A lifetime of specialist care

Royal Brompton & Harefield NHS
NHS Foundation Trust

Minutes of the Board of Directors meeting held on 30 September 2015 in the Concert Hall, Harefield Hospital, commencing at 10:30am

Present:	Sir Robert Finch, chairman	SRF
	Mr Robert Bell, chief executive	BB
	Pr Timothy Evans, medical director and deputy chief executive	TE
	Mr Richard Paterson, associate chief executive - finance	RP
	Mr Robert Craig, chief operating officer	RCr
	Mr Nicholas Hunt, director of service development	NH
	Mr Philip Dodd, non-executive director	PD
	Ms Joy Godden, director of nursing	JG
	Dr Andrew Vallance-Owen, non-executive director	AVO
	Mr Luc Bardin, non-executive director	LB
	Ms Kate Owen, non-executive director	KO
	Mrs Lesley-Anne Alexander, non-executive director	LAA
	Mr Richard Jones, non-executive director	RJ
	Pr Kim Fox, professor of clinical cardiology	KF
	Mr Richard Connett, director of performance and Trust secretary	RCo
By invitation:	Ms Jo Thomas, director of communications and public affairs	JT
	Ms Carol Johnson, director of human resources	CJ
	Ms Jan McGuinness, director of patient experience and transformation	JM
	Mr David Shrimpton, managing director Private Patients (late arrival)	DS
In attendance:	Mr Anthony Lumley, corporate governance manager (minutes)	AL
	Ms Gill Raikes, CE Royal Brompton & Harefield Hospitals Charity	GR
Apologies:	Mr Neil Lerner, deputy chairman and non-executive director	NL

2015/66 <u>DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING</u>
None.

2015/67 <u>MINUTES OF THE PREVIOUS MEETING HELD ON 29 JULY 2015</u>
The minutes were approved subject to the following amendment:

Page 4, item 2015/57, third para., fourth sentence: delete ‘alarm’ and replace with ‘harm’.

Page 5, item 2015/58, first para., seventh sentence: insert ‘approximately’ between ‘recognised’ and ‘1/12th’.

Page 7, item 2015/60, second para., second sentence: delete ‘principle’ and replace with ‘principal’.

2015/68 <u>REPORT FROM THE CHIEF EXECUTIVE</u>

BB said he had nothing exceptional to report and that he proposed to comment on agenda items and answer any questions on specific issues as they arose.

He highlighted a staff contest on quality improvement initiatives which had been on display at Harefield Hospital (HH) recently and on which NH and JG had been judges. This was a classic example of what happened in a hospital with staff driven initiatives without any steer or interference from on top. JG concurred and said it was a fantastic programme driven by ideas from staff teams about how to improve the patient journey. Sixteen teams had presented in all. The projects were all around embedding improvement into the everyday. The winning proposal had been about improving the adult cystic fibrosis experience. The challenge was how could the Trust build on this.

BB invited Board members to consider the display panel on show in the Concert Hall which made reference to a comment by Kenneth Clarke when he was Minister of State for Health (1982–85) in which he had said only a madman would establish a transplant hospital which had since proven to be wrong following Magdi Yacoub's successful programme.

2015/69 CLINICAL QUALITY REPORT FOR MONTH 5: AUGUST 2015

Introducing the report RCo informed the Board that he had received a letter from Monitor which confirmed that the Trust had maintained a Green rating for governance for Q1 2015/16. Monitor noted that the Trust had not met two targets, the 62-day Wait Cancer target and the 18 Week Referral to Treatment (RTT) target(incomplete pathways) and said it had decided not to open an investigation at this stage.

RCo said the main highlights of the report were:

Monitor Risk Assessment Framework:

- 18 Weeks RTT Incomplete: for M4 and M5 the target had been met. The result of M6 was awaited.
- Cancer 62-day wait for cancer first treatment: performance was not met (47.62%) against the threshold of 85%. Nine requests for breach allocation had been sent but as of 30 September 2015 no responses had been received. RCo added that he had reported at the last Board meeting on Monitor and NHS England's (NHSE) planned review of breach reallocations policy. He had asked Monitor on Monday 28 September 2015 for an update and he had been informed there was no outcome as yet. He highlighted the graph included in the report at NL's request which showed an analysis of how performance against the cancer target had varied over time and the numbers of breach reallocation requests made and agreed. This demonstrated that very few reallocations had been agreed, especially over the last three months, and that there had been a widening of the gap between reallocations sought and reallocations agreed.

