

THE ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST

Minutes of the Meeting of the Trust Management Team held on Friday 5th November, 2010 at 1.30 p.m. in the Board Room of the Clinical Skills and Corporate Services Centre

PRESENT:

Dr. M. Cooper	Director of Infection Prevention and Control
Ms. C. Etches	Director of Nursing and Midwifery
Ms. V. Hall	Chief Operating Officer
Dr. R. Horton	Divisional Medical Director, Division 1
Mr. D. Loughton CBE	Chief Executive (Chair)
Dr. J. Odum	Divisional Medical Director, Division 2
Dr. D. Rowlands	Lead Cancer Clinician
Dr. B.M. Singh	Director – IT
Mr. K. Stringer	Director of Finance and Information

IN ATTENDANCE: Professor Magi Sque

APOLOGIES: Mr. B.G. Millar, Dr. S. Kapadia, Dr. J. Cotton, Maxine Espley

The Chairman welcomed Professor Magi Sque, Chair in Clinical Practice and Innovation.

MINUTES OF THE MEETING HELD ON FRIDAY 1st OCTOBER, 2010

10/239 It was noted that Dr. Odum had been present at the meeting held on 1st October, 2010.

Following this slight amendment, the Minutes were agreed as a correct record.

MATTERS ARISING FROM THE MINUTES

10/240 Minute 10/203 and 10/177 – Quality Innovation Productivity Prevention (QIPP) Programme – Wolverhampton Care Co-ordination Centre

The Chief Operating Officer advised that the business and finance strategy were still to be completed. The Director of Finance and Information would give further consideration to how any potential loss of income as a result of QIPP proposals could be reflected in the organisation's costs.

The Chief Executive had attended the Wolverhampton City PCT Board this week where the Director of Finance had reported that they had achieved this year's targets but there was uncertainty going forward. Further discussions would be held with the PCT.

There were various assumptions behind the QIPP programme and the Director of Finance and Information suggested the analysis should be shared with the Trust Management Team.

ACTION SUMMARY

10/241 The Action Summary was reviewed and updated.

Minute 10/180 Assisted Automated Dialysis Services could be closed. Agreement has been reached for this year, payment non-recurring and then will be submitted to tariff next year.

QUARTERLY REPORTS

10/242 Lead Cancer Clinician

The report provided an update on waiting times, implementation of the Network Review of Cancer Services, Peer review, patient survey, implementation of the Liverpool care pathway and data collection and national cancer audits.

The Lead Cancer Clinician highlighted the need to strengthen MDT attendance. There were good referral pathways and joint working within the groups but the Trust did risk being marked down by external evaluation processes because of the non-attendance of some individuals. There was a further issue in that the work of the meeting could not be completed, which might particularly affect cancer waiting times. Attendance at MDTs was included in job plans and the Lead Cancer Clinician requested support to the prioritisation of attendance at these meetings.

The Divisional Medical Director, Division 1 commented that 100% attendance at MDT meetings was difficult because of commitments for study and annual leave. The Divisional Medical Director Division 2 felt this was an important part of patients' management during the course of a week and if a crucial person was not at the MDT this could undermine the decision making at the meeting. He suggested that deputies should be able to attend.

The Lead Cancer Clinician advised that meetings had taken place to discuss this issue. The Chief Executive requested further information to be brought to the next meeting of the Trust Management Team with details of how many individuals were not attending MDT meetings and for what reason.

The Chief Operating Officer reminded the Trust Management Team of management processes that were in place where issues and concerns could be raised.

Referring to the Patient Survey, the Lead Cancer Clinician advised that two rounds of the first part of the survey had been received and reported back to MDTs. Overall the findings are positive about the Trust. The negative findings were summarised in Appendix 2 to the report. The main issues were regarding the quality of information provision, support and how well “bad news” consultations are conducted. The role of the Cancer Nurse Specialist (CNS) was fundamental to resolving these issues but their presence at consultations to support the patient was not always achieved. This was due to the number of roles that the CNS was fulfilling. The role of the CNS was being reviewed.

The Director of Nursing and Midwifery commented that it was essential to have someone available at the consultation when “bad news” was being broken. She would review how the CNS role was organised to ensure priorities were being addressed.

