Kingston Hospital NHS
NHS Foundation Trust

Minutes of the meeting of the Board of Directors held on 25th May 2016 – 9.30 am to 12.30 pm

Seminar Room 1, Kingston Hospital Surgical Centre, Kingston Hospital NHS Foundation Trust

Present voting:		
Sian Bates	Chairman	SB
Rachel Benton	Director of Strategic Development	RB
Duncan Burton	Director of Nursing and Patient Experience	DB
Jo Farrar	Director of Finance	JF
Martin Grazier	Non-Executive Director	MG
Sylvia Hamilton	Non-Executive Director	SH
Joan Mulcahy	Non-Executive Director	JM
Ann Radmore	Chief Executive	AR
Chris Streather	Non-Executive Director	CS
Rachel Williams	Chief Operating Officer	RW
Jane Wilson	Medical Director	JKW
Jacqueline Unsworth	Deputy Chairman	JU
Present non-voting:		
Allan Jones	Interim Divisional Director,	AJ
Anne Robson	Interim Director of Workforce	ARo
John Wong	Divisional Director, Clinical Support Services	JW
In attendance:		
Susan Simpson	Company Secretary & Head of Corporate Affairs	SS
Lisa Ward	Head of Communications	LW
Apologies:		
None Received		
Governors:		
Marita Brown	Public Governor - Kingston	MB
Dennis Doe	Public Governor - Kingston	DD
Marilyn Frampton	Public Governor - Merton	MF
Bonnie Green	Public Governor - Richmond	BG
CJ Kim (part)	Public Governor - Elmbridge	CK
Frances Kitson	Lead Governor	FK
Nicola Urquhart	Appointed Governor - Richmond	NU
Members of the public:		
Erica Farmer		
Kate Fitzsimmons		
Sunil Arora		
Alison Heeralall		
Ajay Melita		
Christine McDonald		
Huda Baig		
Staff:		
Lisa Cheek	Deputy Director of Nursing	
Sonia Faria	PA to the Director of Nursing & Patient Experience	
Sarah Joseph	Matron	
Belinda Brophy	Matron and Service Manager	
Berenice Constable	Hed of Nursing - Emergency Services	
Georgina Gray	Emergency Planning Manager	

		Actions
1.	**Patient Story**	
1.1	The Board heard the story of a patient receiving treatment for leukaemia. She praised co-operation between Kingston and Kings, explaining the difference this made to her being able to access treatment. She was thankful for continuity of experienced staffing in the Haematology Day Unit and for the support offered by the Volunteers, but drew attention to the impact that sharing the Unit with other patients who do not understand the needs of patients with conditions such as hers.	
1.2	The patient highlighted shortcomings in the overall environment within the Day Unit and associated services, and pointed out some simple things that would make a difference to patients who receive regular treatment. She had also noted that staffing wards with permanent nursing staff rather than agency made for a smoother running environment.	
1.3	When asked what would be one thing to change if she could, the patient confirmed it would be the environment within the HDU.	
1.4	DB asked Board members how hearing the story had made them feel. JU commented that the story showed the power of listening and putting yourself in others shoes. JM noted that simple things can make a huge difference. She had been proud to hear of the care staff were giving and asked that these compliments be conveyed.	
1.5	CS had been pleased to hear that communication was good between the two hospitals involved in the patient's treatment and suggested that lessons be learned from that good experience that could be transferred to other departments. JKW noted how important it was for clinicians to work together with patients to give them the best overall experience.	
1.6	SB recognised how important independence was for patients receiving long term treatment. Hearing the story had made her feel energised to deliver the strategic change being discussed in SW London. All agreed that hearing the story as the first item on the Board agenda was very powerful.	
2.	**Apologies for absence**	
2.1	None received.	
3.	**Declarations of interest**	
3.1	None declared.	
4.	**Minutes and Matters arising**	
4.1.	The minutes of the meeting held on 30th March 2016 were approved as a correct record. One outstanding action was closed. AR was working with the local authorities to understand the impact of nursing home closures, however nothing had been reported formally to either council as yet. RW had taken on the work to find long term solutions to delayed transfer.	
5.	**Chairman's Report**	
5.1.	The Chairman gave a verbal report, firstly welcoming AR to her first meeting as permanent Chief Executive and RW as Chief Operating Officer. SB outlined the plans for recruiting a new Non-Executive Director following the resignation of MJ.	
5.2.	SB had carried out extensive work with external partners since the last meeting. She had also taken part in interviews for Consultants and was delighted to report that the Hospital was attracting high calibre applicants.	

