Forward Plan Strategy Document for 2012-13

Royal Brompton & Harefield NHS Foundation Trust
Section 1: Forward Plan

A. The Trust’s vision is summarised as:

In line with the Annual Forward Plans that we have submitted over the last two years, the strategic Vision of the Trust continues to be that which we articulated when we became a Foundation Trust in 2009 – namely to be the UK’s leading specialist hospital for heart and lung disease. Our three strategic goals (Service Excellence, Organisational Excellence, Productivity & Investment) also have remained the same.

We believe that we cannot achieve this vision with the current configuration of our two hospital sites and their physical infrastructure, and the constraints they place on clinical service delivery. We have reviewed options to redevelop the Royal Brompton Hospital on site, or to relocate elsewhere from its current location in Chelsea. In pursuit of this latter set of options, we are investing time and resources to identifying available land in the White City area of London, upon which, subject to planning consent, a hospital could potentially be built that could be wholly fit for 21st century healthcare delivery. This prospectively could be the catalyst for the creation of a dynamic new health environment in west London that will create a medical city which best integrates research and clinical care. This hospital would be a part of a wider cluster of tertiary and specialist clinical service providers and bio-medical research bodies, linked to Imperial College (and in particular the activities on its adjacent Imperial West campus), our principal research and academic partner. Under this set of options, the new hospital also would be large enough to accommodate not just many of this Trust’s activities, but also those of other tertiary specialist providers, for whom collaborative co-location of some services would be justified by clinical and operational synergies. The development of this hospital could be financed by receipts from the disposal of the land in Chelsea owned by the Trust. These receipts could also support the redevelopment of Harefield Hospital, not only as the acute cardiovascular and thoracic interventionist centre for Outer London and the Home Counties, but also as the hub of a set of specialist respiratory rehabilitation and cardiac diagnostic and rehabilitation services, to be delivered in partnership with GP practices and in community locations across the region.

Our most important stakeholders are: 1) our patients - by whom we intend to be seen as consistently and effectively delivering safety of outcomes and quality of care, and conscientiously assessing and improving their experience in our hospitals through innovation; 2) our staff - to whom we wish to demonstrate our commitment to clinical excellence in our chosen specialty areas and to establishing an equitable structure for the allocation and management of resources, such that staff-members are happy to develop and maintain their careers with the Trust; 3) the District General Hospitals (DGHs) and Primary Care Trusts (PCTs) / Clinical Commissioning Groups (CCGs) who currently refer to us the majority of our patients and commission the majority of our services, with whom we aim to share the benefits of our specialist expertise and of whom we can be supportive as they tackle their own particular challenges and issues; 4) our research funders, to whom we aim to demonstrate our competence in translating research into direct clinical benefits and our ability to provide a clear and valid return on research funding investments; 5) our academic partners, principally Imperial College and its School of Medicine; and 6) our Governors, several of whom are drawn from our patients and our staff.

B. The Trust’s Strategic Position

The Trust’s strategic position is summarised as:

The Trust is a centre that provides a comprehensive range of tertiary and quaternary cardiac and respiratory services to treat paediatric and adult patients across a number of disease cohorts, the majority of whom are referred to our two hospitals from cardiac and respiratory clinicians based in DGHs located not just in North West London, the North West Home Counties, London and the South-East of England, but also from many other regions of the UK. Included within this service portfolio are nationally commissioned services such as our adult Cardiothoracic Transplantation, Pulmonary Hypertension and ECMO programmes, and our paediatric Primary Ciliary Dyskinesia and respiratory ECMO services.
To adhere to our strategic vision, we aim to offer clinical services of the highest quality to our patients. Central to this aim is our ability to develop and maintain both the critical mass of clinical and research expert resources and the volume of patient referral flows that are necessary to enable services across all sub-specialty areas of cardiac and respiratory medicine to flourish. This ability is predicated on our readiness to compete with peer centres to the benefit of patients: to facilitate this, for example, our interventionists in cardiac and thoracic medicine have over a number of years supported colleagues at DGHs by regularly attending their weekly multi-disciplinary team (MDT) meetings. However our preference, wherever possible, is to collaborate with peer centres in order to maximise best practice transfer (e.g. in pathway design) and economies of scale (leading to improved outcomes). Consequently we look forward to being a founder partner in the Imperial College Health Partners academic health science partnership; contributing to the formation of effective clinical networks emerging from the London Cancer Alliance programme and the London tertiary paediatric review; working with GP commissioners to provide tertiary respiratory and cardiac services in community and primary care settings in under-served parts of North West London and the surrounding counties; and continuing to invest in joint consultant appointments with our DGH partners. We remain enthused by and committed to our research collaborations, both with our academic partner Imperial College principally (though not exclusively) through our two joint BRUs (Biomedical Research Units), and also with Liverpool Heart & Chest Hospital through our joint partnership of the Institute of Cardiovascular Medicine and Science.

