A lifetime of specialist care

Royal Brompton & Harefield NHS
NHS Foundation Trust

Minutes of the Board of Directors meeting held on 30th March 2017 in the Concert Hall, Harefield Hospital, commencing at 10.30 am

Present:	Baroness Sally Morgan, Chair	SM
	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 Jo Thomas, Director of Communications and Public Affairs	JT
	Ms Joanna Smith, Chief Information Officer	JS
	Ms Jan McGuinness, Dir. of Patient Experience & Transformation/Interim HR Dir.	JMc
	Mr Tim Callaghan, Deputy Director of Finance	TC
In Attendance:	Mr Anthony Lumley, Corporate Governance Manager (minutes)	AL
Governors in Attendance:	None.	
Observer:	Ben Horner, Principal, The Boston Consulting Group (BCG)	BH
Apologies:	Mr Neil Lerner, Deputy Chairman & Non-Executive Director	NL

2017/14 DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING

None. SM announced that a Part II meeting would be held immediately following this meeting for a discussion on strategy.

2017/15 MINUTES OF THE PREVIOUS MEETING HELD ON 25th JANUARY 2017

The minutes were approved.

2017/16 REPORT FROM THE CHIEF EXECUTIVE

BB announced that a new Director of Human Resources, Lis Allen, had been appointed and she would be commencing work in April. On behalf of the Board he acknowledged the sterling contribution of Jan McGuiness in covering this post in between the substantive appointments.

BB updated the Board on the Congenital Heart Disease (CHD) Consultation led by NHS England (NHSE). On Friday 31 March Professor Huon Gray, NHSE's National Clinical Director for Heart Disease, and Will Huxter, senior officer for the CHD review were hosting an open staff forum at the Royal Brompton Hospital (RBH) site to present on the status of the review and hear feedback and comment from Trust staff. RCr added that as there was likely to be substantial interest but the capacity of the room being used was limited to a hundred and fifty people. The session was therefore being recorded and would be made available on the staff intranet.

AVO asked, as it had been included on the agenda at the last meeting, if there was an update on the North West London Sustainability and Transformation Plan (NWL STP) and the status of the contract. BB said there was nothing official to report and the Board heard that the Trust continued to attend STP meetings on specialist services with NH and RP in attendance. NH reported anecdotally that, at a recent Hillingdon Health and Wellbeing Board meeting, a local councillor had expressed the view that the STP process was effectively 'dead'. SM added that a strategy update was due this week which could lend credence to this opinion while RP, who attended NWL STP finance and board meetings, attested to the volume of papers and meetings but characterised forward progress as glacial. BB said it was still the case that the Trust was being pressurised to sign the contract. The Board was assured by RP that this had become less of a concern with risk sharing apparently being defined as over performance and under performance both set at 70% rather than any threat that the Trust could be obliged to contribute to bail outs of other NWL providers.

2017/17 FINANCIAL PERFORMANCE REPORT FOR MONTH 11: FEBRUARY 2017

RP presented the M11 report which summarised the financial performance of the Trust to 28 February 2017.

The Board noted the key headlines:
- a deficit of £3.9m against £2.4m the main factors being the absence of a contribution from Kuwait while Wimpole Street was also behind in terms of footfall and referrals, and NHS income was also off plan.
- Year to Date (YTD) there was a £15m deficit which was about £4m worse than plan and £4m worse than needed to achieve the control total, a result which was flattered by the £4m extra gain on sale of 151 Sydney Street (so effectively the Trust was £8m off plan). Kuwait, Wimpole Street and NHS, in particular paediatric surgery both inpatient and critical care, were again responsible for income shortfalls. - While savings were being made, costs were proving stickier than income. In terms of the full year outturn to achieve the £7.5m deficit control total a particularly strong final month in 2016/17 was required but this was not anticipated from operational performance.
- Update on the pound for pound (£ for £) incentive scheme offered by NHS Improvement (NHSI) for over performance against the Trust's 2016/17 control total. The Finance Committee recently had two days earlier received an illustrative paper which gave some assurance this could be achieved and that the Trust would thereby achieve a benefit. The Royal Brompton and Harefield Hospitals Charity (the Charity) had given the Trust £2m which had been banked. An additional revaluation surplus on Chelsea Farmers Market would be accounted for in the Income and Expenditure budget.
- In summary, as a result of these combined efforts, the Trust should come in with a small overall surplus, subject to confirmation at the next Board meeting on 26 April 2017 and subsequent audit.

