Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

TRUST BOARD
28th June 2012

TITLE	**Trust Executive Committee Meeting held on 25th May 2012 (draft Minutes) and 8th June,**
EXECUTIVE SUMMARY	The formal TEC on 25th May 2012 considered or approved : ▪ Preparations for the Olympics ▪ Business Case for an Admissions Lounge (to come back to June TEC) ▪ Business Case for an Upper GI/Bariatric Surgeon ▪ Business Case – Picture Archive in Communication System The developmental TEC on 8th May focused on the Epsom Transaction.
BOARD ASSURANCE (Risk) / IMPLICATIONS	Compiled according to the Trust Committee Policy
STAKEHOLDER / PATIENT IMPACT AND VIEWS	None
EQUALITY AND DIVERSITY ISSUES	None
The Trust Board is asked to:	Note the draft minutes of the Trust Executive Committee held on 25th May 2012
Submitted by:	Andrew Liles Chief Executive
Date:	15th June 2012
Decision:	For Noting

Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

TRUST EXECUTIVE COMMITTEE MINUTES

Friday, 25th May 2012
2.00 pm to 4.30 pm
Room 3, Chertsey House, St Peter's Hospital

PRESENT:	Andrew Liles	Chief Executive
	David Fluck	Interim Medical Director
	Donna Marie Jarrett	Associate Director of Health Informatics
	Giselle Rothwell	Head of Communications
	Peter Wilkinson	Divisional Director for Acute and Emergency Medicine.
	John Hadley	Divisional Director for Surgery
	John Headley	Director of Finance and Information
	Mick Imrie	Divisional Director for Anaesthetics, Critical Care & Theatres
	Tariq Bhatti	Specialty Lead Paediatrics
	Andrew Laurie	Divisional Director for Diagnostics and Therapeutics
	Raj Bhamber	Director of Workforce and OD
	Suzanne Rankin	Chief Nurse
	Paul Murray	Lead Clinician for Cancer
	Gulam Patel	Divisional Director for Specialist Medicine and Specialist Surgery
	Claire Braithwaite	Associate Director Performance Improvement
SECRETARY:	Jane Gear	Head of Corporate Affairs
APOLOGIES:	Valerie Bartlett	Deputy Chief Executive
	Paul Crawshaw	Divisional Director for Women's Health and Paediatrics
IN ATTENDANCE:	Clare O'Brien	Head of Emergency Preparedness & Resilience (minute 95/2012)
	Heather Caudle	Associate Director of Quality (minute 98/2012)

. **ACTION**
ITEM

84/2012 Minutes

The minutes of the meeting held on 27 April 2012 were agreed as a correct record.

Matters Arising

TEC reviewed all of the actions from the previous minutes. The nominated leads confirmed that all respective actions had been completed, appeared as agenda items for the meeting or were on track within agreed timescales.

The following was noted:

85/2012 Q3 Marketing – ENT (minute 48/2012 refers):

It was noted that discussions had taken place with representatives from RSCH in respect of the potential ENT threat in West Byfleet. It was understood that the issue had now been resolved, but as the specialty had transferred out of the Division of Surgery, it was agreed that the Divisional Director for Specialist Medicine and Specialist Surgery be asked to confirm. **GP**

86/2012 Corporate Risk Register – C Difficile (minute 72/2012 refers):

Monitor had set a de minimis level of 12 for C difficile hospital-acquired cases in the Compliance Framework 2012/13. This meant that for trusts with a DH level below 12, Monitor would only count non compliance for the purposes of their governance rating when cases exceeded 12.

As the Trust's DH level was 20, the Monitor de minimis level was irrelevant.

TEC NOTED the position.

87/2012 Replacement Microbiologist (minute 77/2012 refers):

It was confirmed that the work to conclude the job description for the replacement microbiologist was underway. Subject to this, the appointment could proceed.

TEC AGREED the position.

88/2012 Eliminated Mixed Sex Accommodation (minute 81/2012 refers):

The Chief Nurse confirmed that the relevant Division had been asked to investigate and undertake any necessary mitigation of the risk.

TEC NOTED the position.