5.3.	Capsticks had invited SB to speak to a meeting of Trust Board Secretaries about effective Boards and this had been an insightful experience.	
5.4.	SB described a busy and complex period for the Trust, with finance and workforce challenges, increasing demand and multi-faceted strategic decisions to be made. Talking to Chairs of Trusts outside London, it was clear to her that the pressures were the same across the country. She believed it had never been more important for the Board to put the patient first and to focus on what the organisation needs to achieve.	
6.	**Chief Executive's Report**	
6.1.	The Board had received the Chief Executive's report providing an overview of matters to bring to the Board's attention which were not covered elsewhere on the agenda.	
6.2.	The Chief Executive reported that information related to the Carter report was being analysed, with more information still to come. Productivity gains continued to be important and she was pleased to report that the Trust had delivered on financial commitments made for 2015/16. The greatest pressure within the Hospital continued to be in Emergency Services.	
6.3.	AR emphasised the complexity of the Sustainability & Transformation Plan for SW London and the important work taking place to crystallise the Trust's own vision for the future alongside the STP.	
6.4.	Colleagues from the Department of Health had visited the Hospital and reciprocal visits were planned. SB had been interested to note that technology and dementia were focused upon and noted that feedback from the visit had been positive.	
QUALITY AND PERFORMANCE		
7.	**Clinical Quality Report**	
7.1.	The Board had received the Clinical Quality Report for April 2016. JKW highlighted good performance in safety KPIs and that patient satisfaction KPIs were stable. She noted that the Complaints response rate had slipped but that in some areas this was due to the complexity of the cases being dealt with. AR observed that capacity within the Complaints team was limited and may need to be re-examined.	
7.2.	In the previous report to the Board it had appeared that better traction on hand hygiene had been achieved. Some areas were not achieving as well as others and the Infection Control team had now gone back to basics. JKW noted how the patient story had demonstrated strongly why hand hygiene was important.	
7.3.	CS welcomed the renewed focus on hand hygiene, saying that there can be a lag between slippage and infection control. The Quality Assurance Committee would continue to seek assurance on reaching the required standards. JU asked whether hand hygiene was included in mandatory training. JKW confirmed that it is included but the delivery method had changed and this may have brought unintended consequences.	**QAC**
7.4.	The number of elective Caesarean sections had risen and was higher than the national average. The consultant labour ward lead was looking at every case to identify themes and ensure correct pathways are being followed.	
7.5.	A discussion took place on a number of indicators relating to patient experience in A&E. DB acknowledged that there was more work to be done in improving the experience and said that better governance systems were now in place to drive this. CS reminded the Board that waiting in A&E needs to be seen as a quality measure as much as performance.	
7.6.	SB Concluded the discussion by reinforcing the message that the patent story brought the importance of hand hygiene into sharp focus. She asked the	