Given that key parts of the NHS’s future commissioning infrastructure are still forming, the commissioning intentions with which we will be engaging are not yet finalised, although we are continuing to build and strengthen links with Clinical Commissioning Groups chairs and leads in and around North West London, as well as with the London Specialised Commissioning Group. We will continue to support the development of a collaborative networked model of care involving the Royal Brompton Hospital and its two other peer centres in London, through which the current provision of paediatric cardiac interventions and related services in London & the South East of England can be advanced and improved. We have also enhanced and reconfigured several of our clinical services in line with (and in some cases in advance of) service reviews led by commissioners and local cardiac and respiratory networks. By way of example, we have extended the sub-specialisation of interventionist teams within cardiac surgery; responded to the CTAG / NHSBT-led review of cardiothoracic transplantation by significantly strengthening our organ retrieval resources so as to improve the yield of donor organs and subsequent volume of transplants; and added or reconfigured level 1 & level 2 bed capacity to ensure that we remain within acceptable patient access time parameters.
C. Clinical and Quality Strategy

The Trust’s Clinical and Quality strategy over the next three years is:

In aspiring through its overall vision to be ‘the UK’s leading specialist centre for heart and lung disease’, the Trust has set out its strategic goals of Service Excellence, Organisational Excellence, and Productivity and Investment. These are underpinned by a set of key objectives of which the most important is continuously to improve the patient experience in its totality. Accordingly in December 2010 the Trust put in place a 3 year “Quality & Safety Improvement” plan (“The Plan”), which set out our commitment to providing the highest quality care for all our patients and ensuring that evidence-based care is provided at the right time, in the right way, by the right people.

The Plan aims to meet the challenge put forward by Lord Darzi (in his 2010 report “High Quality Care for All”) and the requirements of Regulators and Commissioners to build on our current systems and services to deliver improvements across the three dimensions of service; safety, quality and patient experience. The Plan is currently being revised and brought fully up to date.

Given the Trust’s principal scope of activity – the provision of specialist, innovative, tertiary cardiovascular and respiratory services - there are risks to patients and the organisation inherent in the healthcare delivery, clinical innovation and research that are undertaken through these services. The Trust recognises that not all risk can be eliminated or avoided but specific risks can and should be mitigated and managed. Hence the Trust’s “Risk Management Strategy” (described more fully under “Risks to Quality” in appendix 1 of this document) lays out the Trust’s intent to do everything possible to reduce risk (avoidable harm and death) to patients as well as to deliver high quality, safe and cost-effective care. It, the risk register and the risk management practices within its ambit therefore directly complement and support the Plan.

There are three key strategic goals have been agreed to monitor the Quality and Safety of the Trust from 2010-2012;

1. To reduce HSMR
2. To reduce harm rate as measured by the GTT (Global Trigger Tool) by 10% year on year
3. To develop the attributes of a high reliability organisation (HRO)¹ and make safety our priority

There are six sub-strategies within the Plan through which the Trust aims to achieve these strategic goals:

1. Make safety and improvement leadership visible through;
   - Ensuring a coordinated approach to safety, quality improvement and modernisation
   - Board engagement through regular reporting of safety and quality indicators, discussion at Board meetings of patient safety issues and direct engagement through (e.g.) Executive Safety Walkrounds
   - Ensuring action and feedback in relation to safety and quality issues, learning from failure and celebrating success
   - Ensuring that all formal meetings and committees at ward, unit, divisional, management and Board level include quality and patient safety as an agenda item
   - Instil ambition across the organisation by demanding an expectation that we will meet and exceed goals set by external regulators/agencies and benchmarks and aim for absolute levels of exceptional performance (best in class)

¹ HROs can be defined as organizations which have fewer than normal accidents. An HRO expects its organization and its sub-systems will fail and works very hard to avoid failure while preparing for the inevitable so that they can minimize the impact of failure. There are 5 characteristics of High Reliability Organizations that have been identified as responsible for the “mindfulness” that keeps them working well when facing unexpected situations – i) a preoccupation with failure, ii) a reluctance to simplify interpretations, iii) a sensitivity to operations, iv) a commitment to resilience, and v) a deference to expertise

• Consistently communicating the vision of patient safety and quality improvement through actions and messages optimising any opportunity to create shared commitment to achieve our strategic goals
• Working with an overarching set of principles to guide the organisation including communication and team work, reliability and standardisation, elimination of waste, openness, and patient involvement.

2. **Develop a culture of safety and quality improvement by:**
   • Identifying safety improvements as a corporate objective
   • Setting explicit corporate goals to challenge the organisation
   • Developing and communicating compelling reasons why patient safety and quality improvement are the priority for all staff, clinical and non-clinical, regardless of role
   • Including patient safety and quality improvement in all job plans as a personal objective for all staff to be reviewed as part of appraisal
   • Allowing and encouraging openness in reporting to allow learning from error or system failure in a constructive way

3. **Ensure reliability of care delivery by:**
   • Developing the attributes of a high reliability organisation in which staff are empowered to act to improve safety
   • Monitoring and measuring the implementation of evidence based interventions to track progress
   • Providing regular feedback to all staff & patients on implementation
   • Developing care bundles to improve patient safety
   • Achieving standardisation within the evidence base and reducing variation in practice e.g. using lean techniques
   • Ensuring spread of improvements and learning across the organisation
   • Providing reports on implementation to all committees including the Board.

4. **Use patient experiences to inform improvements by:**
   • Using patient stories to focus staff on the things that matter
   • Using patient surveys to inform patient safety initiatives and improvements
   • Giving patients a voice at relevant committees including the Board
   • Involving patients in safety and quality improvement programmes

5. **Align organisational strategies to patient safety and quality improvement by:**
   • Making safety and quality core strategies reinforced by all other strategies including research, IT, procurement, HR, Patient & Public Involvement
   • Using audit to drive safety improvement
   • Ensuring all systems of work, care pathways and team functions have safety and quality improvement as key drivers
   • Making explicit links to ensure synergy between all initiatives aimed at reducing harm e.g. modernisation, quality improvement, risk management, patient involvement

6. **Develop improvement capability across the organisation by:**
   • Targeting improvement skills training to those who demonstrate scope and capacity for leadership in the improvement of patient safety
   • Use data effectively to support the implementation and measurement of improvement interventions
• Spreading learning throughout the organisation through safety and quality improvement events, clinical governance half-days and study days
• Creating opportunities for staff to attend national and international conferences on quality improvement and patient safety
• Supporting a culture in which small tests of change are encouraged and regarded as integral to improvement and development
• Introducing Human Factors and team training for all relevant staff with regular updates
• Providing training in ‘lean’ and service improvement techniques
• Creating opportunities for staff to be involved in safety and quality improvement projects and initiatives

Finally, the Trust Board monitors and is assured of delivery of the Plan (as well as the Risk Management Strategy) through the Quality Governance Framework (QGF). Progress against the four areas of measurement within the QGF, which apply to the Plan and its sub-strategies, is reviewed by the Board on a quarterly basis.

