

## **CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST**

Minutes of the meeting of the Governor / Director Forward Planning Group on Wednesday 17 March 2010 in the Boardroom, Addenbrooke's Hospital.

### **PRESENT:**

Michael Bright (Chairman)	Patient Governor
Roly Cockman	Public Governor
Frances Cousins	Director of IS&A
Judith Ewer	Public Governor
Stephen Graves	Director of Corporate Development
Maureen Hart	Patient Governor
Georgina Pharaoh	Patient Governor
Eric Revell	Public Governor
Jim O'Sullivan	Staff Governor
Lorne Williamson	Public Governor

### **IN ATTENDANCE:**

Ann Alderton	Trust Secretary
Lawrence Ashelford	Asst Director, Planning and Development
Simon King	Committee Secretary

### **APOLOGIES:**

Susan Bullivant (Vice Chairman)	Patient Governor
Robert Burgin	Papworth, Advisor
Peter Dalton	Director of Funding ACT
Derek Jones	Non-Executive Director
Jonathan Nicholls	Partner Governor
Patrick Smith	Public Governor

### **01/10 MINUTES OF THE PREVIOUS MEETING**

#### Noted

The minutes of the meeting held on Wednesday 11 November 2009 were accepted as a correct record. There were no matters arising from the minutes.

### **02/10 MATTERS ARISING NOT OTHERWISE ON THE AGENDA**

#### Noted

- (i) The Chairman congratulated Stephen Graves on his new appointment and thanked him for his work with the FPG over a number of years.
- (ii) The Chairman advised that the Vice Chairman, Susan Bullivant, was making a good recovery from her Achilles tendon operation.
- (iii) The Governors' effectiveness review had been completed. A number of issues had been identified, notably communications between Governors and Members; and holding the Board of Directors to account. Judy Ewer had met with the Trust Chairman and the Trust Secretary to draw up an action plan to be circulated to the Governor/Director working groups and to the Constitution Committee. Progress would be reviewed on a monthly basis. The response to the review questionnaire had been disappointing but it was recognised that the questionnaire had been complex and difficult to understand.

### **03/10 20/20 VISION CAMPAIGN**

#### Noted

Peter Dalton had been delayed. He would make his presentation at the next meeting.

### **04/10 PLANS FOR PRIVATE HOSPITAL**

#### Noted

- (i) Stephen Graves reported that including a private hospital had been part of the site plans for over a decade, which had been consulted upon and had been set out in the Trust annual plan for 2-3 years, and the Board supported the concept. To date there have been no negative comments for these public processes and statements. The procurement process had not started but some key criteria for selecting a partner had been considered: managing private hospitals in UK and overseas; managing tertiary services; construction of the hospital and marketing the hospital. Once a decision had been taken to proceed, procurement would follow the EU process and would take some 16-18 months to award of contract.
- (ii) The business model had been complicated by a recent tightening of the private patient cap (PPC) rules which no longer allowed exemption for Joint Ventures. A rental arrangement with the provider might avoid this problem.
- (iv) A number of questions and observations was raised by Governors. The management effort needed to progress the plan was considerable and the financial advantage might be limited, given the declining market in private health; and any benefits seemed to depend on attracting overseas patients. It was not clear whether the viability of this had been independently assessed.
- (v) Given the untested financial case and the considerable departure from historical activity at Addenbrooke's, it was suggested that much wider consultation, not only with the Governors, but also with the public, should be considered, not least to discover whether or not there was general support for the idea. The consultation with the public could follow the Hinchingbrooke format used by the SHA. In addition to consultation, the importance of explaining the objectives of the initiative to the public was stressed.
- (vi) The question of consultation with clinicians was raised. They had been involved at an early stage and had met some of the potential partners.
- (vii) A question was raised about the level of independent evidence to support the argument that a mix of private/public provision would benefit the general population. No such evidence was readily apparent, but the extra surplus generated would, by definition, improve what the Trust could do for the public.
- (viii) The importance of managing the possible impacts of extra demand on intensive care and shared services was raised. It was clear that some services, such as pathology, would not be overtaxed but that there could be difficulties in some areas.
- (ix) Drawing some of these threads together, the Chairman commented that the difficulties of integrating private and NHS services deserved very wide consultation. The financial situation was complex. International demand for Cambridge-based private care was probably high. There were major constraints at the two local existing private providers and they carried out little tertiary or international work. It was likely that Providers' responses during the procurement process would throw some light on this issue.

