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

TRUST BOARD
29th September 2011

TITLE	**Trust Executive Committee Meetings held on 22nd July 2011 , 12th August 2011, 26th August 2011(draft Minutes)and 9th September 2011**
EXECUTIVE SUMMARY	The formal TEC on **22nd July** considered or approved: ▪ Car parking Policy-phase 1 ▪ Telecommunications Resilience Business Case ▪ Acute Oncology Business Case ▪ Neurology Business Case ▪ The One Plan ▪ Volunteer Strategy The developmental TEC held on **12th August 2011** focussed on winter planning. The formal TEC on **26th August** considered or approved: ▪ Report on progress via the PMO ▪ Site Capacity Management Plan ▪ Replacement of Respiratory Medicine Consultant ▪ Grievance Policy ▪ Access Policy The developmental TEC held on **9th September 2011** undertook an Observational Audit in clinical areas
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 minutes of the Trust Executive Committee held on 22nd July 2011 and the draft minutes from the meeting held on 26th August 2011
Submitted by:	Andrew Liles Chief Executive
Date:	18th September 2011
Decision:	For Noting

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

TRUST EXECUTIVE COMMITTEE MINUTES

Friday, 22nd July 2011
2.00 pm to 4.30 pm
The Lecture Theatre, The Ramp, St Peter's Hospital

PRESENT:	Valerie Bartlett	Deputy Chief Executive
	David Elliott	Divisional Director for Trauma & Orthopaedics
	Andrew Laurie	Divisional Director for Diagnostics and Therapeutics
	John Hadley	Divisional Director for Surgery
	David Fluck	Deputy Medical Director
	Michael Wood	Divisional Director for Medicine
	Donna Marie Jarrett	Associate Director of Health Informatics
	Raj Bhamber	Director of Workforce and OD
	Paul Murray	Lead Clinician for Cancer
	John Headley	Director of Finance & Information
	Giselle Rothwell	Head of Communications
	Suzanne Rankin	Chief Nurse
	Dr Tariq Bhatti	Paediatric Consultant
	Jenny Martin	General Manager ACCT
	Barrie Jones	General Manager Ambulatory Care Division
SECRETARY:	Jane Gear	Head of Corporate Affairs
APOLOGIES:	Andrew Liles	Chief Executive
	Mick Imrie	Divisional Director for Anaesthetics, Critical Care & Theatres
	Mike Baxter	Medical Director
	Paul Crawshaw	Divisional Director for Women and Children's Services
	Gulam Patel	Divisional Director for Ambulatory Care
IN ATTENDANCE	Claire Braithwaite	Associate Director of Performance Improvement
	Chris Bell	Associate Director of Estates and Facilities
	Wendy Munroe	Clinical Fellow in Clinical leadership (KSS Deanery)
	Matthew Tambling	Contracts manager (Minute 121/2011)

Claire Braithwaite was introduced as the new Associate Director of Performance Improvement, commencing on 1st August 2011.

ITEM **ACTION**

111/2011 Minutes

The minutes of the meeting held on 24 June 2011 were agreed as a

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correct record subject to amending minute 98/2011 second sentence to read: "It was confirmed that if possible this matter would be brought to the July TEC meeting for consideration. Divisional Directors expressed concern about the sufficiency of representation in July but the Chief Executive confirmed the matter should not be delayed."

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 the agreed time scales.

The following was noted:

112/2011 Cancer Reform Strategy (minute 33/2011 refers):

It was agreed that Paul Murray would progress the idea of an annual event highlighting cancer outside of the meeting.

OPERATIONAL PERFORMANCE, QUALITY AND SAFETY

113/2011 Corporate Risk Register

The Risk Register identified one risk as having been closed and no risks as having been added or with changes to either the treatment plans or the level of risk.

During the discussion, it was agreed:–

- To consider whether the risk level on escalation beds (Risk 1147) should either be reduced or the wording of the risk reframed to identify it as a factor in A&E performance and therefore relating to a risk on the emergency pathway overall. **VB**
- The privacy and dignity risk (CRR767) was green rated. There had been no recorded breaches of SSA but work remained to be done in respect of A&E and a number of other limited clinical areas so the risk should remain for the time being.

The Risk Register was APPROVED

114/2011 Quality Report

The SMR was reflective of mortality two months ago and had shown an increased to 102.7. The Trust's CMR had fallen but it was important that this reduction in deaths was constantly monitored particularly in the light of the increasing levels of Trust activity.