LB said the assumptions had been thoroughly tested at the Finance Committee meeting referred to above. He had a good deal of confidence in the outcome RP had described and the Non-executive Directors stood firmly behind their Executive counterparts.

AVO concurred that this was pleasing but noted that 2018/19 was still set to be a crucial year (financially) and that pressure on cost controls would have to be maintained.
The Board noted the report.

2017/18 REFRESHED 2017/18 – 2018/19 OPERATIONAL PLAN (THE 'PLAN')

RP presented the report and outlined the context. Earlier in March 2017 NHSI had called on all Trusts to refresh their plans as a result of an expected deterioration in the outcome for 2016/17 in the provider sector as a whole - hence this paper and the requirement for the Board to approve the Plan before its submission by midday today (30 March 2107). The Trust still accepted the control total for the forthcoming financial year (2017/18). However, the decline in 2018/19, which the Trust Board had noted in the earlier Plan submission, was still expected and the related control total was therefore still not agreed by the Trust. RP said the regulator appeared to be focused on the 2017/18 rather than 2018/19.

The Board noted the changes to the Plan as described in the accompanying paper and then asked questions.

Noting that one of the changes was that a contribution from Kuwait had been removed, RJ asked if the Board could hear more about the cause of this. BB described how a change in regime in the country (right at the end of 2016 and the beginning of 2017) had greatly affected the work the Trust had been putting in over the last eighteen months. The new minister of health had called a halt on all previous commitments and practices which included ours. These other commitments had included major hospital infrastructure projects which had been mired in fraud allegations. The Trust was left with no alternative but to follow the advice of the client and put in a pause. The client still wanted to engage with the Royal Brompton & Harefield NHS Foundation Trust (RB&HFT) in terms of development and training and a scope of work with terms and conditions was being put together. The aim was still for a management contract over three years but prospects of this being achieved were now significantly reduced at least in the short-term.

LAA said that when the Board had previously discussed Kuwait the risk of political change had been identified but now it was unclear how that translated to the budget process. She asked if we had 'missed a trick' and what were the (missing) mitigations. BB said that the expected income was previously factored in from the second half of 2016/17. Then the risk was reassessed that no income would be realised until post 2018 and in this 'refreshed' Plan Kuwait had been taken out. RP expanded and said the budget had been adjusted accordingly and the Kuwait contract removed not as a loss because whether the contract would commence at some future date (or not) was not yet known. He added that the mitigation was the exclusion of all related costs from the Plan. SM said it appeared that the whole Board had taken a decision cognisant of the risk as set out in the risk register. It may be appropriate for the Audit Committee to look at any lessons that could be learned from this. LAA accepted these points.

KF asked why Wimpole Street had been less successful than expected and whether it was as a result of lower than projected footfall or because there had not been enough staff engagement. In response BB said the Trust had got its projections wrong and to some

extent was hampered by a lack of expertise and knowledge having assumed the conversion rate would follow similar patterns. As to uptake, some of this had been more than expected some had not. An example of the former was a higher than expected demand for imaging. As for staff engagement, there was a bifurcation with some willing to go, others not. The former, typically, were assertive and forthright younger consultants, the latter were generally older and had established private patient practice at RBH. Last month some consultants not from our Trust accepted appointments for Wimpole Street. Private Patient (PP) activity was flattening out with moderate demand from overseas patients and as the effect of 'Brexit' was felt. This was a pattern experienced in major private hospitals. PP inpatient activity at RBH was, in contrast, steady.

Noting that the advantage at Wimpole Street was based entirely on inpatients and that the Trust's outpatient facilities were not large enough KF said that replacing consultants would not help a translation into inpatient referrals. This, therefore, was in his view still a concern. He asked if plans to approach other institutions to extend private inpatient bed capacity were still being pursued. BB said that specific discussions with Bupa had not ended and he acknowledged that the premise of KF's comments was correct. It remained the case that it was very likely RBH's private outpatient facilities would be decommissioned during RBH redevelopment works (and this probably was only a year away). Senior Consultants at RBH were currently not willing to move but they would be forced to reconsider as they would still have to find space to treat their PPs.

AVO gave some intelligence on the current state of the market – while the international market was suffering UK insured numbers had started to go up as people noted the escalating pressures in the NHS. He reiterated his concern for the future expressed under discussion of the Finance Report for M11. Moreover, the Trust could become too reliant on the support of the Charity and sales of estate to mitigate the worsening financial situation. LB said (in giving his own assurance to the Board) that the Trust would not sign off 2018/19 in the shape it was currently in and transformation was essential to ensure the organisation remained a going concern. BB said that in part of the Plan for 2017/18 there was still mention of the intention to open additional PP inpatient facility at Harefield Hospital (HH) and that some of that income was included in the Plan.

