Ashford and St. Peter's Hospitals NHS
NHS Trust

TRUST BOARD
25th March 2010

TITLE	Trust Executive Committee Minutes held on 12th February 2010 and 22nd January 2010
EXECUTIVE SUMMARY	The Trust Executive Committee key points include : **12th February 2010** • Approved 2010 Low Priorities Procedure Policy from PCT • Communications and Engagement Strategy agreed for approval by Trust board • Claims Policy – updated version agreed • Job Planning guidance approved **26th February 2010** • Progress recruitments for 2 Radiologists with an interest in Interventional radiology • Presentation on IM&T review with agreement on next steps
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 March 2010
Decision:	For Noting

Ashford and St. Peter's Hospitals NHS
NHS Trust

TRUST EXECUTIVE COMMITTEE MINUTES
12th February 2010
Lecture Theatre, Ramp, St. Peter's Hospital

PRESENT	Andrew Liles	Chief Executive (Chair)
	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
	Robin Gammon	Interim Head of Information Services
	Andrew Laurie	Clinical Director for Pathology
	Jonathan Glover	Acting Clinical Director for Imaging & Endoscopy
SECRETARY	Helen Aitken	Administrator
IN ATTENDANCE	Faris Zakaria	Consultant Gynaecologist
	Vanessa Avlonitis	Deputy Chief Nurse
APOLOGIES	Paul Murray	Lead Clinician for Cancer & MSC Chair
	Peter Finch	Clinical Director for Imaging & Endoscopy
	Caroline Becher	Chief Nurse
	David Fluck	Clinical Director for Medicine
	Jeremy Wright	Clinical Director for Women's Health
	Jane Gear	Head of Corporate Affairs

DRAFT

ITEM		**ACTION**
40/2010	**MINUTES**	

The minutes of the meeting held on 22 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:

41/2010 Stroke (minute 5.1 13/11/09 refers)
Results were below where the Trust would like them to be, but confident there is no disparity in the targets from the PCT for March.

42/2010 Single Sex Accommodation (minute 20/2010 refers)
A progress report on the capital scheme and the capacity plan for next year would be presented to the next TEC. It was confirmed that from 1st April the Trust will be compliant.

43/0201 LIPS – (minute 5 of 11/12/09 refers)

TEC were advised that LIPS would be incorporated into Work stream 2 although there was also some cross over with Work stream 1.

44/2010 Interventional Radiologists (minute 28/2010 refers)

An advertisement had been placed for 2 Radiologists with an interest in interventional radiology as the trust had not been successful in attracting Interventional Radiologists. The Trust now has some promising candidates with interviews set for 15 April.

The sessions would be for 7 days not 24 hour cover. 9-5pm with sessions at weekends.

It was AGREED to compare the proposed job plans and amount of the interventional work with the approved Business Case. **JGI**

45/2010 Masterplan (minute 36/2010 refers)

The Masterplan had been circulated.

DELIVERY PROGRAMMES

46/2010 Programme 2: Improving Service Quality, CIPs, Productivity
Valerie Howell, Mike Baxter, Mick Imrie, Chris Schofield

As a key component of this programme we have commenced a long term lean based programme of improvement and organisational development to reduce waste and increase efficiency in a patient focused manner. The programme will increase the redesign capability of the organisation and focus attention on a set of specific redesign skills

The Trust was on track to have 50% of CIP schemes risk rated as green by the end of February 2010 and an expectation that 70% will be rated as green by the end of February. Project teams for major Trust wide schemes in place by early March.

NW Surrey partnership board was to agree its programme of work and timescales by end of March including pathway work.
There would be a further review of first two EQUIP projects to confirm realisation of benefits by May.

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In discussion, it was noted that the Trust was planning to identify £12m programme of CIPs in 2010/11 with firm delivery of at least £9m.

Corporate CIPs More work remained to be done to confirm the detail of the corporate CIPs.

The overall Programme was about Productivity, Efficiency and Quality with an emphasis on productivity and efficiency, The Trust was already focused on embedding quality and needed to maintain a balance; ensuring productivity and efficiency, without negatively impacting on safety.

Nationally it has been shown that improving quality can reduce costs.

Medical ward discharge, good multi-disciplinary, next event – ready for EQUIP training.

Steps needed to be taken to reduce repeat attendances to A & E and hospital as part of the drive to reduce hospital admissions by 5 a day. The Trust was to focus on patients who had more than 4 attendances a year and would work with particular GPs/Nursing Homes. This approach is supported by the PCT.

