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

TRUST BOARD
30th June 2011

TITLE	**Trust Executive Committee Meetings held on 27th May 2011 (draft Minutes) and 10th June 2011**
EXECUTIVE SUMMARY	The formal TEC on 27th May considered or approved: ▪ Revised Terms of Reference ▪ Dermatology Consultant Business Case ▪ Acute Medicine Business Cases ▪ Ashford Hospital Outpatient Re-modelling Project Business case The developmental TEC held on 10th June 2011 had considered the Strategic Context And Opportunities
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 27th May 2011
Submitted by:	Andrew Liles Chief Executive
Date:	18th June 2011
Decision:	For Noting

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

TRUST EXECUTIVE COMMITTEE MINUTES

Friday, 27th May 2011
2.00 pm to 4.30 pm
The Lecture Theatre, The Ramp, St Peter's Hospital

PRESENT:	Valerie Bartlett	Deputy Chief Executive
	Mike Baxter	Medical Director
	David Elliott	Divisional Director for Trauma & Orthopaedics
	Andrew Laurie	Divisional Director for Diagnostics and Therapeutics
	Mick Imrie	Divisional Director for Anaesthetics, Critical Care & Theatres
	John Hadley	Divisional Director for Surgery
	David Fluck	Deputy Medical Director
	Paul Crawshaw	Divisional Director for Women and Children's services
	Michael Wood	Divisional Director for Medicine
	Gulam Patel	Divisional Director for Ambulatory Care
	Donna Jarrett	Associate Director of Health Informatics
	Harriet Stephens	Head of Learning and Development
	Richard Lloyd-Booth	Head of Nursing Medicine & Emergency Services
SECRETARY:	Jane Gear	Head of Corporate Affairs
APOLOGIES:	Andrew Liles	Chief Executive
	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
IN ATTENDANCE	Wendy Munroe	Clinical Fellow in Clinical leadership (KSS Deanery)
	Hugh Jelly	Divisional General Manager Medicine

ITEM **ACTION**

80/2011 Minutes

The minutes of the meeting held on 6 May 2011 were agreed as a correct record subject to amending minute 69/2001 Bariatric Surgery to include "TEC would support the post being a FTE if the Trust was successful in the tendering process. This could be confirmed via review at the Commercial Group and need not return to TEC."

ITEM **ACTION**

Matters Arising

TEC reviewed all of the actions from the previous minutes. 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:

81/2011 Business Cases:

The business cases for

- Obstetrics and Gynaecology (minute 71/2001)
- Interventional Radiology (minute 68/2001).
- Bariatric Surgery (minute 69/2001).
- Breast/Endocrine (minute 70/2001).
- Obstetrics and Gynaecology (minute 71/2001),

had been ratified by the Deputy Chief Executive.

The issue regarding the Job Plan for interventional radiology had been resolved.

82/2011 Mandatory Training (minute 74/2001 refers)

The Policy had been updated to address the 50 recommendations made by RSL Consultancy who had undertaken an independent review of the Learning, Education and Development Policy, the Staff Induction Policy and their associations with NHSLA and their requirements. The Policy had been updated and would be made available electronically to TEC members showing the changes proposed. In addition, the training matrices were being updated. **HS**

TEC NOTED the update and that the Policy would be formally agreed at the next meeting.

83/2011 Trust Executive Committee – Terms of Reference:

The Terms of Reference had been reviewed and refreshed in the light of changes in the Trust's management structure, the implications of Foundation Trust status and to reflect the introduction of developmental TEC sessions.

In discussion, the following points were made:

- Paragraph 6 'attendance' – the wording allowed for fully briefed deputies of sufficient seniority to attend. Typically this could be the Divisional General Manager or a Clinical Specialty Lead.
- Paragraph 7 'quorum' as drafted required the attendance of either the Chief Executive or Deputy Chief Executive. In the light of the experience at May 2011 meeting it was agreed to confirm whether this was the de minimus position. **JG**

ITEM **ACTION**

- 2 Divisional Directors were required as part of the Quorum- deputies would not count.

Subject to clarifying the above point, the Terms Of Reference were AGREED.

84/2011 Urgent Care Delivery Plan

The letter dated 18 May 2011 detailing the Trust's immediate priorities in addressing the severe operational pressures had also been discussed by the Trust Board. It remained essential that the Trust collectively continued to work to improve the way we deliver patient care.

The efficiency of undertaking Day Surgery at Ashford Hospital was noted, although it was highlighted that this was the benefit of a dedicated Day Case Unit facility.

The weekly meetings reviewing the position would continue. The recent meeting with representatives from Social Services had been very positive with a clear range of actions and review identified.

TEC NOTED the report.

