Ashford and St. Peter's Hospitals NHS
NHS Trust

TRUST BOARD
25th February 2010

TITLE	Trust Executive Committee Minutes held on 8th January 2010 and 22nd January 2010
EXECUTIVE SUMMARY	The Trust Executive Committee key points include : **8th January 2010** • Approved Policy on Media Handling • Noted and discussed Operating Framework 2010/2011 • Approved Business case for Urology **22nd January 2010** • Approved business cases for Neurophysiology and remodelling Endoscopy • Received update on Major Incident Preparedness
BOARD ASSURANCE (Risk) / IMPLICATIONS	Compiled according to the Trust Committee Policy
STAKEHOLDER / PATIENT IMPACT AND VIEWS	None
EQUALITY AND DIVERSITY ISSUES	None
LEGAL ISSUES	None
The Trust Board is asked to:	Note the minutes of the Trust Executive Committee held on the 8th January 2010 and 22nd January 2010
Submitted by:	Andrew Liles Chief Executive
Date:	15th February 2010
Decision:	For Noting

Ashford and St. Peter's Hospitals NHS
NHS Trust

TRUST EXECUTIVE COMMITTEE MINUTES
8th January 2010
Lecture Theatre, Ramp, St. Peter's Hospital

PRESENT	Andrew Liles	Chief Executive (Chair)
	David Fluck	Clinical Director for Medicine
	Elliot Chisholm	Clinical Director for Surgery
	Giselle Rothwell	Head of Communications
	John Hadley	Clinical Director for Specialist Surgery
	John Headley	Director of Finance & Information
	Mike Baxter	Medical Director
	Mick Imrie	Clinical Director for Anaesthetics & Theatres
	Paul Crawshaw	Clinical Director for Children's Services
	Raj Bhamber	Director of Human Resources & OD
	Valerie Howell	Chief Operating Officer
	Chris Schofield	Clinical Director for Trauma & Orthopaedics
	Jonathan Robin	Interim Clinical Director for Emergency & A & E
	Barry Sellick	Clinical Director for Critical Care
	Jonathan Glover	Acting Clinical Director for Imaging & Endoscopy
	Caroline Becher	Chief Nurse
	Paul Murray	Lead Clinician for Cancer & MSC Chair
	Andrew Laurie	Clinical Director for Pathology
SECRETARY	Jane Gear	Head of Corporate Affairs
IN ATTENDANCE	Harriet Stephens	Education , Training and Development Manager (Item 4/2010)
APOLOGIES	Robin Gammon	Interim Head of Information Services
	Paul Bentley	Director of Strategy
	Peter Finch	Clinical Director for Imaging & Endoscopy

ITEM **ACTION**

1/2010 MINUTES

The minutes of the meeting held on 11th December 2009 were agreed as a correct record.

MATTERS ARISING

TEC reviewed all of the actions from the previous minutes. Nominated leads confirmed that all of the respective actions had been completed, appeared as agenda items for this meeting, or were on

track within the agreed timescales. The following was noted:

13th November 2009

2/2010 **Ward Quality Indicator Report(4.5)**
It was confirmed that the January publication of the Quality Report would include the revised format for the ward quality indicators and that issues such as trend analysis and RAG rating had been addressed.

3/2010 **Stroke CQUIN and Trust Performance Report (5.1)**
The review of definitional understanding had been completed and the data validation would be concluded by next week. The extent of any issue could be reviewed at the next TEC but thereafter the 2 reports would be aligned and would provide consistent information. **RG**

27th November 2009

4/2010 **3.2 Learning and Development Policy (3.2)**
Harriet Stephens was welcomed to TEC. Following earlier discussions at TEC further work had taken place with Paul Crawshaw and Barry Sellick on the Mandatory Training Grid. TEC welcomed the revised approach; in particular the benefits of clearly identifying the source and rationale of each requirement for training and that mandatory training for consultants could be achieved in a shortened timeslot.