	Executive team to continue to focus on this area.	
8.	**Operational Performance Report**	
8.1.	The Board had received the Operational Performance Report for April 2016. RW noted that A&E performance in April had been good on the whole but that the Trust was struggling to maintain this in May. A&E performance trajectories had been revised and AR described these as very challenging.	
8.2.	The Trust had met all targets for Cancer in March and for Q4, which was a much improved position on the same period last year. Performance against the 62 day target was one of highest in London and nationally. A Trust Access Board had been introduced to increase assurance for both Cancer and RTT.	
8.3.	JM noted the red indicators against ED & Ambulance handovers and asked what were the key underlying processes to be improved. RW believed having the right systems for mobilising staff within the department was an important issue.	
8.4.	CS noted that the Trust's A&E performance was much improved on a year ago whereas the national average had nose-dived, and asked what could be learned from this. RW and AR believed that the Trust had carried out short to medium term activities which had led to improvement but these would not guarantee sustained delivery. The Board would start to consider in Part 2 how the system might adapt to reduce demand coming.	
8.5.	CS asked that a message be conveyed to staff that, although there is more to do, the Trust is bucking the national trend. DB noted that thanks would be expressed across the Hospital as many had contributed to reducing delayed discharges. SB commented that better co-operation had been key to improving patient flow and noted that the current had dipped slightly in the wrong direction. AR noted the vulnerability of home care providers and reported that there were currently operational problems in social care in Richmond. However, there was progress to report in terms of shared discharge documentation which had been approved across the three local authorities for use on the wards.	**DB**
8.6.	SB concluded by singling out for praise the improvement in cancer performance, saying that this mattered immensely to patients	
9.	**Workforce Report**	
9.1.	The Board had received a progress report in respect of performance against agreed workforce targets at the year end. ARo reported that trends were broadly encouraging and she was optimistic that the Trust would continue to move in the right direction.	
9.2.	SB was encouraged by the vacancy fill rate, linking this to comments from the patient story and the importance of agency reduction to the patient experience. Anecdotally, she had also received some positive feedback from the organisation about improved recruitment processes.	
9.3.	The Board heard that the Executive Management Committee had discussed the Trust's retention plan in detail and it was noted that the monthly Performance Review meetings were very helpful in focusing attention on local issues.	
9.4.	JU commented that the Workforce Report had returned to presenting whole Trust data, whereas she had found greater granularity more helpful in unmasking variation. The Board discussed different options and levels of detail to be considered in the Workforce Committee and by the Board. It was agreed to provide more granularity to the next meeting.	**ARo**

9.5.	SB noted that the turnover position should be helped by retention. DB shared the experience that Filipino nurses had described at the Nursing & Midwifery conference that they felt needed and had appreciated the support they had received. All agreed that the conference had been very successful and a chance to showcase powerful staff and patient care stories.	
9.6.	The Board thanked ARo for an encouraging report and looked forward to further developments emerging from the Workforce Strategy, particularly sustainable and innovative solutions around the workforce and multi-disciplinary education and training.	
10.	**Finance Report**	
10.1.	The Board had received the Finance Report for April 2016. JF highlighted the key points to note in the executive summary and selected points in the supporting detail.	
10.2.	Members were encouraged to see agency spend going in the right direction, although control of spend on staffing in A&E and on medical locums continued to be difficult, the latter being a national issue. National pressure had improved the position on the cost of agency nursing but the same behaviour was not being seen with Medical locums and AR had sought the support of regulators to see what could be done. Every agency request was being reviewed to see whether it could be managed in a different way. JF reported that winter escalation capacity had now been closed and this would have a positive impact on pay in coming months.	
10.3.	The CIP programme was currently behind. JF explained the underlying factors and mitigating actions taking place. RB commented that phasing may mean the position was more positive than it appeared.	
10.4.	JU asked about the impact on income of the industrial action by Junior Doctors and asked whether the Trust might catch up during the year. JF anticipated that there would be some return in May 2016, but not at no cost. He emphasised that the Trust had been communicating frequently with NHS Improvement who recognised that the impact was out of the Trust's control.	
10.5.	SB noted that the M1 report had been discussed in detail at the Finance & Investment Committee where it had been acknowledged that, whilst M1 often revealed prior year impact, the industrial action confused the picture.	
10.6.	The workforce challenges in both Emergency Services and Elderly Care were recognised but AR also referred to high attendances in A&E, which had been unexpected and different solutions were being developed to support flow.	
11.	**Nursing, Midwifery and Care Staffing Establishments**	
11.1.	The Board had received a report on progress with the requirements of the safe staffing guidance. As the recruitment of nursing staff continued to be challenging, the report provided the Board with an overview of current and future recruitment activities and key areas of focus in developing nursing my midwifery and care staff.	
11.2.	DB explained that a new measure would be introduced in June 2016 in response to the Carter review. This would be an indicator for Nursing efficiency and productivity, and would measure care hours per patient per day. He believed this would need to be triangulated with acuity dependency to be meaningful.	
11.3.	DB highlighted that turnover was decreasing and that predicted vacancies were at the lowest level ever reported to Board. He described a number of initiatives supporting the development of the Nursing and Midwifery workforce. SB welcomed the focus on accommodation for nurses to support recruitment.	