89/2012 Strategic Delivery Board

The Strategic Delivery Board had met on 22nd May and considered the new project dashboard contained within TEC papers.

As previously advised, the PMO schedule consisted of fewer projects of a higher value. In addition, all projects were linked to one of the Strategic Objectives as detailed in the Corporate Business Plan for 2012/13. The dashboard had been reviewed to incorporate more project performance information and less narrative. TEC agreed that the project dashboard was clearer and highlighted the following points:

- Integrated Critical Care: It was agreed that the Divisional Director for ACCT and the Lead Clinician for cancer would discuss outside of the meeting any steps needing to take place prior to co-terminosity being achieved. **MI/PM**
- It was noted there were a number of projects involving IT. The newly appointed Director of Finance and Information highlighted that he was undertaking a review of capacity to support their delivery.
- Project: capacity allocation: It was agreed that Dr Rod Hughes should be involved in discussions on the re-allocation of beds in respect of the provision of medical cover on MAU. **VB**
- It was highlighted that if the Trust proceeded with the Epsom

transaction, there might need to be a review of the Trust's capacity to undertake the current SDB programme.

- The Associate Director of Performance Improvement confirmed that interdependences between the projects were being considered.

TEC NOTED the report.

OPERATIONAL PERFORMANCE, QUALITY AND SAFETY

90/2012 Corporate Risk Register

The Register identified:

1. One new risk having been opened.
2. Two risks with a decreased risk.
3. One risk closed.

The new risk related to the potential underperformance of the Cost Improvement Programme. Delivery of this was essential to the financial strength of the Trust.

It was reported that the recent Council of Governors' meeting had highlighted five areas of future focus in discussions with the Board. One of these related to the new Surrey Pathology Service network which covered three trusts. It was confirmed that all the risks were being tracked by the Division and mitigated actively.

TEC APPROVED the Risk Register.

91/2012 Quality Report

The Quality and Safety Balanced Score Card Indicators had been reviewed and included a number of new dimensions. These would need to be reviewed in approximately three months to confirm if the measures were appropriate and trajectories were correct. The Chief Executive stressed the need for targets to be stretching but possible.

The Medical Director and Chief Nurse highlighted the following aspects of the report:

- There were now three metrics for mortality; CMR, HSMR and SHMI. It was confirmed that the targets for these indicators would be reconsidered, including the mortality targets for specific diagnoses/conditions (mortality for hip fractures and UTI). A review of palliative care coding was underway and should result in the mortality figures being revised.
- The stroke indicators needed to be aligned with aspects of service where the Trust had greatest concern.
- The Trust's priority was to reduce the number of highly graded serious incidents requiring investigation while still increasing the level of reporting of SIs generally.
- The relationship between divisional dashboards and the Trust dashboard was also important.

One NPSA safety alert remained overdue. This related to the need to minimise risks of mismatching spinal, epidural and regional devices with incompatible connectors.

The Divisional Director for ACCT explained the difficulties in

implementation as most hospitals wanted independent testing of the wide range of devices available to be undertaken, whilst the NHS in England was not willing to pay. If the Trust selected a local device, this would need to be adopted across local Trusts as the junior doctors were key users and moved between hospitals.

Failure to close NPSA alerts featured in Dr Foster reports and it was agreed to confirm with Dr Foster whether this would become an issue on their dashboard. **DF**

Inpatient Survey: The results of the survey were now available. It was noted that direct comparison between questionnaires was not fully possible as year on year there was some variation in the questions. However, the Trust had not maintained the three "better than most Trusts" scores from the previous years relating to; receiving copies of letters; being asked to give views on the quality of care; and somewhere to keep personal belongings. However, overall the CQC report indicated the Trust's performance had improved. Divisional action plans were being developed and would be monitored through the Clinical Governance Committee.

In discussing the results, it was noted that a number of aspects related to patient experience, including in the Admissions Lounge.

CQC Visit: The Chief Nurse verbally apprised TEC of the feedback received following the unannounced visit by CQC on 23 May 2012.

TEC NOTED the report.