The revised grid was AGREED noting that a number of minor changes would be made prior to circulation. These included:-

- Frequency of refresher manual handling training for non- clinical staff.
- That the training on consent to undertake PMs only related to consent takers.

It was confirmed that the Trust had arrangements to support sufficient capacity for training at Level 3 on Safeguarding Children. This could be arranged through Kate Brocklesby.

The revised grid would now be published and Directorates would need to agree local implementation in respect of scheduling training for Consultants which could be through the Educational half-days or within SPAs. **ALL**

11th December 2009

5/2010 Job Planning (5.ii)
The draft Job Planning Guidance framework would be circulated in the following week.

6/2010 **TRUST 6 DELIVERY PROGRAMMES**

6.1/2010 **Programme 1: Improving our Patients' Experience**
Project lead: Caroline Becher
Clinical directors: Andrew Laurie & Director of Women's Health

This Programme had been divided into 6 deliverables which were primarily derived from patient feedback, in particular the national Inpatient survey and complaints. The actions for the Programme

would be dynamic as it would continue to develop as the results from new surveys (such as the forthcoming results from the national Out-Patient Survey and the 2009 Inpatient survey) were received.

It was noted that patient experience was a key theme under the national Operating Framework and the trend was increasingly to link patient experience to financial incentives.

TEC discussed the Programme deliverables and progress to date noting the following points:

(i) Patient feedback tools
The Trust was commencing a pilot of a Patient Experience Tracker (PET). This was a powerful tool as questions could be changed easily and tailored to the area /service. PET was currently being piloted on Kingfisher/MAU/ELM.

It was suggested that consideration be given to incorporating the questions onto HOSPICOM. **CB**

(ii) Information to patients
An in-patient folder was being developed.

(iii) Complaints
The Customer Services team was starting to identify if staff were repeatedly identified within complaints. This would enable Clinical Directors to have greater intelligence to support service improvements. It was also noted that there needed to be a stronger link between incidents and complaints.

(iv) Visiting hours
The matrons wished to reduce visiting hours as this could bring benefits to patients in terms of their recovery, and also have associated benefits such as facilitating improved cleaning. However any changes needed to recognise that some visitors were constrained as to when they could visit either because they were elderly or had work /family commitments.

It was also noted that there was a common complaint regarding lack of communication between Doctors and relatives which could be compounded if visiting was restricted.

Following discussion on the principle of any change it was agreed that :-

- Any reduction in visiting hours would need to be balanced with systems to enable relatives to make an appointment to speak to Doctors, either in person or by telephone.

- Ward staff would need to make exceptions to the visiting hours by considering the requirements of individual patients and their visitors.

It was AGREED that a pilot on reducing visiting hours would help

inform a wider consultation which could also seek views via the membership. This should be explored by the Programme Group. **CB**

(v) Noise at Night
A degree of caution needed to be exerted in respect of the use of earplugs in order to avoid harm to the patients.

6.2/2010 **Programme 5: Workforce Redesign**
Project lead: Raj Bhamber
Clinical Directors: Peter Finch & Jonathan Robbin

Discussion on the Programme deliverables highlighted :
HealthRoster. Implementation of HealthRoster would enable greater understanding within the Trust of the mix of temporary/permanent staff. Full implementation would, however, be a major project for the Trust.

Job Planning. The guidance was being drafted for circulation and discussion at the next TEC and then at LNC. RB

TEC confirmed the previously agreed principles on timing:

January- March	Complete My Job Plan
April – June	Appraisal

The intention of the draft guidance would be to ensure consistency of implementation and equity. It was agreed to obtain up to date information on the number of Consultants who had not opted to transfer to the new Consultant contract although it was noted that the requirement for Job Planning applied to all Consultants. MB

Different Directorates had previously implemented Job Planning in different ways, and it was highlighted that involving the General Managers in the process was helpful both in supporting joint working and also in robust capacity planning.

Workforce redesign. The national Workforce Redesign Team was working with the Trust looking at opportunities to harmonize and ensure consistency across the Trust for different job titles/grades.