The Chief Operating Officer advised that when the internal evaluation peer review had been undertaken, the CNS had been shown to be a highly valued part of the team and had a positive contribution to the work of the team, and to patients.

The Chief Executive commented that this was not just an issue for CNS’s and suggested that other systems should be reviewed, including the booking of patients for appointments and consultants to enable patients to be batched to be seen and therefore provide better use of everyone’s time. He requested further detail from the Lead Cancer Clinician.

The Chief Operating Officer was disappointed with the results on the Care of the Dying Pathway as no improvement had been seen over the last two years. The Lead Cancer Clinician advised that funding had been received for End of Life facilitators. Two individuals had commenced during the summer and projects had started.

AGREED that the Quarterly Report of the Lead Cancer Clinician be noted.

DIVISIONAL MEDICAL DIRECTORS’ REPORTS

Division 1

10/243 Quality and Safety Report

There were no new red incidents reported in the period 18th September to 26th October 2010. There is one open red risk within the Division at present concerning routine reporting of plain X-ray films. Anthony Leese, Radiology Manager had updated the Quality and Safety Committee on this matter in October. On-going training for Radiographers was taking place and some of the issues will be resolved with the arrival of the new PACS system, which is anticipated for early February.

The Chief Executive questioned whether the delivery of the new PACS system would take place in February and whether there was an option to delay delivery further because of winter pressures. The Director of Finance and Information confirmed that he was confident that the system would be delivered in February. An operational decision had been taken to delay implementation until February because of the Christmas/New Year break and the ability to deal with any “go-live” issues during this time. The delivery was an internal matter for the Trust.

AGREED that the Quality and Safety Report for Division 1 be noted.

10/244 Nursing Report

There were risks associated with theatre staffing. These issues would be raised later in the report.

AGREED that the Nursing Report be noted.

10/245 Business Case for the Implementation of Intensity Modulated Radiotherapy

The Divisional Medical Director explained that IMRT is an advanced type of high precision radiotherapy which focuses rays on cancerous tissue and avoids surrounding healthy tissue. The NHS Cancer Reform strategy cites the need for IMRT in at least one centre per Network. Within the West Midlands this is undertaken at Stoke, UHB and Coventry. The NRAG recommend that IMRT should be available for all centres with head and neck cancer units. Other areas where the treatment could be utilised were included in the report and an analysis of future IMRT cases for Wolverhampton, 500 patients, was shown as Table 2. Implementation of this treatment would improve clinical outcomes and quality of care for patients and is crucial in supporting research into cancer within the Trust.

Referring to the Options appraisal, the Divisional Medical Director reported that Option 3 – Invest in an expanded IMRT service was the preferred option. The service would be implemented in three phases.

The Divisional Medical Director turned to the financial proforma and advised that the first two years were covered by the greater Oncology Expansion Plan but an impact would be seen in year three. At the moment it was unclear where the tariff for IMRT would be.

The Chief Operating Officer reported that the Business Case had been through the Contract and Commissioning Forum. Most of the costs, particularly around consultants are linked to the Oncology Expansion Plan. Approval had been given by the Contract and Commissioning Forum subject to a number of caveats; the decision should not be based on finances in isolation but must be linked to the Oncology Business Case. There was no guarantee on income as commissioners have not yet signed up to this. Dr. Brammer had been running a trial of the service. The exit strategy needed to be understood. The Business Case fitted with the strategic direction of the Trust but was dependent on the Oncology Business Case.

The Director of Nursing and Midwifery queried whether this was a new technique and was advised by the Lead Cancer Clinician that this was a new way of giving radiotherapy and that training had been given as part of the trial. The Chief Executive asked for the matter to be reviewed and a further report to be brought to the Trust Management Team.

AGREED that the Business Case for the Implementation of Intensity Modulated Radiotherapy (IMRT) be approved, subject to the approval of the Business Case for the Expansion of Oncology Services and commissioners agreement to the service.