The following actions in respect of mortality were agreed:-

- Discussions between the Associate Director of Informatics and Deputy Medical Director on possible coding issues linked to SMR. **DMJ/DF**
- To reinstate the bi-weekly and monthly review meetings . **DF**

ITEM **ACTION**

- Correlate the CMR audit.

The report identified that the software application to resolve the NPSA alert on 'the early identification of failure to act on radiological imaging reports' would be transferred to a live environment from 22 July 2011 with rollout to all users by the end of August 2011. However, TEC was advised that the pilot was still being planned and it was therefore agreed that Chief Nurse and Associate Director of Health Informatics should review the position to be clear on the precise timetable and also the flow of information into the Quality Report regarding this development. **DMJ/SR**

It was noted that iSOFT was still testing the version release which it was hoped would be available towards the end of September. Informatics were actively pursuing the supplier but the position was the same for all Trusts using the CliniCOM PAS.

The level of complaints was static although TEC were advised that the response rate had declined. Systems were being introduced to improve tracking which should to lead to an improvement in response rate.

TEC NOTED the report.

115/2011 Balanced Scorecard

The Balanced Scorecard comprised four areas aligned to the Trust's four key strategic objectives.

Workforce

The following points from the workforce quadrant were highlighted:

- The lines on the scorecard relating to CIP WTE reduction were green although it was highlighted that the Trust was behind target in respect of CIPs.
- Agency use had decreased in June, including medical agency usage. Plans to develop the in-house bank for temporary medical staff rather than using agency staff were highlighted.
- The level of appraisals completed needed focus.

Clinical Strategy

The quadrant highlighted that the number of emergency admissions had fallen in June. The number of elective admissions had shown a small increase and the number of emergency re-admissions following an elective primary admission had decreased.

Finance and Efficiency

Overall, month 3 had shown a better financial performance and the Trust was confident of securing FRR3 at Q1. This was a good outcome following a difficult start to the financial year.

The month 3 results had benefited from an upturn in activity and

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income, better control of expenses and a review of accruals and pre-payments. It was also noted that considerable effort had been put into improving the CIP position.

However, the average length of stay for non-elective admissions continued to increase and a number of additional theatre sessions had been undertaken.

It was noted that while the Trust's overall day case rate was green, there was underlying variability between specialties. Improving the day case rate would have a positive impact on capacity generally.

While discussing the approach to day cases, the interrelationship of coding and patient flow was noted; e.g. day cases who had to stay in could be counted as a re-admission, and in addition there was the potential for all patients not admitted from a waiting list to be coded as an emergency. It was noted that the Medical Director was already looking at aspects of this and there should be further discussion at the next operational meeting.

TEC NOTED the report.

116/2011 Compliance Framework

The Trust would deliver an amber/green rating for Q1. The Trust had delivered its C difficile target and had met the A&E waiting time for the quarter. However, the Trust had failed to achieve the RTT target for elective admissions although a good recovery had been made in June.

As a result, the Trust started Q2 from a strong position. However, two significant changes impacted on the A&E indicators in Q2; firstly activity in Community Walk-in Centres could no longer be counted, and secondly the Trust would be measured against five A&E standards which considered wider aspects of the service.

In discussing the A&E changes the following points were noted:

- Some clinical presentations took more than four hours to treat. Therefore there was a risk that patients were admitted to avoid a four-hour breach. The introduction of the pit stop for ambulances had reduced the space previously available to deal with these patients. This was being addressed and TEC expressed support for a Clinical Decisions Unit.
- A root cause analysis of patients breaching the four-hour target would be useful.
- Analysis of patients admitted within the 3 $^{1/2}$ to 4 hour time period could be informative.
- The care of frail elderly patients in the middle of the night remained a significant concern. It was noted that discussions were being actively pursued with Social Services regarding an approach of escorting such patients who did not need admitting back to their home and undertaking a basic assessment of the home conditions. There was general support from TEC for such a

ITEM **ACTION**

scheme to be worked up which needed to be condition related rather than age-defined.

TEC was advised that approximately 25% more patients were being listed by Trauma and Orthopaedics than there was theatre capacity. The Division was utilising short-term fixes to resolve this, but long-term solutions were required.

TEC NOTED the report.