It was intended to refocus the HRBMs' role towards workforce planning and redesign rather than maintaining the current focus on employee relations activities. The latter would then be supported through external sources. When the scope of this project was clearer, this would be presented to TEC. RB

7/2010 **CORPORATE RISK REGISTER**

The Corporate Risk Register for the period ended 24th December 2009 was received. This recorded no changes from the previous version. It was understood this reflected the Christmas period and the next version should be more dynamic.

It was reported that a review of the function and role of the Integrated Governance and Risk structure was underway. One aim would be to

achieve greater integration of clinical and non-clinical risk. Any input from CDs would be welcomed.

TEC was advised of a major risk in relation to radiology reporting following an upgrade to PACS in December. This impacted on both clinical care and also on productivity within radiology.

It was understood that this problem with the upgrade was unique to ASPH and it had been escalated to NPfIT. It had now been included on the Risk Register.

The Risk Register was NOTED by TEC.

8/2010 BUSINESS CASE- UROLOGY

The Business Case sought approval for the appointment of a fifth full time Urological Consultant. This appointment would build on the current service provided, would develop the services further and would also start a process to support longer term succession planning.

TEC noted that urology was a key service of the Trust and it was important that the Trust was able to remain as one of two urological cancer sites in Surrey. The post would be used to strengthen the Trust's place in the network.

TEC APPROVED the Business case subject to

- Clarification that if consultant job planning meant there was a net increase in theatre lists, that the additional theatre costs would be covered by additional income
- That the Job Plan for the new post took account of the implications of on–call and the likelihood of the post holder undertaking private practice.

9/2010 RENAL BID

A verbal progress report was given by the Chief Executive.

The Trust was in the final stages of preparing its bid as part of a consortium. The PCT timetable had slipped and was now likely to require submissions by the end of February.

A very positive workshop for stakeholders had been held at the end of December. The Trust's strengths were its geographical location, its partnership arrangements and its interrelationships with other providers. The bid would also highlight the strengths on quality, safety and the marginal impact on services outside Surrey PCT borders compared with the other consortium's bid.

However, further work was on-going in respect of staffing, revenue and capital to ensure the ASPH bid was successful.

Discussions were underway with Epsom and St Helier to finalise the commercial agreement.

10/2010 FOUNDATION TRUST APPLICATION

The next steps in the application process were to update the IBP and LTFM for submission to the SHA by the end of January 2010. There would be a key meeting with the SHA on 22 February 2010.

Progressing the application was a key priority and integrated with existing work on the development of the 2010-2011 Business Plan.

11/2010 OPERATING FRAMEWORK

The 5 broad national priorities in the Operating Framework remained consistent with previous years, so the focus would be on consolidation rather than addressing new targets. Many of the themes highlighted in the Operating Framework, such as addressing staff satisfaction, were consistent with the Trust's 6 programmes.

The Operating Framework placed an increased emphasis on integration between organisations and services rather than organisations seeking to simply increase income levels. One of the levers to achieve this was a cap in the level of emergency admissions above which threshold there would be a reduced tariff.

Some implications for the Trust would be:
To focus on repatriation of patients into Surrey
Collaborative working within the SHA
To focus on efficiency and productivity.

More detailed analysis of the impact of the Operating Framework on ASPH was underway but the following areas were highlighted:

To understand the Trust's role (if any) in reducing the number of postgraduate medical specialist training posts and pre registration commissions. **RB**

An initial assessment of the additional income achieved through increased emergency activity for 2009-10 was c£1.4m and this had been equated to a need to reduce admissions by 4 per day. This assessment needed validating. **JH**

The introduction of best practice tariffs meant the Trust needed to be confident in its data and then consider and understand variations between clinical practice.

The Operating Framework set targets for the reduction of management costs in SHAs and PCTs. ASPH was currently examining its own management costs.

12/2010 POLICY APPROVAL: MEDIA HANDLING

The purpose of the Policy was to protect the Trust's reputation and also to protect patients' confidentiality.

