# TRUST BOARD

**Minutes of an Extraordinary Meeting held in the Ramsay Winter Room, Partnership Learning Centre, Good Hope Hospital**

**at 4.00pm on Tuesday 26th February 2008**

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| **PRESENT:** | Mr C Wilkinson *(Chairman)* | Mr M Goldman |
| | Mrs F Baillie | Professor C Ham |
| | Mr D Bucknall | Mr P Hensel |
| | Ms M Coalter | Prof J Perry |
| | Mr I Cunliffe | Dr H Rayner |
| | Ms A East | Mr R Samuda |
| | Mrs Beccy Fenton | Dr S Woolley |
| **IN ATTENDANCE:** | Ms L Bubb | Mr J Sellars |
| | Mrs L Dunn | Mr A Stokes |
| | Mr J Gould | Mrs M Pittaway (Minutes) |
| | Mrs D Robinson | |

The Chairman introduced the meeting which had been called to consider the Trust's 10 year Strategic Review and Site Strategy. Prior to the meeting the Board had been invited to attend a tour of the Good Hope Hospital site.

Action

**08.23 1. APOLOGIES**

Apologies were received from Ms N Hafeez.

**08.24 2. 10 YEAR STRATEGIC REVIEW AND SITE STRATEGY**

John Sellars had previously circulated a report on Estate Strategy to members of the Board.

Mr Goldman advised the Board that this would be the first of a number of meetings to consider this project. The Trust's asset base was £400m and the Trust would be looking at an investment of approximately £200m.

Mr Stokes presented a report to the Board: Developing a 10 Year Finance Strategy: Stage 1 and copies were circulated.

Mr Stokes informed the Board that the Trust had built up a significant recurrent surplus and could now invest in the estate. The Trust's aim would be to offer the best patient care. Some areas would remain outside the Trust's control and it

was necessary to determine which assumptions were within the Trust's control and would have the greatest value impact. The ED's had discussed the inter-relationships of the key assumptions:

- Efficiency (CIP Target)
- Service Development and Cost Pressures
- Estates Development Costs

Mr Sellars introduced his report to the Board that had been prepared in line with the Trust's Vision 'to be the most exciting and influential healthcare organisation world wide'. Estate Strategy would be fitted around the medical strategy. Estate development strategic targets were:

- The demolition of all not fit for purpose buildings
- Provision of high quality inpatient facilities providing privacy and dignity
- Redesign of clinical areas to provide improved patient pathways
- Refurbishment of areas to provide high quality NHS facilities for staff and patients

**THIS MINUTE IS RESERVED UNDER SECTION 43 OF THE FREEDOM OF INFORMATION ACT 2000**

Financial Strategy Version 1: Results
The Board were informed that the Trust's recurrent surplus would fall from £17.7m to £0.8m but that predicted cash flow at Year 10 was positive. Consideration should be given to the following:

| | **Upside Risk** | **Downside Risk** |
|---|---|---|
| **TARIFF** | Tariff price increases | Tariff price decreases |
| **ACTIVITY** | Modest activity growth forecast is under estimated | Modest activity growth forecast is over estimated e.g. greater impact of patient choice |
| **CAPEX FORECASTS** | | Cost higher than expected |
| **CIP DELIVERY** | | Targets not met |
| **REVENUE INVESTMENT** | | Unforeseen cost pressures |
| **INTEREST RATE** | A rate increase would improve return on surplus cash | A rate decrease would reduce the return on surplus cash |

An Issue of Timing

Mr Stokes informed the meeting that in order to reduce financial risk the Trust could grow its surplus further before investing. However this low risk option increased the risks of not delivering efficiencies and delayed benefits to patients.

To ensure that patients benefit as soon as possible, the total investment in estates could be made by year 6/7. However this would be a high risk financial

strategy as the Trust would go into debt and the repayment would depend on future CIP, which at this stage should be considered as uncertain.

The Board were asked to consider an investment strategy that would allow room for manoeuvre if at any point the income and/or expenditure assumptions that were beyond the Trust's control should change. The work should be completed in stages and subject to regular review.

**THE NEXT STEPS**

Stage 2: Finance Strategy Document & Phase 1 Business Cases.
A Report would be presented to the Board in 3 months time.

Stage 3: Funding Options
A Report would be presented to the Board in 6 months time.

The Board were invited to ask questions at this stage and to consider in particular the following:

1. Is the Estates plan in the right direction?
2. What is our appetite for risk over 10 years?
3. What is our risk appetite for Phase 1?
4. Is the balance right?
5. Recommendations: To agree the overall vision and the next steps

**Q** With a projected surplus of only £0.8m 10 years from now, could there be major problems if the forecast proved to be slightly out?
**A** Mr Stokes confirmed that there should be no major problems from a cash perspective, or with Monitor. Mr Goldman stated that it was impossible to predict what would happen over a ten year period but that the proposal to undertake the work in staged blocks, with regular progress reviews, would give the Trust the greatest flexibility.

