Kingston Hospital NHS
NHS Foundation Trust

Minutes of the meeting of the Board of Directors held on
1st December 2016 – 9.30 am to 12.00 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
Dr Nav Chana	Non-Executive Director	NC
Kelvin Cheatle	Director of Workforce & OD	KC
Jo Farrar	Director of Finance	JF
Chris Grindal	Non-Executive Director	CG
Sylvia Hamilton	Non-Executive Director	SH
Dr Rita Harris	Non-Executive Director	RH
Joan Mulcahy	Non-Executive Director	JM
Ann Radmore	Chief Executive	AR
Dr Chris Streather	Non-Executive Director	CS
Rachel Williams	Chief Operating Officer	RW
Jane Wilson	Medical Director	JKW
Jacqueline Unsworth	Deputy Chairman	JU
In attendance:		
Susan Simpson	Company Secretary & Head of Corporate Affairs	SS
Lisa Ward	Head of Communications	LW
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	Public Governor - Elmbridge	CJK
Frances Kitson	Public Governor - Kingston	FK
Robert Markless	Public Governor - Kingston	RM
Cllr Margaret Thompson	Appointed Governor - Kingston	MT
Members of the public:		
Erica Farmer		EF
Kate Fitzsimmons		KF
Alicia Pickering	Department of Health	AP
Ping-Yi Kuo		PYK
Staff:		
Stephen Machalepis		SM

		Actions
1.	**Welcome**	
1.1.	Dr Nav Chana and Chris Grindal (present from 11.45 am) were attending the meeting for the first time since appointment and SB warmly welcomed them to the Board.	

2.	**Patient Story**	
2.1.	Due to unforeseen circumstances, the patient story could not be told as planned.	
2.2.	The Chairman invited EF to talk about her role as an ambassador for Bloodwise. She explained that the charity supports research into blood cancer and provides information for people affected by blood cancer and related disorders. EF felt valued in her ambassadorial role.	
3.	**Apologies**	
3.1.	None received.	
4.	**Declaration of Interests**	
4.1.	None declared.	
5.	**Minutes**	
5.1.	The minutes of the meeting held on 28th September 2016 were confirmed as a correct record. Progress with actions was noted and there were no further matters arising.	
5.2.	SB asked whether a structure could be put around measuring the impact of MEGA as part of Deep Dive programme. KC agreed that this would be possible but thought it would be the end of the financial year before any impact would be measurable.	**KC**
6.	**Chairman's Report**	
6.1.	The Chairman gave a verbal report on activity since the last meeting of the Board.	
6.2.	The Board was informed that JU had tendered her resignation from the Board after 10 years as a Non-Executive Director in NHS, including 6 years at Kingston. She would remain until the end of March 2017 in order to support CG in picking up his role as Finance & Investment Committee Chairman. The Council of Governors had been informed and the recruitment process for her replacement would commence shortly after Christmas.	
6.3.	SB had attended the NHS Provider Conference and had found it interesting to get a feeling of the national context and our position in it. It was clear that the increasing demand being experienced in the Hospital is being seen across the country. The Non-Executives had discussed this in their pre-meet and had agreed that they must continue to focus on the wellbeing of the staff in challenging times as well as patient outcomes.	
6.4.	Highlights since the last meeting for SB had been the long service awards, staff awards ceremony and the opening of the refurbished Derwent Ward. She was proud that the Board had committed capital to the Derwent Ward project. SB had also been thrilled to open the CDU. She commended this as a great use of space and noted that it gives staff chance for development. SB singled out the Communications team for praise in organising the events superbly and asked that LW convey this to the team.	LW
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. AR noted that this report was fuller than previously as a different approach to the agenda was being trialled; comments were sought from	