Discharge around Aspen and Day Surgery – good progress and very impressed by clinical teams with practical changes with evidence of length of stay coming down about a day in each case.

This is about ownership and making changes, the time spent is intensive and is a slow progress, with more people wanting to go through the process.

The next pathways to be focused on by the Equip programme have now been selected and these include:

A&E
Fractured NOF
Elective hip fracture
Corporate pathways (e.g. procurement & recruitment)

For EQUIP to work – it will take a lot of time and support to implement; it is not always possible to see the results immediately. A number of suggestions as to means of raising the profile were discussed; these included an EQUIP newsletter, a large board in PGEC to advertise this training or screens to advertise around the hospital. This will be considered as part of the programme.

The executives and clinical directors were asked to encourage the uptake of Bronze training,

47/2010 Programme 6 – Building Stronger Clinical Directorates (Re-branded to Service Line Reporting)
Valerie Howell, Paul Crawshaw, Barry Sellick

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Tracey Paton was the lead on this Programme. Feedback from SW Coast had highlighted areas where increased focus was needed; real clarity is needed particularly Finance, HR, IT. Clinical directors need to drive on this ambition data.

The Trust needs to produce timely SLR reporting data. The intention was to roll out reports to directorates alongside training and support, and to ensure the reports were clear to the recipients.

There will shortly be a workshop for Directorates and support services to work on the nature of customer; supplier relationships.

SLR 2009/10 data will be available shortly and will be worked through with each directorate in a workshop format.

OPERATIONAL PERFORMANCE, QUALITY AND SAFETY

48/2010 Corporate Risk Register

Staff Recruitment & Retention (risk 768)

Barry Sellick stated that Junior staffing was at a critical state with 75% of staff unavailable for different reasons: annual leave, maternity leave, sick leave. Recruitment of certain types of staff was a national problem.

The Director of Workforce & OD explained that there were 3 hotspots across the Trust and the Assistant Director of Workforce & OD has identified Paediatrics, Anaesthetics and ITU and would be able to meet up with Barry Sellick to discuss this further.

Loss of Person Identifiable Data (risk 887)

This could be removed from the CRR at the beginning of March as the Trust was assured that staff are now trained and acting appropriately.

Information Governance courses end in early March. Thereafter, there will be on-line training to those who have not attended although IT will be happy to provide local the training. Clinical Directors were asked to check if their teams were adhering to training and asked for a final list of those who had not attended. **ALL**

Swine flu (risk 907)

It was agreed this could be removed form the register as the Trust has now been stood down.

Venous thromboembolism (VTE)

Following IGAC, the Medical Director advised that venous thromboembolism (VTE) should be added to the CRR.

TEC AGREED to the addition of this risk **CB**

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49/2010 Operating Framework 2010/11

The NHS was facing a challenging economic time, and organisations in the local health economy needed to work collaboratively and differently.

Targets would be underpinned by penalties and levers to ensure delivery. Mixed sex accommodation must be addressed as the Trust could be fined for this. The Trust is expected to deliver on all targets; in general terms our performance is better than most, but we cannot afford to be complacent.

Incentives around quality included best practice tariffs which would affect cataracts, cholecystectomy, fracture and stroke. There will be incentive payments for better quality performance and shorter length of stay. The Trust must remain cautious with emergencies making sure a reduced tariff is not incurred.

Surrey PCT is facing a reduction in management costs; this will affect SHAs and PCTs directly in 2010/11. ASPH does need to address management costs and to bring these costs down to neighbouring organisations, with greater focus on working in partnership to integrate services across organisational boundaries.

Directorates are improving their understanding of their performance and taking acting upon it every day, with support being given to those directorates which are not succeeding on their targets. The Trust must identify and understand the variation between teams in the hospital.

The Trust must consider its future relationships with community hospitals as this could help deliver the reduction of 5 emergency admissions a day and also be a more appropriate means of caring for these patients.

TEC noted that within the Trust and Directorates there will need to be a strong focus on performance, quality and performance management.

Much of this work will also need to be taken forward in partnership, and the new NW Surrey Transformation Board creates a useful platform for this.

50/2010 2010 Low Priorities Procedure Policy - Change of Contracts

The PCT had issued a revised policy covering Treatments which they would not routinely fund.

The revised Policy included a new section covering a range of orthopaedic procedures, stricter guidelines on providing sterilisation services and a wider section on ophthalmology as the previous policy had only covered laser corrective surgery. This new policy lists a range of procedures which require prior approval from the PCT. Orthopaedics would be the most impacted with these changes.