Care Quality Commission (CQC)

- CQC had published in August 2015 a list of Trusts for planned inspection in January 2015 and the Royal Brompton and Harefield NHS Foundation Trust (RB&HFT) had not been included. The list for February 2015 had as yet not been published but was expected imminently. TE said that if the Trust was not in the February list then the Trust would definitely be inspected sometime between March and June 2015 as the CQC had announced their intention to complete all inspections by then. Asked by SRF if the Trust was ready if it was inspected now JG said not entirely and there was always work to be done. However, she confirmed that she was getting support from within the Trust.

NHS Standard Contract

- 18 Weeks Referral to Treatment (RTT) by National Specialty – Incomplete Pathways: at specialty level not met for Cardiothoracic Surgery (77.05%) and Cardiology (90.37%) against the target of 92%.

Noting that the report referred to six Serious Incidents (SIs) in August SRF asked TE if he was concerned by this. TE said he was always very concerned about any SI. He had undertaken a preliminary look at the SIs and the associated Root Cause Analyses which had been carried out for the unexpected deaths. However, on the basis of the preliminary look he had no concerns. AVO said the Risk and Safety Committee would continue to take a deep look at each SI. Pressure ulcers were a concern but the Trust was continuing to work at it. JG added that a new focus on pressure ulcers in the summer of 2015 had seen a rise in reporting. These SIs were at the acute end of the critical care range. Reporting was to be encouraged but more work needed to be done.

TE said cancer waits continued to concern clinicians greatly. Two new cancer specialists had been appointed by the Trust one of whom had started on 9th September 2015 while the other would begin work at the Trust on 1 October 2015. The Trust should look at its own performance and at how long patients were waiting after their referral had been received by RB&HFT. This was under the Trust's control and it should make certain referrals are managed as rapidly as possible once received - ideally within 20 days of receipt of the referral.

LAA said that the outcome for patients always appeared to be missing in this report. She had no sense of the impact of delays on patients. TE said he could only answer in general terms. The Trust had no control over the pattern of referral and no control over radiotherapy and chemotherapy. North West London did have one of the lowest rates of referral for chemotherapy and radiotherapy and was below the national average. TE said that the facts pointed to a whole pathway problem.

LAA said if people were dying as a result of pathway inefficiencies the Trust should not shy away from saying that. TE acknowledged that this was probably correct. KF said it depended on the tumour type and the date referred. TE said there were patients admitted to the Trust who were not operable because of the delay. This was a problem that was widely recognised. The recent Vanguard Initiative involving The Christie Hospital , the Royal Marsden Hospital and University College London Hospitals was evidence of support for this.

Noting that the action plan had been in place for a very long time PD asked if was too early to see improvements. TE said it was not too early for the Trust to get its own pathway right but it was too early to see whether the new appointments would have an effect.

BB said the Trust's surgical intervention was only one nodule on a patient journey. (TE commented that this accounted for 20% of patients). The Trust could answer on what are our outcomes based on the surgery. What was not being tracked was what was the survival rate given the whole journey gone through. BB added that this required the sort of databank that the Trust did not possess. LAA said it was right that the Trust should use the weight of its reputation to try and influence and change the whole pathway but it was equally important to have its own house in order.

NH said referrals were reviewed monthly at the Clinical Quality Review Group meetings with NHSE and Clinical Commissioning Groups. NHSE had recognised and acknowledged the Trust to be taking on a leadership role and NH said he thought that NHSE would report this to CQC. Niall McGonigle, Consultant Thoracic Surgeon and the Trust's Cancer Manager would be holding separate meetings at Director level with the referring hospitals in order to seek to drive improvements in the diagnostic part of the pathway. LAA reiterated that the Trust should not shy away from saying people were dying because of inefficiencies in the pathway.