	Directors on the effectiveness of this approach.	
7.2.	AR gave her observations following attendance at the NHS Providers Conference. Pressure across the NHS had been evident and she believed enacting 'valuing each other' became even more important in that scenario. She therefore endorsed the Non-Executives' comment on the need for the Board to focus on the health and wellbeing of staff. AR noted that almost all health outcomes are improving in this country and that the key message from the Conference was about how to maintain this performance whilst achieving further efficiency.	
7.3.	The report had noted that action on agency spend had had a significant impact and this was being sustained. However, the action had not reduced medical locum spend due to market pressures and there was a need to think again about how to make a difference on that issue. SB's reflection on the impact of the agency reduction was that it was noticeable how much staff appreciated having more permanent staff in their team; this brought better service for patients and improved staff morale.	
7.4.	KC confirmed that the Trust now had 800 more permanent staff than the same period last year. He had met with Bank Partners regarding the new outsourced bank service the previous year and was confident that the change will help to expand bank usage, thereby reducing agency further and particularly in the use of medical locums. JM asked whether the service would cover Admin & Clerical staff. KC confirmed the service would be multi-disciplinary.	
7.5.	Under the Single Oversight Framework the Trust had been placed in category 2 of shadow segmentation and AR believes this was the right outcome. She emphasised the importance of improving the CQC assessment as a means of moving the Trust into segment 1.	
7.6.	JM asked whether the Board should be highlighting that cash liquidity is a serious risk. JF agreed and assured the Board that this is being monitored closely but he would formally assess the risk. He had requested a meeting with NHSI regarding contingency facilities for next year.	**JF**
7.7.	AR reported that the Trust had experienced a mains power outage at 6.00 am on 30th November 2016. Power and water had been lost in Esher Wing, affecting CT and MRI scanning, 280 patients and the main Theatres. The cause had been a fault on a ring main. UK Power had attended and had called in a high voltage power expert. Services were fully operational again at 12.30 pm, a full afternoon Theatre list had been possible and all patients cancelled from the morning had been rebooked. AR commended staff for their tremendous response. Learning from the incident would be discussed by the Emergency Planning Group (led by RW), reported to the EMC and any process improvements built into revised policies. The financial consequence was still to be assessed.	
QUALITY AND PERFORMANCE		
8.	**Integrated Quality and Performance Report**	
8.1.	SB noted that the integrated report now included Workforce and thanked the Executive for their work in bringing the report together; she believed it was a great improvement. JKW reminded the Board that the report was now constructed under the CQC domains to be consistent with the inspection framework.	

	Safe	
8.2.	JKW highlighted that many areas were performing well. Reduction in pressure damage indicated that this was well controlled. Falls remained difficult to manage and there was an ongoing QIP to address this. JKW commented that the changes made in Derwent Ward would be interesting in terms of evaluating whether bay-based nursing and making the environment more familiar to patients has an impact on reducing falls.	
8.3.	JKW drew attention to the KPI on Caesarean rates where the indicator fluctuated significantly. The Maternity team continued to assess what might be contributing to this and a review was being undertaken of every emergency Caesarean to identify themes. CS noted that the Quality Assurance Committee (QAC) had heard an excellent presentation on this and Committee members had taken a great deal of assurance from what they had heard.	
	Effective	
8.4.	CS noted the good news that Hand Hygiene audits were improving, although there was still improvement to be made in a small number of areas. He was aware of recent messages from NHS England on Gram-negative bacteria. JKW responded that the Trust was starting to track EColi and would add this to later reports. CS also referenced discussion at QAC on tracking catheter usage.	
8.5.	JKW highlighted the importance of tracking prescribing of antibiotics and reported that the Trust will also be looking at the frequency of prescribing. AR asked whether KPI standards were set for the CQUIN on prescribing and administration of antibiotics. JKW explained that a target could be put against it but that the Trust was working towards 100%.	
8.6.	JKW had been pleased that the Research and Development team had had the opportunity to showcase their work for the Board at the Development Forum the previous month, and that they had received an award at the recent Staff Awards ceremony. The Hospital had not had an active R&D programme for some time but the team was now very proactive, which was good news for both staff and patients.	
8.7.	JU commented on Dementia screening scores, asking why the Trust's score was below standard when it had a reputation for leading edge care in this area. JKW and DB explained that further work was needed to embed the process of completing the whole assessment as the score reflected that the extent of completion was variable. The process was being amended to make this easier and DB predicted that the score would improve in the coming months.	
8.8.	RH observed that reinforcing behaviours, such as Hand Hygiene, was about setting standards from induction and keeping people focused on it. KC reported that corporate induction was in the process of being revised. The new approach would focus on values and what it means to work in the Trust in the face to face session. AR agreed with RH's comment, pointing to evidence from top organisations that having the right discussions within the first month is vital; getting that right would get the Trust from good to outstanding.	
	Caring	
8.9.	DB highlighted key points under this domain. JM was pleased to see complaints on a downward trajectory and observed that this was consistent with comments from the Communications area and overall performance of the Hospital. DB noted that the Inpatient Friends and Family Test (FFT) score had improved but that the response rate in A&E was not good enough. Options	

