CHAIRMAN'S SUMMARY REPORT

Name of Committee/Group:	Trust Management Committee
Report From:	Chief Executive
Date:	22.11.13
Action Required by receiving committee/group:	X For Information □ Decision □ Other
Aims of Committee:	▪ To oversee and co-ordinate the Trust operations on a Trust-wide basis ▪ To direct and influence the Trust service strategies and other key service improvement strategies which impact on these, in accordance with the Trust overall vision, values and business strategy.
Drivers: Are there any links with Care Quality Commission/Health & Safety/NHSLA/Trust Policy/Patient Experience etc.	The matters highlighted below are not driven directly by the CQC, Monitor, or any other outside body. They are driven by the need and desire to enhance patient experience, ensure patient safety, maximise operational efficiency and effectiveness, improve the quality of services, and safeguard the financial position of the Trust.
Main Discussion/Action Points:	▪ Considered and approved the business case for the **refurbishment and modernisation of Outpatients 1**. The reception area and other rooms in this part of the hospital have not been updated since the facility first opened, over 30 years ago. Among other things, the reception area does not meet DDA standards and is not conducive to dealing with patients who suffer from dementia. The work will be completed before the end of the financial year. The recent CQC inspection of the hospital picked up on the need for this work. ▪ Approved the business case for additional staffing and non-pay resources required to deliver the **Family Nurse Partnership Programme**, which delivers targeted care to vulnerable first time teenage mothers, and is delivered in conjunction with Health visiting targeted services. This is part of a national initiative, which the Operating Framework 2011/12 anticipated would increase significantly by 2015. ▪ Discussed and approved the business case for the **expansion of the Haematology Service**. This has come about because of sustained increases in demands upon the service, and it is now considered essential to appoint a fifth consultant, with commensurate support services, to safely

	sustain the current level of workload and allow for further development of the service. ▪ Considered and approved in principle the business case for the replacement of an Associate Specialist (who provided the lead for the neonatal audiology screening programme) with a **Consultant Paediatrician with a specialist qualification in Audiology**. This would not only safeguard the existing level of service but potentially enable the expansion of services and develop an Audio Vestibular Service for children and young people in Wolverhampton. ▪ Approved a new **Revenue Business Case Process** designed to remove any uncertainty about the correct method of developing and gaining approval of revenue business cases. It is intended that this process will provide additional robustness to business development and ensure congruence with Commissioning intentions. ▪ Received a progress report on the development of the **Integrated Electronic Patient Medical Record**. The Committee noted the progress made towards all services working safely in OPD without the paper medical record by the end of this financial year, along with the intention to capture all inpatient documentation in the e-record by the same deadline. The third phase will be to ensure that all entries to the medical record are made electronically by the end of 2016/17. The risks to the programme were discussed, and assurance taken that mitigating actions are being taken, including working closely with clinicians to provide the necessary support and resource during and beyond the transitional period.
Risks Identified: **Include Risk Grade (categorisation matrix/Datix number)**	The Trust Management Committee has had regard to any risks identified in respect of these matters. The TMC also has a standing item on every agenda, at which point anybody present may raise any matter which is deemed to be worthy of consideration for inclusion on a risk register.

The Royal Wolverhampton NHS Trust

TRUST MANAGEMENT COMMITTEE

Date:	22 November 2013	
Venue:	Boardroom, Clinical Skills and Corporate Services Centre, New Cross Hospital	
Time:	1.30 p.m.	
Present:	Mr D Loughton CBE	Chief Executive (Chair)
	Mr G Argent	Divisional Manager, Estates and Facilities
	Mr I Badger	Divisional Medical Director, Division 1
	Ms R Baker	Head Nurse – Division 2 (part)
	Dr M Cooper	Director of Infection Prevention and Control
	Dr J Cotton	Director of Research and Development
	Dr M Cusack	Divisional Medical Director, Division 1
	Ms C Etches	Chief Nursing Officer (part)
	Mr M Goodwin	Head of Estates Development
	Ms D Harnin	Director of Human Resource
	Dr J Odum	Medical Director
	Ms G Nuttall	Chief Operating Officer
	Mr T Powell	Deputy Chief Operating Officer
	Dr D Rowlands	Lead Cancer Clinician
	Dr B M Singh	Lead Clinician – IT
	Dr S Smith	Divisional Medical Director, Division 2
	Mr K Stringer	Chief Finance Officer
	Ms Z Young	Head Nurse, Division 1 (part)
In Attendance:	Mr S Evans	Head of Performance
	Mr A Sargent	Trust Board Secretary
	Ms K Winchurch	Finance Department (Observer)
Apologies:	Ms M Espley	Director of Planning and Contracting
	Mr L Grant	Deputy Chief Operating Officer, Division 1
	Ms D Hickman	Head of Midwifery
	(Note: In the absence of Mr Loughton at the start of the meeting, Mr Stringer took the chair)	