RJ asked if there was any reason why the 18-week RTT performance on the cardiothoracic surgery specialty was worse than others, and was this expected to continue. RCr said that the cardiothoracic surgery pathway was the most challenging, as many cases came to the Trust at the end of a complex pathway. The Trust had to 'keep its own house in order' too and, in May 2015, RCr had invited the Elective Care Intensive Support Team (IST) to review its processes – but there was also a fundamental capacity shortfall. HH, in particular, received more referrals than it had the capacity to treat. The Board would recall that, in previous years Trust teams had undertaken cardiac surgery cases in additional (private sector) capacity. Two years ago commissioners had paid the extra costs of this additional work; in 2014/5 the Trust had met these costs itself; but in 2015/16 the Trust was not in a position to do so. IST provided (NHS 'internal') consultancy services based on experience in hospitals across the country and their final report was due imminently. They had engaged with staff on both sites and had identified issues about referral, demand/capacity

modelling, patient pathways and also how associated data is recorded and reported. RCr said, in summary, that there would be a body of work to take forward over the coming months. However, he re-emphasised that this would not, in itself, solve the capacity shortfall.

The Board noted the report.

2015/70 FINANCIAL PERFORMANCE REPORT FOR MONTH 05: AUGUST 2015

RP reported the following performance for M05:

- I&E account - general comments on month: in August activity was usually lower than in over months. As costs tended to be fixed it was usually a poor month in financial terms. The Trust had planned for a deficit of £1.9m in M05, the actual position was a deficit of £1.4m, £0.5m better than plan. The overall position however benefited from capital donation receipts of £1.1m recognised earlier than the plan for M07. The underlying position was a deficit of £2.5m, £0.6m worse than plan. £0.7m of income for previous periods had been recognised in M05 as NHSE clinical income as it had incorrectly been classified under CCG contracts. However, because of the block contract this meant no additional income - effectively lost by transfer. Pay costs were on plan (in fact slightly underspent) for the first time since he could recall.
- I&E account - year to date. There had been an NHSE block adjustment of £1.2m. On a cost and value basis the Trust had carried out more work than plan so it had been removed. In the first six months of the financial year £6.9m of the planned £10m deficit had been incurred when the plan had been for £7.5m to have been incurred. However, this was also flattered by earlier than expected capital donations.
- EBITDA (Earnings Before Interest Taxes Depreciation and Amortization): this had generated a small amount of cash but less than budget - £1.1m against plan of £2.1m.
- Cash: the position was healthy because the Trust was drawing down on two ITFF loans; £10m WCF had also been repaid. Furthermore, all of the outstanding NHSE debt had been collected at the end of September 2015. The upside of a block contract was that the Trust was paid every month which meant the building up of NHSE debt each month, seen in previous years, was not being repeated.
- Capital expenditure: this was behind plan but within Monitor tolerance.
- Appendix FSP (Financial Savings Plan) CIPs (Cost Improvement Programmes): work on CIPS had continued monitored by RCr. The biggest challenge was the procurement CIP. Because the Trust was not generating any cash the capital programme had been almost entirely funded from borrowings and charity donations. The Trust would not be able to draw down from borrowings from the end of the next financial year and would have to pay back borrowings then.

PD asked what could be done to address the £9m worth of debtors over 60 days old. RP said this was substantially Private Patient (PP) debt. As this income went up, the balance owed went up. It was extremely difficult to put pressure on embassies to pay who would not pay until instructed to by their own governments. He added that the Trust had never had a bad debt of substance from these organisations. The board would be discussing a proposal in Part II following this meeting and sensitivity about ensuring cash up front would be part of that discussion.

Noting that the Trust was half way through the year AVO asked if there was any news about new tariff arrangements. RP said consultation was in progress but this was piecemeal so it was not possible to see the whole picture yet. It did not appear that HRG4+ would be the 'silver bullet' the Trust had hoped for. RP added that last year there had been a raft of objections from Trusts to the tariff process. In order to avoid this the Department of Health were proposing that the threshold required for objections to be successful be increased from 50% to somewhere between 66 – 75% and that objections would be measured on the basis of each provider having one vote rather than by value. RP said that under the new rules it would be virtually impossible to reach the 66% threshold.

LB said he understood that the Trust had eighteen months to balance its books and asked what was the effect on the three year plan. RP said that as of today, there was no long term plan. He understood that Monitor would ask for a three or five year plan after the Autumn Statement due in November 2015. At a recent Association of UK University Hospitals meeting he had attended Trusts had been asked how many of them were behind plan at this mid-point in the year (the answer was about half); how many were on plan (again about half including RB&HFT); and thirdly, how may were ahead (the answer – none).