	were being scoped and further work done in A&E to improve this. In response to a question from RH, it was noted that learning from complaints came to the Board through QAC and that an annual review report was also received by the Board. DB and AR also reviewed complaints data on a fortnightly basis.	
	<u>Responsive</u>	
8.10.	RW drew key points from the report on performance against the constitutional standards. The Trust was continuing to help St Georges on the backlog of ENT cases. 65 cases had been accepted but transfer was proving unpredictable and she would be meeting with St Georges again to see whether transfers could be achieved in a more consistent way.	
8.11.	A&E in November had finished at around 88% (still to be validated). Increased attendances continued; these were not borough specific but there was a trend of increased attendances in working age adults and paediatrics. Ambulance attendances had also risen. As the pattern was unpredictable it was difficult to find a solution to Workforce resourcing. There had been significant bed pressures in October and November and there was more discussion to be within the health and social care system had on solving discharge and intermediate care issues.	
8.12.	CS observed that A&E attendances were up but FFT was down. He asked what was being done to maintain quality of care despite the challenges. DB responded that a close eye was being kept on all the metrics and gave more detail on what was being done to increase the FFT response. JKW commented that the clinical governance framework was noticeably stronger after recent intervention but that intelligence from incident reporting was not giving cause for concern. DB reminded the Board that there would be an unannounced internal audit review in December and this would be a source of assurance.	
8.13.	SB asked what assurance there was on triaging of patients on low percentage days. JKW commented that streaming times are longer at the busiest times but she did not regard them as excessively long. She was satisfied that there was tight control at the front end. The patient tracker screen included those who had not yet been full assessed and this was reviewed constantly. RW added that there was a process in place to check indicators, of which one was “do we have a senior decision maker in streaming?”	
8.14.	SB asked whether RW had a sense of where Ambulance Handover times were in November. RW had a sense that, despite difficult days in November, the month would not reach October levels overall. She noted there was now national pressure on this issue.	
8.15.	AR’s reflection on A&E was that 50% of the improvement focus should be within the Hospital and it was easy to get distracted by growth and management of DTOC. The Executives needed to focus on both. The Trust had done what had been agreed but performance was still below where it needed to be, so there now needed to be another look at further high impact actions both internally and externally. The pressure on delays in discharge and the feedback into slowed flow throughput in the hospital was having significant impact on performance. Discussions were ongoing on the need to ease or open escalation capacity and the financial risks involved.	