Minute		Action
	DECLARATIONS OF INTEREST	
13/317	There were no declarations of interest.	

13/318	**MINUTES** **IT WAS AGREED: that the minutes of the meeting of the Trust Management Committee held on Friday 25 October 2013 be approved as a correct record.**	
13/319	**MATTERS ARISING** During consideration of this item, the following updates were given and the status of certain items amended accordingly: • 13/287 – Mr Evans indicated that this matter was still with the Commissioners. • 13/288 – Ms Nuttall said that the question of recovering additional income from the Dudley Group of Hospitals would be taken up by the Divisional team and would be added to the Action List. • 13/293 – Divisional Accountability Agreement: Ms Nuttall confirmed that the wording of the Agreement had now been finalised. • 13/303 – Business Case for a Change in the Treatment Algorithm for *C.difficile*: Dr Cooper said that a date for a meeting with other Clinical Directors about this business case was yet to be arranged.	**Pathology Directorate** **M Cooper**
13/320	**ACTION POINTS** With regard to item 13/216, Mr Powell indicated that the commissioner was unwilling to support the business case. However, the Trust had identified 8 PAs it could use towards this business case and was now looking to the CCG to commission some asthma work so that the activity could be covered. He indicated that there was pressure on the team and requested approval in principle to place an advert subject to finding funding for the 2 additional PAs required. **IT WAS AGREED: that the Division be authorised to place an advertisement for the Consultant, in principle, subject to the business case for funding the two additional PAs being developed and approved by the commissioner.**	**TP**
13/321	**NURSING WORKFORCE REVIEW SKILL MIX** Ms Etches presented a business case for an increase in nurses and health care assistants, following the second phase skill mix review of the existing workforce. The business case related to adult nursing inpatient wards (excluding midwifery and paediatric inpatient services). She underlined the intention to maintain a skill mix of 70:30 in acute wards, based principally on Hurst evidence. She reminded the meeting that the recent report of the CQC following the inspection of the hospital had stated that the Trust should employ additional numbers of nurses, particularly in maternity, care of the	

	elderly, and surgical wards, and generally during night times. This did not imply that staffing levels were currently unsafe because during the last two years the Trust had used ad hoc funding to employ staff in particular areas, such as Trauma and Orthopaedics. However, last year the Trust had been £1.3M overspent on nursing pay from baseline budgets and there had been little room for flex. Looking ahead, it was expected that Safe Hands and E-rostering were tools which would enable the Trust to be more efficient in the deployment of its nursing staff and that it would be possible to do this having regard to patient dependency data on a shift by shift basis. She confirmed that the business case was being submitted to the Trust Board for approval on the 25 November. She acknowledged that there would be a significant challenge in regard to ensuring there was a strong recruitment and retention process. In response to a question by Dr Singh, Ms Etches said that the WCCCG would be requested to support this proposal and that they were being requested by the TDA to reach an early decision by mid December. She explained that consideration was being given to an effective recruitment strategy as well as further work on retaining existing staff. She acknowledged, however, that it was likely to be a phased recruitment process. Dr Odum added that there had been a long discussion at the CQC summit meeting on nurse staffing within the Trust, and that the TDA had been adamant that all agencies in the area must commit to helping RWT to solve the problem. The CQC would revisit the issue in due course. Mr Badger asked whether there was a specific budget for the recruitment process, and Ms Harnin said that there was an existing budget but that for a sustained campaign of this sort additional resources would have to be identified, particularly if it was to encompass overseas recruitment with mechanisms to support overseas nurses when they arrived in this country. Ms Etches pointed out that other Trusts had already approved business cases for increased nurse staffing but that this Trust remained in a good position to proceed with this matter. Mr Badger commented that there remained other areas within the Trust with shortages of nurses and he cited the operating theatres. Ms Etches acknowledged that the workforce review would have a further one or two phases in the future. Ms Etches went on to explain that following a challenge by the Chief Financial Officer the business case had been completed with reference to the layout of wards and the throughput of patients, both being factors which were additional to the ones covered by Hurst methodology. She explained that if this business case was approved, the increased numbers of nurses would be accompanied by absolutely rigorous control over the employment of bank staff, more intelligent use of nursing staff across the Trust, and generally better management of the workforce and budgets. In response to a question by Dr Odum, she explained that the business case would lead on average to one extra nurse per shift on the wards involved, although in practice some of those wards would require more staffing than others. Dr Odum noted that there was some concern that there was a shortage of trained nurses nationally. Ms Etches acknowledged the concern and explained that some overseas recruitment was anticipated. Ms Harnin indicated that the increased	

