplus land' was very broad and included all non-operating lands and buildings. He proposed that the Trust report the sales of 151 Sydney Street and Chelsea Farmers Market as these were already known and an undefined part of the forty

acres at Harefield Hospital and make it clear that the plan for the Chelsea properties was to reinvest in clinical facilities.

NL said he supported this as did KO who felt the risk was greater if we did not make the return. RJ said as the Chelsea properties currently produce income there should be a note that this is used to support health services. He pointed out that selling 151 Sydney Street would mean the Trust forfeiting future rental income. RP confirmed this but responded that the Trust's pressing cash flow needs represented a more important factor in the business case supporting the sale of the property. He added that the decision had been made on 151 Sydney Street but not on Chelsea Farmers Market. BB said the Trust was on the record regarding 151 Sydney Street and on the record that he had complained that Crossrail 2's plans for the station had blighted Chelsea Farmers Market. However, to the best of his knowledge, the Trust was not on record as regards the disposal of any land at HH and no reference had been made to the approach received from a third party (Kent Health Sciences). RP said this was correct with reference to 151 Sydney Street.

b) RP reported that he had received revised unsolicited offers for CFM and 151 Sydney Street via a law firm which appeared to be representing an individual who had previously proposed a land swap with the Trust. The offers were conditional on the Charity agreeing to sell 250 King's Road and on Crossrail 2 not proceeding on these sites. If Crossrail 2 did proceed the buyer(s) would put the properties back to us. RP said he did not propose to respond to these unsolicited offers. The Board noted this item and endorsed RP's proposal.

c) KO asked if the seminar planned for late May could also examine income generation from other sources. This was agreed.

2016/29 QUESTIONS FROM MEMBERS OF THE PUBLIC

Noting that the Trust was suffering adversely from the effects of the Junior Doctors dispute, HS2 and bad debt from NHSE, Mike Gordon (MK) asked if an extraordinary item could be added to the Accounts that stated that the losses had occurred through no our fault of the Trust's. He urged the Trust to respond to the tough stances being adopted by the commissioners and regulators in a like-for-like manner.

NL said in reality NHSE was the Trust's only major (funding) customer. RP said that from a pure accounting point of view such an item could not be included but that did not preclude some comment being included in the body of the Annual Report. He added though that it was difficult to identify who was the 'villain of the piece'.

NEXT MEETING Wednesday 27th April 2016 at 10.00am, Boardroom, Royal Brompton Hospital