BUSINESS CASE AND POLICY APPROVALS

117/2011 Car Parking Policy

Chris Bell was welcomed to the meeting and introduced the draft Policy which had been substantially reviewed and changed as a result of comments received in the consultation period. The Trust was legally required to reduce the number of people parking on its site. The only way to raise money to provide alternatives for car parking was through charging.

Many of the comments received during the consultation related to the fairness of a 1% ceiling, the application to part-time staff, and the lack of guaranteed spaces.

The draft Policy now proposed:-

- A pay-as-you go scratch card system based on salary bandings, all to be set at less than 1% of base salary.
- Reductions in the visitor charges for both the first hour and daily periods.
- Changes to the exclusion zone.

Details of the charges would be phase two of the policy development. These would be worked through by the Car Park Policy Group which had a wide representation of staff groups on it, and the reviewed by the Employee Partnership Forum and final approval by TEC. It was noted that the document was a Policy, and not a procedural manual, therefore precise details, for example, changes to the Hopper Services were not included

In the general discussion on the Policy, concerns were raised about the lack of financial information linked to the Policy and the benefit from TEC approving the Policy in a two-phase basis as it was essential that there were proper discussions on charging.

The benefits of linking the payment scheme to salary were also considered; it was questioned whether it was truly possible to incentivise changes of behaviour, particularly for staff whose car was essential to their work. However, it was pointed out that the only way the Trust could raise money to provide alternatives to car parking and enhance facilities for cycle riders, was to introduce charging. It was noted that the patient concessionary groups had been considered as part of consultation, but additional groups could be added.

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	Concerns were expressed that the Policy talked about a pay-as-you go approach without the mention of a ceiling. It was reported that most consultants were unhappy with the proposal, and concern was expressed by some of the Divisional Directors that the Policy was seen as de-motivating by this senior group of staff and it was therefore concerning that neither the Medical Director nor Chief Executive were present for the discussion. However, it was confirmed that both the Chief Executive and Medical Director had confirmed their support for the discussion proceeding. The Chief Nurse also advised TEC that there were also strong views expressed by many less well paid staff in the organisation that those who earned more should pay more. Each of the TEC members were invited to summarise their views on the draft Policy and then a vote was taken. The following TEC members voted against the Policy: Michael Wood, Paul Murray, Dr Bhatti, Andrew Laurie and John Hadley. and The following TEC members supported the Policy: Suzanne Rankin, David Elliot, Raj Bhamber, Donna Marie Jarrett, Giselle Rothwell, John Headley, David Fluck and Valerie Bartlett. The Policy was therefore APPROVED, and it was confirmed that Phase 2, the charges would revert to TEC at the earliest opportunity.	**VB**
118/2011	**Telecommunications Resilience Capital Programme – Business Case** The Trust's Telecom Resilience Six-Year Capital Programme had previously been approved and commenced in 2009. A shortfall in funding had now been identified for the remaining four years of the Trust's six-year programme, primarily caused by inflation, variations in design or estate growth. The proposal had been reviewed by the Capital Control Group and Finance Committee who had supported the Business Case. Discussions would take place between the Associate Director of Estate and Facilities and the Associate Director of Health Informatics to confirm the final allocation of the funding due to the convergence of telecommunications and information technology.	**DMJ/CB**
	TEC APPROVED the Business Case.	
119/2011	**Acute Oncology Business Case** The Business Case sought to provide an Acute Oncology Service in line with national guidance in the Manual For Cancer Standards published in April 2011. A local solution which would provide excellent care for the Trust's patients had been developed utilising a combination of current	

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services with additional funding to meet the gap in service provision. Although the proposal was not revenue generating it was noted that the Year 1 costs were small, £22k.

Strong clinical support was expressed for the Business Case which TEC APPROVED.

120/2011 Neurology Business Case

The Business Case presented the case to replace a vacant full-time consultant post, currently covered by a locum.

In considering the Job Plan it was noted that input into the Stroke Unit was required for differential diagnosis purposes and that the Job Plan itself needed to be re-written in hours, reflect the additional input into wards and private practice and ensuring that the SPA activity was proportional between the Trust and St George's.

