A lifetime of specialist care

Royal Brompton & Harefield NHS
NHS Foundation Trust

Minutes of the Board of Directors meeting held on 30th November 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
	Mr David Shrimpton, Director Private Patients	DS
	Mr Piers McCleery, Director of Planning and Strategy	PMc
	Ms Jo Thomas, Director of Communications and Public Affairs	JT
	Ms Carol Johnson, Director of Human Resources	CJ
	Ms Joanna Smith, Chief Information Officer	JS
	Ms Jan McGuinness, Director of Patient Experience and Transformation	JMc
In Attendance:	Mr Anthony Lumley, Corporate Governance Manager (minutes)	AL
	Ms Gill Raikes, CE Royal Brompton & Harefield Hospitals Charity	GR
Observers:	Ms Laura Middleton, Director Pricewaterhouse Coopers LLP (PwC)	
Apologies:	None.	

2016/87 <u>DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING</u>
None.

2016/88 <u>MINUTES OF THE PREVIOUS MEETING HELD ON 26th OCTOBER 2016</u>
The minutes were approved.

Board Action Tracking
BD16/81 Produce new Clinical Quality Report (CQR).
The Board noted that this was work in progress and an update would be received on agenda item 5 (see minute 2016/90).

BD16/81 Additional Commentary on 18w RTT in the (CQR).
NL noted this was included in the report and additional commentary had been provided. A note could therefore be added to the tracker and the action marked as complete.

BD16/81 Cancelled trend in rolling 12 months to be made clearer.
NL said this should have read 'Trend in cancelled operations' but this had also been included and could be marked as complete.

Matters Arising

- Page 1, Collaboration with Chelsea and Westminster NHS Foundation Trust (C&W)

NL said the oral update had been omitted from the agenda but RCr was expecting to provide the update as requested. RCr reminded Board members that the main focus of the collaboration had been children's services, but there were also important, long-standing links for adult services. The arrangements were important in meeting Coronary Heart Disease (CHD) standards and the challenge set by NHS England's (NHSE) proposals. The two Trusts were planning a joint children's' service – combining the ICU, Critical Care strength of RBH with general and specialist services across both organisations. C&W had a strong maternity service which included neo-natal intensive care and, since C&W's merger with West Middlesex University Hospital in 2015, they now had a very large maternity and children's service across the whole organisation. The initial focus was on strengthening critical care, with support from the Royal Brompton Hospital (RBH) to C&W. RCr said that, in parallel, Attain Management Consultancy had been jointly commissioned to develop an operational and organisational model for a single service. Attain would be mapping out what the future of collaboration could look like over the next two to three years in line with reviews of paediatric care services across the country. This would be part of the presentation to the Board at its meeting in January 2017. One consideration was bringing Imperial College Healthcare NHS Trust (ICHT) into the discussions with respect to paediatrics.

LAA asked for whom the presentation in January was intended and would the Board be expected to make decisions or receive an update. RCr said it would be a joint presentation by both Trusts, possibly with Attain. At this stage, he did not anticipate seeking decisions from the Board but advice would be sought on the direction of travel, with a view on ICHT's involvement, thus making it a tripartite piece of work.

2016/89 REPORT FROM THE CHIEF EXECUTIVE

BB gave a verbal report on the following items which were follow-ups on items discussed at the last meeting:

Congenital Heart Disease (CHD) Proposals

The Trust had received notification last week from Will Huxter, Regional Director of Specialised Commissioning (London) at NHS England (NHSE) that the expected consultation had been deferred to an unspecified date in 2017. The Trust had been planning to launch a public action campaign. Aspects of this would still go ahead as planned in December 2016 coinciding with Christmas events involving stakeholders. BB added that in the same week a letter from the Chair of NHSE to NL (in response to a letter sent two months ago) had stated that the consultation would start in December. BB said it was certain that the process would commence at some point and he assured the Board that the Trust would be ready.