10/246 Business Case for the Expansion of Oncology Services

The Business Case outlines the rationale, benefits and resource implications of expanding the Oncology Services in the Trust, which includes a recommendation of the appointment of two new Clinical Oncologists and one new Medical Oncologist. Implementation of the Business Case will deliver five additional oncology sessions to Mid Staffordshire NHS Foundation Trust; deliver the requirements of NCEPOD, NCAG, Cancer Peer Review and NICE guidance. It will also allow the implementation of IMRT in the Trust. A new radiographer structure would be put in place and support for junior doctors would be improved.

The Divisional Medical Director advised that the last consultant appointment for this service was made five years ago and activity levels had risen considerably and were predicted to rise further by 16%. The introduction of IMRT would increase pressure on consultant job plans. Expansion of the Oncologist's job plan will enable there to be an acute Oncologist of the day to ensure patients are seen immediately following admission.

Page 12 of the report highlighted the proposal for three firms of four Oncologists, which would facilitate team working, improve patient care and help support junior doctors on the ward. NCAG recommends five consultant clinical sessions are required to deliver this. The role of the Advanced Nurse Specialist was outlined.

An Away-day had been held at the Molineux in January, chaired by Dr. Jonathan Mann where options had been discussed and the favoured option is Option 5.

The Divisional Medical Director apologised to the Trust Management Team as the incorrect financial proforma had been provided with the report. He assured the TMT that there was £100,000 difference as locum costs should have been incorporated and the total contribution should read - £479,114.

The Chief Operating Officer advised that the total non pay costs for year one are £424,720 and the full year impact are £1,629,854. The Business Case was approved by the Contract and Commissioning Forum. However, the Trust needed to make sure that the fraction costs were negotiated with commissioners.

A firm agreement was needed from Mid Staffordshire NHS Foundation Trust for funding of one of the consultant posts; the Divisional Medical Director had received a confirmatory letter from Mid Staffordshire. Contract performance on spells is under-performing against plan at the moment and the Trust needed to ensure that the extra activity could be picked up.

The Chief Operating Officer stated that the Business Case had been put together to off-set a workload that was unsustainable by the existing consultant workforce. The Trust had exit strategies in place that could be deployed if necessary.

Dr. Singh noted the number of deliverables included in the Business Case that needed to be performance managed. The Chief Executive agreed with Dr. Singh and stressed the importance of strong leadership. The Director of Nursing and Midwifery suggested the opportunity should be taken to develop quality indicators around this service which could be monitored. The Chief Operating Officer advised that a process was already in place for monitoring business cases to ensure that they deliver what they have stated. Penalties are incurred for any deviation.

AGREED that the Business Case for the Expansion of Oncology Services be approved.

10/247 Business Case to appoint to two vacant Consultant Anaesthetist Posts within Critical Care Services and convert one of the posts to a Consultant Anaesthetist with an Interest in Chronic Pain Management

The Business Case identifies the need to recruit to the current vacancies and convert one of the vacant posts to a Consultant Anaesthetist post with an interest in Chronic Pain Management. This option would allow the appropriate level of medical cover for the existing services within the integrated critical care unit, theatres and chronic pain service.

AGREED that the Business Case to appoint to two vacant Consultant Anaesthetist posts within Critical Care Services and convert one of the posts to a Consultant Anaesthetist with an Interest in Chronic Pain Management, be approved.

10/248 Business Case for the Provision of a Theatre Nursing Workforce to Deliver Planned and Predicted Activity Incorporating New Ways of Working

The Business Case identifies an expansion in nurse staffing levels in order to staff the additional twin-theatres and five-bedded recovery room based on the current activity in the 2010/11 plan, and the nurse staffing levels required to staff both new operating theatres to their full capacity. There has been a period of sustained growth in elective and emergency surgery and all scheduled operating theatre capacity within the Critical Care Directorate has been exhausted. The theatre workforce are currently delivering a significant level of activity out of hours

The introduction of a four day working week for full time theatre staff across all areas would accommodate session overruns within the rostered working day and significantly reduce overtime costs.

Given the challenges in recruiting trained theatre staff there is a national drive to develop a Band 3/4 Assistant Theatre Practitioner role. At the moment, there was no support forthcoming from local universities but discussions were being held with Telford.