TEC APPROVED the business case subject to the Job Plan being re-written and approved by the Deputy Medical Director. **BJ(GP)**

STRATEGY and PLANNING

121/2011 The 'One Plan'

Matthew Tambling was welcomed to the meeting to give highlights of the 'One Plan'. This Plan identified how the NHS in Surrey would ensure that there was a coordinated approach to the delivery of the £360 million productivity challenge over the next four years. All NHS providers were being invited to formally approve the Plan, and a presentation was being made to the forthcoming Trust Board meeting. The following points from the Plan were highlighted –

- Moving to a zero tariff for zero LOS. This was against the National PbR Guidelines.
- Paediatric short stay: Capping admissions or introducing reduced short-stay tariffs.
- Planned care: Fast steady stop. This could introduce intentional delays into the system and risk compromising the patient and adversely affecting the Trust's RTT target. The proposal also introduced requiring patients to attend an eight-week Stop Smoking Course.
- Routine surgery patients to be treated in turn, which would impact negatively on the Trust's ability to plan effectively and assure efficiency in the system.
- Payment for right care in the right place only once – it was unclear what this meant.

Overall, there were some reservations about the operational implications of the 'One Plan' although it was noted that the Plan also included sections on working across boundaries thus introducing improvements to the system. Any comments TEC members had would be welcome so they could inform the Board discussion.

ITEM **ACTION**

122/2011 Marketing Report

The report provided a summary of GP commissioning and developments together with recent competitor and market share information (Q4).

Overall, it was important that the Trust was strongly aligned to GPs as commissioning groups started to develop.

The report identified that the Trust had the highest proportion of market share in Surrey for Outpatients, day cases and emergencies and overall, the Trust's market share for Surrey continued to hold up. However, Hounslow activity had consistently dropped off over a number of years. It was noted that the improvement to Outpatient's at Ashford Hospital might help target improvements for this catchment area and also that Hounslow PCT were trying to repatriate activity.

The report identified a range of outlying clinics; whilst the majority of these were not revenue generating, each needed to be reviewed on a case by case basis.

TEC NOTED the report.

123/2011 Epsom Hospital

The tender return date was 16 September 2011. The report identified the time line for the transaction and the high-level Trust clinical strategy which was based on a campus approach.

The Trust now had access to an electronic data room and TEC members could request information via Rebecca Rose.

Initial financial data suggested that the Trust would need to achieve significant cost reduction through efficiencies.

It was highlighted that Epsom were undertaking a number of initiatives either through the introduction of significant technology or senior staff recruitment which would have a financial and service implication should the Trust be successful in its tender.

All Divisional Directors confirmed they would wish to be involved in stakeholder engagement which was currently being mapped out.

The transaction would be reviewed at each future formal TEC meeting.

TEC NOTED the report.

(Raj Bhamber left the meeting).

124/2011 Surrey Pathology Consultation – update

The first of two stages of consultation had recently been completed. The model of centralisation for each site had now been agreed.

ITEM **ACTION**

TEC NOTED the update.

125/2011 Volunteer Strategy

The document set out the three-year Strategy for volunteering at Ashford and St Peter's Hospitals NHS Foundation Trust.

TEC APPROVED the Strategy noting that an implementation plan would be produced.

ANY OTHER BUSINESS

126/2011 Orthopaedic Wards

David Elliot informed the meeting that Elm and Juniper wards were combining and would be called the Rowley Bristow Unit.

127/2011 Date of Next Meeting

Friday 12th August (developmental)
Friday 26TH August (formal),

128/2011 OPERATIONAL UPDATE

Trust performance had improved in the previous week. MAU had been working effectively and the Trust had sufficient capacity on the wards. However, it was too early to note whether these were sustained improvements.

Action log

Date Action Agreed	Minute Number	Topic	Action	Owner	Timeline for completion	Comment
22/07/2011	114/2011	**Quality Report**	NPSA alert on Code 5- Confirm plan for pilot	**SR/DMJ**	26/08/2011	Meeting on 27th July 2011(Mike Baxter, Vijay Gautam, Neville Menezes & Donna Marie Jarrett) agreed to commence the pilot of the code 5 tracker at the beginning of September. Specialties selected to be involved in the pilot were A&E, Respiratory Medicine, Rheumatology,Upper GI, Surgery, Vascular Surgery, Colorectal Surgery & Gastroenterology
Due at a future meeting						
24/06/2011	103/2011	**Compliance Framework**	Discuss complex shoulder activity with Specialist commissioning team	**SR**	23/09/2011	
22/07/2011	117/2011	**Car parking**	Agree car parking charges	**VB**	23/09/2011	
22/07/2011	113/2011	**CRR**	Review risk level or wording (risk 1147) on escalation beds	**VB**	**23/09/2011**	