TEC APPROVED the revised Policy.

13/2010 STAFF AWARDS

The Trust's current approach on Staff Awards had been reviewed and aligned with the Trust's values.

It was agreed to see whether the closing date for nominations could be deferred from the end of January 2010 due to the pressure caused by the extreme weather on workloads. CDs were encouraged to attend the presentation event in March. **RB**

TEC AGREED the revised Scheme.

14/2010 IM&T STRATEGY STEERING GROUP

The report from the Group was NOTED. This identified continued progress against the 2009-2010 IM&T work plan.

It was also noted that further work was required on the business case for the Cardiology interface to PAS (PRISM). It was pointed out that the Report did not refer to EDM but that a discussion on progress on EDM was scheduled for the next TEC meeting. The Email Archiving Policy would also be discussed at TEC in due course.

An external consultant was supporting the Trust undertake a review of Informatics; the Report would be presented to TEC. **JH**

15/2010 TEC WORK PLAN

The TEC workplan was NOTED. This included discussion on 2 of the 6 Programmes each meeting.

TEC members were reminded that they could always include agenda items relating to Trust matters.

ANY OTHER BUSINESS

16/2010 New Appointments

It was noted that a strong appointment had been made to the post of Bariatric Surgeon.

17/2010 DATE OF NEXT MEETING

Friday 22nd January 2010.

ACTION LOG

Date Action Agreed	Minute Number	Topic	Action	Owner	Timeline for completion	Agenda Item
13/11/09	5.1	**Quality Indicator Report**	There was currently a disparity between information in the CQUIN report and the Trust performance report. Review how these can be aligned.	**RG**	08/01/10	
13/11/09	3	**Single Sex Accommodation**	Proposals from SSA task group to revert to TEC.	**VH**	19/01/10	
11/12/09	5(i)	**6 Programmes- CIPs**	Prepare an approach to monitoring management costs	**JH**	22/01/10	
11/12/09	6	**Corporate risk register**	Clarify whether unencrypted data sticks were banned or could be used on a read-only basis	**JH/RG**	22/01/10	
11/12/09	11	**Nursing Roles**	Clarify and share relationship of roles of Chief Nurse, Deputy Chief Nurse and Heads of Nursing	**CB**	22/01/10	
11/12/09	8	**St Peter's OPD upgrade**	Seek involvement from CDs involved in the use of St Peter's OPD prior to scheme commencing	**PB**	22/01/10	
08/01/10	13/2010	**Staff Awards**	Assess feasibility of putting back closing date for nominations	**RB**	22/01/10	
08/01/01	6.2/2010	**Job Planning**	Quantify the number of Consultants who have not transferred to the new contract. Circulate draft guidance for discussion	**MB/RB**	22/01/10	
08/01/10	11/2010	**Operating Framework**	To understand the Trust's role (if any) in reducing the reduction of postgraduate medical specialist training posts and pre registration commissions	**RB**	22/01/10	

08/01/10	11/2010	**Operating Framework**	Validate the potential reduction in income from emergency activity in 2010/2011 with number of admissions we should reduce by .	**JH**	22/01/10	
13/11/09	6.3	**Access policy**	Implementation Group to oversee ** Separation of a Children's policy ** EQIA ** Consistency of approach to DNAs Policy to revert to TEC for final approval	**VH**	22/01/10	
13/11/09	5.1	**Workforce Report**	Validate apparent over- establishment on medical staffing from the Workforce report.	**JH**	22/01/10	
11/12/09	5	**LIPS**	TEC to review LIPS when there is a clear proposal on correlation with 6 Programmes and the overall way forward on patient safety.	**MB/ALa**	12/02/10	
08/01/10	6.1/2010	**Patient Experience Programme**	Ascertain if HOSPICOM can be used for patient feedback	**CB**	26/02/10	
08/01/01	6.2/2010	**Workforce redesign**	TEC to discuss changes to HRBM role	**RB**	26/02/10	
08/01/10	14/2010	**IM&T report**	Present report from Informatics Review	**JH**	12/03/10	
08/01/10	6.1/2010	**Patient Experience Programme**	Pilot changes in Visiting Hours prior to a wider consultation	**CB**	09/04/10	
11/12/09	3.1	**Infection Control**	Review costs and service implications of systems to deliver on emergency screening for MRSA	**VH/AL**	11/06/10	
13/11/09	5.1	**Workforce Report**	Introduce systems to facilitate review of reasons why staff left within one year of appointment.	**RB**	25/06/10	

