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

TRUST BOARD
29th March 2012

TITLE	**Trust Executive Committee Meetings held on 27th January 2012, 10th February 2012, 24th February 2012 (draft Minutes) and 9th March 2012.**
EXECUTIVE SUMMARY	The formal TEC on **27th January 2012** approved or considered: ▪ CQC action plan ▪ Corporate Risk Register ▪ Barrier-Controlled Car Parking at Ashford Hospital ▪ Committee Policy ▪ Updated Hospitality Policy ▪ Colorectal Surgeon business case The formal TEC on **24th February 2012** (draft minutes) approved: ▪ Corporate Risk Register ▪ Change of Trust Standard Owner– Outcome 02 ▪ Short to Medium Term Strategy for the Department of Urology ▪ ENT Business Case ▪ Registration Authority Policy The developmental TEC held on 10th February 2012 focussed on Medical Workforce Planning and mandatory training. The developmental TEC held on 9th March 2012 focussed on enhancing effective clinical governance.
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 approved minutes of the Trust Executive Committee 23rd November 2011 and the draft minutes of the Trust Executive Committee held on 16th December 2011
Submitted by:	Andrew Liles Chief Executive
Date:	15th March 2012
Decision:	For Noting

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

TRUST EXECUTIVE COMMITTEE MINUTES

Friday, 27th January 2012
2.00 pm to 4.30 pm
Room 3, Chertsey House, St Peter's Hospital

PRESENT:	Andrew Liles	Chief Executive
	Valerie Bartlett	Deputy Chief Executive
	David Fluck	Deputy Medical Director
	Donna Marie Jarrett	Associate Director of Health Informatics
	Giselle Rothwell	Head of Communications
	Gulam Patel	Divisional Director for Specialist Medicine and Specialist Surgery
	John Hadley	Divisional Director for Surgery
	John Headley	Director of Finance and Information
	Mick Imrie	Divisional Director for Anaesthetics, Critical Care & Theatres
	Mike Baxter	Medical Director
	Paul Crawshaw	Divisional Director for Women's Health and Paediatrics
	Andrew Laurie	Divisional Director for Diagnostics and Therapeutics
	Paul Murray	Lead Clinician for Cancer
	Raj Bhamber	Director of Workforce and OD
	Suzanne Rankin	Chief Nurse
	Hugh Jelley	Divisional General Manager
SECRETARY:	Jane Gear	Head of Corporate Affairs

ITEM **ACTION**

1/2012 Minutes

The Minutes of the Development TEC held on 9th December 2011 were AGREED as a correct record.

The minutes of the formal meeting held on 16th December 2011 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:

2/2012 Quality Report (minute 192/2011 refers):

The Trust had two contracts with Dr Foster. The first was due for renewal in January and would be rolled forward for a further year. The second expired in September with no facility for roll-forward, so the Trust would be procuring a new benchmarking tool. The procurement was identified in the Business Plan for 2012/2013 as a project.

3/2012 Health Informatics – RealTime (minute 219/2011 refers):

It was confirmed that Divisional Directors were being given access rights to RealTime.

4/2012 Integrated Critical Care (minute 228/2011 refers)

The intention was to set up a steering group, ideally outside the Critical Care Delivery Group. Work was underway to draft a roadmap to achieving the objectives.

It was AGREED to have further discussion at the next TEC meeting where consideration also needed to be given to the Trust's compliance with level II facility requirements and the possible impact of non-compliance on the commissioner's contracting documentation. **MI**

5/2012 STRATEGIC DELIVERY BOARD

Key messages from the Strategic Delivery Board were:

- Skill mix review – CMAO. This was a major project which would be complex and require significant change management. The final project brief was being presented to the next wider Strategic Development Board to which all divisional directors were welcome.
- The intention was to focus the PMO on supporting a small number of critical projects within the Business Plan 2012/2013.
- Consideration was being given to how projects under the IT banner tied in with the PMO and its monitoring and reporting System.

In discussing the report, TEC noted the importance of embedding the ambulatory pathways (improving service quality and productivity and effectiveness – project 2).

It was confirmed that despite a slow start to the Living Our Values project (LOV), more than a thousand staff had now attended. The training was now a half day session; it was important that the quality of the programme was maintained and this might mean reducing large group sizes. The consequence would mean the target date for completion of the programme might need to be extended.