**(A) Terms of Reference – Board Approval**

Noted

The new Terms of Reference had been approved by the Board. The concept of Core Governors had been abandoned. The FPG's Core NED would be Richard Barfield.

**(B) Hinchingsbrooke PQQ**

Noted

- (i) Stephen Graves reported that approval from the Secretary of State was needed for the intervention order and that the Trust Board was to stay. The proposed franchise would be for 7-10 years. The payment model would be a fixed fee to the franchisee and profit share between the NHS and the franchisee. Current scope of services would be maintained. Demand risk would be with the franchisee. The clinical insurance scheme would be available to the franchisee. Physical assets would stay with the NHS and staff contracts would remain with the NHS, under the ROE scheme. This had not been used before for clinical staff.
- (ii) The five bids were being evaluated and the SHA would announce the shortlist of preferred bidders on 12 April. Selection of the preferred bidder would be by September 2010, with contract award in December 2010 and service start in April 2011.
- (iii) CUH had met all the private sector organisations expressing interest at PQQ stage. All had stated that they would be keen to work with CUH if they won. A number of visits had been made to Hinchingsbrooke and Divisional Directors had met the Medical Director there. The core requirement had been examined in detail and the difficulty of integrating two hospitals, especially two very different hospitals, had been examined. It was clear that the potential benefits of integrating with Hinchingsbrooke were low and the risks were high, especially given the management effort needed for other key activities, including making Addenbrooke's the best possible DGH, continuing to improve research, assisting with the relocation of Papworth Hospital to the Cambridge Biomedical Campus and at the same time achieving significant efficiencies. The Board of Directors had therefore decided against the initiative and the CUH bid had been withdrawn. CUH would continue to work with the remaining bidders to ensure effective co-operation in areas such as pathology services and sterile services which could be provided for Hinchingsbrooke; and in using their under-utilised theatres.
- (iv) Clarification of the current joint working arrangements with Hinchingsbrooke was requested. In some cases, for instance dialysis, Addenbrooke's rents part of a building. There are a number of joint appointments for Hinchingsbrooke activity delivered by Addenbrooke's Consultants, for instance in urology. The SLAs covering these arrangements could be terminated at six months notice after the franchise contract award.
- (v) Given the risks and unfavourable financial model, concern was expressed about what would happen if all the bidders withdrew. In that eventuality, the Trust Board would carry on, and the SHA would probably initiate a Foundation Trust process. It was also possible during the procurement process that the bidders could suggest alternative models to balance the risks and rewards in a different way. It was clear that there were a

number of major difficulties to be overcome and that some contingency planning to cover Addenbrooke's involvement might be needed in case the procurement process fell apart.

- (vi) Following Stephen Graves' presentation there was a general discussion and it was noted by the Chairman that all Governors present supported the decision of the Board of Directors not to proceed further with any bid for the franchise at Hinchingsbrooke.