	requirement for nurses would have to be translated into new commissions at the training stage. **IT WAS AGREED: that the business case to invest £3.6M into 135wte additional nursing posts (84wte registered nurses, and 52 HCA) be approved, and the funding sought from Wolverhampton City Clinical Commissioning Group.** (Note: Ms Baker, Ms Etches and Ms Young left the meeting at this point.)	
13/322	**<u>RED INCIDENTS, RED COMPLAINTS AND HIGH LEVEL OPERATIONAL RISKS FOR CORPORATE AREAS.</u>** **IT WAS AGREED: that the monthly report on Red Incidents, Red Complaints and High Level Operational Risks for corporate areas be noted.**	
13/323	**<u>CP13A – WOUND MANANGEMENT POLICY FOR ADULTS AND CHILDREN</u>** **IT WAS AGREED: that the revised policy CP13A Wound Management Policy for Adults and Children be approved.** **(Note: at this point in the meeting, Ms Etches, Ms Baker, and Ms Young left to return to the Matrons' Away Day.)**	
13/324	**<u>THE INTEGRATED ELECTRONIC PATIENT MEDICAL RECORD</u>** Dr Singh presented the quarterly report on the development of the Integrated Electronic Patient Medical Record, identifying additional risks identified, and summarising progress made since the report to the June meeting. Dr Cusack referred to reservations expressed by certain clinicians on the use of the portal, especially regarding scanning of documents, and said that there was a reluctance to accept that all elective and non-elective contemporary inpatient records 'must' be scanned until there had been further engagement between representatives of IT and clinicians. Dr Cusack noted that there had been few such meetings during the last 15 months and urged that these should be instituted as a matter of urgency. Dr Singh acknowledged that whilst it was not acceptable to have uncertainty about where documents were filed, he accepted the point made about scanning and the need for further engagement. He added, however, that there was already informal engagement across the Trust. Dr Higgins pointed out that difficulties arose when staff were working off site and were unable to access the portal, as was the situation, for example, in certain schools and clinics. Dr Singh noted the particular problems faced by staff working within the community and understood the need to look into ways of overcoming the problems now identified. He responded to a question by Dr Odum by saying that it was expected to take another year before	

	every service had the opportunity to work electronically. Mr Badger said that as far as the surgical division was concerned, the problem was not so much the wards but the clinics and that where a number of people required access to patient records there must be a timely and rapid access for doctors and anaesthetists, especially when there could be up to 10 lists running simultaneously, which would suggest the need for a significant increase in the amount of hardware available. Dr Singh repeated the Trust's commitment to find solutions to the problems being cited, and anticipated that a process to deal with these matters should be agreed within the next 6 months. **IT WAS AGREED:** **a. That all services must be compliant with the recommendations approved by the Trust Management Committee in March 2013 in support of the integrity of the electronic medical record.** **b. That all elective and non-elective contemporary inpatient records will be scanned following the procedure outlined to Trust Management Team in March 2013, and that this would be fully implemented by end of March 2014 in a continuous planned rollout.** **c. That all such scanned episodes will be shredded after a one month period of retention.** **d. That the Trust Management Committee in March 2014 will be requested to approve that, trust wide, the historical paper medical record will not be made available for acutely admitted patients unless requested, but that if so requested it will be made available within 30 minutes, and that the cost of medical records (inpatient elective, non-elective and outpatients) will be allocated to services in proportion to their use of the paper case record.** (Note: Mr Loughton joined the meeting during discussion of this item, and assumed the Chair for the remainder of the meeting)	
13/325	**<u>DIVISION 1 - GOVERNANCE REPORT</u>** Dr Cusack presented this report and confirmed that a Trust wide policy for the management of retained swabs was under preparation. With regard to risk 3299 (safer child birth and NHSLA requirement for 60 hour dedicated labour ward consultant presence) Mr Badger indicated that births remained below the 4000 births per year threshold and the business case was not yet required. He confirmed that there had been an increase in the number of births and in response to a question said that 12 consultants were working in obstetrics and that 5 more would be required to move to a full shift system. The Chief Executive requested Ms Nuttall to discuss this matter further with Mr Badger and other senior staff within the Division in order to develop a picture of how many hours of consultant time were currently available to deliver the number of births at the Trust. **IT WAS AGREED: that the Governance Report for Division 1 be**	**GN/IB**