It was agreed that consideration should be given to ways of focusing on cancer within The Business Plan at either corporate or divisional level. **VB**

TEC NOTED the report.

OPERATIONAL PERFORMANCE, QUALITY AND SAFETY

6/2012 Corporate Risk Register

The Corporate Risk Register had no risks which had been opened or closed, two risks with an increased risk score and four risks with a reduced risk score.

CRR 112 – failure to act on radiological imaging reports: Following discussion, it was agreed that SUIs which occurred prior to implementation of the electronic system still required investigation in order that a robust response could be provided to the patient. However, the solution was now known.

An issue was raised regarding reporting of x-rays within A&E and it was agreed that this should be reviewed between Mike Wood and David Elliot. **MW/DE**

The next meeting of TEC should receive a report confirming the robust deployment of the electronic system. **DMJ**

TEC APPROVED the Corporate Risk Register.

7/2012 Quality Report

The report indicated that the CMR had risen and that the Trust had a high SMR. This occurred at a period of considerable operational pressure, when length of stay increased and the number of complaints also rose. Most of the increase in mortality was attributed to medicine.

A comparison of this year's figures with the previous years was reassuring, although it was important to note that 2011 had been a period of higher throughput at the hospital and the flu pandemic. A further point of assurance was the data contained within HSMI.

TEC had a wide ranging discussion on the validity of the data and in particular the processes for generating the discharge letter and arriving at clinical codes. Paul Crawshaw highlighted that over the three-month period, there have been more than one paediatric death. It was noted that the Associate Director of Quality was looking at developing a systematic process for monitoring clinical data and escalating it as appropriate as part of a Quality and Safety Strategy.

It was agreed there would be a substantive agenda item on the next TEC meeting regarding mortality. This would address:

- The process map for collecting the mortality data which was eventually submitted externally.
- A summary of the active steps being taken to reduce the number of deaths occurring in hospital. **DMJ/SR**

In the interim, it was AGREED that discharge summaries for deceased patients should be done by a specialist registrar or above.

Other elements highlighted from the Quality Report included:

- The Quality Account Dashboard identified an increasing number of complaints relating to discharge. This needed to be addressed urgently.
- The level of complaints was rising. Whilst this reflected a national trend, it was important that divisions had a focused effort on answering complaints as otherwise the backlog would continue to rise.
- Medicine had been excused from completing the Best Care Dashboard in December but had completed it early for January 2012.

TEC NOTED the report.

8/2012 CQC Report and Action Plan:

The CQC Compliance Report had now been published and the Trust was intending to submit its action plan immediately. Andrew Liles briefed TEC on the recent media coverage and also a discussion which had taken place between himself, the Chief Nurse and Monitor. In order for the impact on the Trust's Monitor governance rating to be removed, the Trust either needed to be re-visited by the CQC, or the Board would need to self-assess compliance against its action plan.

The action plan was divided into three sections:

- Immediate actions.
- Compliance actions.
- Improvement actions.

It was important that targets within the plan were realistic and the following elements were discussed:

Living Our Values: It was agreed a realistic target would be to have 85% staff having participated on the project by the end of March 2012, with 95% completion by the end of May.

Mandatory Training: It was agreed to keep the proposed target of 70% compliance by the end of March 2012. The February TEC development session would re-visit the mandatory training grid and training processes. There would need to be a major focus on delivering training.

It was highlighted there were two design pieces within the action plan:

- 24-hour observational audit of the Trust.
- A clinical day programme (outcome 4).

Both of these would need to be designed with the help of divisional directors and other senior clinicians.

It was suggested that the Trust should consider how to use the membership or governors in relation to the action plan.

It was important that the action plan was fully completed and that by the end of March the Trust was in a strong position on both A&E performance and being able to self-assess compliance against the action plan.

TEC APPROVED the action plan.

9/2012 Balanced Scorecard:

The Balanced Scorecard comprised four quadrants

Quality:
Discussed earlier on the agenda.

Workforce:
The quadrant included three red indicators:

- Agency Usage – This was related to increased operational capacity and short notice opening of wards.
- Staff Appraisals – This was an area also identified as an issue by the CQC in terms of the quality of staff appraisal. The number of staff undergoing appraisal appeared to have dropped during the busy winter period.
- Mandatory Training.