North West London Sustainability and Transformation Plan (NWL STP)

BB said Board members would recall that the Trust had joined this grouping late and had no prior involvement and were not allowed to see the final plan. The plan had evolved from the Shaping a Healthier Future exercise and nothing in it directly related to the Trust. However there were some concerns. Within the NWL STP the principal representative of Trusts was the Chief Executive of ICHT who would not have due regard to the interests of the Royal

Brompton and Harefield NHS Foundation Trust (RB&HFT). BB assured the Board that the Trust's involvement was appropriate - representations had been made flagging lack of input and concerns and he liaised with RP and NH regularly to ensure a meeting was not missed. He confirmed that there was nothing as yet to express a specific concern about in the STP but there was a concern about broader issues. RP added that all the participants in the STP had expressed concern about the Control Totals. As of last week, there was a shortfall of £140m between (i) the expected outcomes in aggregate of all commissioners (c. £40m) and providers (c. £98m) and (ii) the NW London STP control total which represents the aggregate of all the individual control totals for 2017/18. AVO said the process was led by Clinical Commissioning Groups with a prevention and healthy living focus with providers not featuring prominently. NH said there was no detail on savings of £188m on specialised services. BB said he was concerned the process was not balanced and the input of providers was largely absent.

Care Quality Commission Draft Inspection Report

BB reported that the draft inspection report from the Care Quality Commission (CQC) had been received on the 9 November 2016. This had an overall rating of Requires Improvement (RI) and had included a mix of scoring in the matrix which went between Outstanding, to Good, to some RIs. Two RI's in either a domain or a service meant an RI rating in the line, and having two out of five domains being identified as RI meant the overall grading for the site was RI. The Board had received a presentation from JG at the Part II meeting on 21 November 2016. On 28 November 2016 after a short extension the Trust had sent its response to the draft report. BB added that the response had not been circulated owing to its size (over 300 pages). The Trust team analysing the data had found at least 300 inaccuracies. Two supplementary commentaries had been included in the Trust response, one on Critical Care at RBH and the other a comment to the Deputy Chief Inspector from BB. BB said he hoped the response from the CQC would be measured and considered and not be rushed – a peremptory response could mean that our concerns were not being taken sufficiently seriously. The Trust's team had done a great job and the response was professional and accurate. The Chairman thanked the team on behalf of the Board.

Carol Johnson

BB thanked Carol Johnson for her service over eight and a half years and expressed his appreciation for her contribution. On behalf of the Board NL said they absolutely supported that statement.

PD asked three questions

- Were there any developments on the ECMO (extracorporeal membrane oxygenation) resubmission. RGM said that since the last Board the Trust had received the draft report from NHSE's Quality Surveillance Group following their visit on 11 October 2016. The report had acknowledged some good practice and achievements, commending the change in culture and MDT working. The Trust had responded querying points of factual accuracy and now awaited a factual report back on that. The parallel process for procurement of respiratory ECMO covered just the geographic section of the country provided by RB&HFT and a letter had been received explaining that and stating that a tender would be beneficial for service 'new market entrants' and create a level playing field. They had also stated that they had no assurance that the Trust could provide a service over the winter. A market event had been held on 7 November 2016. Representatives from the Trust and other bidders had been present. The departure of intensive care consultants from the Trust to Barts Health NHS Trust had been mentioned again. An advert would be put out at the beginning of December with a decision

expected in April and a new service starting in July 2017. BB said the Trust response would be a joint proposal with Guy's and St Thomas' NHS FT.

- Had the Trust responded to the article in the *Daily Mail* about weekend mortality which had quoted experimental data from NHS Digital appearing to show that patients admitted to the Trust at weekends were 47% more likely to die. RGM said the Trust had responded and this had been circulated to the Board. The article had not taken into account the case mix of patients seen by the Trust. Patients admitted at weekends, were very ill in comparison with admissions at other hospitals because they were admitted suffering from heart attacks and cardiac arrests. Survival rates for patients admitted as an emergency were the same at the weekends as during the week.

- How was the Trust handling cyber attacks. JS said that in terms of assurance she could give to the Board, the Trust had significant investment in place including updates to the network and firewall. The Trust had signed up to the NHS Digital Care Programme as an early adopter which meant additional alerts were received. Internally her department had run a faked phishing attack and staff in the main had not clicked on the email. This would be repeated periodically and formed part of cyber awareness training.

