Kingston Hospital NHS
NHS Foundation Trust

Minutes of the meeting of the Board of Directors held on
27th July 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
Jacqueline Unsworth	Deputy Chairman	JU
Present non-voting:		
Anne Robson	Interim Director of Workforce	ARo
In attendance:		
Susan Simpson	Company Secretary & Head of Corporate Affairs	SS
Lisa Ward	Head of Communications	LW
Apologies:		
Jane Wilson	Medical Director	JKW
Governors:		
Richard Allen	Lead Governor	RA
Dennis Doe	Public Governor - Kingston	DD
Marilyn Frampton	Public Governor - Merton	MF
Frances Kitson	Public Governor - Kingston	FK
Nicola Urquhart	Appointed Governor - Richmond	NU
Members of the public:		
Cheryl Cavanagh		CC
Erica Farmer		EF
Kate Fitzsimmons		KF
Rebecca Gilmour		RG
Mark Jenkin		MJ
Richard Jno-Rose		RJR
David Roche		DR
Tony Soteriou		TS
Staff:		
Paul Hargreaves	Deputy Director of Workforce	PH
Sarah Gigg	Deputy Director of Nursing	SG
Sudha Thirou	Management Accountant	ST
Clover Fernandez	Associate Director, Finance	CF

		Actions
1.	**Thanks**	
1.1.	Head of Midwifery, Anna Dellaway,was retiring after 40 years service in the NHS and her significant impact at Kingston was evident from the excellent reputation of its Maternity services. The Board expressed their thanks for her exceptional leadership and wished her well in her retirement.	
2.	**Patient Story**	
2.1.	The Board heard the story of a patient who had been admitted through A&E with facial injuries after a fall at home in any 2015. She described the excellent care she had received on initial admission by ambulance and treatment, followed by a long wait in A&E. Her long wait had made her feel frustrated and worried because she had to keep repeating her story to different people and received little feedback on progres. She was also embarrassed to be waiting in a public place where her wounds attracted attention.	
2.2.	DB asked Board members how hearing the story had made them feel. SB spoke of mixed feelings; she was glad of the outcome and the care the patient had received initially, but there were some aspects around dignity and respect that did not match expectations. RW was sorry that the A&E experience had not been right for the patient or her family. AR acknowledged that the patient's experience echoed the Hospital's CQC headline; the Hospital was caring throughout but processes in A&E needed to be improved. CS remarked on the story being a useful reminder that the A&E waiting time target is not about the number but about the patient experience of human beings.	
2.3.	The Board considered whether there were aspects of the story that related to the agenda for the meeting ahead. RW noted the correlation of the story with the work of the Emergency Care Programme Board, which could learn from the patient's story as an example. JM observed that the importance of communicating to patients what is happening had been noted from other sources and should continue to be worked on.	
2.4.	SH cited experience elsewhere that highlighted re-entry to a process as a weak point, as in this story, and that learning should involve people in other departments where there is regular transfer into A&E. SB agreed that A&E could not be looked at as separate from the whole hospital and suggested the Board use Walkabouts to look at the patient pathway, which should be a caring and dignified as possible. DB was also asked to think about how to help the staff have the same powerful learning experience the Board has just had.	**DB**
3.	**Apologies for absence**	
3.1.	Accepted as noted above.	
4.	**Declarations of interest**	
4.1.	None declared.	
5.	**Minutes and Matters arising**	
5.1.	The minutes of the meeting held on 25th May 2016 were approved as a correct record and the action log noted.	
5.2.	RW gave a verbal report on progress with winter planning, Systems evaluation had been completed as far as possible and the opportunity taken to build this into planning for winter 2016-17. A clear baseline had been set and measures agree going forward. RW had just received confirmation on funding.	