11.4.	Use of technology was releasing time to care and DB was hopeful that there would be more funding for this. The roll out of the wireless observations and alert system was to be continued in the Emergency Department. JU welcomed the positive impact on patient care and asked, as the speed of roll out was limited by funding, whether there was a business case to support technology being funded more quickly. DB explained what was being done to source additional funding and to expand current plans.	
11.5.	SB noted that the Workforce Committee had heard from the Respiratory team about some excellent team development work and the impact this had had. DB confirmed that team development days would be continued.	
11.6.	JU observed that staffing is still the number one issue raised during Board Walkabouts and asked what assurance there was that day to day issues were about sickness and not establishment. DB pointed to reviews against the safer staffing guidance and scrutiny at Divisional performance meetings which confirmed the establishment was there. He believed the comment was more likely to be about agency cover, which staff were keen to replace with substantive employees.	
11.7.	SH commented that the exciting developments in technology giving early warning signs potentially required a different style of management, anticipating problems and putting staffing there. DB agreed and also referred to the need to shape patient expectations about use of technology since patients do not always realise that the mobile devices are supporting their care, seeing them as barriers or distractions.	
12.	**Delivering the London Quality Standards and 7 Day Services**	
12.1.	The Board had received a progress report on performance against the London Quality Standards and delivery of the four priority clinical standards to support 7 day services. JKW explained the background and how decisions on prioritisation of delivery had been reached.	
12.2.	The Board discussed the difficulties of medical recruitment, particularly in AAU and Emergency where appointments had now been made but consultants had not yet started. Some areas, such as Care of the Elderly, had settled on different delivery methods and were progressing well.	
12.3.	CS asked how the Trust compared with others. JKW explained the difficulty of comparison and of measuring the impact of actions when these were process standards rather than output. She judged that achievement of the standards in SW London was similar across those that apply.	
12.4.	DB asked whether the Trust should be monitoring consultant reviews more frequently. It was explained that further analysis is being completed to understand what the reasons were for not meeting the 14 hour standard.	
12.5.	JU recalled that benchmarking had previously revealed that the Trust had fewer consultants in Care of the Elderly than others and asked whether a similar exercise should be carried out now. She was concerned that by delivering what is mandated the Trust's local needs may be suffering given the demographics of the local area. JKW believed the standards were in alignment with the Trust's needs and the solutions found for Care of the Elderly were appropriate for KHFT. SB asked that the audit results be brought back to the Board when completed.	**QAC**
12.6.	SB observed that during recent industrial action by Junior Doctors patient flow had improved. She was grateful to the Consultants for their response to the situation and understood that other activity had been paused, but asked what could be learned from the experience. JKW reminded the Board that pathways were different and fewer patients arrived in A&E during the industrial action.	