	noted.	
13/326	<u>**NURSING MIDWIFERY AND QUALITY REPORT – DIVISION 1**</u> Dr Cusack presented the monthly Nursing Midwifery and Quality report from Division 1. **IT WAS AGREED: that the Nursing, Midwifery and Quality Report be noted.**	
13/327	<u>**REFURBISHMENT OF MAIN THEATRES 3-6**</u> Mr Badger presented a business case for the upgrading of main theatres 3-6 to create a safe and acceptable standard to maintain safety to patients and staff and ensure service continuity. In response to a question by Mr Loughton, he indicated that a business continuity plan was in place. Mr Goodwin added that he would work with Division 1 to minimise the loss of operational capacity. Mr Goodwin said that it was hoped to commence work by late February. Mr Loughton requested that he be given further information about the contingency plans for this scheme. **IT WAS AGREED: that the business case for the refurbishment of main theatres 3-6 be approved.**	**MG**
13/328	<u>**REFURBISHMENT AND MODERNISATION OF OUTPATIENT DEPARMENT 1**</u> Mr Badger presented the business case for the refurbishment and modernisation of the reception area and other rooms within Outpatients 1. He pointed out that the recent inspection of the hospital by the CQC had led to some criticism of this part of the estate, which was not compliant with current DDA standards and not conducive to dealing with patients with dementia. Mr Goodwin confirmed that this scheme would be delivered by the end of the financial year. **IT WAS AGREED: that the business case for the refurbishment and modernisation of Outpatients 1 be approved.**	
13/329	<u>**NURSING AND QUALITY REPORT – DIVISION 2**</u> Mr Powell presented the monthly Nursing and Quality Report from Division 2, highlighting that the Division had 10 grade 3/4 pressure ulcers during the period under review, and no reported non clinically justified breaches of the Same Sex Policy. He also drew attention to the opening of additional ward capacity on 12 November.	

	IT WAS AGREED: that the monthly Nursing and Quality Report for Division 2 be noted.	
13/330	**GOVERNANCE REPORT – DIVISION 2** Mr Powell presented the monthly Governance Report for Division 2, which included details of one new red risk. **IT WAS AGREED: that the monthly Governance Report for Division 2 be noted.**	
13/331	**FAMILY NURSE PARTNERSHIP PROGRAMME** Mr Powell presented the business case for additional staffing and non pay resources required to deliver the Family Nurse Partnership Programme in Wolverhampton. Funding from NHS England had been confirmed. **IT WAS AGREED: that the business case for the delivery of the Family Nurse Partnership Programme in Wolverhampton be approved.**	
13/332	**THE INTEGRATED HEALTH AND SOCIAL CARE TEAM PROPOSAL** Mr Powell requested that this report be withdrawn. He said that it would be amended and submitted to the Trust Management Committee in January 2014. **IT WAS AGREED: that this business case be deferred until the January meeting.**	**TP**
13/333	**HAEMATOLOGY SERVICE EXPANSION** Mr Powell presented the business case for expansion of the Haematology Service in order to maintain and deliver current contracted activity. **IT WAS AGREED: that the business case for the expansion of the Haematology service be approved.**	
13/334	**REPLACEMENT OF ASSOCIATE SPECIALIST WITH PAEDIATRIC CONSULTANT WITH INTEREST IN PAEDIATRIC AUDIOLOGY** Mr Powell presented the business case for the replacement of an Associate Specialist with a Paediatric Consultant with an interest in Paediatric Audiology. He explained the financial background to this matter and requested authorisation in principle to proceed to advertise one post subject to approval of the financial model at the	