6.	**Chairman's Report**	
6.1.	The Chairman gave a verbal report and started by thanking MG for his contribution to the Board and commitment to the Hospital, this being his last meeting as a Non-Executive Director. Dr Rita Harris would join the Board from 1st August 2016 and SB thanked the Governors, particularly the Nominations & Remuneration Committee, for their work on her appointment.	
6.2.	SB had been meeting with other Chairmen across the SW London area in relation to the Sustainability & Transformation Plan (STP). The STP had been submitted on time and SB believed good progress was being made.	
6.3.	The recent Clinical Audit and Quality Improvement Seminar was highlighted as an outstanding example of the Hospital's focus on quality. It had been well-attended and showcased presentations on audits resulting in different and improved practice, as well as multi-disciplinary working and excellent team working. Thanks were expressed to all who had been involved in making the event happen.	
7.	**Chief Executive's Report**	
7.1.	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.	
7.2.	AR noted that the next submission of the STP was due at the end of September/early October, with lots of work to be done, not least because the plan was not currently balanced financially. She commended the significant engagement from Executives across SW London and this would continue.	
7.3.	Reference had been made to consultation on a Single Oversight Framework by NHS Improvement; Board members were invited to contribute to the response being collated within the Trust. AR noted that this was likely to bring a very different level of interaction with NHS Improvement.	
7.4.	A set of rotas had been built through negotiation and discussion with the Junior Doctors. A report on the outcome would be received by the Board. Interviews would be taking place on 10th August 2016 for the Guardian role and Junior Doctors would take part in the process. SB asked what sense AR had of morale amongst the Junior Doctors. AR believed the Junior Doctors' Forum had enhanced relationships and enabled their views on services and the development of the Hospital to be heard. It was clear they were dissatisfied with the national position but understood this was not within the Trust's gift to resolve.	**JKW**
7.5.	AR drew attention to the release of the joint NHS Improvement and NHS England document entitled 'Strengthening financial performance and accountability in2016/17' which had been circulated in full to the Board. The challenged financial position of the NHS meant that it was essential that the Trust would have to deliver on its commitments; should renew its focus on improvement and efficiency; and may be asked to go further.	
7.6.	Both AR and SB commented on the success of the improvements to Outpatients following phase 1. The decant for phase 2 had started as had work on Derwent Ward as part of the Dementia Strategy.	
7.7.	The Trust was the only Trust in London to be selected to pilot approaches to earlier cancer diagnosis, which recognised the quality of leadership in cancer pathways. JM concurred, highlighting the progress that had been made on cancer performance in the last 18 months.	
7.8.	AR thanked all who had contributed to making the Trust's Open Day a great success.	

QUALITY AND PERFORMANCE		
8.	**Clinical Quality Report**	
8.1.	The Board had received the Clinical Quality Report for June 2016. DB highlighted key points for the Board to note. Overall, performance indicators were good and improvement was noted in sepsis.	
8.2.	The Quality Assurance Committee (QAC) had focused on hand hygiene and Board members were disappointed to see continuing low rates. DB outlined new approaches to audits and training which appeared to be making a difference. CS noted that there were some outliers and asked that consideration be given to what could be learned from places that were getting it right.	
8.3.	DB noted from Safer staffing figures that Nursing agency spend had further reduced. A new metric (Care Hours Per Patient Day) coming out of the Carter review would be included in the report to supplement existing metrics.	
8.4.	Acknowledging that the report was positive overall, CS singled out two Maternity metrics for comment. DB reported that a deep dive was being undertaken to understand the PPH rate. AR noted that she had asked Maternity to consider the benchmarks used for Caesarian sections; this was a complex picture to understand given the juxtaposition of safety and choice.	
8.5.	SB asked that QAC receive the results of the Maternity deep dives and continued to focus on hand hygiene. The latter was not good enough in a few areas and the Board expected to see an improvement.	QAC
9.	**Operational Performance Report**	
9.1.	The Board had received the Operational Performance Report for June 2016 together with a briefing on the Emergency Care Programme Board and Q1 activity analysis. Performance for A&E stood at 93.65% for July against a trajectory of 95%, which would not now be achieved. Cancer performance remained strong.	
9.2.	DTOC remained constant, the main barrier to change being the social care elements and particularly in Richmond. RW was confident that the position in Richmond would improve as there was now a dedicated officer in place so engagement and escalation would be easier. SB noted that DTOCs were still high in comparison with other parts of London and referred to a Walkabout with another NED and the Lead Governor where they had seen examples of patients waiting in acute beds due to their homes being unfit for discharge. This was not good for patients and tied Nursing staff up in trying to find solutions. RW acknowledged that there was still lots to be done and that the Emergency Care Programme Manager was targeting where impact would be greatest.	
9.3.	DB suggested sharing individual patient stories to make the situation more real than the data was able to get across. AR observed that the level of financial challenge for local authorities is especially difficult and the Trust would need to work with them to find out what is possible. The right structures were coming into place to agree the plans but the difficulty should not be underestimated.	
9.4.	SB asked that the Board be kept up to date on intermediate care with a report to the Board meeting in September.	**RW**
	<u>Emergency Care Programme Board</u>	
9.5.	RW drew attention to data showing increased Attendances; the Trust was working with others to understand what is driving demand. AR noted that the only CCG which seemed to have flattened attendances was Surrey Downs, where a walk-in hub had been opened. It was not clear if there was cause and effect here. Other demand management activities appeared on the face of it	