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These changes affect all Trusts in Surrey. It was the PCT responsibility to notify all the GPs.

TEC NOTED receipt of the Policy and the recommendations and AGREED that Directorates should disseminate this within their clinical teams

51/2010 Communications & Engagement Strategy

Following a discussion about the nature of the stakeholders and how they link in with the Trust, the Communication & Engagement Strategy was APPROVED by TEC.

52/2010 Claims Policy

The Claims Policy was APPROVED by TEC.

53/2010 Job Planning

The plan is to move forward on the timetable for job planning. This guidance has been formulated through negotiation involving the Medical Director, Clinical Directors, Chair of MSC and the Chair of LNC. All Consultants employed by ASPH need to be reviewed and have agreed their job plan in line with this guidance by the end of March.

It was noted that there was a substantial difference with the LNC approved planning. A verbal update has been received from LNC and the original document has been seen.

The Job Planning Guidance was APPROVED subject to making sure that there was LNC support and some rewording of Page 11 by the Director of Workforce and OD. Workshops will be made available by Kate Clarke for Clinical Directors. **RB**

The Director of Workforce and OD proposed another day for training 26 Feb following TEC.

54/2010 Quality Report

There is currently no RTM report from Dr Foster. This will be resolved as soon as possible and a verbal update may be available at Board. Although from previous reports there has been an increase on colorectal surgery and rectal bleeds.

Part 3 of Quality report

The report provided a comprehensive approach to reviewing quality across the Trust and supplemented the approach within Directorates. It was noted that TEC had a role as a constructive critical eye to ensure that the Trust is answering questions as part of assuring that we have a quality organisation.

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55/2010 Business Case for Replacement Orthodontic Consultant.

The Business case proposed the appointment of a replacement part time Orthodontic Consultant. The post will ideally be a 4.5 session post with 3.5 clinical sessions and 1 SPA. It will consist of a varied mix of new patients, multi-disciplinary clinics, treatment and supervisory sessions. The department would like to run a new outreach clinic at Woking Hospital to improve patient access.

The following points were raised in discussion:

- SPA too tight for the job plan
- The table indicated that activity had doubled in 2 months – this need to be reviewed to see if it was a coding issue
- TEC requested clarity on the nature of the 'Occasions meeting' at St George's

The Business case was then APPROVED TEC.

56/2010 Feedback from Trust Board 28th January 2010 to TEC

Closed Session

SUIs and also individual NCAS issues.
Clinical exclusion issues.

The IBP and LTFM were both approved in the closed session as confidential data are contained in both.

Open Session
This is the routine board meeting which includes quality reports and balanced score card.

The Organisational Development & Workforce Strategy was approved in this session.

CQC registration was also approved.

57/2010 Management of 16 & 17 year olds

Deferred

ANY OTHER BUSINESS

58/2010 Leadership

It was proposed to undertake a team building event to strengthen TEC. This would be a half day workshop facilitated by Foresight Partnership who had worked with the Trust before.

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59/2010 Visiting Hours – Proposed Change

A proposal to conduct a pilot in relation to changing visiting hours The proposal was to commence the pilot from 1st April:

Monday – Friday visiting hours to be 6pm – 8pm

Weekends visiting hours to be 2.30 – 8pm

This will be evaluated in June with questions on "How the public felt about the changes?"

It was noted that visiting hours were changed at Frimley and this had been a positive move for them as it was easier for patients to rest. Therapists' and Doctors' appointments with relatives were booked from the ward. Car parking thereafter was better during the afternoons.

TEC discussed the proposal commenting :
Care would be needed in respect of frail elderly patients; steps would be needed to ensure that relatives were not isolated from the frail & elderly.

There would need to be a number of exceptions particularly with MAU.