	Well Led	
8.16.	KC noted staff health and wellbeing as the counterpoint to hard issues being dealt with. Whilst the sickness absence rate is strong, being in the top 20% of Trusts, much of the absence is long-term stress related. He would be bringing a Health & Wellbeing Strategy to the Board in January for approval.	**KC**
8.17.	KC commented on the importance of the Staff Survey. He was pleased to report that the completion rate had just exceeded last year at 46%, which actually represented a greater number of staff as the permanent establishment had grown. There would now be a push in the final 48 hours to get to the target of 50% and he would report back in January on the final percentage.	**KC**
9.	**Surge Plan**	
9.1.	RW reminded the Board of discussion in September on the Winter Plan. On 31st October NHS England had issued the Operational Pressures Escalation Level (OPEL) framework. The plan had been reviewed in the light of this and the opportunity taken to draw together a number of policies business continuity, winter and rapid discharge into a simpler set of instructions.	
9.2.	AR drew attention to the Surge Plan being held by all organisations in the system; it will set out expectations on actions required of all. She had some concerns that the Hospital was operating currently at high amber/red and occasionally black as defined by OPEL, which could lead to escalation being overused and the plan losing traction. More time was needed to work through the plan with partners next week in more detail as a clear protocol would be essential if there was a bad Winter.	
9.3.	The Board agreed to delegated authority to the Executive Management Committee to sign off the Surge Plan and to report back in January on the final version.	**RW**
10.	**Finance Report**	
10.1.	The Board had received the finance report for Month 7. JF presented the key points, saying that the situation remained challenging.	
10.2.	JF noted the detailed conversation that had taken place at Finance & Investment Committee (FIC) on Sustainability & Transformation Fund (STF) monies. He confirmed funds had been received on 30th November 2016 in relation to Q1 and Q2 and clarified that the payment comprised 100% for Q1 and 70% for Q2. The performance payment outstanding was on a slightly delayed timescale and the Trust was also currently in an appeals process on the A&E element (18.5%) due to mitigating circumstances. Payment of £3.4 million had been expected on 22nd November 2016, but notice was given late on that day that the payment was delayed. This had required immediate discussion with Lloyds who had expected repayment of the overdraft, explaining that this was a systemic issue. No notice had been given of the payment made on 30th November and also no indication whether the performance element due on 1st December 2016 would be paid on time. All agreed the situation was unacceptable.	
10.3.	JF gave an overview of financial positions by Division. He noted a £70k cost pressure per month due to unfunded escalation beds currently open. He reported that it had been agreed at FIC to review how CIP analysis is presented in order to bring more clarity.	

10.4.	RW provided detail on an internal special measures regime, identifying the following areas receiving targeted support: Theatres; Gastroenterology; Paediatrics; Ophthalmology; Breast & Gynae. Support was focused on finances and KPIs had been agreed with the service lines. RW highlighted particular issues in Ophthalmology and described what was being done to monitor performance and support improvement. KPIs for all special measures areas were being tracked weekly and a regular report would be made to FIC.	
10.5.	SH welcomed the special measures approach and use of KPIs. She had the impression that this was a top-down approach and asked what was being done to encourage senior leaders to become self-diagnosing. RW explained that the approach was about holding to account and supporting senior leaders to turn their service lines around. JKW was involved with respect to quality aspects.	
10.6.	JF summarised, saying that the Trust was committed to recovery but that the position was not without risk. He reminded the Board that the Trust had gone to formal arbitration on zero length of stay tariff vs national tariff and it was not clear what the likely timing of the outcome would be.	
10.7.	JF was in regular communication with Lloyds on the liquidity position but had requested a meeting with NHSI to propose that a facility be provided for Trusts that were not in significant financial distress but still required some short-term support. He emphasised that the Trust was not in a unique position and if STF monies were achieved liquidity would not be an issue, however he thought it prudent to plan for eventualities. JM agreed that it was important to look at alternatives to Lloyds, even though the relationship with the bank was good. She asked whether CCGs were likely to pay the cash they are forecast to pay. JF confirmed that CCGs were paying on time and the main issue was around the amount that had gone to arbitration. He agreed that it may help to write to CCGs to make sure they are still on board.	
10.8.	AR reported that she had written to NHS Improvement (NHSI) to complain about the delay in receipt of the first tranche of STF money. Based on the response, it was clear that as a result of the delay a number of organisations had been tipped into distress. AR acknowledged the Board's responsibility to run the payroll and noted for future reference that others had received support in extremis. It would not be satisfactory but it was clear this could be regarded as the ultimate safety net. JM complimented the Finance team on the planning that had enabled the Trust to weather this particular challenge.	
10.9.	NC asked whether there had been an opportunity to think about what income was guaranteed in the light of proposed changes in the SW London 5 Year Forward Plan. JF explained that the current picture was complicated and that the first two years of the plan were scenario based at present. Beyond that it was difficult to take things further.	
STRATEGY AND POLICY		
11.	**Draft South West London Five Year Forward Plan**	
11.1.	The Board noted submission of the draft plan (formerly referred to as the STP), which the Board had previously endorsed following earlier discussion and contribution from the Council of Governors. The plan was now in the public domain.	
11.2.	SB remained concerned that there was little information available about the communication and engagement plan and asked LW for an update. LW had received an outline plan which indicated the majority of the engagement would take place in January and February 2017. She confirmed that she would	