The sessional requirements for the two new theatres have been identified in line with the 2010/11 activity plan and were shown in Table 1. Currently 12.5 sessions are being delivered within the existing arrangements; the proposed new service required six additional sessions

The Divisional Medical Director drew attention to page 69 of the report, Option 3 and advised that the information provided under "Disadvantage" was incorrect. The disadvantage to the Trust related to the financial implications only and not the other two points indicated.

Costs associated with the Business Case were £580,000 in order to deliver current activity in a more acceptable way, to secure additional activity when the two new theatres are open to full capacity and to make the Trust's recruitment and retention in theatres secure for the future.

The Director of Finance and Information and Chief Operating Officer advised that this was their first sight of the Business Case and questioned whether this was the revenue for the capital investment that was approved by the Board as some of the analysis needed to be clarified. The Chief Executive delegated approval of the Business Case to the Director of Finance and Information and Chief Operating Officer who would review the analysis prior to presentation to the Trust Board.

The Chief Executive asked that HR provide information on how this recruitment campaign was to be conducted to ensure successful recruitment.

AGREED that delegated approval of the Business Case for the Provision of a Theatre Nursing Workforce to Deliver Planned and Predicted Activity Incorporating New Ways of Working be given to the Director of Finance and Information and Chief Operating Officer who would review the analysis prior to presentation to the Trust Board.

Division 2

10/249 Diabetes Service Provision

The Divisional Medical Director, Division 2 reported that the Directorate were struggling to provide a service for those patients with diabetes within Paediatrics. The service consists of a lone consultant paediatrician who had reduced to a 6PA job plan and a locum. The Directorate wished to substantively appoint into the locum post and thereby allow the quality of the diabetes management of the paediatric population to be improved.

It also allows a concentration on endocrine services within the department without children being referred out to tertiary referral centres. The frequency of on-call will move from 1 in 5 to 1 in 6.

The number of diabetes out-patients which would be expanded both for new and review and the number of general paediatric outpatients which would be carried out by all the paediatricians and has been factored into their job plans, increases. The impact on activity and the income associated was detailed in the report.

The Chief Operating Officer reported that the Business Case had been approved by the Contract and Commissioning Forum, depending on activity coming through. Further clarity was being sought on this matter.

AGREED that the Diabetes Service Provision be approved.

10/250 Podiatrist Business Case

The Business Case will improve foot care with a view to minimising amputation rates. The number of clinic slots for those patients with high-risk feet who needed to be reviewed on a quarterly basis and those requiring annual reviews were given in the report and there was a shortfall of 2,017.

The Directorate wished to appoint a Podiatrist who would be able to pick up the shortfall in the workload. The financial proforma indicated that tariff and the number of appointments would generate £250,000 of income.

The Chief Operating Officer advised that the service is currently provided by the Podiatry Team from the PCT Provider arm. Dr. Singh reported a good working partnership with the Podiatry Team.

The Chief Executive stressed the importance of the benefits of the Business Case, particularly amputation rates, should be written into the personal objectives of the people delivering the service.

AGREED that the Podiatrist Business Case be approved.

10/251 Nursing Report

The Nursing Report was noted.

REPORT OF THE CHIEF OPERATING OFFICER

10/252 Performance Report – September 2010

The Chief Operating Officer reported that eleven cases of *c.difficile* had been reported for the month of September. This was above the target of 7.5 and had been discussed at the Infection Prevention and Control Committee.

The Trust had met the target against the compliance framework for Monitor on Cancer Waiting Times.

However, the 62 day target was still proving challenging. The National Intensive Support Unit had been invited to visit the Trust in November or December to scrutinise systems of working to ensure that they are robust.

The Trust had achieved over 98% against the target for A & E four hour waits for over seventeen months. The Chief Operating Officer congratulated the A & E teams for their hard work.

The Chief Operating Officer drew attention to the improvement on cancelled operations.

Referring to 3.3, PROMS, the Chief Operating Officer advised that Wolverhampton PCT have determined that they will not pay the performance from last year because the Trust did not hit the target predicted, although the Trust is the best performing in the country. The target related to the distribution of questionnaires to patients before surgery for hips, knees, varicose veins and hernias.

The Director of Infection Prevention and Control referred to the Foundation Trust – Compliance Framework and stated that against the target for *c.difficile* of 8.8 per month the Trust had 9 in September, not 11. Eleven were seen against the target of 7.5 which is an internal measure.