	not to be having a similar impact but further investigation was needed.	
9.6.	RW responded to a question saying that the Trust's performance is on a par with, if not better than, the sector and considered to be in a good position in London. She was discussing with other COOs to learn about different approaches and would share her learning with the Board.	
9.7.	DB was pleased to see a work stream on mental health and noted how many other agenda items had issues around mental health within them. AR thought the Executive team should consider whether a formal conversation with counterparts in mental health was needed given the enormous challenges.	
9.8.	JM asked what lay behind the picture given on ambulance targets, RW would email the detail to the Board outside the meeting.	**RW**
9.9.	Board members thanked RW for a helpful report and discussed how the Board would be kept informed. RW was working on a critical path analysis and would bring this to the Board; a progress report to each meeting was requested.	**RW**
10.	**Workforce Report**	
10.1.	The Board had received a progress report in respect of performance against agreed workforce targets for Q1 of 2016/17. Divisional dashboards had been included in response to the request at the last meeting for greater granularity and this was found to be helpful..	
10.2.	ARo reported on an encouraging picture on agency spend and explained the governance structure in place. There was clear visibility on breaches of agency caps and use of locums, which was helping to drive spend down. Divisional Performance Review meetings were being used to identify and share good practice. AR advised that Trusts had been asked to identify unsustainable services as part of measures to reduce use of medical locums. This might lead to networking of fragile services in order to reduce spending in other Hospitals and increase productivity for the Trust.	
10.3.	SB was pleased to see signs of a reduction in turnover.	
10.4.	ARo highlighted the MEGA group launch on 21st September 2016 and encouraged all managers to release staff to attend. The. Chair of the group had been asked to give the staff story at the next Board meeting to talk about their work.	**All**
11.	**Finance Report**	
11.1.	The Board had received the Finance Report for June 2016. This was a summary report as the Board would receive a Q1 review report in Part 2 of the meeting.	
11.2.	The financial position was largely on track and JF believed the impact of the Junior Doctors strike accounted for the differences. He believed the Trust qualified to receive STF funding but this was still unclear. JF provided further detail on the latest CIP position.	
11.3.	Use of medical locums in A&E was the primary reason for pay being out of line. The Trust was under trajectory on agency spend, with medical locums being the main area of non-compliance with caps. This was a National problem and difficult to crack. The cost of non-compliance was estimated at £15k/week, of which £10k related to medical locums.	
11.4.	The Board discussed cash flow and Capex timing. There had been a delay in CCG payment but this was now received. MG asked about plans should the STF funding not be paid. JF outlined a number of options but emphasised that the ambition was to receive the STF funding and all verbal indications from NHS Improvement had supported this. He confirmed that the working capital provider was being kept informed and that the agreement for that facility	

	extended to June 2017.	
11.5.	JM asked how much activity is at risk. JF explained that the Trust is still working with CCG on the contract in relation to zero length of stay and urgent admissions. A clinical model had been agreed but both parties were seeking further guidance and confirmation on zero length of stay tariffs.	
11.6.	JM asked whether there were any consultants working for the Trust receiving excessive payments for overtime. JF outlined work taking place on variable elements of pay and the aim to have standard and transparent set of rates.	
11.7.	SB asked that JF email the Board with developments on the STF money and to bring a report to FIC on pay once there was progress to report	**JF**
12.	**CQC Inpatient Survey Results 2015**	
12.1.	The Board had received a report on the annual CQC Inpatient Survey results for 2015, published in June 2016, including a summary of the key findings and areas for focus. An action plan had been produced with support from Picker, Quality Improvement volunteers, governors and staff members.	
12.2.	JU echoed the introduction given by DB, acknowledging the importance of there being local ownership of improvement issues. This had been demonstrated by the great attendance from Matrons seen at Patient Experience Committee.	
12.3.	The Board noted that there were a number of NHS surveys that arrived a long time after the data had been collected, this being one of them, and whilst the surveys were useful as an indicator in time, they would be more helpful in terms of getting staff ownership if they could be more timely. AR was asked whether CEOs could take forward a request for even a small improvement in timeliness and she agreed to raise the matter.	**AR**
13.	**CQC Inspection Report**	
13.1.	The CQC's report on the planned inspection of the Trust had been published on 14th July 2016, the inspection having place during January 2016. The Board had received for this meeting a summary of the key findings and next steps.	
13.2.	AR summarised the headline messages of the report. Caring resonated as a core value within the Hospital but there were some key things that required improvement. The Trust would also build towards outstanding where things were already good. Briefings had taken place for staff and a governance structure put in place to deliver the action plan.	
13.3.	DB was working on the 7 must do items for a formal action plan to be agreed a the Quality Summit to be held in September 2016. The Trust would then produce a formal response. AR highlighted that finances within the NHS meant that the Board would need to decide which 'should do's' can be achieved in the current year and which will follow. Further discussion would take place at the next meeting.	
13.4.	A CQC Programme Board chaired by AR had been set up to drive improvements and to plan for self-assessment. An unannounced inspection was likely to happen in the next year. An Internal Audit had been commissioned to look at the Emergency Department report to Audit Committee.	
13.5.	SB asked whether the 'must do's' had been costed. JF confirmed this had not yet been done formally but noted that the bigger costs were likely to be in the 'should do's'. JF had had informal conversations with NHS Improvement about actions required as a result of CQC that had revenue consequences.	