In response to a question from PDd on whether the Trust was implicated in any allegations of fraud in Kuwait, BB stated for the record that the Trust did not know if fraud had taken place.

The Board approved the report and the submission of a refreshed Plan to NHSI by the deadline of noon today (30 March 2017).

Action: submit Refreshed Operational Plan 2017/18 – 2018/19 by midday 30 March 2017 (RP)

2017/19 THE BOSTON CONSULTING GROUP (BCG) – PRESENTATION

The Chair had allowed for the inclusion of this additional item which was an important follow up to the discussion under the preceding item. RCr introduced Ben Horner from BCG and gave the context to the presentation which was about the Trust's (not BCG's) plan, with support and challenge provided by them. BH delivered the presentation and described how the Trust had been involved in shaping the points behind the "Ready, Willing and Able" (RWA) survey. One hundred 'leaders' within the Trust had been sent a specific survey and a shorter version had been circulated to all staff. Almost 300 replies had been received. BH

said that he felt that, even in the areas in RWA where there was less confidence they could be delivered, the ability and readiness to tackle them was present. In the initial prioritisation matrix, there was enough opportunity to address the challenge. All areas were under scrutiny but there had been a lot of focus on clinical areas. RCr expanded and said the focus had been on the cost base rather than income. BH said there had been an 11% growth in staff numbers across the organisation since 2014/15. In parallel, inpatient income had only gone up by 6% and inpatient activity was no longer growing. This did not give all the answers, but showed where the opportunity lay. Initiatives were already starting in Cath Labs and Theatres, inpatient flow and day case activity.

The Chair invited comments and questions from Board members.

LB asked if the Medical Director and Director of Nursing were assured that these projects were sufficiently embedded already. (LAA supported this question and asked how it could also be viewed from the patients' perspective and the degree of their involvement). JG said that while no formal work with patients had been carried out this could be very helpful going forward for specific projects. She added (and in response to a further point from LAA that the staff group needed to be very positive with patients on the challenge) that some patients did not like changes, and managing their expectations as part of the process was essential. RGM acknowledged that behind the question was an implication that there was a lot of work to be done. He assured the Board that all the clinical directors and he himself were absolutely committed to change. The Board also noted RGM's points that patient choice impacted on plans; complete rigour was needed in all aspects of patient flow; the input of the new Director of HR in recruitment, retention and role-changes would be important; the benefits of changes in IT processes had to be felt; and that, overall, it could take one to two years for the benefits to be realised.

The Board discussed how the headlines in this presentation could be integrated with the key points from the Care Quality Commission's (CQC) inspection report so that there might be one story, one action. JG said the CQC recommendations, for example on theatres, were very specific but agreed that it should be one programme of work.

KF said the focus on growth in WTE consultant staffing (in the presentation) was unfair - in comparison to ten to twenty years ago there had been a huge increase in workload and regulation and the differences even from three or four years ago were significant. He also thought that identifying cath labs, theatres and day case as sources for greater efficiency was a well-worn theme. Consultants not working hard enough because of increased patients may not be within their scope to address. RGM agreed that pressures on consultants had increased exponentially. However, the slide was designed to illustrate that income had become flat but WTE was going up. The skill mix between consultants and Junior Doctors on the Health Education England contract and Trust Doctors would be reviewed. In addition there were some overlaps in tasks with specialist nurses. A 10% vacancy rate in Junior Doctors highlighted the fact that it was becoming more difficult and expensive to recruitment good quality junior medical staff in some Specialties.

RCr said the workforce slide was intentionally stark to provoke comment. It had not been BH's intention to imply that consultants were not working as hard as they had been. Addressing the point KF had made that some of the proposed target for savings had been seen before, RCr said changes had been made before but had not always been sustained. It was not just about delivering savings but also doing some things better than we currently do – for instance having a dedicated day-case facility might appear to be an obvious solution,

but the facility was not essential whereas changing the mindset was. SM said the points made in mitigation of consultant practices and the novelty of the changes proposed were all valid but it was still obvious that there had to be some sort of change.

Other points raised by Non-executive Directors included the impact of more 'industrial' processes which could result in more cancellations (PDd); the importance of engagement of clinical staff who may feel there is too much administration and management, and the impact of the new tariff which meant that the delivery of some very complex work was costing us more than we are gaining (AVO); and that the survey had revealed that there was the energy within the Trust to back the approach BCG had set out and which chimed with the energy in this meeting, though maintaining this was a leadership challenge (KO).