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

TRUST EXECUTIVE COMMITTEE MINUTES

DRAFT

Friday, 26th August 2011
2.00 pm to 4.30 pm
The Lecture Theatre, The Ramp, St Peter's Hospital

PRESENT:	Andrew Liles	Chief Executive
	Valerie Bartlett	Deputy Chief Executive
	Donna Marie Jarrett	Associate Director of Health Informatics
	Gulam Patel	Divisional Director for Ambulatory Care
	John Hadley	Divisional Director for Surgery
	John Headley	Director of Finance and Information
	Michael Wood	Divisional Director for Medicine
	Mick Imrie	Divisional Director for Anaesthetics, Critical Care & Theatres
	Mike Baxter	Medical Director
	Paul Murray	Lead Clinician for Cancer
	Jules Arnould	Head of Organisational Development & Living Our Values Project Manager
	Andrew Moth	Lead Superintendent Radiographer
	Vanessa Avlonitis	Deputy Chief Nurse
	Paul Crawshaw	Divisional Director for Women and Children's Services (part meeting)
SECRETARY:	Jane Gear	Head of Corporate Affairs
APOLOGIES:	Andrew Laurie	Divisional Director for Diagnostics and Therapeutics
	Giselle Rothwell	Head of Communications
	Raj Bhamber	Director of Workforce and OD
	Suzanne Rankin	Chief Nurse
IN ATTENDANCE:	Claire Braithwaite	Associate Director of Performance Improvement
	Wendy Munro	Clinical Fellow in Clinical leadership (KSS Deanery)
	Rebecca Matthews	General Management Intern

ITEM **ACTION**

129/2011 Minutes

The minutes of the meeting held on 22 July 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 the agreed timescales.

The following was noted:

130/2011 NPSA alert on Code 5s (minute 114/2011 refers)

It was noted that the pilot of the electronic code 5 tracker would commence at the beginning of September.

131/2011 STRATEGIC DELIVERY BOARD

The Trust had adopted a Programme Management Office approach in order to ensure delivery of major projects, including achievement of benefits. A Strategic Delivery Board oversaw the activity of the PMO. The summary report on progress via the PMO was discussed by TEC and the following points were highlighted : -

- Although it was unlikely that Divisional Directors would be writing detailed business cases, it was agreed that they could benefit from some higher level training associated with the PMO function. It was agreed to arrange individual personal briefings for the DDs. **VB/CB**
- Although there was no clinical representation on the Strategic Delivery Board (SDP), it was agreed that all Divisional Directors should be invited to the quarterly meeting which had a wider membership. **VB/CB**
- Divisional Directors would be involved on individual programme boards.
- A more detailed tracking report was available and this would be circulated with TEC papers in future. **VB/CB**

TEC NOTED the report.

OPERATIONAL PERFORMANCE, QUALITY AND SAFETY

132/2011 Corporate Risk Register

The Corporate Risk Register (CRR) identified one new risk as being added, one risk to be closed, and one where there was a reduction in the risk level.

CRR 1057 related to the possible loss of patient confidence in the Complaints Service. It was noted that management of complaints had been devolved to Divisions in order to ensure ownership and promote mplementation of change in response to complaints investigations.

However, it had become apparent that some Divisions were experiencing considerable pressure in terms of investigation and subsequent timeliness of responses, and also in ensuring the appropriate skills were available within the Division to respond effectively. There was therefore a further review of the systems and processes underway, and it was noted that the optimal approach was where complainants were telephoned for a discussion which would help identify the key issues and the objective which would achieve resolution.

CRR 115 related to code 5 alerts; this risk needed updating to reflect the pilot on electronic notification.

It was also noted that a review of the CRR had been initiated and it was agreed to ensure that Divisional Directors were clear on the requirements of the review. **VA(SR)**

TEC APPROVED the updated Corporate Risk Register.

133/2011 Balanced Scorecard

The Balanced Score Card comprised four areas aligned to the Trust's four key strategic objectives.