**(C) Rosie Extension – Financial Case**

Noted

- (i) Stephen Graves outlined recent developments. The Rosie had been built to care for 3,000 babies a year; that requirement had risen to 6,000. Demand for neonatal intensive care had also risen substantially; the unit is now continuously full and the space between cots is grossly inadequate.
- (ii) The Rosie currently has 33 cots. Analysis had shown that 58 cots were now needed to cope with rising demand and the new regional role, to reduce occupancy to 80%, to provide for the new neuro-protection service and to provide a crash cot.
- (iii) The extension would also provide a midwifery-led birthing centre and would allow for the increased regional demand for foetal medicine.
- (iv) The original proposal met all the aspects of the Case for Change. Given current financial constraints the Board had asked the planning team to look at other options. The "Next Best" option (44 cots) had been considered in detail. It reduced the overall build cost from £30M to £22M and showed a slight improvement in short term I&E deterioration, but came out worse on NPV, average I&E deterioration and EBITDA.
- (v) The Board had therefore decided that the original proposal was the preferred option on both clinical and value for money grounds. The SHA would be asked to consider providing financial support to cover the short term I&E deterioration. The Board had bid successfully for funding for the project from the Foundation Trust Funding Facility. Planning application had been made and design work was almost complete. Building was expected to start in late summer 2010 and to be complete by spring 2012.
- (vi) Questions were invited from Governors and these covered a broad range of issues. GPs and the PCT had been involved in the planning at a number of levels including the regional neonatal network and the specialist commissioning group. The PCT supports the project on the assumption that activity growth will occur and this had been independently assessed.
- (vii) The funding method chosen was quicker and cheaper than a PFI scheme and did not need Department of Health approval.
- (viii) Given the role that provision of new services had to play in the project, the risk of "technology drift" was raised. It was likely that there was little risk of this progressing beyond the current 22/23 week stage. The only main technology advance was the planned neuro-protection/MRI development. It was suggested that the Medical Director would be the best person to answer this general question.
- (ix) It was confirmed that when high-risk babies had stabilised, they would be transferred, this being a normal part of ANTS activity.
- (x) The future of the academic unit was raised. It would be staying where it was. The MRI facility would be for patients and research.

- (xi) ACT involvement was discussed. This charity was raising a total of £7M, £2M of which was for the MRI scanner. The ongoing costs of the MRI facility had been included in the overall business case.
- (xii) The question of the original deeds for the Rosie was raised. The requirement for preserving the southern view had been dealt with.

**(D) Papworth PFI**

Noted

Robert Burgin had not been able to attend and had briefed Stephen Graves on developments. All the approvals were in place and Monitor were content with the proposals. No public decision had been made and an announcement from the Department of Health was expected in the near future.

**(E) Annual Plan**

Noted

- (i) Lawrence Ashelford reported. Comments from the Governor reading group were in the process of being incorporated, but Monitor now required a shorter plan with a very different style and had issued a completely new set of guidelines and a very tightly defined template. This meant that much of the work needed to be redone at short notice.
- (ii) The strategy element of the plan would be tackled first and Lawrence would email a draft of this to the relevant Governors on 19 March.
- (iii) The financial element of the plan (the budget for the year ahead) would go to the Board of Directors in early April. The Trust Secretary confirmed that Governors could be included in the distribution, or a briefing session could be arranged to provide guidance on what was a very detailed document.
- (iv) The timescale for comments was discussed. The Monitor deadline was 31 May. The initial, work-in-progress version would be considered by the Board of Directors on 27 April and the financial information would be added to the amended version from that meeting. Given the time constraints, Judy Ewer and the Working Group Chairmen and Vice-Chairmen of the three Governor Director Working Groups would discuss the plan at their forthcoming meeting on 25 March.
- (v) An extraordinary Governor meeting might be needed to discuss the annual plan in the round. The Chairman and Judy Ewer might need to decide on which parts of the annual plan Governors would wish to comment on.

**(F) Challenge Prize Fund**

Noted

Stephen Graves reported. Since the original advertisement for an expert panel for this NHS innovation prize, nothing further had been announced. It was assumed that the competition had been shelved. He noted that the SHA ran an innovation fund and that Addenbrooke's was bidding for part of it.

**33/09 AGENDA POINTS FOR NEXT FPG MEETING**

Noted

The following Items would be considered for inclusion: Private Hospital Review, Role of Governors in Strategy Development (given its apparent absence from the audit report action plan), and the Children's Hospital Update.

**34/09 DATE OF NEXT MEETING**

Wednesday 16 June 2010 at 1600 in the Boardroom, Addenbrooke's Hospital.

**35/09 ANY OTHER BUSINESS**

Noted

The Trust Secretary noted that it was now a requirement to include "Items for the Attention of the Board of Governors" on the Agenda.