In response to some of these points RCr said the proposed changes should reduce cancellation rates; and that corporate areas would not be immune. On tariff income, NH said that he had previously reported that when details of the new tariff were released, there was a benefit of £6m by optimising HRG4+, but outpatients and specialised top ups had gone down by the same amount. However, a task group comprising Divisional Directors, General Managers, Finance staff and Coders had begun work to ensure clinicians could better record co-morbidity data - with more recognition of more complex procedures more income should be realised. This was work happening now. In addition, a live debate about the 'mitraclip' programme (which NHS England had stopped funding) was taking place. It was an area of expertise in the Trust as part of a comprehensive valve service, and may be funded again in future – but skills and teams could be lost in the meantime if the service could not continue.

BB said there were two variables of what had to happen: being more efficient and therefore saving money and reducing cost, versus the imperative about transformation. If the Trust was under special measures (i.e. direct intervention into the management of a provider by NHSI) we would be expected to focus on a cost saving job within a narrow period of time. However, the Trust was not under immediate threat of special measures nor was it forecasting as such for the next two fiscal years. To achieve transformation the Trust needed to ensure that undue pressure from commissioners and regulators was kept down. The Trust was undoubtedly carrying some dead weight, excess costs and inefficiencies. The Trust had initiated this programme and he suggested that it was the role of the Board to hold the Executives to account on the programme and to show them examples of transformation as they emerged.

BB added that the Trust had to reconceive how it can achieve transformation taking into account the CQC review and the BCG exercise.

2017/20 PATIENT/FAMILY EXPERIENCE ITEM: LONG TERM VENTILATION – SUMMER'S STORY

The Board viewed a video for this standing item which enabled the Board to hear direct patient or family feedback on a service or experience. The Board welcomed the video and continued to find that the format was helpful. SM thought that it would have benefitted from more focus on what we do. LAA said it raised questions on what happened to the patient in the end. RJ said it was a good presentation and was definitely not just for the Board but agreed that it lacked context, specifically what went wrong and what was done. RGM acknowledged that the Board could have had more detail on the Healthcare at Home programme and how the programme shortened visits to hospital. This was about a clinical pathway programme that had also been put into ECMO as well. RCr expanded and said the video had showcased a transformation opportunity. Although only small numbers of children were involved the principle was relevant to other services.

2017/21 CLINICAL QUALITY REPORT FOR MONTH 11: FEBRUARY 2017

RCo presented the report. He explained why the Friends and Family Test and Nurse Staffing data were back in the paper. The principle was that data should not be reported outside the Trust until reviewed internally first.

SM invited Board members to ask questions.

PDd asked if the numbers for 18-week Referral-to-Treatment were satisfactory. RCr referred to the commentary on the quality of reported RTT data and said that the PAS Implementation Group continued to oversee the challenges and corrective actions being taken; he was able to report that steady progress was now being made. He could not accurately predict when the all data and reporting challenges would be resolved – but he was confident that by the time the Lorenzo PAS system had been in use for a year (mid-July 2017) there would be much greater consistency and reliability in data recorded in and reported from the system. RJ asked if NHSI and NHSE were happy with this situation. NH said he attended the Clinical Quality Review Group with JG, RCo and Dr Libby Haxby, the Trust's Lead Clinician In Clinical Risk. The group was fully up to date and happy with progress and had been able to communicate this assurance to NHSI.

RJ said he had noted a seemingly pleasing trend on cancelled operations and asked if this was likely to be maintained. RCr said the improvements in reported performance were creditable and the trend should be able to continue.

The Board noted the report.

2017/22 AUDIT COMMITTEE (AC)

(i) REPORT AND MINUTES FROM MEETING HELD ON 21 FEBRUARY 2017

KO presented the report on NL's behalf. There were no questions.

(ii) UNCONFIRMED MINUTES FROM THE MEETING HELD ON 21 FEBRUARY 2017

The minutes were noted.

2017/23 RISK & SAFETY COMMITTEE (RSC): REPORT FROM MEETING HELD 21 FEBRUARY 2017

AVO gave an oral update and highlighted the following: the committee had received an update on the CQC Action Plan, reviewed Serious Incidents and considered the Risk Register. The Trust, alongside other hospitals across the UK, had been required by NHSE to contact patients who had heart valve replacement or repair surgery, or a heart or lung transplant, since January 2013 to alert them to a potential, but very low, infection risk from a bacteria called *Mycobacterium chimaera* linked to a device used to heat and cool the blood during surgery. It was estimated that only about 1 in 4,000 patients would develop the infection. For RB&HFT this entailed contacting about 3,500 patients and the Trust had begun monitoring and dealing with responses. To date there had about thirty calls but with non-specific concerns. The media had not covered the story extensively. The RSC had also looked at the Quality Priorities for 2016/17 and also the Quality Account indicator form KPMG. Finally the committee had been given an update on the cancer service review and had looked at medico/legal claims. It noted that over the last ten years the Trust had received a comparatively small number of claims.