2016/90 <u>CLINICAL QUALITY REPORT FOR MONTH 7: OCTOBER 2016</u>

NL emphasised that this remained work in progress and that more work would be done to include patients' experiences. He also said that the Board needed to see trends from month to month to track performance.

The Board noted that a meeting would be arranged to look at the format of the new Clinical Quality Report. LAA, AVO, JG and RCo would be attending. This meeting would explore how to balance process measures (still required by NHS Improvement (NHSI) and NHSE) and outcomes for patients. RCo confirmed that the sequence was that Board should see information before it was sent on to the regulator and the lead commissioner. With this report for M7 the Single Oversight Framework (SOF) had commenced. Months were now looked at in isolation by the regulator, and quarterly summaries and averages had gone when the Risk Assessment Framework was withdrawn on 30th September 2016.

The Board noted that there had been a considerable increase in the number of open patient pathways (patients still waiting) in relation to the 18 week Referral to Treatment (RTT) target. They were assured that while this may raise a short term concern about data quality, the Lorenzo Patient Administration System should help improve data quality overall once it was fully embedded.

Noting that all the metrics for the SOF were now green AVO asked how much could this be attributed to data quality and how much to an upping of our game. RCo said that it was not possible provide assurance on this point with regards to RTT while the data validation process was still part way through.

RCo reported that for 62 Day Cancer NHS Improvement was now looking at performance without breach allocation during 2016/17. Shadow reporting using breach allocation was in place for 2016/17 and was expected to come into place nationally from 1st April 2017. The Trust was reporting against the Sustainability and Transformation trajectory as required by NHSI so that while we were not meeting the national standard, the STF trajectory for M7 had been met.

NL summarised that for 62 Day Cancer there had been real progress but for 18w RTT the position was less clear. RCr said it had to be looked at over a period of months and this was slightly better news. Not all the 'new' open pathways since the system went live in July 2016 would still be <18 weeks, as most pathways start at GP referral or in general hospitals (and the challenge was often establishing the correct 'clock-start' date). In summary, there had been some real progress (additional patients treated) but there were also still some data quality challenges.

2016/91 FINANCIAL PERFORMANCE REPORT FOR MONTH 07: OCTOBER 2016

RP presented the M07 report which summarised the financial performance of the Trust to 31 October 2016. The Board noted the key headlines and that the Trust was currently on course to meet or come close to its plan by the end of 2016/17.

RP reported that an additional Board Part II meeting had been held on 21 November 2016 to approve the Draft Operational Plan 2017/18 – 2018/19 (DOP) which had been submitted on 24 November. The Trust had not accepted the Control Totals set by NHSI as a condition for the receipt of STF monies for each of the two years covered by the DOP. We had, however, reserved our position on the possible sale of Chelsea Farmers Market (CFM) in 2017/18: on 23rd December 2016 the Trust would submit the Final Operational Plan (FOP). If that sale went ahead the Trust would meet the Control Total for the first of the two years and as a result would qualify for a receipt of £8m from the STF fund. The Finance Committee had been delegated authority to approve the FOP at its meeting on 19 December absent a significant change in the environment for the Trust. The Board noted RP's warning that at some point in 2018/19 cash would become extremely tight as the Trust is no longer generating cash from operations; the Royal Brompton and Harefield Hospitals Charity is currently heavily indebted and therefore less able to provide financial assistance, nor was the ITFF a possible source of further funds as it was supporting a number of financially distressed Trusts. In summary, RP said that to mitigate the cash position the DOP reflected significant reductions to capital expenditures compared to recent years. This needed to be discussed further with the Chief Operating Officer (RCr).

NL invited Board members to ask questions.