OPERATIONAL PERFORMANCE, QUALITY AND SAFETY

85/2011 Corporate Risk Register

The Corporate Risk Register identified two risks as added since the previous presentation to TEC and one risk to be closed. TEC made the following points in considering the Register:-

- Confirmation was sought as to whether the capacity flow issue had been properly identified. **SR**
- CQC Regulations (CRR 1037). Whilst the Trust was not one of the 100 Trusts recently visited on dignity and nutrition by the CQC, the Trust might still be reviewed. It was important to ensure that the Trust had reviewed and learnt from reports published on Trusts visited.
- The QRP would be included in future editions of the TEC quality report. It was also noted that the National Clinical Director for the elderly would be coming to work with the Trust on a review of services following the Ombudsman investigation into a complaint.
- Loss of income (CRR 832). This was a tolerated risk: IGAC had agreed a process of annual review in relation to tolerated risks.
- Lack of social worker (CRR 1083). It was agreed to review the wording supporting this risk. **SR**
- 30-day readmissions (CRR 1129). It was agreed to try and find out how the Trust performance benchmarked in comparison with other Trusts. **MB**

ITEM		ACTION
	TEC APPROVED the Corporate Risk Register including the addition of the risk on 30-day readmissions.	
86/2011	**Balanced Scorecard**	
	Workforce	
	Attention was drawn to the importance of achieving the CIPs on WTE reduction and associated pay reduction.	
	The level of staff appraisals was currently 90.1% and therefore below target. The level of medical appraisals was 94.5% at the end of April. However, it was noted that medical appraisal was primarily undertaken in a set quarter of the year which impacted on the data. It was important that all appraisees were trained and it was agreed that Divisional Directors should send the information they held on appraisee training status to Harriet Stephens to cross check with centrally held data. It was also noted that Gwen Atkinson was available to undertake training on appraisal within Divisions.	**DDs**
	Different views were expressed by Divisional Directors about the approach to appraising Divisional Directors themselves. It was agreed this would be discussed outside the meeting.	
	Clinical Strategy	
	It was noted that the Medical Director was now the lead for Programme 3 on clinical strategy. Consideration was being given to reviewing the KPIs associated with this quadrant.	
	There had been a drop in the level of emergency admissions but considerable work was still required in order to meet the cap at 08/09 levels.	
	There had also been a reduction in the level of elective activity completed. The Trust's plan was based on a straight monthly calculation, but there had been a significant number of bank holidays in April which would have impacted on the numbers treated. It would be helpful if the plan could be appropriately weighted in future.	**VB/JH**
	There was a target of a 25% reduction on readmissions following an original emergency admission. It was noted that the nursing home project appeared to be having an impact.	
	In reviewing the quadrant, it was highlighted that there was a very successful Fracture Clinic now established at Ashford Hospital. It was agreed Divisional Directors might find it helpful to talk to Greenbrooks generally about referral routes. Contact details would be circulated.	**VB**
	TEC NOTED the report.	

ITEM **ACTION**

87/2011 Quality Report

The following elements of the Quality Report were noted:

- The intention was for the dashboard to become increasingly outcome orientated.
- There had been a small increase in the CMR but it was believed this was associated with a reduction in elective activity which formed the denominator for the calculation.
- There had been eight cases of C difficile YTD; investigation had not identified any common causes.
- The National Diabetes Inpatient Audit had identified good practice but scope for further improvement. Specialist diabetes care for the Trust's inpatients was very important and could impact on length of stay.

  The survey had included some criticism of the Catering Services. It was noted that the catering contract for the Trust would be reviewed during 2011.

- Software to ensure that all radiological alerts were captured, reviewed and clinically signed off was due for testing with the intention of deployment across the Trust in late June.
- The range of WQIs was being reviewed.

TEC NOTED the report.

88/2011 Compliance Framework

In April 2011 the Trust had failed to achieve two of the key performance indicators (A & E four-hour standard and the 95th percentile standard for elective admissions).

A new national target had been introduced in 2011/12 in respect of the 18-week WTT. There was now an imperative to clear the backlog of patients in a financially affordable way. In order to achieve this, it was important that surgeons were encouraged to undertake additional work and following a short discussion about sessional rates, it was agreed that a Trust wide approach would be beneficial and that this should be further discussed at the weekly Thursday meeting. **DDs**

TEC NOTED the report.

BUSINESS CASE AND POLICY APPROVALS

89/2011 Dermatology Consultant Business Case:

Dr Patel introduced the Business Case, noting that Dermatology was a strong income generating service. TEC discussed whether this was a service which GPs might wish to commission differently in the future. It was noted that the service was already undertaking one clinic on behalf of Virgin on the basis of salary recharge. This would be evaluated to see whether the level of surgical referrals rose.

ITEM **ACTION**

The Business Case had previously been reviewed by the Commercial Group and it was noted they had asked for additional detail regarding activity and finance. The financial proforma attached to the Business Case was incomplete.

The Job Plan was based on 10 PAs and it was agreed this should be transparent as to when private patient activity could be undertaken.

TEC AGREED the Business Case in principle subject to:

- Completion of the activity and financial details.
- Sign off by the Diagnostic and Therapeutic Division. **GP**
- Further review by the Commercial Group.

The Business Case would not need to revert to TEC again.

90/2011 Acute Medicine Business Cases

The Business Case presented a proposal for 2-4 new consultant posts in Acute Medicine. High level rationale included:

- MAU required consultants with a special interest in Acute Medicine.
- Consultant input on MAU needed to be a daily, not 1:18.
- Awareness of the alternatives to admissions and familiarity with the Emergency Ambulatory care pathways would be borne from experience.
- The dedicated Acute Medicine consultants would enable the specialists to free up their time to see complex patients, reducing length stay and the number of admissions.