Ashford and St. Peter's Hospitals NHS
NHS Trust

TRUST EXECUTIVE COMMITTEE MINUTES
22nd January 2010
Lecture Theatre, Ramp, St. Peter's Hospital

PRESENT	Andrew Liles	Chief Executive (Chair)
	David Fluck	Clinical Director for Medicine
	Elliot Chisholm	Clinical Director for Surgery
	Giselle Rothwell	Head of Communications
	John Hadley	Clinical Director for Specialist Surgery
	John Headley	Director of Finance & Information
	Mike Baxter	Medical Director
	Mick Imrie	Clinical Director for Anaesthetics & Theatres
	Paul Crawshaw	Clinical Director for Children's Services
	Raj Bhamber	Director of Human Resources & OD
	Valerie Howell	Chief Operating Officer
	Chris Schofield	Clinical Director for Trauma & Orthopaedics
	Jonathan Robin	Interim Clinical Director for Emergency & A & E
	Barry Sellick	Clinical Director for Critical Care
	Paul Bentley	Director of Strategy
	Caroline Becher	Chief Nurse
	Robin Gammon	Interim Head of Information Services
	Andrew Laurie	Clinical Director for Pathology
SECRETARY	Jane Gear	Head of Corporate Affairs
IN ATTENDANCE	Sarah Johnston	Head of Integrated Governance and Risk (items 30 & 31 /2010)
APOLOGIES	Paul Murray	Lead Clinician for Cancer & MSC Chair
	Peter Finch	Clinical Director for Imaging & Endoscopy
	Jonathan Glover	Acting Clinical Director for Imaging & Endoscopy

ITEM **ACTION**

18/2010 MINUTES

The minutes of the meeting held on 5th January 2010 were agreed as a correct record.

MATTERS ARISING

TEC reviewed all of the actions from the previous minutes.
Nominated leads confirmed that all of the respective actions had been completed, appeared as agenda items for this meeting, or were on

track within the agreed timescales. The following was noted:

13th November 2009

19/2010 **Quality Indicator Report(5.1)**
The data analyst was working on validating the stroke data.

20/2010 **Single Sex Accommodation**
The refurbishment and bed remodelling programme was on-going. Failure to comply from April 2010 would bring financial penalties and there were still a number of issues to resolve. A full report would be available for the next TEC and it was agreed this should include data on breaches since December 2009. **VH**

11th December 2009

21/2010 **CIPs and management costs**
Figures on comparative management costs were circulated. Applying the national methodology, these showed that in 2008/2009 ASPH had spent 4.36% of its income on management costs. The Trust would be looking at reducing the cost of 'back office' functions as part of its approach to CIPs in 2010/2011.

22/2010 Data Stick –CRR
Now that encryption had been fully implemented TEC were advised that unencrypted data sticks could be used in the Trust on a read-only basis. The Policy would be updated and re circulated. **RG**

Data sticks were issued to junior doctors at minimal cost to the Trust and did not have to be reclaimed.

23/2010 Nursing Roles (11)
A short note detailing the roles and interrelationship of the senior nursing roles was circulated.

8th January 2010

24/2010 Operating Framework 2010/11
On average the Trust was treating 70 emergency admissions per day in 09/10 compared with 65 in 08/09. This indicated a need to reduce by 5 per day in 2010/11.