Clinical Strategy:
Areas highlighted within the quadrant included the rise in emergency admissions, the high re-admission rate and a flat market share position.

Finance and Efficiency:
2011/2012 was a challenged financial year. The Trust was now on track to deliver a £1 million surplus, although still needed to work on CIP delivery. The Trust remained at FRR-3.

TEC NOTED the report

10/2012 Compliance Framework

The Trust had met all the national targets within the Compliance Framework with the exception of the four-hour A&E target.

The Trust was performing well in terms of the 18-week RTT and was in a good position for the start of 2012.

Divisional Directors were urged to support A&E, visiting the area helped understand the issues and resolve pathway problems.

TEC NOTED the report.

11/2012 Systems Pressures

Valerie Bartlett summarised the Northwest Surrey urgent care capacity programme. This was a cross-organisational programme aimed at achieving the maximum patient care and flow through service position in the community and delivering pathways based on patient needs across organisational boundaries.

A weekly meeting had been set up since the CQC visit and immediate improvements were already evident, for example, the opening of re-ablement beds. The next priority would be to tackle GP urgent referrals and increase the capacity of RACs to reduce pressure on A&E and MAU.

It was noted that SECAmb were working closely with the Trust.

Mike Wood highlighted the need to speed up social services processes, and increase the capacity of the ICT. All Divisions were asked to make suggestions for inclusion in the programme at the next Calm Ordered Care meeting. **ALL**

Overall, it was important that the Trust focus on length of stay and occupancy.

TEC NOTED the report

12/2012 Health Informatics

The following points from the paper were highlighted:

Clinicom PAS: The Trust had a contract with iSOFT for its PAS system. iSOFT had been acquired by CSC Alliance who had now confirmed that the Trust's PAS would no longer be developed or supported beyond 2014/2015. This would impact on the Trust's current IT strategy and an approach needed to be developed in the context of the Trust's bid for Epsom.

Picture Archiving and Communications System: The National PACS contract ended in 2013. The Trust would need to procure a replacement system and retrieve the images stored under the current contract.

Innovations: It was agreed that the innovations workshop should take place at the March development TEC date.

Some of the changes highlighted in the report were significant risks and consideration needed to be given to incorporating them on the Corporate Risk Register. **DMJ**

TEC NOTED the report

BUSINESS CASE AND POLICY APPROVALS

13/2012 ENT Business Case

This was DEFERRED to the next meeting **Agenda**

14/2012 Barrier-Controlled Car Parking at Ashford Hospital

TEC APPROVED the proposal for physical works [1]at Ashford Hospital for the installation of new car parking barrier systems and re-designed access points to car parks

15/2012 Committee Policy

The updated Committee Policy was APPROVED. This would need further updating once changes to the governance/quality committee structure were agreed.

16/2012 Hospitality Policy

The Policy had been updated to incorporate the requirements of the new Bribery Act 2010.

[1] redacted

TEC APPROVED the Policy subject to amending the section regarding corporate responsibility. **JG**

17/2012 Colorectal Surgeon

TEC AGREED the business case subject to:

- Including the agreed statement on the opportunity for extended hours working.
- Making the on-call statement a range.
- Minor changes relating to SPA and DCC activity.

It was noted that whilst the business case did not require additional lists, there was still a small cost pressure for theatres as some new activity would be involved. As all business cases were supposed to reflect the proper cost of a service, it was agreed that Mick Imrie and John Hadley would need to agree the insertion of a small appropriate cost. **MI/JH**

It was confirmed that there were benefits to continuing to seek Royal College approvals for job descriptions.

INFORMATION – inc Sub-Committee reports

18/2012 Equality And Diversity Annual Report:

TEC NOTED the Annual Report 2011 which provided assurance of the Trust's impact and effectiveness in terms of implementing the Single Equality Scheme.

ANY OTHER BUSINESS

19/2012 Pathology Network:

The first major changes would go live from 6 February 2012. These would include microbiology and blood sciences. The intention was that changes would be invisible, but divisional directors were asked to alert pathology of any issues.

20/2012 Epsom Hospital:

The timetable for approving the transaction had slipped and a decision was now likely in March.

The Trust had appointed a new Integration Director, Ian McNuff, who would start next week. This was a temporary appointment funded centrally.