	communicate dates to members by borough once there was more clarity. It was envisaged that engagement would include East Elmbridge and Surrey as well as the six boroughs served by the Hospital.	
11.3.	RB gave a summary of the approach taken in the plan and to assumptions on Out of Hospital shifts. Conversations were taking place with CCGs about QIP plans. An integrated provider delivery group (including Surrey Downs) had been working on Urgent and Emergency Care and Outpatients, starting with how Outpatient services might be redesigned in MSK and Dermatology.	
11.4.	AR drew the Board's attention to a potential issue around bed numbers and growth, which was currently above the growth assumed in the plan.	
12.	**Nursing, Midwifery and Care Staffing Establishment**	
12.1.	The Board had received an update on progress with the requirements of safe staffing guidance (including revised elements). A correction was made to paragraph 3.12 - 'reducing' to read 'improving'). It was noted that the information provided showed the Trust was operating in line with national safe staffing guidance. DB informed the Board that, whilst Care Hours Per Patient Day (CHPPD) was included in the report, national data had not yet been released and he had requested further information from NHSI.	
12.2.	Recruitment of nurses, midwives and support staff continued to be of high priority and Board members were pleased to note the recruitment and retention figures. Midwifery turnover had increased slightly but investigation of causes had revealed nothing of concern. The report had included predictions on overseas recruitment, which continued to be necessary, and the Trust would focus on recruitment from the Philippines due to current uncertainty in the EU.	
12.3.	Progress was noted on programmes of development for nursing, midwifery and care staff groups. DB highlighted deployment of the care certificate and recruitment to the 'recruiting to retain' programme. He was pleased that the Nursing Associate role was to be regulated by the Nursing & Midwifery Council. RH asked whether the Nursing Associate role was intended to be the beginning of a career path. DB confirmed the intended career pathway. There was more to be done to understand the role and its utilisation but he viewed the introduction of the role as very good news.	
12.4.	JU acknowledged the positive messages of the report. She asked how to interpret the CHPPD data and whether DB had any concerns about it. DB suggested triangulating current information with other patient data but thought that it would be difficult to use the data effectively until the national picture was known.	
12.5.	DB noted that the Trust was doing well with producing rosters 6 weeks in advance. AR asked what was known about plans to use rostering systems to interpret daily CHPPD; she believed CQC intended to use this measure as an early indicator and NHSI planned to use it as input into decisions on segmentation. The Board had previously agreed to schedule a masterclass on understanding CHPPD at a Development Forum in 2017 and DB would consider whether this needed to be brought forward to the January Board meeting.	DB
12.6.	The Board was pleased to hear that provision of accommodation for nurses had significantly improved since the previous report. SB asked what had made the difference. JF reported that the short term accommodation policy was being applied more robustly but that the longer term accommodation offering would need to be resolved as part of the overall Estate Strategy. The Trust	