ANNUAL REPORTS		
14.	**Safeguarding Adults**	
14.1.	The Board had received a report providing information on activities to safeguard adults within Kingston Hospital during the year 1st April 2015 to 31st March 2016, and priority areas for 2016/17. The CQC had confirmed processes were sound but with some work needed on Mental Capacity Act training and application.	
14.2.	DB reported on significant growth in this area of work. Deprivation of Liberty work had grown nationally and a review was taking place but would take time to conclude.	
14.3.	DB drew the Board's attention to reporting on FGM and monitoring of patients with learning disabilities to understand why they were attending and reduce attendances.	
14.4.	As well as focusing on Mental Capacity Act training, there was more to be done on Prevent training to bring it up to the right level.	
15.	**Safeguarding Children**	
15.1.	The Board had received a report providing information on activities to safeguard children within Kingston Hospital during the year 1st April 2015 to 31st March 2016, and priority areas for 2016/17.	
15.2.	DB introduced Kate Allen as the new lead for Child Safeguarding; providing additional capacity within the team had been a previous CQC recommendation. DB highlighted a number of key areas of work carried out by the team, including the impact of domestic abuse and child sexual exploitation. He gave assurance that the Trust participates fully in the Local Child Safeguarding Board and the Chair would be coming to carry out training for the Board following this meeting. DB described the implementation of a new electronic system that would give more visibility on child protection; this was part of a national programme to be implemented by 2018.	
15.3.	SB noted a section in the report on the challenges and increasing workloads in Midwifery around home visits. She was aware of a difficulty around Mothers who are reluctant to be found and asked if this was potentially an area of risk. DB would discuss with the team whether there was more that could be done working with community staff to reach these Mothers. However, he thought the Board could take positive assurance from the increase in cases and this point had been more about having sufficient capacity for clinic visits in place of home care.	
15.4.	The Board supported the recommendations made in the report, including approval of the annual declaration.	
16.	**Health & Safety**	
16.1.	The Board had received the annual Health & Safety report for 2015/16 giving an overview of how the Trust is performing against Health and Safety requirements. JF described the operation of the Health & Safety Committee as having become more focused during the year. Attendance had been good and he was confident its terms of reference had been discharged. He highlighted the key successes and areas of concern from the Executive summary.	
16.2.	The Board discussed the issues around assaults on staff and asked what more could be done. JF was asked to look at the record-keeping by security officers that had been stepped up to see what could be learned. It was noted that swipe access controls in Esher Wing would be completed by the end of the week.	**JF**

16.3.	DB noted that the Trust's plans to change the environment to be more dementia-friendly may reduce incidents. A Dementia Improvement Lead was now in post and training staff in practical skills in de-escalation. He thought more could be done through the mental health liaison team, members of which were now attending the Dementia Steering Group. CS suggested the Executive team look at measuring the level of harm from these assaults.	**JF**
16.4.	In response to a question on incidents of stress reported by staff, ARo would look at provision of support to staff on mental and physical well-being, and report back to EMC. This featured as part of a CQUIN in Occupational Health.	**ARo**
17.	**Information Governance**	
17.1.	The Board had received the annual report of the Information Governance Committee for 2015/16. JF commented that compliance with the IG Toolkit had been discussed in detail and compared well with benchmarks.	
17.2.	The burden of FOI requests was noted and the Board discussed what could be done to make it easier for people to find the information they were looking for. LW was asked to review the publication scheme and signposting on the website.	**LW**
18.	**PALS, Complaints, Claims and Incidents**	
18.1.	The Board had received a report providing the annual review of the Patient Advice and Liaison Service (PALS) contacts, complaints, compliments, claims, inquests and incidents (including serious incidents (SIs) that occurred during 2015-16, identifying themes and trends across these areas and over time. SB acknowledged the themes within the report as having been considered at the Patient Experience Committee during the year.	
18.2.	JU recalled a previous concern that PALS workload was driven up because patients could find no other way to communicate difficulties with appointments and asked whether this had now changed. CS referred to a presentation at the last QAC meeting where it had been evident that progress had been made in improving patient administration and it was hoped this would now be reflected in contact with PALS	
STRATEGY AND POLICY		
19.	**Apprenticeship Levies**	
19.1.	ARo gave a verbal report on emerging Government policy on Apprenticeships, noting that there was some opposition nationally to the proposals. The Trust planned to work with the National Skills Academy and intended to employ the apprentices direct.	
19.2.	The financial risks were still being worked on, pending release of further information, but it appeared that a levy of approximately £600k would be paid by the Trust, with money reclaimed for training apprentices. Whilst there was some concern about the methodology, the Board recognised the positive potential opportunity that apprenticeships offered young people and the Trust.	
20.	**Communications and Engagement Strategy**	
20.1.	The Board had received the Communications and Engagement Strategy setting out plans for communicating sustainably with the Trust's key internal and external audiences over the next 18 months and how communications will support the delivery of other key strategies and developments. LW gave a presentation on key elements of the strategy.	
20.2.	SH welcomed the clarity of the four quadrants and the different platforms incorporated. She noted that this was a small team and encouraged LW to think about whether there was scope for senior leaders below Executive level to do their own communication. RW agreed that internal engagement should	