D. Clinical and Quality priorities and milestones

The Trust’s Clinical and Quality priorities and milestones over the next three years are:

There are a set of indicators covering the three main areas of clinical quality (safety, clinical effectiveness and patient experience) as well as staff satisfaction which measure the ongoing level of progress in achieving the Plan and its constituent sub-strategies. These are ongoing metrics whose target levels of achievement for the Trust are reviewed on an annual basis. Examples include: for safety - MRSA per 10,000 bed days, C diff per 1000 bed days, ‘Never event’ rate, medication related safety incidents / 1000 bed days, compliance with use of PAR scoring (>90%); for clinical effectiveness - HSMR, 30 day Mortality Rates for cardiothoracic surgery and transplantation, primary angioplasty treatment times; and for patient experience – the proportion of patients who score the Trust as excellent or poor, the proportion treated with dignity and respect, and the number of complaints per 1000 contacts.

Complementing this group of ongoing metrics are the Trust’s clinical and quality priorities and the CQUIN measures, both of which are set on annual basis. The Trust’s priorities for FY2012/13, each of which have been chosen by a different set of stakeholders and have their own particular metric, are as follows:

• For patient safety:
  1. Improving patient satisfaction on advice and information given to patients on their medication (chosen by Local Involvement User Networks): to be measured by patient feedback at discharge asking about their medications, using a variety of formats e.g. paper and electronic forms.
  2. Effective content and organisation of paper-based patient notes, especially loose papers in notes, legible clinical entries, written evidence the patient has had contact with their consultant during their last admission (chosen by Members and Governors): to be measured by monthly cross-site case note review across all specialties and reported quarterly.

• For patient experience:
  1. Effective communication with patients, focusing on communication with a) outpatients around tests / procedures and patient views – i.e. informed of need for test, reason why, when to expect results – and b) inpatients on communicating outcome of multidisciplinary team discussion to patients (chosen by patients and public): to be
measured by a) the Trust's annual outpatient survey and b) a review of how many patients receive a letter within a set period of the MDT discussion.

- For clinical outcomes:
  1. Participation in national PROMs programme – Elective coronary revascularisation *(chosen by the Trust Board)*: metric to be determined by the national programme
  2. Managing complications effectively – using the ‘safety thermometer’ to measure venous thromboembolism, pressure ulcers, patient falls and catheter related urinary tract infections *(chosen by staff)*: current projects are ongoing to ensure that where these complications occur, they are managed effectively with the focus on reduction.

The Trust’s has 11 CQUIN indicators to comply with in FY12/13:

- There are four national indicators - improving VTE Prevention (target - 90% of all adult inpatients to have had a VTE risk assessment upon admission); responsiveness to patient need (target – to remain within the top 20% of Trusts as rated by the Picker survey); improving diagnosis of dementia (target to be confirmed – a percentage of all patients aged 75 and over who have been screened upon admission); and use of the NHS Safety Thermometer (a pilot is currently in use in the Trust but further clarification regarding the target is required.

- Five indicators have been set by NW London commissioners – four relate to GP real time information (notification of emergency admissions, notification of discharge planning within 24hrs, summary to be sent 24hrs before discharge, and outpatient care letters within 2 days of the appointment). The fifth is compliance with the NWL Integrated Formulary. Targets are not yet set as implementation timescales and content are still under discussion, although all five are seen by NWL commissioners as long term projects.

- The final two indicators related to clinical care groups – firstly, a COPD discharge bundle (target - 95% of patients admitted with diagnosed OPD exacerbation should be discharged with a completed COPD care bundle); secondly, an indicator relating to end of life care (which is still under development, although the Trust has already implemented the Liverpool pathway.)

E. Financial Strategy

E. The Trust’s financial strategy and goals over the next three years:

Introduction
Against a difficult economic backdrop and Government expenditure cuts, the Trust continues to face a combination of reducing PbR tariffs and cost inflation. As a result it has for the past [three] years had to tighten its belt on its costs while seeking to grow its income through the expansion of activities, whether organically or through new service developments.

Looking ahead, there is every indication that this regime will continue for the foreseeable future and certainly over the period covered by this Three Year Plan. Tariffs are expected to fall by some 2% p.a. and cost inflation of a similar order is anticipated. The Plan therefore reflects improvements in costs and revenues of some 5% p.a. to accommodate these developments.