It was AGREED that a short paper should be presented to TEC from Chief Nurse prior to approval. **CB**

60/2010 ENT Service –

RSCH have reported problems with our joint members of staff with keeping to the 18 week pathway. As a result RSCH want to keep one F/T member of staff and the other member of staff wants to resign. We need to repatriate work back to ASPH and there is a process to go through. There needs to be a strategy for ENT. Therefore this needs to be brought back to TEC to be discussed at length **JHa**

61/2010 DATE OF NEXT MEETING

Friday 26th February 2010

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ACTION LOG

Date Action Agreed	Minute Number	Topic	Action	Owner	Timeline for completion	Comment
13/11/09	3 & 20/2010	**Single Sex Accommodation**	Proposals from SSA task group to revert to TEC. Include data on possible breaches since C. 2009	**VH**	12/02/10	Paper to 26 Feb TEC
12/02/10	57/2010	**Management of 16 & 17 year olds**	Discuss following deferral from agenda	BS	26/02/10	
22/01/2010	28/2010 44/2010	**IBP & clinical Strategy**	Review position on recruiting 2 Interventional radiologists Compare proposed job plans with original business case	JGl	26/02/2010	
08/01/2010 12/02/10	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	
12/02/2010	48/2010	**CRR**	Add VTE to risk register	**CB**	26/02/2010	
12/02/2010	48/2010	**CRR**	All Directorates to review the position on IG Training and produce list of those who have not attended	**ALL**	05/03/2010	
12/02/2010	59/2010	**Visiting Hours**	Produce short paper on proposed trial for discussion at TEC	**CB**	05/03/2010	

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12/02/2010	60/2010	**ENT**	Discuss strategy for ENT in the light of proposed changes by RSCH	**JHa**	05/03/2010	
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	Agenda 26/02/10
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	

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Ashford and St. Peter's Hospitals NHS
NHS Trust

TRUST EXECUTIVE COMMITTEE MINUTES
26th February 2010
Lecture Theatre, Ramp, St. Peter's Hospital

PRESENT	Andrew Liles	Chief Executive (Chair)
	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
	Robin Gammon	Interim Head of Information Services
	Andrew Laurie	Clinical Director for Pathology
	Jonathan Glover	Acting Clinical Director for Imaging & Endoscopy
	Caroline Becher	Chief Nurse
	Jeremy Wright	Clinical Director for Women's Health
	Paul Murray	Lead Clinician for Cancer
SECRETARY	Jane Gear	Head of Corporate Affairs
IN ATTENDANCE	Mike Haynes	Information Consultant (Minute no 68/2010)
APOLOGIES		
	Peter Finch	Clinical Director for Imaging & Endoscopy
	David Fluck	Clinical Director for Medicine

Jeremy Wright was welcomed to his first meeting as Clinical Director for Women's Health.

ITEM **ACTION**

62/2010 MINUTES

The minutes of the meeting held on 12 February 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:

63/2010 Management of 16 & 17 years olds (minute 57/2010 refers)

It had previously been agreed that paediatrics would take the lead for 16 &17 year olds, and patients of this age group could be admitted to the paediatric wards. The service would maintain a flexible approach particularly regarding the management of the transition into adult services. The position whereby 17 year olds would be admitted to (adult) ITU had not changed. These arrangements appeared to be working satisfactorily.

The position was NOTED.

64/2010 Interventional Radiologists (minute 44/2010 refers)

A brief report was tabled showing that the revised job plan for the two radiologists with an interest in interventional radiology actually delivered an increased number of interventional radiology sessions over the original business case. Although it did not provide a 24/7 service there would be cover at weekends.

It was AGREED to continue with the recruitment.

65/2010 Master Plan (minute 36/2010 refers)

The Master Plan had been circulated.

DELIVERY PROGRAMMES

66/2010 Programme 1: Improving the Patient Experience
Caroline Becher, Andrew Laurie

It was AGREED that Mr. Jeremy Wright would become one of the 2 CD leads for this programme.

The Programme continued to progress although it was noted that the Programme Report only captured the main areas of work. New areas of improving the patient experience were being added all the time; for example through EQUIP.

The following points were highlighted and discussed ;

The first cut of the information from the Hand Held Device pilot on Orthopaedics, MAU and Surgery was now available; this would be circulated to the relevant CDs. There was disappointing number of patients saying they had not seen a Matron and noise at night created by other patients was an issue.

The proposal on a consultation on Visiting hours, including a potential pilot, would be brought to TEC in March with the aim of undertaking

this in April.

One of the potential benefits to visitors could be free evening car parking- this needed to be explored.

It would be essential to formalise the arrangements for relatives and carers to access Consultants or other senior clinicians. Issues for the services might vary; for example MAU needed very early carer input, and evenings were very busy for Doctors with little opportunity for consistency in knowing the patients.

The Picker analysis of the Trust Outpatient survey identified that in addition to the hygiene factors surrounding an out-patient attendance (car parking, letters etc) there was also an issue regarding communication within the consultation itself. Whist this varied between specialties it was also consistent with the inpatient results suggesting this was not simply an issue with junior staff.