It as agreed to continue to review the implications of the Operating Framework at each TEC. **VH**

25/2010 Access Policy
This was deferred until the end of March. **VH**

26/2010 Workforce
Work on validating the data on medical establishments was underway and would revert to TEC in March. **JH**

TRUST 6 DELIVERY PROGRAMMES

27/2010 **Programme 4: Leadership Development**
Project lead: Raj Bhamber
Clinical directors: John Hadley and Paul Murray

This Programme had been divided into 4 deliverables and progress was being made on all aspects.

During the discussion the following points were highlighted:

(i) Staff attitude survey
The Trust had achieved one of the highest response rates to the national survey in 2009 from the acute sector.

A random survey to evaluate the quality of appraisals was to be conducted in February.

(ii) Leadership strategy
Invitations to tender to develop a Trust Leadership Programme had been sent out with a clear timetable for selecting a supplier.

It was estimated that the first phase of the Programme might cost c.£50k and that there was a clear balance to be achieved between spending too much and spending too little and thus not achieving meaningful benefits. It was noted that, in the main, it was anticipated that the programme would be funded by reducing the current ad-hoc spend on management development where individual post holders were sent on external courses.

It was proposed that the first tranche of participants would be c100 but the advice of the successful provider would be taken to ensure the number of attendees was appropriate and also that it was properly aligned and tailored to support delivery of the 6 Programmes and Trust strategic objectives. Participants would be selected from across the Trust and it was intended that this would become a rolling-programme.

The Programme Group had recognised that there were differing skills and competencies required at differing levels in the Trust and therefore the Trust would also look to refresh existing programmes such as LEO and Leadership at the Point of Care so that they also underpinned the 6 Programmes.

It was confirmed that in due course the Trust would also consider how it supported team development, which might be cross-Organisational.

28/2010 Programme 3: Clinical Strategy
Project lead: Paul Bentley
Clinical Directors: Elliot Chisholm and David Fluck

The report summarising the progress on Programme deliverables was NOTED by TEC. The work was also closely interrelated with the refresh of the IBP.

A presentation on the work on refreshing the IBP was given, highlighting some of the drivers for the strategy. This included the alignment of the Trust's strategy to the work ongoing across NW Surrey, and also looking at some of the successes to date. Arising from the Trust's strategy, all Clinical Directorates would need to develop their own strategies, recognising that Directorates would

need support to do this from corporate functions such as finance and information.

TEC members were supplied with a full copy of the latest draft IBP which would be presented to the Board on 28th January. Any comments on the draft should be submitted to the Director of Strategy as soon as possible. **ALL**

The Integrated Business Plan which needed to be submitted as part of the Trust's application for Foundation Trust status contained the Trust's clinical strategy. The IBP set out the four key objectives, as previously agreed , but this had been refreshed, taking into account the DOH publication 'From Good to Great' covering the next 5 years and also the Operating Framework for 2010/2011. The context across Surrey was on delivering more services outside hospital, and of a seriously challenged financial environment. Nevertheless, the IBP reflected that there were real opportunities for ASPH as a result of the national framework and also as a result of acute reviews underway including adjacent London sectors.

There was no significant shift in the service developments contained in the IBP when compared with previous iterations of the Plan. The LTFM contained five year financial projections including the downside case. This reflected the Operating Framework of zero tariff growth in 10/11 with the possibility of zero or less in subsequent years. The non elective cap also came into play, along with a taper on the Market Forces Factor.

Contained within the LTFM base case was the assumption that cardiovascular repatriation started in 2011/12, but renal was not included as it was subject to a bidding process and the Trust had not yet secured the renal unit.

Over the 5 year period there was an overall reduction in staffing numbers; the intention was to protect the level of clinical staff and, as far as, possible target reductions towards back office functions.

TEC discussed the IBP and the workstream on the clinical strategy noting the following points:

Cardiovascular repatriation needed to be broken down into components, looking at when the various elements would impact, and also reflecting the achievements to date. This would be needed as part of ongoing budget setting and the IBP could provide the overview.

There was general interest about the possible opportunities of working closely with Epsom Hospital as a natural partner. Over January and February the Trust would be looking at patient flows to see if there were any significant opportunities.