21/2012 Trust Performance

It was essential that the Trust was able to demonstrate strong performance. Key areas for focus included:

- Achieving the A&E four-hour target.
- Reducing length of stay.
- Reducing bed utilisation.
- Having a robust budget for 2012/2013 which delivered a significant surplus.

It was essential that all TEC members focused on these issues.

22/2012 Medical Director

Mike Baxter was thanked for his significant contribution as Medical Director over the last 10 years.

23/2012 Date of Next Meeting

10th February – Developmental.
24th February – Formal.

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

TRUST EXECUTIVE COMMITTEE MINUTES

Friday, 24th February 2012
2.00 pm to 4.30 pm
Room 3, Chertsey House, St Peter's Hospital

PRESENT:	Andrew Liles	Chief Executive
	Valerie Bartlett	Deputy Chief Executive
	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
	Paul Crawshaw	Divisional Director for Women's Health and Paediatrics
	Andrew Laurie	Divisional Director for Diagnostics and Therapeutics
	Raj Bhamber	Director of Workforce and OD
	Suzanne Rankin	Chief Nurse
	Barrie Jones	Divisional General Manager
SECRETARY:	Jane Gear	Head of Corporate Affairs
APOLOGIES:	Paul Murray	Lead Clinician for Cancer
	Gulam Patel	Divisional Director for Specialist Medicine and Specialist Surgery
	David Fluck	Interim Medical Director
IN ATTENDANCE:	Ian Fry	Clinical Director Surrey Pathology Services Network

Peter Wilkinson was welcomed to the meeting having been appointed as the new Divisional Director for Acute and Emergency Medicine.

ITEM **ACTION**

24/2012 Minutes

The minutes of the meeting held on 27 January 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:

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25/2012 Integrated Critical Care (minute 4/2012 refers)

Mick Imrie advised TEC that the project was now formally part of the PMO. A project brief had been prepared and the first meeting of the Project Board had taken place.

There were three stages to the project:

Stage 1: The business case with respect to co-location of facilities would be completed by July.
Stage 2: Action including approving options for co-location.
Stage 3: Implementation.

Approaches were being made to the PCT to see if there was any risk to funding from the current arrangements.

TEC NOTED the briefing and that the business case on co-location would be available for the July TEC meeting.

26/2012 Code 5 Reporting Solution (Minute 6/2012 refers)

The electronic system was due to be rolled out to Clinical Hematology, Vascular and Obstetrics & Gynaecology, as the final stage.

Prior to withdrawing the existing paper system, it was essential that the Trust and clinicians were confident in the robustness of the electronic system including actions if e-mails were not opened. The overal aim was to ensure that the patient received the correct treatment in a timely fashion.

Following discussion, TEC AGREED that a formal report should be presented to the next meeting. **DMJ**

27/2012 Mortality (Minute 7/2012 refers)

It was highlighted that managing mortality was not a standalone activity and needed to be integrated with an overall quality and safety strategy.

It was noted that to determine cause of death Dr Foster used primary diagnosis on admission and any procedures undertaken during the patient stay.

During the discussion, it became apparent that there needed to be a clear understanding of the purpose of quality and safety half days. The aim was to introduce a standardised process of reviewing every death. These mortality reviews were not to replace more detailed mortality and morbidity meetings, although the two functions could be integrated. A number of concerns as to how the mortality reviews could be undertaken were expressed by the Divisional Directors and it was agreed that there was more work to do on agreeing the standardised mortality review approach.

In concluding the discussion, it was AGREED that the paper on mortality should be discussed at the next Calm Ordered Care Meeting and that the wider aspects of the paper on improving clinical outcomes would benefit from a workshop discussion which would explore the vision and how to implement the mortality reviews in a structured way. **SR**

28/2012 Change of Trust Standard Owner– Outcome 02 (Minute 8/2012 refers):

Outcome 02 related to consent to treatment. The proposal was for a consultant surgeon to be the owner.

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TEC AGREED to the appointment of Mr. Neville Menezes as the Outcome owner subject to an audit trail demonstrating that he had a clear understanding of the role and confirmation that the CQC did not have any expectation about executive director ownership of individual standards. It was noted that the overarching CQC 'nominated individual' was the Chief Nurse. **SR/JH**

29/2012 STRATEGIC DELIVERY BOARD

The Strategic Delivery Board had met on 21 February 2012. The summary progress report had been circulated with the agenda.