BB said he did not anticipate a balanced I&E account for several years. The major concern was cash. The aim was to manage costs and generate income streams to ensure that the Trust did not run out of cash by 2017/18. The Trust was forecasting continuous deficits for the next two to three years and this had been openly presented to Monitor in July 2015. Monitor had agreed that the fiscal predicament was not of the Trust's making and had encouraged the search for other sources of revenue. RP said he was meeting a senior Monitor official on 1 October 2015 but he understood that Monitor would not be chasing the Trust to address the deficit. He emphasised that the board should be under no apprehension that there was a magic bullet which would sort out I&E any time shortly. The cash position was satisfactory but was a worrying concern at the end of the next financial year. An aggressive effort to address new income streams was essential.

AVO asked if the board was being asked up to sign up to deficits and if this was in breach of their fiduciary duty. Was the Trust saying that quality and patient care came first. BB said the board had pledged to Monitor that over the next twelve months it would not reduce patient care activity. SRF said a

£2 billion deficit for all providers was being anticipated and that he had recently attended an event for FT Chairmen at which it had seemed that there was no real plan to tackle the deficit.

The Board noted the report.

2015/71 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 in Adult Cardiomyopathy (cross-site) and had been chaired by RJ who presented the recommendation for appointment. RJ said there were five applicants, three of whom had been deemed suitably qualified and were invited to interview. The selected candidate was universally considered to have been the best candidate. TE said the selected candidate had an excellent profile and was well know from his work at the Barts and the London School of Medicine and Dentistry.

The Trust Board ratified the appointment of Dr Antonios Pantazis as a Consultant in Adult Cardiomyopathy (cross-site).

The second form related to the appointment of a Consultant in Radiology which was a joint appointment with Chelsea and Westminster Hospital NHS Foundation Trust (C&W), and had been chaired by AVO who presented the recommendation for appointment. AVO said the Trust had wanted a person skilled in cardiac CT. TE concurred and said the candidate was well known and an excellent appointment.

The Trust Board ratified the appointment of Dr Saeed Mirsadraee as a Consultant in Radiology, joint appointment with C&W.

2015/72 REGISTER OF DIRECTORS' INTEREST

The Board confirmed the accuracy of the Register.

2015/73 APPROVAL OF AMENDING AGREEMENT FOR £10M RCF

RP said the original agreement had referred to the first ITFF loan only. Since that agreement a second ITFF loan has been put in place and Barclays had asked that the agreement be amended to reflect the second ITFF loan.

There was produced to the meeting a document (the Amending Agreement) amending the terms of the revolving credit facility dated 1 October 2014 from Barclays Bank PLC (the Bank) to the Foundation Trust setting out the terms and conditions upon which the Bank is prepared to make available to the Trust a facility in the maximum principal sum of £10, 000, 000.

Schedule 1 of the Amending Agreement comprised an amendment to the definition of the ITFF loan. It was proposed that the previous definition be deleted and replaced with the following:

'ITFF loan means (a) a £30,000,000 term loan facility agreement between the Secretary of State for Health and the Borrower pursuant to a facility agreement dated 22 April 2014; and (b) a £20,000,000 term loan facility between the Secretary of State for Health and the Borrower pursuant to a facility agreement dated 17 July 2015'.

IT WAS RESOLVED

1. That the proposed Amending Agreement be accepted in its entirety.

2. That Mr Richard Paterson, Associate Chief Executive – Finance; and Mr Robert Craig, Chief Operating Officer, are authorised to sign the Amending Agreement and the Directors' Certificate on behalf of the Foundation Trust, in their capacity as board members, to indicate acceptance of the terms and conditions.

2015/74 ANY OTHER BUSINESS

SRF said LAA had recently been given an award for Britain's' Most Admired Charity CEO. He congratulated LAA and led the board in a round of applause.

2015/75 QUESTIONS FROM MEMBERS OF THE PUBLIC

None.

NEXT MEETING Wednesday 28 October 2015 at 2:00pm in the board room, Royal Brompton Hospital