Workforce:

The following points from the Work Force quadrant were highlighted:

- Results from the Trust's summer staff survey were now available and meetings have taken place with leads to agree action plans. The response rate from the summer staff survey was 56.3%.
- The Trust needed to ensure actions were taken early as the next National Staff Survey data collection would commence shortly.
- The number of staff trained in EQUIP was low; 11. It was noted that training had been shortened to two days, and consideration was being given to how training could be linked into specific projects.

Quality:

- One case of MRSA had occurred in August. The RCA indicated that this was not hospital acquired but had been identified whilst taking a second blood culture post admission which was clinically indicated.
- The SMR was 98.4 YTD. Following review of the Dr Foster data, investigation was underway on bladder surgery

- .The report identified zero mortality from VTE. It was important that re-admission data picked up VTE events.
- It was thought that the rise in SMR could be due to the threshold being reset by Dr Foster. It was agreed to check the Trust's position compared with suitable benchmarks. It was also agreed to find out the latest position on the new hospital mortality indicator being developed by the NHS Information Centre. **MB**

Clinical Strategy

There has been a small increase in the number of emergency admissions. The Trust was still on track for delivering the annual target .There was a small fall in elective admissions in July.

Readmissions across the Trust had shown a decline. The reduction of readmissions from nursing homes (25%) appeared to be sustained. There had also been a 16% reduction in emergency-emergency readmissions ,

Elective –emergency readmissions had shown a small reduction (10%). Mike Baxter tabled information relating to emergency admissions following a previous planned inpatient spell with drilled down information relating to urology as an example.

This data indicated that more than 30% of the readmissions were on surgical specialties and that many had a very short initial admission and then a longer readmission. In addition, patients were not necessarily readmitted into the same specialty. This type of data would enable the Trust to examine coding and also clinical practice issues.

A report was being produced for each specialty on a weekly basis.

It would also be important that the Trust understood the technical definitions on readmission.

It was also agreed to follow-up progress on the outcome of the surgical readmission audit **WM**

Finance and Efficiency

Year to date, both EBITDA and surplus were £0.3 m adverse to budget. The main issue behind the month's EBITDA shortfall was a non-pay cost overrun in clinical supplies. However income exceeded target and it was now possible that the Trust would breakthrough the £2 m cap.

Although the average non-elective LOS remained above target, there were signs that this might be reducing in month. It was important that the Trust continue to grow elective activity, and tackle any RTT backlogs.

TEC NOTED the report.

134/2011 Compliance Framework and Operational Performance Report

Overall a green performance rating was predicted for Q2 with the risk to this being the delivery of two of the clinical quality indicators for A&E.

The Trust had delivered the RTT target in July and was on track for delivery in August.

A&E performance had improved substantially between Q1 and Q2 especially at St Peter's although performance at St Peter's alone was 94% and therefore below target. Over the last 72 hours the team had achieved 0 breaches, which was a very significant achievement. In addition, there had been a very significant reduction in the overall waiting times and numbers of long waiters in the department

It was noted that the SHAs were clustering nationally from October and that the new Chief Executive for the South cluster (South West, South Central and South East Coast) was Sir Ian Carruthers who would bring a major focus on performance.

TEC NOTED the report.

(Paul Crawshaw joined the meeting)

135/2011 Performance Reviews

The summary report provided an overview of the latest Performance Reviews.

Major themes from the report related to difficulties in achieving financial balance, delivery of CIPs and completion of appraisals. Nevertheless, it was noted that many of the Divisions were near financial break-even.

It was noted that appraisal data was drawn from ESR. It was important that data was entered on a timely fashion in order for the report to be accurate. However, it was agreed to check whether two separate and different reports were being generated as some Divisions expressed concern about the accuracy of data. **JA(RB)**

TEC NOTED the report.

136/2011 Site Capacity Management Plan

The purpose of the Plan was to have a clear process for managing bed capacity and patient flow, ensuring consistency in approach, roles and responsibilities.

TEC welcomed the Plan but agreed it should be clearer in differentiating between weekdays and weekends, in particular attendance at meetings during 'black' escalation. It would then be essential that responsibilities were clearly communicated to on-call consultants. **CB**

TEC APPROVED the Plan and agreed to review it again once updated.

BUSINESS CASE AND POLICY APPROVALS

137/2011 Replacement of Respiratory Medicine Consultant

The business case for a replacement consultant in Respiratory Medicine was discussed. A number of inaccuracies in the business case were noted, including the overstatement of savings arising from the retirement.