	was actively contributing to discussion on the Local Authority's plan for key worker accommodation.	
13.	**Patient and Public Involvement (PPI) Strategy**	
13.1.	The Board had received a report on implementation of the Trust's PPI Strategy 2016-18, approved by the Board in January 2016. The report had been discussed by the Patient Experience Committee, where the work done on development of Derwent Ward had been identified as a good practice model on involvement. DB highlighted continuing work with Kingston Healthwatch, particularly focusing on Outpatient areas and discharge, which would provide feedback from patients to complement FFT.	
13.2.	The Board was asked to note planned activity for 2017, including focus on building on success in quality improvement volunteering and encouraging interactive engagement of boys with the Children & Young People's Group.	
13.3.	There would be a drive to improve Mental Health services in 2017, particularly for patients presenting at A&E with a mental health crisis. A bid had been made to Health Education England to do more Mental Health training with staff. DB had been working closely with the Director of Nursing from SW London & St George's Mental Health Trust. It had been agreed to present a joint patient story to both Trust Boards and to share the learning from it.	
13.4.	The Board welcomed the progress report. DB and RH would continue discussion on supporting the initiatives within the strategy outside the meeting.	DB
BOARD COMMITTEE CHAIR REPORTS		
	The Board had received a summary report on the work of each of the following committees since the last meeting.	
14.	**Quality Assurance Committee (QAC)**	
14.1.	CS summarised the important matters discussed by the Committee and already been covered on the agenda: concerns about potential impact on quality in A&E due to increased attendances; and the excellent presentation from the Consultant midwife on C-section rates. He commended her very clear presentation on complex issues. The Committee had recommended that the quality account combine a number of issues into a goal focusing on infection control.	
15.	**Workforce Committee**	
15.1.	The principal matter on the agenda for the Committee had been the Workforce Strategy and SH commented that it had been useful to test thinking with the Council of Governors prior to the Committee's discussion. She observed that the Committee was now very close to being where members wanted to be on metrics and integrated reporting. The next major agenda item would be the outcome of the staff survey. She noted that SB had asked the Committee to look at best practice in aligning the Workforce Strategy and Two Year Plan.	
16.	**Finance & Investment Committee**	
16.1.	JU reported on three FIC meetings since the last report to the Board, acknowledging some challenging issues for the organisation. The Committee had found it helpful to have RW and DB come to FIC as the Executives working with service lines in special measures and looked forward to hearing more from them on this. She reminded NEDs that they have an open invitation to attend FIC. She took the fact that there had been good attendance as an indication of concern amongst NEDs but also assurance on how focused NEDs	

	are in supporting Executive colleagues.	
CHARITABLE TRUSTEE ITEMS		
17.	**Kingston Hospital Charity Committee**	
17.1.	The Board had received the report of the Committee and attention was drawn to review of the annual accounts as being the main item on the agenda. JM commented that this was a simple set of accounts but it had been evident that record keeping was much improved. There were no issues to report with regard to the accounts. Due to the imminent retirement of the auditor, it was agreed to delegate authority for approval of the Final Report and Accounts for 2015/16 to the Audit Committee rather than the January Board meeting as previously planned.	
GOVERNANCE		
18.	**Forward Plan**	
18.1.	The Board noted the content of the forward plan for Trust Board meetings.	
QUESTIONS FROM THE PUBLIC		
19.	DD pointed to an assumption in the SW London 5 Year Forward Plan that local authorities will close their financial gap through their own action. He believed that there was very little chance of that happening. AR replied that local authorities had endorsed the plan but that did not stop the reality being difficult. SB thanked him for the observation, which had been included in the feedback provided following discussion at the Council of Governors.	
20.	DD noted that it would assist public engagement if patient pathway examples were used to demonstrate the difference between what happens now and how that will change. AR agreed that this was a good way of articulating the change envisaged and LW would take this forward as a suggestion with the central Comms team.	LW
21.	DB confirmed the meaning of a statement in the PPI Strategy about the footprint of the STP. This covered the six boroughs served by the Hospital.	
22.	FK was pleased to see that the number of complaints made had reduced but noted that there was also a small increase in time taken to respond. RW confirmed that she was discussing complaints response rates in performance reviews and referred to earlier discussion on work within A&E to improve responsiveness.	
23.	SM asked a question about the impact of acute reconfiguration on A&E, asking what the likely impact would be for KHFT. AR replied that extensive modelling had been undertaken to achieve a clear understanding of growth depending on which solution was chosen. The Trust had begun to think about what would be needed in A&E and how to build in flexibility to cope with the future. *CG arrived.*	
24.	BG welcomed achievements in cancer performance and asked whether this was a result of primary care delivering 2 week wait referrals. JKW thought several elements underpinned the Trust's success. The number of patients referred had increased but the Trust had tried hard to see patients in the first week. A new referral form and process had also been introduced.	
25.	The meeting closed at 12.00 pm	

26.	**RESOLUTION TO MOVE TO CLOSED SESSION**	
26.1.	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.	