13.	**Dementia Strategy**	
13.1.	The Board had received a report demonstrating that good progress is being made against the Dementia Strategy 2014/17. It was noted that key areas of further focus were on developing the dementia score card, setting an action plan to deliver reduction in harms for patients with dementia, completion of the first ward refurbishment and expansion of the training programme.	
13.2.	DB reported that the Head of Audiology had been awarded a Churchill Fellowship and would be travelling to the US to study hearing loss and dementia.	
13.3.	A full-time Dementia Improvement Lead was now in post and making a difference. Work on transformation of Derwent ward would begin shortly and meanwhile colour coding of doors and installation of dementia-friendly signage was progressing, Staff, patients, carers and visitors had engaged positively with the furniture showcase event where furnishings for Derwent Ward were on display.	
14.	**Annual Report: Infection Prevention and Control**	
14.1.	The Board had received the annual report for 2015/16 which provided assurance of the Trust's compliance with the Health and Social Care Act 2008 and highlighted key areas of focus for 2016/17, which were duly noted.	
14.2.	DB emphasised that infection prevention and control went beyond CDiff and Hand Hygiene to managing a wide range of infections and other potential issues. He highlighted new issues emerging, such as the Zika virus and Middle East respiratory syndrome (MERS). The Trust had adhered to guidance on Norovirus from Public Health England, who were content with the Hospital's handling of outbreaks during the year.	
14.3.	CS commented that antimicrobial resistance had begun to feature in news stories and this was a major concern for Public Health. He asked that the Quality Assurance Committee hear about antibiotic prescribing and cross contamination. AR suggested the Committee should also look at where the prescribing started in the community before coming into hospital.	**QAC**
15.	**Annual Report: Emergency Preparedness**	
15.1.	The Board had received the report for 2015/16 which informed the Board on regulatory requirements and provided assurance that systems, training, policies and procedures are in place to ensure the Trust responds appropriately in the event of a major incident or civil contingency event. DB had taken on responsibility for Emergency Preparedness during 2015/16 but responsibility had been returned to the Chief Operating Officer from April 2016. The Board welcomed Georgina Gray who had recently joined the Trust as Emergency Planning Manager.	
15.2.	DB explained the breadth of scopes for the report and outlined the activity that had taken place during the year. Details of Business continuity plans were noted. DB reported that these were all now in place but interdependencies would be mapped to ensure all were correct and the plans would be tested to ensure they did not affect other departments negatively.	
15.3.	It was noted that assurance could be gained from live incidents during the year in the form of industrial action, flooding and breakdown of IT systems. All had been successfully managed.	
15.4.	DB confirmed that the Emergency Planning Group had now been strengthened and that the Director of IM&T had been included in the membership to allow for a specific focus on increasing threats associated with IT systems failure and cyber terrorism.	

16.	**Winter Plan 2016/17**	
16.1.	The Board had received a report reviewing Winter 2015/16 and setting out proposals for 2016/17. RW added further verbal comment.	
16.2.	A brief review of schemes had taken place and whereas some schemes had had no impact, others had an impact but were not funded. A proposition document for 2016/17 was expected from the SRG within the coming week. The next step would be to agree how monies would be used going forward, although it was noted that Richmond CCG had no funding available.	
16.3.	SB asked for an update on use of GPs in the Emergency Department. RW confirmed that this was continuing at present and that discussion with CCGs on maintaining funding was still supportive. AR reported that the two predominant CCGs had different views on how the model should work and agreement had not yet been reached on how to fund the service.	
16.4.	JM asked why plans to use rehabilitation units flexibly had not been implemented. RW confirmed that the need and commitment had been there but the practicalities had not been ironed out. For 2016/17 the Trust would need to work alongside external colleagues to deliver.	
16.5.	SH commented on the importance of educating the public in order to avoid admissions and asked whether there was any national evidence on what worked or did not. AR said there was limited evidence that asking the public to change their behaviour around non-elective treatment worked as the public tended to default to what they have most confidence in. However, she noted that attendance in A&E had not risen as it could have done and extended hours in General Practice was intended to deal with planned activity rather than reducing unplanned attendances.	
16.6.	SH asked why admissions avoidance was included in areas for development if it did not reduce attendances to ED or admissions to hospital. JKW referred to the ways in which people access non-healthcare related appointments; there were many things that could be booked online or accessed without appointments, so although it was difficult to influence the numbers of people involved made it important to do something.	
16.7.	SB asked whether the SRG had reviewed the impact of the schemes. JKW thought the Board should continue to ask for a formal evaluation of what works or does not for the SRG's many partners. JKW explained that providers were being asked to sign up to a different approach for 2016/17 but it was not yet clear what that approach was. It appeared that providers would be expected to agree how to spend block of money for integrated work. This would be instead of a competitive bidding process.	
16.8.	JM asked whether any impact on financial plans had been assumed and JKW confirmed some allowance had been made. It was noted that development of the proposition had been CCG-led conversation and CCGs had not engaged with any partners.	
16.9.	The Board authorised the actions proposed and requested a progress report be made to the next meeting.	**RW**
GOVERNANCE		
17.	**Corporate Objectives**	
17.1.	The Board had received an overview of the achievement of Corporate Objectives set by the Trust Board for 2015/16. A correction was made to paragraph 2.5 which noted that refurbishment of the main outpatients department did not progress according to plan. However, real progress was now being made.	