AGREED that the Performance Report for September 2010 be noted.

10/253 Transforming Community Services – Proposal for Clinical Service Management

The Chief Operating Officer reminded the Trust Management Team that the Trust had determined that it would follow the Service Line Management route and a lot of work had been undertaken on this initiative. Due to Transforming Community Services the strategy had had to be reviewed. A number of options had been considered.

It was proposed that the Trust retain the two Clinical Divisional structure – Surgical and Medical services. It was believed that this particular model would give greater integration. The main changes to the Surgical Division would be the inclusion of Women's, Neonates and Sexual Health, along with Orthopaedics and Gynaecology. The Medical Division would include Oncology and Haematology and Adult Community Services.

A workshop was held on 19th October and included Clinical Directors, Directorate Managers and Matrons from both organisations. All Clinical Directors have been offered the opportunity to discuss the proposal with the Chief Operating Officer.

The Director of Nursing and Midwifery considered that Neonates should be included with Children's Services. The Divisions are considering the proposals and the Divisional Medical Director, Division 2 advised that discussions were still taking place.

AGREED that the principles and proposals reached to date in regard to Transforming Community Services – Proposal for Clinical Service Management be approved.

10/254 Liberating the NHS: consultation on Greater Choice and Control

The Chief Operating Officer reminded the Trust Management Team of the launch of two consultations on the changes that will need to take place to deliver the aspirations described in the White Paper. The consultations are on Greater Choice and Control and the Information Revolution. Her report focused on the proposed changes for Greater Choice and Control which she believed could have a great impact on the Trust.

The Chief Operating Officer highlighted some of the proposed changes particularly that from 2011 patients will be able to choose where they go for diagnostic tests and following those tests patients will be able to choose whether they stay with the consultant/provider or ask to be referred to another consultant/provider. GP contracts are being reviewed to ensure that they offer choice at the point of referral.

Steps were being taken to ensure that the Trust is compliant from 1st April and the Head of Strategic Development will be liaising with clinical teams to ensure that every consultant delivering a service in Choose and Book is registered on the national spine and can be linked electronically to that service. The Directory of Services is to be refreshed to include information about consultant's sub-speciality interests and this information will be published on the Trust's website and NHS Choices, as well as via Choose and Book and will be circulated to all GPs ahead of 1st April, 2011.

AGREED that the proposals to respond to the consultation where relevant and the plan to implement changes required to ensure the Trust is able to meet its contractual obligations from 1st April, 2011, be approved.

10/255 Robotic Surgery

Minimal Access Surgery has evolved rapidly and is now established as the preferred treatment for many operations. The Chief Operating Officer reported that the Trust had made inroads into starting MAS programmes, although this was restricted to a few experienced individuals who had trained to undertake laparoscopic surgery.

The robotic technique is essentially a surgical tool and facilitates complex laparoscopic surgical procedures. The technical advantages are 3D vision, 10x magnification, tremor filtering and a much more advanced range of movements than possible with conventional laparoscopic surgery. There are 21 centres offering robotic surgical treatments within the UK

Three specialities have been identified initially to participate in robotic surgery; Urology, Gynaecology and Colorectal Surgery. There is also an interest from Head and Neck Surgery and Cardiothoracic Surgery.

The Chief Executive requested the Chief Operating Officer and Director of Finance and Information to review provision of the equipment, either capital or leasing, and to seek advice from two centres who are currently offering the service on which system offers the most benefits and value for money.

The Director of Nursing and Midwifery questioned the cost of consumables. The Chief Operating Officer advised that the consumables would cost more than those used for laparoscopic surgery and were excluded from PbR. The Trust needed to assure commissioners that the outcomes can be demonstrated.

AGREED that the proposal to introduce robotic surgery into the Trust be approved

REPORT OF THE DIRECTOR OF FINANCE AND INFORMATION

10/256 Financial Position of the Trust at the end of Month 06 (September 2010)

Appendix 1 to the report sets out the financial position to the end of September. The Trust's surplus was £6.377m, which was £2.126m above plan. This is predominantly due to the over-performance against contract levels for PCTs of £1.086m. Against a plan of £6.5m surplus the Trust is forecasting £7.5m to £8.5m surplus based on risk.