Information on communication was already incorporated within 360^{o} feedbacks. The Cancer Services team underwent an advance communications skills course which could be considered if training was required or it might be feasible for a tailored short session to be available within the Trust. However, training might not be the solution as this issue could be the model /system supporting the consultation.

TEC AGREED to support finding an approach to improving the position on communication in the out-patient consultation process which might require different approaches for different areas. The Programme Group would report back at the next session. **CB**

Information on medication was also an issue for patients. The cartons included manufacturers' information and a solution might be to separate this out to make it more visible.

TEC NOTED the Programme update.

67/2010 Programme 4 Leadership
Raj Bhamber |John Hadley, Paul Murray

Key highlights on progress included:

Staff Awards ceremony – to be held on 23 March 2010. Around 48 nominations have been received. Clinical Directors are encouraged to attend.

Consideration is being given to a staff awards committee which can address increase ways of celebrating achievements.

Highlights from the staff survey were emerging. The Trust had received a report from Picker (Trust contractor) which allows benchmarking with the limited number of other Trusts who use them as contractor, plus tracking of the Trust's year on year performance. Areas emerging for attention included

Mandatory training- this could be a staff perception issue and the way the question is phrased in the national questionnaire.

Support from immediate managers

Highlights included senior management communication. There were no scores where there had been no improvement year on year.

Leadership development programme

An interesting and challenging approach had been taken to identifying a service provider; all of those interviewed had demonstrated a range of different approaches to delivery.

Due to technical difficulties with the preferred supplier, further work was to be undertaken to consider other options for a supplier. Overall the approach had demonstrated the potential value for money from the Trust running its own tailored leadership programme rather than continuing to send participants on expensive external programmes.

The importance of focussing on middle management development was also stressed.

The development day for TEC had now been agreed.

OPERATIONAL PERFORMANCE, QUALITY AND SAFETY

68/2010 IM&T Review

Mike Haynes was welcomed to TEC and gave a presentation on the key findings from his review of IM&T.

The opportunity for the review was timely, in line with the changes to the National Programme which meant that the Trust could now develop a long term approach rather than take tactical and shorter term decisions. There was unlikely to be a continuation of a national PAS deployment, and in addition the economic climate was shifting dramatically.

Key recommendations included

- Rebranding IM&T to 'health informatics'
- Change the ISSG to a programme board with clinical leadership and a capital budget
- Maximize delivery from existing assets (for example Prism)
- Develop a clear vision and strategy
- Restructure and strengthen the IM&T department

The Director of Finance and Information proposed that the next steps would be to develop a new strategy through a series of workshops and consider how to move from the current ISSG towards a Programme Board , as these were fundamental to all the recommendations. **JH**

The importance of robust , timely and accurate information to support business and clinical decisions was emphasized ; this required close working with Clinical Directorates, for example clinical coders, and the right skills in the right places.

69/2010 Performance

1. Workforce

The overall level of appraisals reported was rising. There was an issue with medical staff appraisal, which was potentially a recording issue, and it was also noted that it had previously been agreed that consultant appraisals were to be completed in the first quarter of the year which gave the potential for an in-year issue as the sequence became embedded. It was also noted that the NHS appraisal web site was currently not available.

The HR Business Partners would be circulating details of appraisals as recorded in ESR to all CDs and TEC were asked to ensure this was progressed. **ALL**

Agency usage was above plan and a special meeting was being arranged to agree how this could be targeted. It was essential the level of agency spend was reduced.

2. Operations/ performance

Overall the Trust was performing well and the movement from the current amber to green on the Monitor assessment was achievable.

The Trust was only narrowly missing the target on elective MRSA screening, and was actually performing better than many other trusts.

The A&E figure shown related to the whole LHE performance but the Trust need to reach the target in terms of Type1 attendance (main A&E only) which meant for the rest of the year there could be no more than 3 breeches per day. Work was underway in A&E to achieve this but it also needed the support from across the hospital.

3. Finance

The Trust was broadly on target for all indicators. The main area for attention was capital, where the delay in being able to submit the Master Plan had impacted on projects. However, steps were underway to ensure the capital level of expenditure was achieved.

The draft budget for 2010/2011, including the capital programme, would be discussed at TEC in March.

70/2010 Quality report

The Quality report was an important tool as it should enable TEC to help ensure that high standards of quality and safety were achieved and maintained.

The correct figure reported for #NOF treated within 48 hours was 72.9%. The Clinical Directorate was checking the precise definitions of the target and ensuring that robust systems were in place to track the information and then be able to respond.