As well as meeting this challenge, the Trust is considering the redevelopment of its Chelsea campus, either in situ or in another location. Although the substantial majority of related expenditures is expected to fall beyond the next three years, there will be planning and design costs incurred within this timeframe.

Aside from this specific requirement, the Trust’s financial performance must respond to a number of further demands:

- To provide working capital for its ongoing activities
- To finance expansion
- To finance investment in capital assets
- To pay dividends on Public Dividend Capital
- To maintain a Monitor Financial Risk Rating of a minimum of 3
- Possibly, to accommodate any impact of the Safe & Sustainable review of paediatric cardiac surgery

To meet these demands the Trust expects to have access to these sources of funds:
- Funds generated from clinical activities
- Revenues linked to research
- Borrowings from financial institutions
- Donations

Funds generated from clinical activities
These must be maximised. This will require a rigorous regime of cost control and, where appropriate, of cost reduction. It also obliges the Trust to consider ways and means of generating additional revenues, including changing how we do things now.

The Trust has established a project team chaired by the Chief Operating Officer and supported by the Finance Department: the role of this team is to establish and monitor performance against budget, and within this to monitor performance against our cost and revenue improvement plans. All budget holders, including clinical directorates, will participate in quarterly performance reviews: if they are falling behind their targets appropriate action will be taken to bring them back on track.

We have recently expanded capacity at our Harefield site and will look for further opportunities to do so. Another opportunity will be in private patient services where the new Health and Social Care Act has substantially reduced the constraints over growth. The financial projections incorporate our assumptions on incremental revenues.

The Trust has for the past twelve months invested in improved service line reporting (‘SLR’) and patient level costing (‘PLICs’) methodologies, and plans to introduce formal reporting during 2012/13. This will be a valuable tool in determining which services we should particularly invest in, always having regard to the list of mandatory services under our authorisation as a Foundation Trust.

For a number of years the Trust, as a specialist London hospital trust, has benefited from transitional funding designed to compensate for the inadequacy of the PBR tariff for reimbursing the cost of the more complex operations it typically undertakes. Although this transitional funding has declined over recent years it is the Trust’s expectation that these funds will continue to be available to it over the next three years. From 2013/14 Monitor will assume the tariff-setting responsibilities currently vested in the Department of Health; as a result it is possible that this transitional funding will be consolidated into the tariff arrangements rather than it being received separately.

Revenues linked to research
The Trust enjoys an excellent reputation in research in association with its academic partner Imperial College. It receives substantial research revenues from NIHR, charitable institutions and commercial enterprises in part in relation to its two Biomedical Research Units. Not only does this provide financial benefits but it also adds lustre to the Trust’s reputation as a centre of excellence which attracts patient referrals both nationally and internationally, as well as high calibre candidates for consultant posts.

Borrowings from financial institutions
The Trust has a working capital facility of £22m from a commercial bank. Although there has been no drawdown against this facility since 2011 it provides a cushion in the event of an unexpected drain on cash flow and it is intended that this facility will be maintained.

It is also likely that future pressures on liquidity may require that the Trust borrows on a project basis to finance capital expenditure for specific items; such borrowings would likely be from commercial lenders although the Foundation Trust Financing Facility is also available. The Trust currently has a long-term borrowing authorisation from Monitor of £56m although no facility has been arranged at this time.
Donations
The Trust receives donations from charitable sources, including charities linked to Trust. The principal charity concerned is Royal Brompton & Harefield Charitable Fund: with effect from 1 April 2012 a new corporate trustee to this charity, Royal Brompton & Harefield Charity Trustee, was authorised and a new chief executive of Charitable Fund appointed.
Although the corporate trustee is independent of the Trust in terms of both ownership and control, its objects and those of the Charitable Fund include supporting the Trust's activities. The financial projections reflect our estimates of the improved donation stream anticipated as a result of these changes. These funds will be available, in particular, to support the Trust's capital investment plans.