Following discussion, particularly around the job plan, the business case was approved subject to reviewing the session supporting R&D and also ensuring that the post had links into Community Services if possible . **MW**

TEC APPROVED the business case.

138/2011 Grievance Policy

The Policy had been updated with legal review and discussion with EPF and the Joint Local Negotiating Committee.

TEC APPROVED the Policy but noted that it introduced a three-month cut-off period. It was agreed to review of the type of matters which had previously been raised outside of this period in order to consider whether this meant that extenuating circumstances should be referred to in the Policy. **JA(RB)**

139/2011 Access Policy

In introducing the revised Policy, it was noted that one further update would be made to the section on private patients where it needed to state that a GP referral was required following a private outpatient appointment.

It was suggested that a standard letter following a DNA, would be helpful rather than leaving it to individual clinicians to craft. **CB**

TEC APPROVED the Policy.

140/2011 Car Parking Policy- Quality Impact Assessment

The Impact Assessment formed part of the formal policy approval process. In reviewing the Impact Assessment, it was noted that the Trust was providing more disabled car parking than the Council required; it was felt this reflected the client group of the hospital but should be reviewed over time.

It was also agreed to monitor the frequency of visitors having to stay for reasons beyond their control. **VB**

The Impact Assessment was APPROVED.

STRATEGY AND PLANNING

141/2011 Epsom Hospital Transaction Update

The Deputy Chief Executive updated TEC on discussions with key players at Epsom Hospital, and other proposed partners, together with the impact on the current timeline.

TEC NOTED the update.

142/2011 Perinatal Mortality

Dr Crawshaw updated TEC on an issue previously raised in a Quality Report regarding 42 deaths (1% of activity). Most were stillbirths and nothing untoward had been identified. It was agreed to find out whether it was a formal requirement for these deaths to be linked to paediatricians and issued with hospital numbers and to find out what other Trusts did in these circumstances. **DMJ**

143/2011 Date of Next Meeting

Friday 9 September- Developmental
Friday 23 September- Formal

Action log

Date Action Agreed	Minute Number	Topic	Action	Owner	Timeline for completion	Comment
24/06/2011	103/2011	**Compliance Framework**	Discuss complex shoulder activity with Specialist commissioning team	**SR**	23/09/2011	
22/07/2011	117/2011	**Car parking**	Agree car parking charges	**VB**	23/09/2011	On agenda
26/08/2011	132/2011	**CRR**	Update risk on Code 5 alerts to reflect pilot	**SR**	23/09/2011	
26/08/2011	133/2011	**Balanced scorecard-clinical strategy**	Find out the latest position on the new hospital mortality indicator being developed by the NHS Information Centre	**MB**	23/09/2011	
			Follow-up progress on the outcome of the surgical readmission audit	**WM**	23/09/2011	Audit is still a work in progress
26/08/2011	135/2011	**Performance reviews**	Check if 2 separate reports are circulated on ESR data	**RB**	23/09/2011	
26/08/2011	131/2011	**Strategic delivery board**	Invite DDs to quarterly meetings of Strategic delivery board	**VB**	23/09/2011	DDs now on distribution list
Due at a future meeting						
26/08/2011	131/2011	**Strategic delivery board**	Arrange personal briefings on PMO for DDs	**VB**	18/10/2011	Personal invitation issued to meet individually
			Provide detailed tracking report to future TECs	**VB**	18/10/2011	August dashboard issued to DDs and will continue routinely
26/08/2011	133/2011	**Balanced scorecard-Quality**	Check the Trust's SMR with appropriate benchmark Trusts	**MB**	18/10/2011	
26/08/2011	136/2011	**Site Capacity management plan**	Policy to differentiate between weekdays and weekends, in particular attendance at meetings during 'black' escalation.	**VB**	18/10/2011	

26/08/2011	138/2011	**Grievance policy**	review of the type of matters which had previously been raised outside of this period in order to consider whether this meant that extenuating circumstances should be referred to in the Policy.	**RB**	18/10/2011	
26/08/2011	139/2011	**Access policy**	Develop standard letter for all clinicians to use following a DNA	**VB**	18/10/2011	
26/08/2011	142/2011	**Perinatal mortality**	Clarify the position on linking still births to paediatricians/issuing hospital numbers and what other local trusts do	**DMJ**	18/10/2011	