The main areas of risk included the financial position of Division 1 and the Finance team were working closely with the Division on this matter.

AGREED that the report on the Financial position of the Trust at the end of Month 06 (September 2010) be noted.

REPORT OF THE DIRECTOR OF NURSING AND MIDWIFERY

10/257 Red Incidents, Complaints and Operational Risks for Corporate Areas

Within the time period 11th September to 26th October, 2010 there had been no new red incidents, no new red formal complaints and no existing operational-level red risks on Datix.

AGREED that the report on Red Incidents, Complaints and Operational Risks for Corporate Areas be noted.

10/258 Safeguarding Vulnerable Adults from Harm and Abuse

The report gave a brief summary of the activities and achievements of the Joint Health Safeguarding Adults Committee in the Trust. It provided information on all activities, governance arrangements and the action plan for future developments and spans the period September 2009 to October 2010. Zena Young was leading on this work supported by Dr. Dainty as lead clinician.

The Director of Nursing and Midwifery advised that there were no clear definitions locally at present from the Local Authority who lead on Safeguarding Adults and this could mean large numbers of referrals into the system.

The Quality and Safety Committee oversee the work on Safeguarding Adults and an annual report will be presented to the Trust. Board.

The Chief Operating Officer advised of a review of Quality Standards in May 2011.

AGREED that the report on Safeguarding Vulnerable Adults from Harm and Abuse be noted.

10/259 High Impact Actions Initiative

The Trust's self-assessment against this initiative was attached to the report. The High Impact Steering Group will use this self-assessment to agree their work plan and monitoring of associated metrics.

The Chief Operating Officer questioned whether systems were in place where the high impact actions could be measured and reported upon. The Director of Nursing and Midwifery assured the Trust Management Team that the Trust could demonstrate measurements against the HIAs.

AGREED that the report on the High Impact Actions Initiative be noted.

10/260 Patient Safety Culture Survey

An assessment of the Trust's safety culture had been undertaken using the Manchester Patient Safety Framework (MaPSaF) with the Trust Board and the two clinical Divisional Management Groups in early 2010. The staff patient safety culture survey was undertaken on behalf of the Trust by Capita during June and July 2010 and the organisation wide report was attached to this report. An action plan, also attached, is informed by the MaPSaF exercises, the staff safety culture survey and also a report from Monitor – The Role of Boards in Improving Patient Safety.

AGREED that the report on the Patient Safety Culture Survey be noted.

10/261 Review of the Trust Risk Management and Patient Safety Reporting Policy OP10

This Policy has been reviewed to align with the latest national guidance on incident reporting, external notifications and investigation. Updates to the Policy were shown in the report.

AGREED that the Trust Risk Management and Patient Safety Reporting Policy – OP10 be approved.

10/262 Review of the Being Open Policy OP60

This Policy has been reviewed in line with NPSA being open guidance. Leadership and accountability for the Being Open process had been clarified. Formal training has been established for senior clinical counsellors and support staff. A procedure has been created to offer guidance on the Being Open process and patient issues to consider prior to initiating the process. A further measure had been added to evaluate the effectiveness of the policy via PALS, complaints management and patient survey results.

An implementation plan and formal launch of the Policy will occur alongside the provision of formal NPSA training to staff.

AGREED that the Being Open Policy – OP60 be approved.

10/263 Revised Visiting Policy OP43

The updated Policy was attached as Appendix 1. The purpose of the Policy is to ensure a clear and consistent approach to visiting across the Trust.

AGREED that the revised Visiting Policy – OP43 be approved.

10/264 Central Alert System Policy HS07

Amendments to the Central Alert System (CAS) reporting and monitoring process have been made as a result of the recent AMVA report regarding non-compliance to National Patient Safety Association alerts. Highlighted sections identified the changes made within the Policy.

The main change was the addition of paragraph 4.3 Action to be taken on receipt of National Patient Safety Agency (NPSA) Alerts. The Divisional Medical Directors will nominate the lead for an alert, an action plan on how the alert will be implemented and the expected timeframe will be provided by the lead within one month of receipt of the alert. All overdue NPSA alerts will be reported to the Quality and Safety Committee on a monthly basis until fully compliant.