F. Leadership and Organisational Development

F. The Trust’s approach to ensuring effective leadership and adequate management processes and structures over the next three years is:

In last year’s Forward plan we outlined four priorities for leadership and governance – appointments of non-executive directors on the Board, the role of the Responsible Officer, ensuring new consultants and directors are appropriately inducted into the Trust, and the maintenance of a strong standard of clinical leadership across all of the Trust’s clinical pathway groups.

With regard to the first of these priorities, we are looking to replace Professor Sir Anthony Newman-Taylor as he comes to the end of his long and productive tenure as the non-executive director on the Trust Board with particular medical expertise. Preparations have already been made for an interview and appointment process for his replacement that will be run in June of this year. This will take note of any relevant conclusions from the Board Evaluation report (see below). In addition our Chairman and two more of our non-executive directors will be up for re-appointment at various times during this calendar year.

Following the appointment of the Medical Director as Responsible Office for the Trust last year, both the risks identified in relation to this appointment have been managed. With regard to the third priority, senior clinical leaders and managers continue to commit time and energy to the induction process and the mentoring of new consultants. Finally, the Trust’s service line reporting capability was not sufficiently developed in FY11/12 to enable clinical care group leaders to take more responsibility for the financial (as well as the clinical) performance of their teams: the acceleration of this development, and the subsequent adoption and usage by senior clinicians of financial service line reports, is a priority for the finance team.

The Trust has commissioned a formal evaluation of the Board and its performance which has been carried out jointly by the law firm, Beachcroft, and a management consultancy, Foresight Consultancy. This process has involved an extensive series of interviews and focus groups with all Board and non-Board directors as well as with some of our Governors, observation of the Board and its committees in session, and a skills inventory of all Board members. A report and a plan of recommended actions will be provided to the Board at the end of May 2012.

Below Board level, the Trust continues to amend management structures in response to strategic and operational issues. For example, as a result of the IT reorientation programme referred to in section G below, the Trust has identified the need to expand the role of the Head of IT Services to encompass both a closer working relationship between the IT function and clinical divisions and also the capabilities required to lead the delivery of several significant applications and systems over the next three years. This role is therefore being redesigned. Another example – in this and previous Forward Plans we have identified the importance of the Trust’s referral relationships with DGH clinicians and CCG Chairs and leads. Consequently senior appointments made earlier this year have strengthened the team of the Director of Service Development which plays a lead role in supporting these relationships.
G. Other Strategic and Operational plans

The Trust’s other strategic and operational plans over the next three years:

The Trust is undertaking (or is about to undertake) a number of other strategic and operational initiatives (see below) that should feed into and provide a positive contribution to the main elements of this Forward Plan during its three year period.

A strategic priority for the Trust (as evidenced in our two previous Annual Plans, and referenced in the section A of this Forward Plan document) has been the generation of a) a set of options to redevelop, or relocate and rebuild, the Royal Brompton Hospital, b) a plan to redevelop Harefield Hospital.

In February 2011 our Trust and Imperial College Healthcare Trust (ICHT) together set up a joint aortic dissection service involving a shared rota of six cardiac surgeons across three tertiary sites (Hammersmith, Harefield and the Royal Brompton Hospitals). Over the past 6 months, clinicians at both Trusts have met to discuss how further collaboration relating to tertiary services might come about. In the longer term, the principal vehicle for such collaboration is envisaged to be our Trust’s potential development of a new hospital in White City (see section A), wherein a number of ICHT’s tertiary specialist services could conceivably be based. There is a common understanding between both Trusts as to the potential scope of these services: it is anticipated that if and when our Trust secures a site in White City, both Trusts then will be able to explore in greater detail the operating, governance and financial models for these service collaborations.

The potential raising of the ‘cap’ on Foundation Trusts' private patient activity as a percentage of total clinical income to 49% could lead to some financial protection against increasing NHS tariff / volume uncertainty. However maintaining sensible pricing positions while increasing volumes of activity is unlikely to be achieved on a ‘more of the same’ basis, especially with some insurers’ aggressive moves against consultant fee levels and plan coverages. Embassy and overseas patient flows may become contingent on more specialist activities and services we have yet to develop, such as training programmes for overseas medics and nurses. We consequently need to formulate a new strategy for our private patients’ business to address these issues.