A major topic had been to agree the list of projects which should be incorporated into the PMO for 2012. The Chief Executive detailed the list agreed.

TEC discussed *Living Our Values-2*, and it was clarified that the majority of staff would have attended the original *Living Our Values* programme during 2011/2012. Phase 2 of the programme was about embedding improvements.

It was agreed to bring the benefits tracker to the next TEC. **VB**

TEC NOTED the report.

OPERATIONAL PERFORMANCE, QUALITY AND SAFETY

30/2012 Corporate Risk Register

Since last reported to TEC, no risks had been opened or closed but one risk had a reduced risk score. It was noted that this was a lower level of change that normally reported and it was agreed to ensure that regular review was being maintained.

CRR832, loss of income on contracts, showed a reduction in risk level. It was noted that this would change annually with the contract cycle.

CRR1057 – possible loss of patient confidence in the complaints service. It was confirmed that performance in responding to complaints was improving, and the risk level would be reviewed shortly. However, it was essential that the Trust continued to monitor and maintain sustained performance improvement. The number of re-opened complaints was an indicator of the patient's level of confidence in the overall service.

Good quality information to support performance management was essential. In reviewing the information available from Bluespier, it was suggested that consideration be given to whether this was a Trust wide issue. It was noted that the post-implementation review of Bluespier would revert to the next TEC. **Agenda**

In discussing the general issue it was noted that managers and clinicians were demanding more from the Informatics Team which was leading to a capacity issue, in particular prior to the transition to a new data warehouse. It was therefore agreed that a presentation could be made to a future TEC on how the Informatics Department were developing and responding to information demands. **DMJ**

TEC APPROVED the register.

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31/2012 CQC Action Plan:

Progress on the CQC action plan looked steady although areas judged to be red included:

- Immediate capacity management plan:
- Outcome-1 – discharge related complaints.
- Outcome-4 – care planning and nursing documentation.

An Audit in Practice on four outcomes would be undertaken during the week commencing 27 February 2012.

Following the last developmental TEC, a final mandatory training grid had been produced and was tabled. A meeting of all mandatory training leads had taken place the previous day and had included sharing training materials to ensure maximum usage, and had discussed the use of electronic packages.

Compliance on mandatory training had now reached 57% and regular reports were supplied to divisions. A member of the Training Department had been aligned to each division or directorate. This would help ensure that baseline recording was accurate.

TEC NOTED the report.

32/2012 Balanced Scorecard:

The Balanced Score Card comprised four quadrants.

Quality:
The quadrant was noted but not discussed in detail due to the absence of the Medical Director. However, it was noted that the CMR had risen in January and was mainly attributable to medicine. However, a detailed note audit had taken place and no concerns had been identified.

Workforce:
The importance of appraisal both in terms of coverage and quality was highlighted. Performance as at January 2012 was 87.0%. Although it was recognised there were operational pressures on front line staff, it was essential that all corporate areas achieved a 100%.

Clinical Strategy:
Operational pressures continued with an increase in emergency admissions.

Finance and Efficiency:
Overall the month had been reasonable, and the Trust was on track to delivery £1m surplus at year end. The in-month surplus had been £0.1m above plan.

It was important that the Trust achieved a significant surplus in 2012/2013 which was part of the budget setting challenge for 2012-2013.

It was pleasing to note that the Outpatient DNA rate continued to improve and also that both elective and non-elective lengths of stay showed a downward trend.

TEC NOTED the report.

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33/2012 Compliance Framework

Although performance on the four-hour target in A&E had improved from December to January 2012, achieving the target of 95% remained a significant challenge. The impact of not achieving the target, together with the penalty attributable to the concerns expressed by the CQC report, meant the governance score was 3 and the Trust remained amber red.

TEC NOTED the report.

34/2012 Health Informatics:

The following points were noted:

PAS. The supplier had now agreed to offer support until 2017. A tender waiver covering the next two years would be considered in order to allow a strategic review including the implications arising from an Epsom transaction.

RealTime:
The team was on track to finish deployment of RealTime by the following Friday. At this point, the white boards would be replaced as the electronic white boards went live.

Wireless on Wheels:
The go-live date had now been achieved, and the role out of work stations on wheels had been accelerated with requests being received to extend it further.

E-prescribing - the business case would come to the next TEC meeting.