92/2012 Balanced Scorecard:

The Balance Scorecard comprised four quadrants. The scorecard included a new overarching commentary section, drawing together the implications from the four quadrants. Individual commentary sections were no longer being included.

Quality: This item had been addressed under the Quality Report.

Workforce: It was confirmed that the target level for completion of both staff appraisals and statutory and mandatory staff training would be 98%.

Clinical Strategy: The Scorecard included a number of new dimensions including measuring aspects of market share. These included two indicators related to bariatric and vascular services and the metrics would be discussed with the Divisional Director outside the meeting. **DF/JH**

Finance and Efficiency: At the end of April the Trust was reporting a Monitor Financial Risk Rating of 2 and a £207k deficit. It was absolutely essential that the Trust recover the CIP programme.

It was noted that the outpatient DNA target had been reset and the rating should have been changed to amber rather than red as recorded.

Length of stay targets were included within several programmes of work with different external targets. The target for the dashboard would be included from May.

TEC NOTED the report.

93/2012 Compliance Framework

The Trust was consistently achieving all the performance targets associated with the Monitor Compliance Framework with the exception of the four-hour standard for waiting times in the Emergency Department. In particular, the Trust achieved all of the 18-week referral to treatment targets at both aggregate and specialty level during the month of April. It was confirmed that this was an aggregate performance within the Compliance Framework itself.

Significant progress had been made over the last weeks in reducing waiting times in the Emergency Department. However, there was still considerable work required in order to achieve consistent performance and embed compliance.

It was noted that the C difficile target was also a risk for the Trust. To date, there had been five hospital-acquired cases of C difficile in Q1. This was against the annual trajectory of a maximum of 20 cases. It was confirmed that the Root Cause Analyses of the cases had suggested they were unavoidable.

It was agreed there needed to be a major focus on increasing communication and awareness. A suggestion was made that Board rounds might be a good opportunity to involve junior doctors. It was also suggested that all clinicians needed to be reminded of the importance of antibiotic prescribing. It was confirmed that both C difficile and MRSA should have been included on the refreshed balance scorecard.

TEC NOTED the report.

94/2012 Health Informatics:

The new NHS Information Strategy had been published on 21 May 2012 and a briefing would be included for the June TEC agenda. However, it recommended the appointment of a Chief Clinical Information Officer within Trusts as strong clinical leadership was recognised as important.

It was noted that information had been highlighted as key to underpinning delivery of the CMAOR work streams. Completion and delivery of a number of important business cases had been considered and a proposal to take this work forward would be shared and consulted on as part of the OD Steering Group being established to progress the work stream.

The Director of Finance and Information highlighted that he was assessing the Trust's capability to deliver the required changes to PACS, E prescribing and PAS across current time scales.

TEC NOTED the report.

95/2012 Olympics

Clare O'Brien was welcomed to the meeting and gave a presentation on preparations for the Olympics. This covered:

- The Games in the South
- Countdown
- Olympic Route Network

- Events
- Business as usual
- Absorbing demand
- Games Family
- Unplanned events

It was important that all Divisions and departments were aware of the potential issues.

TEC NOTED the briefing.

BUSINESS CASE AND POLICY APPROVALS

96/2012 Business Case for an Admissions Lounge

TEC had previously discussed an initial business case setting out the rationale for building a new Admissions Lounge. The formal Business Case now being considered highlighted the potential positive impact such a development would have on both the patient experience and on overall productivity and efficiency. The Business Case looked at four options including do nothing.

During the discussion, the following points were made:

- The scheme impacted positively on the patient experience, but had increased revenue costs.
- The vacated space would be used to help create additional bed capacity for vascular services.
- The Chaplain was aware of the discussions and it was confirmed that at least part of the multi faith garden would remain available for staff use.
- A number of aspects of the design were queried including the level of consulting rooms provided and whether the accommodation fully met single sex requirements.

In concluding the discussion, it was highlighted that there was considerable pressure on the Trust's capital programme so it would not be possible to fund option 4. If option 3 was selected, this would deliver a good outcome and a high quality patient facility. However, it was important to ensure that the design was correct and project estimates were robust.