It was noted that ASPH's geographical position and track record on delivery should be a good basis from which to secure opportunities to grow the business.

TEC AGREED the draft IBP for discussion and agreement by the Board.

In due course, as the application progressed, all CDs would need to able to articulate how the Trust had delivered its Strategy to date e.g. Waterfall and refocusing Ashford.

The Trust Strategy needed to recognise the interrelationship of services. In addition, the PCT needed to recognise the synergy between services.

JGl

It was agreed to actively pursue the recruitment process for the 2 interventional radiologists as this underpinned many elements of the clinical strategy.

29/2010 **BALANCED SCORECARD**

Workforce
The Trust had the lowest vacancy level in the South East and London at 7%, however turn-over had risen.

Clinical Directors were asked to encourage staff to progress appraisals.

Operational
Monitor's Compliance Framework: This was currently assessed as amber primarily due to SBH standards and also performance targets on 'subsequent treatment target for cancer' and MRSA elective screening. Only marginal improvements were needed In order to achieve green, and it would be important that the Trust was able to achieve improved consistency in meeting all targets in 2010/11.

The meeting was advised of changes to the Trust's internal performance management regime. Currently, good performing directorates had a degree of earned autonomy and review meetings were bi-monthly. A new category would be added for underperforming directorates. Where a major target was not being achieved, a formal recovery plan would be required.

Quality
The detailed quality report would be included on the next TEC agenda, but it was encouraging to note the improvement in the level of cancelled operations and in reducing C-sections. However there had a been an underachievement in #NOF which might have been caused but the snow pressure.

Finance
Additional income due to increased emergency activity had brought the Trust to financial balance. The Trust was currently red on actual capital spend but had plans to manage this.

30/2010 **CQC Registration**

Sarah Johnston was welcomed to the meeting and gave an overview of the new system of Registration which would go live in April 2010.

This replaced the Standards for Better Health and was intended to be more outcome focussed. The Trust had to submit its application by 29th January 2010 which would detail Locations, Regulated Activities undertaken at the Trust, and compliance.

The application would be reviewed by the CQC who had available to them a Quality and Risk Profile (QRP), linked closely to intelligence gathered from the national patient and staff surveys. The Trust's quality team were currently mapping the 16 new regulations/standards to SBH and looking at the red rated standards from the QRP.

It was essential that all leads collated the information onto the Performance Accelerator to substantiate the Trust's registration application as the CQC would be undertaking visits where areas of possible concern were identified.

TEC would be kept apprised of progress. **CB**

31/2010 QUALITY ACCOUNT

The Trust needed to agree 3-5 indicators to form part of its Quality account for 2010/2011, due to be published in June 2010.

The draft report included a number of suggestions as to possible indicators; TEC members were asked to consider these and feed back comments to Sarah Johnston as soon as possible. **ALL**

32/2010 BUSINESS CASES

Two business cases had been approved by the Capital Control Group and, in line with SFIs, also required approval by TEC.

Remodelling of Endoscopy: This case related to remodelling the Endoscopy service which should ensure the Trust met the physical requirements of the JAG standards and were required for accreditation. It was confirmed that the service could continue while the works took place. It was also noted that the financial details in the Case did not represent absolute profit.

Neurophysiology: This case supported the purchase of 3 EMG recorders. This represented normal maintenance of the current service rather than being income generating.

Both cases were APPROVED by TEC.

33/2010 JOB PLANNING

It as noted that 22 consultants were not on the new Consultant contract and had been written to by the Medical Director to ascertain if they now wished to transfer.

The previous decision that Job Planning would take place in Q4, leading to appraisal in Q1 was noted.

The draft planning guidance to support job planning was received and NOTED. The outline timetable included in the paper was AGREED, and the matter would revert to TEC on 12 February.