	Contracting and Commissioning Forum. Dr Higgins supported the business case by saying that there was definitely a local need, but that it was currently difficult to quantify it. In response to a question by Mr Loughton, Mr Powell said that despite being requested, the CCG had not so far quantified the level of need for this service. **IT WAS AGREED: that approval in principle be given to advertising this post, subject to the financial model being signed off by the Contracting and Commissioning Forum.**	
13/335	**INTEGRATED QUALITY AND PERFORMANCE REPORT** Ms Nuttall introduced the monthly Quality and Performance report and confirmed that performance in Accident and Emergency during October looked good, but that this would dip in November and that further consideration was required in terms of how this was related to patient experience. Activity was not significantly increasing but there were issues with length of stay, which was linked to comorbidities and case mix, as well as the timing of discharges. Ms Nuttall indicated that the indicator for 31 day sub surgery was now green. Mr Loughton said that performance in Accident and Emergency would be discussed at the Directors' meeting next week. **IT WAS AGREED: that the monthly integrated Quality and Performance report be noted.**	
13/336	**NATIONAL CANCER PATIENT EXPERIENCE SURVEY** In presenting this report Ms Nuttall highlighted the significant improvements over the report submitted 12 months ago, and the Committee noted that there were now 12 green and only 1 red indicators. **IT WAS AGREED: that the result of the most recent National Cancer Patient Experience Survey be noted.**	
13/337	**TRUST STRATEGIC GOALS UPDATE – Q2 2013/14** Ms Nuttall introduced this quarterly report, which gave an assessment against the business outcomes contained within the Trust's Strategic Goals for 2013/14. She confirmed that this report would continue to be submitted on a quarterly basis for the time being. **IT WAS AGREED: that the Trust Strategic Goals update 2013/14 (Quarter 2) be noted.**	
13/338	**FINANCE REPORT FOR MONTH 7** Mr Stringer drew out the highlights of his report on the Trusts	

	financial position at the end of October 2013 (month 7), which was a surplus of £2.97M which was £650,000 below plan. He then summarised the key issues by division which were that Division 1 was under-performing on patient care income by £2.3M and that Division 2 was over-performing on non-elective income by £2.1M, which was offset by under performance in renal of £0.3M and smaller under-performances in other areas. He added that the expenditure position showed a net overspend of £978,000. He also reported that the position for October in regard to the Cost Improvement Plan was a withdrawal of £8.48M from annual budgets, representing 39.8% of the annual total, of which £2.59M was delivered non-recurrently. There was now a significant risk for 2014/15, as any recurring gaps would have to be carried forward. In response to the Chief Executive's question, Mr Powell said that he was confident that Division 2 would hit the year end control target; Mr Badger said that for Division 1 this would depend upon beds being available for surgery. **IT WAS AGREED: that the report on the financial position of the Trust at month 7 (October 2013) be noted.**	
13/339	**CAPITAL PROGRAMME 2013/14** Mr Goodwin outlined the main points of the report on the progress of the capital programme as at month 7 (October) 2013/14. It was noted that the actual monthly expenditure position at month 7 was £8,979,063, which represented an underspend of £2,375,097. **IT WAS AGREED: that the monthly report on progress of the capital programme 2013/14 be noted.**	
13/340	**REVISION TO CAPITAL PROGRAMME 2013/14** Mr Goodwin submitted his report recommending that the capital programme for 2013/14 be revised in the light of additional commitments. He said that if approved this programme would lead to a potential overspend of approximately £524,000 against a CRL of £19.07M. **IT WAS AGREED: that the revised capital programme for 2013/14, as set out in the report, be approved.**	
13/341	**REPORT OF THE CHANGE PROGRAMME BOARD** Mr Evans presented the monthly report from the Change Programme Board which highlighted that as at month 7 a total of £8.48M (£706,000 in month) had been removed from budgets against the 2013/14 target of £21.28M, representing almost 40% of the annual amount. The Trust had therefore underachieved against the month	