The Business Case should revert to the next TEC meeting for further consideration and in particular confirm that the design met clinical and patient objectives (potential to use experience-based design) and also confirm the use of space underneath the extension and its interrelationship with the estate plan. **JHa**

TEC NOTED the Business case

97/2012 Business Case for an Upper GI/Bariatric Surgeon

The Business Case proposed the substantive recruitment of a second full-time upper GI/bariatric consultant surgeon. This would replace the 0.6 WTE short-term appointment currently supporting the service.

The appointment was important to enable the Trust to grow and develop the Bariatric Service and have less reliance on St George's Hospital.

TEC discussed the following aspects of the proposal:

- The Director of Finance and Divisional Director agreed to discuss the trajectory for achieving additional activity and then reconcile it to income outside the meeting. **SM/JHa**
- TEC discussed the number of revenue generating activities included within the Job Plan. It was proposed that there should be a core expectation of every post's ability to deliver activity/income or have patient facing time across all Job Plans. It was suggested that all Job Plans should be tested on CRMS.
- The business case did not include additional funding for new anaesthetic sessions; the Divisional Director for Surgery stated that this was using time already funded.

TEC AGREED the Business Case subject to:

- The Medical Director reviewing the Job Plan and confirming it contained appropriate levels of income generating PAs. **DF**
- The Finance Director agreeing the financial aspects of the case. **SM**
- Confirmation that all theatre/anaesthetic costs and the impact of any displaced activity had been included.

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98/2012 Quality, Safety and Risk Management Strategy:

The current Risk and Integrated Governance Strategy had been reviewed and re-drafted. The intention was to strengthen the Trust's quality processes and the new Strategy proposed significant changes around compliance with the CQC Essential Standards, risk management processes and improving clinical outcomes.

Heather Caudle was welcomed to the meeting and gave a brief presentation on improving quality and safety outcomes. This focused on the importance of getting data correct and also outlined the content of quality and safety half days, suggesting next steps on implementation. The presentation supported delivery of Strategy.

Overall, the Strategy aimed to:

- Identify where risk management happened.
- Detail changes to the Clinical Governance Committee and augmenting the role of divisions.
- Detail the quality and safety half days which were aimed at enabling the workforce to support delivery.
- Develop ownership of the CQC standards in divisions together with mapping of compliance across the Trust.

Overall, TEC supported the revised draft Strategy noting that the proposed Quality Governance Board should be renamed to be consistent with the Trust's approach on nomenclature for its committees and meetings. It was also agreed that appendix 2 should be simplified to focus on milestones rather than being a detailed implementation plan. **HC**

In respect of the quality and safety half days, it was noted that meetings to discuss implementation would be scheduled with each Divisional Director. However, it was essential that these were brought into being as quickly as possible.

TEC APPROVED the draft Strategy.

99/2012 Business Case – Picture Archive in Communication System[1]

The Trust's current PACS and RIS systems were provided by the National Programme for IT (NPfIT) Connecting for Health. However, the contract would expire at the end of June 2013 with no current option for extension.

ASPH had joined the Surrey and Sussex Consortium for a replacement procurement. The cost for the new fully managed service for ASPH would be a reduction on current contract values. However, implementation would require capital investment which was not currently budgeted.

During the discussion, it was confirmed that the procurement would result in additional functionality for the Trust. However, the risk of losing the archive records would need to be actively managed. The Trust would also need to consider the potential impact of the transaction with Epsom once the Trust was agreed as preferred partner. It was also highlighted that the business case resulted in a cost pressure in year 1/2 and that the timetable was being driven by the consortium.

TEC APPROVED the business case and agreed that Simon Marshall should be the Project Executive.

INFORMATION – inc Sub-Committee reports

100/2012 Informatics Group Annual Report:

This would be available for the next meeting.

101/2012 Report of the Major Incident Planning Group:

TEC NOTED receipt of the Annual Planning Group and APPROVED the updated Terms of Reference.

ANY OTHER BUSINESS- none raised

102/2012 Date of Next Meeting

8 June 2012 – developmental.

22 June 2012- formal.

[1] Redacted due to commercial nature