34/2010 ELECTRONIC DOCUMENT MANAGEMENT

Robin Gammon gave a verbal update on the project. The first Phase of the project was to scan the casualty cards. This had stalled but should resume in the current month. The next Phase, which was the larger scale scanning of active records, involved a major procurement exercise. This had been delayed due to a technical issue but the documentation would shortly be ready for issuing. An expert advisor was assisting the Trust and would be meeting a number of Consultants.

35/2010 MAJOR INCIDENT PLANNING GROUP

The report from the Group was NOTED. This identified continued progress particularly in respect of preparedness for a Flu pandemic. However it was noted that there was still work to do on Business Continuity.

TEC were advised that Liz Towell was leading on emergency planning on behalf of the Chief Operating Officer pending agreement on plans for the longer term replacement of the non-clinical risk manager.

ANY OTHER BUSINESS

36/2010 MASTER PLAN

As joint owners of the site, the ASPH and Surrey and Borders Trusts had prepared a 20 year masterplan for submission to Runnymede Borough Council to show how the health care environment of the whole site was to be improved. This represented a very long-term view, and would only be realised over a number of years but was required before individual planning applications could be submitted.

The significant change since this had last been discussed at TEC was that there was no longer an expectation that the Abrahman Cowley Unit would be rebuilt at the bottom of the site for a number of years, with associated consequential changes.

Information on the masterplan would be circulated to TEC members. **PB**

37/2010 DATE OF NEXT MEETING

Friday 12nd February 2010.

ACTION LOG

Date Action Agreed	Minute Number	Topic	Action	Owner	Timeline for completion	Comment
08/01/10	13/2010	**Staff Awards**	Assess feasibility of putting back closing date for nominations	**RB**	22/01/10	
13/11/09	5.1	**Quality Indicator Report**	There was currently a disparity between information in the CQUIN report and the Trust performance report on stroke. Review how these can be aligned.	**RG**	12/02/10	
13/11/09	3 & 20/2010	**Single Sex Accommodation**	Proposals from SSA task group to revert to TEC. Include data on breaches since Dec. 2009	**VH**	12/02/10	
11/12/09	5	**LIPS**	TEC to review LIPS when there is a clear proposal on correlation with 6 Programmes and the overall way forward on patient safety.	**MB/ALa**	12/02/10	
22/01/2010	28/2010	**IBP & clinical Strategy**	Review position on recruiting 2 Interventional radiologists	JGl	12/02/2010	
22/01/2010	28/2010	**IBP & clinical Strategy**	feedback comments on IBP to Paul Bentley	ALL	12/02/10	
22/01/2010	36/2010	**Master plan**	Circulate to TEC members	PB	12/02/10	
08/01/10	6.1/2010	**Patient Experience Programme**	Ascertain if HOSPICOM can be used for patient feedback	**CB**	26/02/10	
08/01/01	6.2/2010	**Workforce redesign**	TEC to discuss changes to HRBM role	**RB**	26/02/10	
22/01/2010	30/2010	**CQC Registration**	Review position on registration	CB	26/02/10	
13/11/09	5.1& 26/2010	**Workforce Report**	Validate apparent over- establishment on medical staffing from the Workforce report.	**JH**	12/03/10	
08/01/10	14/2010	**IM&T report**	Present report from Informatics Review	**JH**	12/03/10	

22/01/10	22/2010	**Data Sticks**	Update policy and re-circulate	**RG**	12/03/10	
13/11/09	6.3 &25/2010	**Access policy**	Implementation Group to oversee ** Separation of a Children's policy ** EQIA ** Consistency of approach to DNAs Policy to revert to TEC for final approval	**VH**	26/03/10	
08/01/10	6.1/2010	**Patient Experience Programme**	Pilot changes in Visiting Hours prior to a wider consultation	**CB**	09/04/10	
11/12/09	3.1	**Infection Control**	Review costs and service implications of systems to deliver on emergency screening for MRSA	**VH/AL**	11/06/10	
13/11/09	5.1	**Workforce Report**	Introduce systems to facilitate review of reasons why staff left within one year of appointment.	**RB**	25/06/10	