2017/24 REGISTER OF DIRECTORS' INTERESTS

SM reminded the Board that this paper was presented on the basis that it was accurate and also covered related party transactions.

The Board confirmed its accuracy.

2017/25 RECOMMENDATIONS OF ADVISORY APPOINTMENTS COMMITTEE

The Board were presented with six ratification forms for the appointment of consultant medical staff. The first and sixth forms related to the appointment of a Consultant in Radiology and a Consultant Cardiac Surgeon and had been chaired by RJ who presented the recommendations for appointment. The second form was presented by AVO and was for a Cross-site Consultant in Cardiac Electrophysiology. RGM (on behalf of NL) then presented the third form which was for a Consultant in Respiratory Medicine with Expertise in Lung Failure. The fourth and fifth forms were presented by PDd and LAA respectively for a Consultant Congenital Cardiac Surgeon with Expertise in Adult Congenital Heart Disease and for a Consultant Paediatric Cardiologist/Electrophysiology.

It was agreed that the new Director of Human Resources should examine the recruitment process – there were merits in a two stage process (when a candidate is interviewed and then observed in practice) which had been used in the recruitment of some consultants.

The Trust Board ratified the appointments of:
- Dr Sujal Desai as a Consultant in Radiology;
- Mr Sunil Bhudia as a Consultant Cardiac Surgeon;
- Dr Shouvik Haldar as a Cross-site Consultant in Cardiac Electrophysiology;
- Dr Alanna Hare as a Consultant in Respiratory Medicine with Expertise in Lung Failure;
- Mr Johann Hoschtitzky as a Consultant Congenital Cardiac Surgeon with Expertise in Adult Congenital Heart Disease; and
- Dr Leonie Wong as a Consultant Paediatric Cardiologist/Electophysiology.

2017/26 RATIFICATION OF APPOINTMENTS TO TRUST BOARD COMMITTEES

Introducing this item SM said under Nominations and Remuneration Committee of the Trust Board it should be herself listed as a member and not NL.

Subject to inclusion of this amendment, the Board ratified the appointments to committees of the Trust Board.

2017/27 SLAVERY AND HUMAN TRAFFICKING STATEMENT

SM proposed that the words 'endeavouring to ensure' be inserted rather than 'committed to ensure'. (The sentence reading 'RB&HFT is committed to endeavouring to ensure that no modern slavery or human trafficking takes place in any part of our business or our supply chain').

Subject to inclusion of this amendment, the Board approved the statement for 2015/16 and delegated authority to RCo to update the statement for 2016/17 with the inclusion of activity and turnover figures for 2016/17 as soon as the Annual Report 2016/17 has been finalised.

2017/28 DEBT WRITE-OFFS

RP said that in accordance with the Trust SFIs (Standing Financial Instructions) the proposed write-off over £50k had been recommended by the Finance Committee for approval by the Board. In addition, the report referred to an approved write off in the£15k to

£50k range as the SFIs also required a note from the Finance Committee meeting to inform the Board that this had occurred.

The Board approved the write-off of the debt over £50k as set out in the report.

2017/29 QUESTIONS FROM MEMBERS OF THE PUBLIC
Ken Appel asked the following questions:

- what effect the closure of services at RBH would have on Chelsea and Westminster Hospital (C&W) and St Mary's Hospital (Imperial College Healthcare Trust).

BB said there would be an impact on children's' services at these two Trusts. However, the relationship between RB&HFT and C&W was getting stronger. Better and more integrated care within NWL was needed.

- in view of the political position in Kuwait was it wise to rely too much on their support.

BB said the Trust was not reliant on the Middle East and sought only to benefit if the opportunity was to arise.

- Was the high number of vacancies related to the CHD review and the effect of Brexit.

BB said it could be partly attributed to these factors. This was concerning but not serious as yet.

- What was the timeframe for financial stability with regard to Wimpole Street.

BB said Wimpole Street as a stand-alone facility was not feasible and was always meant to be integrated with the rest of the Trust.

NEXT MEETING Wednesday 26th April 2017 at 10.00am, Boardroom, Royal Brompton Hospital