**Q** If, hypothetically, the cost of a project increased by 45% what contingency had been built into the costing?
**A** 10% plus 5% for inflation.

**Q** The proposal seemed coherent and sensible but had the Executive Team also considered less ambitious or more ambitious plans?
**A** Mr Stokes and Mr Goldman responded that the start point for the Team had been to determine what the Trust had to do in order to deliver service strategies and general trajectories of policy and to consider the Trust's position within the NHS. The need to develop a bigger and better hospital had resulted in more ambitious plans for the development of the Good Hope Site.

**Q** What proportion of the total investment is to be spent on the Good Hope Site?
**A** Approximately 50%.

The Chairman asked the Board to agree to the proposed level of expenditure during the first three years of the 10 Year Plan. There would be a review after 3 years but if it was deemed to be appropriate a review would be scheduled for an earlier date.

**This was agreed.**

**Q** Why can the Trust meet the target for the quality of the finishes required for refurbishment of wards but not meet the Government's space requirement for new wards?
**A** All refurbishment finishes would be the best that could be provided on the NHS and there would be greater space between beds in the new blocks and single rooms at Good Hope Hospital, in line with current guidelines. However, if these guidelines were applied to those blocks to be refurbished, bed capacity would be greatly reduced.

**Q** At the end of 10 years, would the Trust be fully compliant in providing separate provision for male and female patients?
**A** In order to do this the Trust would have to go back to the old style of female and male surgical wards and the high bed occupancy levels in the NHS made this target unachievable.

**Q** If another hospital is perceived to have better buildings and patient facilities, is it likely that patients who would otherwise have come to the Trust go elsewhere?
**A** There had been very little patient movement. In terms of the Choice Agenda there was little spare capacity in NHS hospitals in Birmingham and no indication that patients were seeking to move elsewhere. Dr Rayner confirmed that the Trust takes a high level of emergency work, sent in either by ambulance or on a walk-in basis to A&E. The Trust is aiming to be in the upper quantile of NHS provision.

**Q** If the Trust is building for current demands have they factored in a flexible policy i.e. in specialities?
**A** Yes, some flexibility has been built into the plans, but they were not modelled on specialities. Mrs Fenton stated that the Choice Agenda would in part be driven by Infection Control and perceived cleanliness.

**Q** What is the current position in relation to outpatient facilities and activities i.e. the Darzi Review, and what scope is there within the programme to provide a different form of intermediate step-down care for patients?
**A** Outpatients is the biggest growth activity for the Trust. If the Trust reduced the waiting times it would reduce the size of outpatients i.e. by holding clinics in the evenings and at weekends. In terms of costs these are small in comparison to running a Ward.

**Q** What will be the percentage of single room provision in the new ward blocks?
**A** This was not yet known.

**Q** Is there some way that the Trust could look at a benchmark?
**A** What was proposed would be better than in the maternity block, which was very good.

**The Chairman asked the Board:**

To agree to the overall Estates plan contained in the report.
**This was agreed.**

To support the proposals for the work to be staged over a 10 year period with a review after 3 years, or sooner if appropriate, and if possible for the work to be completed earlier.
**This was agreed.**

To accept the proposal for the Executive Team to proceed to build up individual business cases, based upon a 10 year strategy.
**This was agreed.**

The Chairman then raised the issue of the poor state of the Outpatients Department at Birmingham Heartlands Hospital which was not scheduled for work until Year 7 of the Plan.

It was agreed that this would be re-visited with a view to making some improvements in the short term.

**THE WAY FORWARD**

Mr Goldman informed the Board that he would meet with colleagues and provide the April Board with a plan on the way forward. A Site Management Programme Team would be created and a reporting structure set up. Regular updates would also be provided to future Board meetings.

Further questions were invited.

**Q** How many people attend Outpatients at Good Hope Hospital?
**A** On a Trustwide basis 600k attend Outpatients Departments, 240k attend A&E, 16k elective and 24k emergencies.

Mr Goldman stated that given the volume of the proposed investment it was important that internal statements to staff and external statements to the media concerning the Trust's plans should issued made via the Communications Department. Mrs Dunn would begin work on this and bring back a proposal to the April Board.

**08.25 3. ANY OTHER BUSINESS**

There was no other business.

**08.26 4. DATE OF NEXT MEETING**

Tuesday 4th March 2008.

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**Chairman**