AGREED that the Central Alert System Policy HS07 be approved.

10/265 Volunteer Policy

The updated second version of the Policy was attached as Appendix 1. The Policy sets out the requirements and standards for the co-ordination of the Volunteer workforce within the Trust.

AGREED that the Volunteer Policy be agreed.

10/266 Policy for the Management of Suspected and/or confirmed Norovirus

The first version of the Policy was attached as Appendix 1.

The Policy sets out the requirements and standards for the management of suspected and/or confirmed outbreak of Norovirus within the Trust.

AGREED that the Policy for the Management of Suspected and/or confirmed Norovirus be approved.

REPORT OF THE DIRECTOR OF ESTATES DEVELOPMENT

The reports were presented by the Director of Finance and Information.

10/267 Capital Programme 2010/11

The outturn position as at Month 6 for the 2010/11 Capital Programme is £18,034,482 against a Capital Resource Limit of £18,035,000. The Director of Finance and Information highlighted the variances on project costs for some schemes, particularly with regard to the relocation of the Medical Illustration Department.

AGREED that the report on the Capital Programme 2010/11 and exception report be noted.

10/268 Carbon Management – Business Case for Carbon Reduction

The report identified the Trust's commitment to carbon reduction to 2014/15 and identifies the Trust's baseline (carbon footprint) as at 2009/10, identifies an initial target reduction figure by 2014/15 and associated revenue cost savings/avoidance and potential capital investment requirements to achieve these targets. The Business Case will be presented to the Trust Board for approval in November and this meets a key commitment to the Carbon Trust Carbon Management Programme signed up to in May 2010 by the Trust. This report is an interim report in advance of the final Carbon Management Action Plan which will be presented for approval by the Trust Board in March, 2011.

AGREED that the report on Carbon Management – Business Case for Carbon Reduction be approved, and the development and implementation of the Carbon Management Plan be supported.

10/269 Delivery of the Estates Strategy 2009/10 to 2018/19 – Quarter 2 Report

The report provided key points of progress against the implementation of the Trust's Estates Strategy – Quarter 2. The Director of Finance and Information highlighted the red areas shown in Appendix 1 – Estates Development Targets and Key Performance Indicators. Plans were in place to tackle all of these issues for delivery in the first quarter of the next financial year.

AGREED that the Quarter 2 report on the Delivery of the Estates Strategy 2009/10 to 2018/19 be noted.

10/270 Section 106 Agreement – Planning Application for the Major Redevelopment of the New Cross Hospital site

The attached Guide outlines the obligations under the Section 106 Agreement of the Trust. This finalises the planning consents for the master plan regarding redevelopment of the New Cross Hospital site and would be presented to the Trust Board for approval in November. The report was provided for information

AGREED that report on the Section 106 Agreement – Planning Application for Major Redevelopment of the New Cross Hospital site be noted.

REPORT OF THE CHIEF EXECUTIVE

10/271 Policy for the Prescription and Administration of Emergency Oxygen in Adults

The safe implementation of oxygen therapy with appropriate monitoring is an integral component of the Healthcare Professional's role. The Policy has been reviewed and approved by the Medical Gas Committee and the Medicines Management Committee.

AGREED that the Policy for the Prescription and Administration of Emergency Oxygen in Adults be approved.

ANY OTHER BUSINESS

10/272 Proposed Meeting Dates for Meeting of the Trust Management Team in 2011

The schedule of meetings dates for 2011 were agreed.

10/273 Terms of Reference – Trust Management Team

The Director of Nursing and Midwifery advised that she was undertaking a review of the Terms of Reference for the Trust Management Team.

The current ToR would be circulated to the Team for comment, particularly around the format of the meeting.

10/274 Collective Grievance

The Chief Operating Officer advised that a collective grievance was expected from the Anaesthetists regarding the proposal to move to a 2-tier on-call system.

DATE AND TIME OF NEXT MEETING

10/275 The next meeting of the Trust Management Team will be held on Friday 3rd December, 2010 at 1.30 p.m. in the Clinical Skills and Corporate Services Centre, New Cross Hospital.