A discussion paper on the strategic choice regarding moving off IPL would be presented in due course. For RealTime to be effective, it was essential that nursing and other staff implemented data on a RealTime basis. It was confirmed that it was a ward manager responsibility to ensure this took place.

In respect of e-prescribing, it was highlighted that pharmacists spent considerable time on reconciling the drugs patients were admitted on with GPs. It was noted that it was planned to participate in a trial of a summary care record with GPs which would help address the issue. The trial was being organised by the PCT.

TEC NOTED the report.

35/2012 Surrey Pathology Service Six Monthly Report

Ian Fry was welcomed to the meeting and detailed the current position on implementing the network. By the end of Q1, full deployment should have been achieved and steady state reached. However, the current period of implementation was a challenging change period. It was confirmed that the financial objectives were largely on track and a number of plans were underway in respect of quality improvements including extra runs for GPs.

Consistent use of order communications would be important, and there would be a push on Opennet as opposed to ward inquiry.

It was confirmed that the network was very advanced in terms of an NHS

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solution and the opportunity was being taken to seek wide ranging new business development opportunities.

TEC NOTED the report.

36/2012 Business Planning Process 2012/2013:

TEC was informed of the Council of Governors/Board of Directors session which had taken place recently. This had been very constructive with the Council of Governors having a strong focus on patient experience and improvement.

There was still a financial gap which the Trust needed to close and a robust CIP programme would be essential. Capacity planning was integral to achieving the Plan. The Trust was aware that the current bed allocation was not optimal and modeling work was underway to achieve 91% occupancy, although this would mean a 15% reduction on length of stay which would be a significant challenge.

Paragraph 6.3 of the Plan referred to Trust Funds in the context of the capital allocation and it was agreed to check what this referred to. **JH**

The Trust aim would be for a full PBR contract rather than a cap and collar, however the commissioners nationally had significant influence and power, and the national contract included significant penalties, for example, in respect of failure to achieve A&E targets.

TEC NOTED the report.

37/2012 Short to Medium Term Strategy for the Department of Urology:

John Hadley outlined the drivers for change including the headline findings of the external review of Urology Services carried out by Mr. Philip Britton. A copy of his report was available on request.

In discussing the paper, the following points were noted.

- Urology was no longer pushing for a robot.
- The intention was for consultants to be available 24/7 but not resident in the hospital.
- There was a degree of growth anticipated in the strategy but the majority of the activity change would be resultant from a relocation of surgery currently undertaken at Royal Surrey County Hospital.
- It would be important to ensure a good SLR, length of stay and other efficiency markers, as an outcome of implementing the strategy.
- Urology was currently a specialty which lost income and it was therefore encouraging to see a specialty lead developing the strategy.
- It would be helpful to have a joint session on Urology with Epsom who also employed a urological surgeon.

TEC SUPPORTED the outlined Strategy, noting the business cases would revert to TEC for approval.

BUSINESS CASE AND POLICY APPROVALS

38/2012 ENT Business Case

John Hadley noted his interest in the topic. It was confirmed that the business case had been reviewed and supported by the Commercial

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Group. The service made a modest surplus under SLR. The business case did not assume any repatriation of income from the Royal Surrey County Hospital which would be an upside.

TEC APPROVED the business case subject to checking that the rules about One Stop Clinics had been followed and a number of minor changes to the job plan (e.g. the inclusion of on-call). **BJ**

39/2012 Neurophysiology:

The service had recently been successful in securing a contract for the provision of service to Frimley Park Hospital.

TEC discussed the rationale for the Trust employing the consultant noting that it would strengthen the Trust's own service and given opportunities in respect of other local catchments. However, a number of concerns were expressed about the job plan and it was agreed that TEC should revisit the proposal with the benefit of a greater understanding of the job plan, e.g. the relationship with St George's Hospital, and greater clarity on the development opportunities for the service. **BJ**

TEC NOTED the Business case.

40/2012 Registration Authority Policy:

The policy laid out the procedures to be followed, and the roles and responsibilities of staff in respect of issuing smart cards within the Trust.

TEC APPROVED the policy.

41/2012 INFORMATION – inc Sub-Committee reports

None scheduled

ANY OTHER BUSINESS- none raised

42/2012 Date of Next Meeting

9 March 2012 – developmental.

23 March 2012- formal.

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