AVO said he noted that diversifying income was one way of mitigating the deficit, as was reducing capital spend. He asked for more details of the work to reduce the deficit given the 'burning platform'. RP outlined an approaches for RCr and himself to engage with Boston Consulting Group (BCG) on strategy and transformational ideas and possibly with other consultancies on productivity issues. He added that he and the Trust's Deputy Director of Finance had already been in communication with Papworth and Liverpool Heart and Chest Hospitals to benchmark revenues and costs. Preliminary data had indicated that our equivalent costs were higher than Papworth's which would be explored further. BB added that more assurance for this would be given at the Board strategy seminar this same day.

The Board noted BB's views that the Trust faced a systemic challenge and that the Trust would have to address that within the broader agenda for the Health System; income diversification, productivity initiatives and cost cutting would narrow the gap but this process would not provide all the answers; a 'root and branch' review was needed which would include a realistic debate about which future services we should provide and in partnership with whom. If the Trust was to remain a specialist academic teaching hospital with existing historical arrangements was this sustainable. Working with BCG would give the Trust a framework to examine these issues.

AVO suggested that, notwithstanding BCG's undoubted capabilities, the Trust could use its own people to do the required analysis. RP said he understand this view completely but it was also important to hold your hand up with NHSI and say that it is not just the Trust that is saying what was required but someone independent had also arrived at the same conclusion. If we did not commission this work it was likely that NHSI would do so.

PDd asked a series of questions and Executive Directors responded as follows:

- Why was NHS clinical income below plan when it usually over-performed**.** RGM said transplant income was a bit low but there was nothing systematically to explain why there had been a change to this number. STPs were 'place' based and could be a factor in determining patient flows. BB said that system-wide, the NHS was not commissioning certain services but the means being employed to do this were subtle and not easily noticed and, moreover, this would intensify in 2017-19. By contrast the CHD process was largely open and transparent.

- What was the background to the delay in the Kuwait contract. BB said this was a multi-year contract. The allocation had been made by the Treasury and the Ministry of Health in Kuwait was the client. In November the Emir had dissolved Parliament and elections were scheduled for December. Until a new Ministry of Health was established the contract would not be completed. LAA asked if this had been flagged in the risk register and what was the mitigation. BB reminded the Board that it had been in the plan and political change was one of the risks cited as potentially a delaying factor. RCr said part of the mitigation was the deferral of the related costs.

- Update on Wimpole Street. BB said updates were given to the Finance Committee but, if requested, in future these could also come to the Board. DS confirmed that the new facility was now open and going well. He noted a slight delay to opening while CQC registration was confirmed. 37 consultants were now on board. Activity was lower than planned but this should be made up over time. Diagnostics activity and income with the exception of CT Scanners was on plan.

The Board noted the report.

2016/92 <u>REDUCING AGENCY EXPENDITURE – SELF CERTIFICATION CHECKLIST</u>

RCr introduced the report which set out a self-certification checklist which the Board was being asked to complete and authorise in response to a specific requirement from NHSI. RCr said the background to this was NHSI's objective to make more progress in reducing agency usage and costs, which had dropped by around 20% over the last twelve months across the sector. The Trust had also made some progress in narrowing the gap between the total number of shifts covered by agency workers and the cap set by the regulator.

The Board noted the challenges of reducing agency numbers and expenditure, for example: no immediate expectation of quick improvements in the recruitment of more permanent radiography staff; or the difficulty posed by the monopoly held by 'off-framework' agencies of specialist and experienced staff with the skills required by the Trust. The Trust was negotiating lower rates with these agencies, but some of these remained above the NHSI thresholds.

RJ asked for a progress update on the major initiative to recruit nurses from overseas (especially the Philippines) and also how often requests for approval of agency recruitment

were declined by senior staff. JG said the initiative had proceeded more slowly than had been expected. It was hoped that they would begin to join the Trust in the New Year (delayed from October 2016). She added that the Trust had also targeted staff from other EU countries, as well as focusing within the UK (including new graduate programmes and student rotations). Retention was also a key issue as were reducing turnover, engaging staff in different ways and career progression as part of a broad programme. In response to the second of RJ's questions JG said she did not know specifically how many requests had been declined but assured the Board that there was enormous rigour applied by the senior nurses in this process.