The figure on mortality had been drilled down to ward level and the figure for mortality for HDU was c16% rather than that stated. However, these figures were crude mortality and not case mix adjusted. It was suggest that as the Trust aspired to excellence it should consider setting a higher target for SMR, as 100 was an average position.

The Board had commended the open approach to the individual clinician's reflection following the Colorectal audit.

Further analysis of the SHA observatory report on drug errors had clarified that the extraction identified the side effects of medication through looking at clinical coding, not drug errors. Further work was being undertaken on this.

The ward indicator report provided a useful tool but the Board had stressed the need for there to be accountability in completing the audits/performance measures.

On-going work would be needed to ensure all Consultants were aware of the screening form for VTE. This was important as 1% of the CQUIN would be linked to this measure.

There had been 1 SUI (interuterine Death) and 1 serious incident.

71/2010 ESR

The progress report on implementing ESR was received and NOTED.

TEC AGREED to support the roll out of the ESR manager self-service.

72/2010 Single Sex accommodation

All NHS organisations were required to undertake a formal assessment of compliance against same sex standards by March 2010. This was in the context of limited guidance on a data collection system.

The Trust had already undertaken considerable work to ensure consistent delivery of this important standard but there was still some work to complete. This included reviewing compliance in day surgery and endoscopy. A key factor to maintaining the standard in the long term was managing occupancy.

TEC NOTED the report.

73/2010 Marketing Report

Deferred to next meeting.

74/2010 Pathology network

The Board had agreed to progress to outline Business Case the proposal for the 4 Surrey Acute Trusts to create a Surrey wide

network.

The vision was to centralised the automated processes and maintain at each site the activity which needed to be delivered urgently and also the medical input. This would unify the management of services which did not need to be retained on individual sites.

The Board had asked that explicit consideration was given in the OBC to maintaining the quality of the existing service, and also patient and user satisfaction.

Andre Laurie would now be making arrangements to discuss the individual Directorates' needs with the CDs.

There were also important issues regarding communications generally, and specifically with staff; the development would be raised at the next meeting of the Employee Partnership Forum.

It was AGREED this should be a monthly update on progress to TEC.

75/2010 Trust Board 25th February 2010

A verbal report on the discussions at the Trust Board was given by the Chief Executive with the following highlights:

Closed Session

SUIs and NCAS issues.
Renal Services update
Pathology network

Open Session

The Communication and Engagement Strategy was approved.
Additional NED recruitment as part of preparation for FT status
IM&T review

ANY OTHER BUSINESS

76/2010 FT update

The Trust had been successful in securing formal approval from the SHA to proceed to phase 2 of the application process (Department of Health). This was a significant milestone, and in the next phase the SHA acted as the Trust's advocate.

77/2010 DATE OF NEXT MEETING

Friday 12th March 2010

ACTION LOG

Date Action Agreed	Minute Number	Topic	Action	Owner	Timeline for completion	Comment
08/01/2010 12/02/10	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	
12/02/2010	48/2010	**CRR**	All Directorates to review the position on IG Training and produce list of those who have not attended	**ALL**	05/03/2010	
12/02/2010 26/02/10	59/2010 66/2010	**Visiting Hours**	Produce short paper on proposed trial for discussion at TEC	**CB**	05/03/2010	Agenda March 12th
12/02/2010	60/2010	**ENT**	Discuss strategy for ENT in the light of proposed changes by RSCH	**JHa**	05/03/2010	
13/11/09	5.1& 26/2010	**Workforce Report**	Validate apparent over- establishment on medical staffing from the Workforce report.	**JH**	12/03/10	On TEC workplan
13/11/09	6.3 &25/2010	**Pathology Network**	Report to TEC monthly on progress	**Ala**	12/03/2010	
11/12/09	3.1	**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	
13/11/09	5.1	**Infection Control**	Review costs and service implications of systems to deliver on emergency screening for MRSA	**VH/AL**	11/06/10	

26/02/2010	66/2010	**Workforce Report**	Introduce systems to facilitate review of reasons why staff left within one year of appointment.	**RB**	25/06/10
26/02/2010	68/2010	**IM&T review**	Implement first stages arising from Review Develop strategy through working groups Change ISSG to Programme Board	**JH**	25/06/2010
26/02/2010	70/2010	**Programme 1**	Consider options to resolve communications issue within out patient consultation (analyse issues first)	**CB**	