	be prioritised to ensure everyone moves forward feeling they own the plan.	
20.3.	JU was particularly pleased to see website optimisation included as this could avoid some of the issues with patient admin. She asked that the audit of the website include consultation with patients.	
20.4.	SB summarised the Board's support for the strategy overall, suggesting that the action plans be drawn together by month. She noted that communication with and through the Council of Governors needed to be more overt and asked that the Strategy be considered by the CoG's Membership & Engagement Committee so that governors could scope their contribution. She thanked the team for their hard work and very visible presence within the Hospital.	**LW**
21.	**Learning, Education and Development Strategy**	
21.1.	The Board had received the draft Learning, Education and Development Strategy for approval. ARo explained the development route of this strategy to date.	
21.2.	Board members welcomed the strategy overall and approved the content; it was thought to be timely in that it would help to support reduction in turnover. ARo was asked to think how to draw out particularly the development of clinical leadership capacity and support for non-clinical staff. SH suggested use of a 'big ticket' event to gain recognition for the strategy. AR commented that there would need to be further prioritisation given the earlier conversation on financial sustainability of the NHS.	
GOVERNANCE		
22.	**Board Assurance Framework (BAF)**	
22.1.	The Board had received the BAF for month 3 of 2016/17 and noted the content of the report.	
22.2.	It was agreed that the Executive team should review how the Trust anticipates future risks to delivery of strategic objectives.	**SS**
23.	**NHS Improvement Submissions**	
23.1.	The Board approved the submission of the Q1 return to NHS Improvement as proposed.	
24.	**Forward Plan**	
24.1.	The content of the forward plan for Public Board meetings in 2016/17 was noted.	
25.	**Reports from Committees**	
25.1.	The Board had received reports on meetings held by the Quality Assurance Committee (13th July 2016), Workforce Committee (28th June 2016), and Finance & Investment Committee (21st June 2016).	
25.2.	The Board welcomed the approach to reporting within QAC under the CQC domain and noted comments on improvements in patient administration. SH highlighted from the Workforce Committee meeting: development of the employer brand; career progression for clerical staff; and support for the launch of the MEGA group. Items discussed by FIC had been covered on the agenda and there was nothing further to add.	
26.	**Board Committee Membership**	
26.1.	The Board approved proposed changes to membership of its Committees.	
27.	**Questions from the Public**	
27.1.	DD welcomed the Communication & Engagement Strategy and suggested more emphasis be placed on volunteers. His observation was that they often	

	do not know what we think they might know. He was interested to note the link between staff engagement and mortality and infection rates, which was supported by research.	
27.2.	RA was delighted to hear about plans for apprenticeships but suggested being tied to one provider might not be the best route. He drew to the attention of the Board that Kingston Council was to establish a committee looking at recruitment of essential staff across the borough. AR had made contact with the new Chief Executive of RBK and would seek further information on this initiative.	
27.3.	EF made two points: a reflection that the remit of Comms had changed and that keeping ahead must be difficult; and recognition of the importance of thinking about the dignity of patients in designing the environment. DB agreed, commenting that phase 2 of Outpatients redesign will do much to improve the dignity of patients and that the Board's discussion on MRI facilities later in the day would address some of the current issues around separating outpatients and inpatients.	
28.	**RESOLUTION TO MOVE TO CLOSED SESSION**	
28.1.	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.	