17.2.	JU asked what progress was being made in improving patient administration and requested a report be made to the next meeting.	**RW**
18.	**Annual Report and Accounts/Quality Account**	
18.1.	The Board had received the Annual Report and Accounts for 2015/16, including the Quality Account, having delegated approval to the Audit Committee.	
18.2.	SB thanked the Finance team and all those across the organisation who had contributed to the preparation of the documents. The Annual Report demonstrated the large amount of progress made in a year of significant change and challenge, She commented that the documents presented a coherent story of an organisation that delivers what it says it will deliver.	
18.3.	The Board had discussed the documents at length in the Audit and Quality Assurance Committees. Board members asked that the content be well-communicated, particularly the progress on quality measures.	
19.	**Board Assurance Framework (BAF)**	
19.1.	The Board had received the BAF for month 1 of 2016/17. It was agreed that the BAF provided the assurance required to allow for the achievement of the Trust's principal objectives.	
20.	**NHS Improvement Submissions**	
20.1.	The Board noted the content of the Q4 2015/16 submission made to NHS Improvement in April 2016.	
21.	**Forward Plan**	
21.1.	The content of the forward plan for Public Board meetings in 2016/17 was noted.	
22.	**Trust & Charitable Funds Committee**	
22.1.	The Board had received the report of the Trust & Charitable Funds Committee following its meeting held on 17th May 2016. JM reported that the General Fund balance was now depleted and in deficit.	
22.2.	DB asked how balances were invested and JF commented that it was intended to review the investment strategy for the Kingston Hospital Charity; this had been drawn up on the back of losses due to banking failures and may now need a different approach.	
22.3.	AR commented on the need to decide where to invest time and energy in funding raising so as to balance activities.	
22.4.	SB welcomed the update on development of the Haematology Day Care Unit and emphasised the importance of using charitable funds rather than holding them in reserve.	
23.	**Reports from Committees**	
23.1	The Board had received reports on meetings held by the Quality Assurance Committee (11th May 2016), Workforce Committee (11th May 2016), Audit Committee (19th May 2016) and Finance & Investment Committee (25th April 2016 and 19th May 2016).	
23.2	MG noted that FIC had conducted deep dives into Procurement and the Capital Programme. These had been insightful and had provided good assurance on progress.	

24.	**Questions from the Public**	
24.1	DD had read in the press that the NHS was not receiving money it should have been due from medical insurance companies and asked whether this might apply to KHFT. JF'S perception was that this was not an issue for the Trust and that tight process were in place.	
24.2	DD had been encouraged by the Workforce report but asked whether the Trust could be still more creative, perhaps by talking to other organisations outside health. AR commented that, with greater integration, the Trust was building relationships across a widening range. In Kingston there was an emerging group from which advice could be taken, including the University and commercial organisations. The challenge of accommodation for public sector workers in Kingston and Richmond was not yet resolved but AR was hopeful the Local Authority would take this forward. ARo agreed that the Trust should not be too internally facing.	
25.	**RESOLUTION TO MOVE TO CLOSED SESSION**	
	Resolved: that representatives of the press and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.	