The Board reviewed each indicator and agreed that all should remain as presented with the exception of the following - which should be classified under 'yes' with appropriate commentary - because on balance it was agreed that the Trust was more compliant than not:

- The Trust has a centralised agency staff booking team for booking all agency staff. Individual service lines and administrators are not booking agency staff.

- There is a clearly defined approvals process with only senior staff approving agency staff requests. The nursing and medical directors personally approve the most expensive clinical shifts.

NL noted that in these circumstances the key factor, going forward, was recruitment.

The Board also discussed whether 'the board's active involvement in workforce planning' should be changed from a 'no' to a 'yes'. On further review, it was noted that the draft response was accurate (i.e. that workforce planning was principally undertaken at operational or divisional level rather than by the Board) and that the Board's role is reactive.

AVO noted that many providers were hindered from getting the best value out of highly-trained individuals because they had too many 'non-core' tasks to complete.

Acknowledging points made respectively by KO and LAA, that the Trust's strategy for workforce planning had to be looked at and that the Board had to assess whether enough was being done, NL said a presentation should come to the Board in 2017 and at least once every twelve months thereafter.

Action: Workforce Planning on Board agenda in 2017 and then once a year after that (Human Resources Director supported by RCr, JG and RGM).

2016/93 RECOMMENDATIONS OF ADVISORY APPOINTMENTS COMMITTEE

The Board were presented with four ratification forms for the appointment of consultant medical staff. The first and second related to the appointment of two Consultants in acquired Cardiac Surgery Heart and Lung Transplantation and Mechanical Circulatory Support and had been chaired by LAA who presented the recommendations for appointment. The third and fourth forms were presented by AVO and were for a Consultant in Respiratory Medicine with Expertise in Interstitial Lung Disease and a Consultant in Thoracic Surgery.

The Trust Board ratified the appointments of:

- Pr Ulrich Stock as a Consultant in acquired Cardiac Surgery, Heart and Lung Transplantation and Mechanical Circulatory Support;

- Mr Balakrishnan Mahesh as a Consultant in acquired Cardiac Surgery, Heart and Lung Transplantation and Mechanical Circulatory Support;

- Dr Peter George as a Consultant in Respiratory Medicine with Expertise in Interstitial Lung Disease; and

- Mr MadhanKumar Kuppusamy as a Consultant in Thoracic Surgery.

2016/94 APPOINTMENT OF A FREEDOM TO SPEAK UP GUARDIAN

The Board confirmed the appointment of Ms Anne Pike as the Trust's Freedom to Speak Up Guardian. BB said Ms Pike was very capable. She had been an outspoken supporter of the Trust during the Safe and Sustainable review.

2016/95 AOB

Mr Kenneth Appel (KA) asked why Critical Care was behind by 155 days and how could this be improved. RCr said one cause was that more cardiac surgical patients at RBH were now going to Recovery after theatre rather than through ICU. This was often better in terms of patients' recuperation from surgery, overall hospital stay and 'patient throughput'. Perversely in the short-term less income was earned for Level 3 Critical Care, though there was also less expenditure per ICU shift. The economic balance should work out in our favour over time.

KA said he noted the great effort to use bank staff before agency and asked if there were any radiographers in training to deal with the nationwide shortage. RGM said some people had it included as part of their training. The Trust was not a school of radiography but it was trying to make us more attractive as a place to come and work.

In response to a question from KL on how could the Trust remedy the loss of research funding NL said the National Institute for Health Research (NIHR) was not the only source of research funding. BB added that NIHR funding would continue until 31 March 2017. The lost £20m would be replaced over several years. KA asked if this would affect our work. BB said it would as it would affect the financial performance of the Trust.

Don Chapman asked for an update on the Mansion at HH, and had any thought been given to stabilisation once it had dried out. RCr said the stabilisation work had been carried out already. The future would depend on the master plan for the HH site as a whole. A new master plan would be considered in early 2017 and would be finalised in the course of the next one to two years. Future redevelopment would be in line with the building's listed status.

NEXT MEETING Wednesday 25th January 2017 at 2.00pm, Board Room, Royal Brompton Hospital.