	7 plan by £1M, and the underperformance for the year to date was £4.5M. He indicated that high level plans for the next two financial years were being developed and would be considered by the Trust Board in the near future **IT WAS AGREED: that the report on the Change Programme Board at month 7 (October 2013) be noted.**	
13/342	**<u>A JOINT STRATEGY FOR THE PROVISION OF URGENT AND EMERGENCY CARE FOR PATIENTS USING SERVICES IN WOLVERHAMPTON TO 2016/2017.</u>** Dr Odum guided the meeting through the main points of the report on the Joint Strategy, pointing out that it had now been signed off by the Health and Wellbeing Board, the Health Scrutiny Panel (of Wolverhampton City Council) and the Wolverhampton City Clinical Commissioning Group. It was due to be considered by the Trust Board on Monday 25 November. He explained that, subject to approval by the Trust Board, a formal consultation process would commence on 2 December for a period of 3 months, during which time the views of patients, the public, and partner organisations would be obtained, and that the intention would be to implement the Strategy following that period with the consequential changes in primary care and the development of a new Emergency Centre on the hospital site. He paid tribute to those who had assisted in drawing the strategy together, and reflected on the benefits of bringing partners around the table to discuss the significant issues touched upon within the document and the development of working relationships as a result. Mr Loughton stressed the need to develop the new Emergency Centre as soon as possible. Mr Powell reported that the WCCCG had requested the Division to commence work on the nursing home project with effect from 1 December, but that realistically this work would probably commence in the middle of January. **IT WAS AGREED: that the proposals set out in the Joint Strategy for the Provision of Urgent and Emergency Care for patients using Services in Wolverhampton be supported, together with the consultation document and the engagement plan and the proposal to commence consultations in December 2013.**	
13/343	**<u>EMERGENCY PLANNING RESILIENCE AND RESPONSE</u>** Mr Evans introduced a report seeking endorsement of the Self-Assessment undertaken for the Emergency Preparedness Resilience and Response Core Standards and Improvement Plan for the Trust. In response to a question by Mr Loughton, Ms Nuttall confirmed that there was no agreement with the local 111 provider because it had recently been taken over by the West Midlands Ambulance Service. **IT WAS AGREED: that the proposed improvement plan**	

	developed in the light of the self-assessment, as appended to the report, be approved.	
13/344	**REVENUE BUSINESS CASE PROCESS** Mr Evans presented a report on a proposed process to be followed for all business cases with revenue implications. **IT WAS AGREED: that the Revenue Business Case Process has now submitted be approved.**	
13/345	**RESEARCH AND DEVELOPMENT** Dr Cotton presented the monthly update on Research and Development, and tabled a report with revised figures in respect of research activity during the period under review. He also recommended the Committee to approve revisions to policy OP22 (Innovation Policy). In response to a question by Mr Loughton, Dr Cotton said that further work was required on the development of a recovery plan. Dr Cusack asked about progress on development of the Research Hub. Mr Loughton said that whilst he did not wish to engage in a detailed discussion of this development at this meeting, he was able to confirm that the development was generally progressing well and that advertisements had been placed for the appointment of a Chief Operating Officer and a Clinical Director. Dr Odum added that there were a number of practical difficulties to be overcome but that the basic structure for the development was now coming together. **IT WAS AGREED: that the progress report on the Trust's Research and Development function be noted, and that the amendments to policy OP22 (innovation policy) be approved.**	
13/346	**POLICIES FOR APPROVAL** **IT WAS AGREED: that the following policies be approved:** **HR13 – Management of Sickness Absence and Attendance Policy.** **CP13A – Wound Management Policy for Adults and Children**	
13/347	**RISKS** Mr Loughton referred to the Quality Summit at which the report of the inspection of the hospital by CQC had been considered. He explained that it now appeared that there would have to be a further inspection of Community Services, which might not take place until	

	after May 2014, and he commented upon possible delays to the process of becoming a Foundation Trust. Dr Odum emphasised that notwithstanding the situation regarding the Trust's Foundation Trust application, the main thing was for staff to continue to deliver high quality safe services whilst meeting all financial targets and coping with the winter pressures.	
13/348	**ANY OTHER BUSINESS** No other business was raised.	
13/349	**DATE AND TIME OF NEXT MEETING** It was noted that the next meeting of the Trust Management Committee would be held on Friday 24 January 2014 at 1.30pm in the Board Room of the Clinical Skills and Corporate Services Centre, New Cross Hospital.	

The meeting closed at 3.30pm