Five options were examined within the Business Case ranging from the introduction of 24-hour acute physician cover for five days (Monday to Friday) through to the introduction of 24-hour acute physician cover for seven days. The option of no change was also included. It was clarified that whilst the physicians would be active across 24/7, there would not be 24-hour cover on site. The recommendation of the Business Case was to fund four additional acute physician posts. The Trust already had two acute physicians in post, but an additional two would be required.

A number of points were made in a wide ranging discussion. These included:

- The need to move towards an extended working day, particularly to cover the changeover of junior medical staff.
- The need to examine the feasibility of creating savings from the members of the existing medical work force who would no longer being involved on the acute take.

ITEM **ACTION**

- However, this was accompanied with a need to ensure that disengagement did not occur with the existing medical work force and that associated improvements were introduced, e.g. an upper GI bleed rota.

- The benefits of running the changes as a pilot were highlighted, although it was thought this would be impracticable to achieve.

In summary, TEC concluded:

- Although some reservations regarding the proposals were expressed, particularly as the proposals were untested, there was general support for the model.
- The principle of two additional acute medical physicians was agreed subject to robust analysis of the impact on the body of acute physicians and identifying the maximum internal contribution possible from re-utilisation of PAs.

TEC AGREED that the Division would have TEC support to move to the appointment of 4 acute physicians if the residual balance of funding for 2 posts could be found from within the Division. This would need to be signed off by the Director of Finance and Deputy Chief Executive. **JH/VB**

91/2011 Ashford Hospital Outpatient Re-modelling Project

The Business Case supported the development of the Outpatient Department at Ashford Hospital. The Business Case was not self-financing through generating additional income, but was important as a requirement to protect the Trust's level of existing activity and to provide a platform for increasing income. The Commercial Group had reviewed the Business Case and also recognised this.

A number of suggestions were made regarding the layout and content of the scheme.

- Where possible, the layout should consider the requirement of children accessing clinics such as ENT or Surgery.
- All specialties needed to be involved in the final design.
- The project needed to consider the costs of wireless layout.
- As far as possible, the layout should be flexible, allowing opportunity for future business opportunities, e.g., Oncology.
- The design needed to facilitate increasing the use of MDTs.

VB

TEC APPROVED the Business Case which would go to the Trust Board for final decision.

ANY OTHER BUSINESS

92/2011 Epsom Hospital

The Trust had submitted its PQQ and was awaiting the outcome from NHS London.

ITEM **ACTION**

93/2011 Car Parking

Approval of operational type policies lay within the remit of TEC. It was confirmed that the Policy would be presented to TEC after consultation had been completed.

It was noted that it would have been helpful to have issued Divisional Directors with a briefing prior to the wider consultation being initiated.

Date of Next Meeting

Friday 10th June (developmental), Thursday 24th June (formal).

Action log

Date Action Agreed	Minute Number	Topic	Action	Owner	Timeline for completion	Comment
28/01/2011	05/2011	**CRR**	The Risk Register for Anaesthetics and Theatres included three risks relating to patient flow. Deputy Chief Executive to consider whether this therefore warranted a risk being identified in the CRR.	**VB**	25/03/2011	Risk proposal form sent to DD
27/05/2011	82/2011	**Mandatory Training**	Circulate details of the proposed changes to the LED policy	**HS(RB)**	24/06/2011	Circulated ✔
27/05/2011	85/2011	**CRR**	Clarify capacity flow issue is properly identified in CRR	**SR**	24/06/2011	New risk proposed in CRR report ✔
27/05/2011	85/2011	**CRR**	Review wording on CRR 1083 hospital social worker	**SR**	24/06/2011	Reviewed ✔
27/05/2011	83/2011	**Terms of reference**	Confirm what happens if neither CE or deputy CE can chair the meeting	**JG**	24/06/2011	In exceptional circumstances another ED may chair. TOR amended ✔
27/05/2011	86/2011	**Balanced scorecard**	Green Brook contact details would be circulated for DDs to follow/up.	**VB**	24/06/2011	Actioned ✔
27/05/2011	86/2011	**Balanced scorecard-** Medical Appraisals	Divisional Directors should send the information they held on appraisee training status to Harriet Stephens to cross check with centrally held data.	**DDs**	24/06/2011	

27/05/2011	90/2011	**Acute medicine Business case**	Agree final proposal for acute medicine business case	**VB/JH**	24/06/2011	
FOR DISCUSSION AT A FUTURE MEETING						
25/02/2011	33/2011	**Cancer Reform Strategy**	Consider a GP spotlight event and also mapping cancer charities to see if an annual event would be appropriate	**PM/VB**	22/07/2011	
27/05/2011	85/2011	**CRR**	30 day readmissions- see if benchmarking data is available	**MB**	22/07/2011	
27/05/2011	93/2011	**Car parking**	Policy to be discussed at a future TEC	**VB**	22/07/2011	