The Trust has recently laid out its research strategy for 2012-2015. The main goals include increasing the critical mass and productivity of active research leaders and trainees; increasing the “value” of grant applications, grant awards and industry; promoting patient and carer’s awareness of the Trust as ‘research active’; and exploiting the Trust’s clinical information systems for research purposes. We will continue to increase the research output from our respiratory and cardiovascular BRUs; as previously identified, the latter BRU will be of value as a resource that can support the activities of the Institute of Cardiovascular Medicine & Science (ICMS), our collaboration with the Liverpool Heart and Chest Hospital NHS Foundation Trust. Alongside the many joint research initiatives under way, a focus for the ICMS will be the launch of a joint cardiomyopathy service.

The direction of the ongoing development of best practice in cardiac surgical and catheter-based interventions, and sub-specialities such as aortic surgery in particular, is one that (inter alia) increasingly calls for closer collaboration with vascular interventionists. Consequently we see our clinical practice as being more cardiovascular than merely cardiac. We plan to realise this, either by ourselves or through collaboration with a partner, by recruiting interventionists with vascular (as well as cardiac) expertise, and by converting 1-2 of our theatres to a hybrid vascular / cardiac format.

In February 2012, along with other peer UK centres, the Trust was invited to present its five year strategy for cardiothoracic transplantation to a review panel convened by the National Specialist Commissioning Team (NSCT). We reiterate our commitment to the strategic vision laid out in our original response to the NSCT’s review template, and we are planning a number of associated investments.

The age and fabric of many of the Trust’s buildings mean that some of them could potentially pose a risk to the health of patients, staff and visitors. To ensure that current standards/ guidelines for H&S, fire, emergency situations etc continue to be met, a 3 year accelerated and expanded planned preventative maintenance (PPM) programme focused on high-risk areas and issues has been developed to reduce the maintenance backlog, with a significant increase in the investment in estates maintenance to c. £5m planned for 2012/13. Progress against this plan is being monitored by the Director of Operations through the Capital Working Group.
Over the last 9 months, the Trust has been trialling a set of working practices that represent a significant change to the way in which the IT function and its users have interacted and worked with one another to date. During this trial, entitled the ‘IT Reorientation Programme’, a set of five new projects has been initiated in order to test these new working practices, and existing staff have taken on different roles on a temporary basis to facilitate this ‘proof of concept’ process. We are now looking to develop a new organisational model for the IT function and its alignment with the Trust’s clinical and clinical support divisions. We believe that with this model in place we can be more confident that significant investments over the next 3 years in key Trust wide applications are not just technically robust but also more closely satisfy users’ needs.

H. Regard to the views of Trust Governors

The Trust has had regard to the views of Trust Governors by:

The Council of the Governors of our Trust meets four times a year. Each of these meetings is attended by members of the Trust Board and the senior management team, and is minuted by the Trust Secretary. At each meeting, the Trust’s performance and financial teams submit financial performance and clinical quality reports to the Governors’ Council members for their scrutiny and comment, all of which is noted by the Trust Board and senior management team members. In addition, the Trust’s Chairman and Chief Executive provide Council members with a comprehensive briefing on all strategic issues facing the Trust, which Council members nearly always comment upon and ask questions about. For particularly important issues – for example the Trust’s response to the ‘Safe & Sustainable’ review of paediatric cardiac surgical services – Council members provide endorsement of the Trust’s strategy and plans.

To ensure valuable feedback from Governors across the Trust’s portfolio of activities, a number of working groups were set up in 2010. These have continued to provide input into Trust strategy and policy relating to (for example) estates, service developments, communications & marketing, and patient safety.

It can be seen therefore that the Trust has regard to the views of Trust Governors throughout the year and on different issues, many of which are described in this Forward Plan. In addition, the May 23rd 2012 meeting of the Governors’ Council included a presentation by the Trust’s Associated Chief Executive (Finance), Strategy & Planning Director, and Director of Performance, which summarised the full version of the Forward Plan, copies of which were circulated to Governors in advance.