Kingston Hospital NHS Foundation Trust

# Minutes of the meeting of the Board of Directors held on 7th February 2018 – 9.30 am to 1.30 pm

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

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| **Present voting:** | | |
| Sian Bates | Chairman | SB |
| Rachel Benton | Director of Strategic Development | RB |
| Sally Brittain | Director of Nursing & Quality | SBr |
| Kelvin Cheatle | Director of Workforce & OD | KC |
| Jo Farrar | Director of Finance | JF |
| Chris Grindal | Non-Executive Director | CG |
| Jonathan Guppy | Non-Executive Director | JG |
| Dr Rita Harris | Non-Executive Director | RH |
| Tracey Moore | Deputy Chief Operating Officer | TM |
| Joan Mulcahy | Non-Executive Director | JM |
| Ann Radmore | Chief Executive | AR |
| Dame Cathy Warwick DBE | Non-Executive Director | CW |
| Jane Wilson | Medical Director | JKW |
| **Apologies:** | | |
| Sylvia Hamilton | Non-Executive Director | SH |
| Dr Nav Chana | Non-Executive Director | NC |
| Mairead McCormick | Chief Operating Officer | MM |
| **In attendance:** | | |
| Dr Pallavi Bradshaw | Associate Non-Executive Director (NeXT Director scheme) | |
| Dr Gill McCarthy | Director of Medical Education (Med Ed item only) | GMC |
| Susan Simpson | Director of Corporate Governance | SS |
| Lisa Ward | Head of Communications | |
| **Governors:** | | |
| Richard Allen | Public Governor - Kingston and Lead Governor | RA |
| Marilyn Frampton | Public Governor - Merton | |
| Bonnie Green | Public Governor - Richmond | BG |
| Robert Markless | Public Governor - Kingston | RM |
| Jack Saltman | Public Governor - Elmbridge | |
| **Members of the public:** | | |
| Erica Farmer | | |
| Kate Fitzsimmons | | |
| John Adams | | |
| Andrew Howden | | |
| Julie Reay | | JR |

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| **1.** | The Chairman welcomed members of the public to the Board meeting. | |
| **2.** | **Patient Story** | |
| 2.1. | The Board heard the story of a patient living with Type 1 diabetes and his experience after cardiac treatment in June 2015 and as an inpatient in April 2017 with a serious infection in his foot. The patient had been 10 months in recovery from the infection to date and was still not fully recovered. He described how vulnerable he felt and the impact both the long term condition | |

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| | and the infection had had on his quality of life and ability to function as he would wish to do. The patient praised the care he had received through the Hospital and through outreach into the community. He made some suggestions regarding further support, including having literature available with contact details for further support and information on how to access support to cope psychologically. He emphasised that in his case it was not just the physical condition but also the mental ill health issues arising from his situation that he needed support with. | |
| 2.2. | When asked how the story had made the Board feel, SB's response was that it made her think about prioritising the focus on psychological wellbeing of patients and remembering that any impact a condition has on their lives is the patient's main focus. | |
| 2.3. | AR asked the patient what his experience in A&E had been. He explained that he had been admitted through A&E a number of times, including by ambulance and he was used to how things work. He was always seen quickly in majors and had been transferred straight to Cambridge Ward on the last admission. His only concern had been about apparently conflicting judgements by the medical staff, although he believed that his treatment pathway had been right. AR asked if he had felt part of the discussion and he replied no, but he had been informed of the problem and the plan of action. He did not feel there was a choice for him to make in that situation. | |
| 2.4. | RH acknowledged the emotional impact of what had happened, recognising that this was a lifelong condition. She asked what support could be gained from others in a similar position. The patient agreed that it was useful to benefit from the experience of others. Treatment was very different now to when he had first been diagnosed but a support network was still necessary. He commented that the Diabetic Day Unit was always supportive and that a recent DAFNE course had provided help to get into better habits. He would like to see better communication between patients with Type 1 Diabetes, perhaps through social media groups. Although there was a danger that negative stories are spread through networks, he believed the support would a positive influence in the main. | |
| 2.5. | CW ask how well services had been organised to support the patient whilst he could not work and whilst working during recovery. He believed discharge support had been well organised and, as his work was not physical, he had been able to work whilst recovering. This could have been a problem if his work had been physical. Arranging a clinic appointment was not a problem and he welcomed the multi-disciplinary approach to care provided in the Foot Clinic. | |
| 2.6. | The Board considered the agenda ahead of them in relation to the patient story and drew links with the Quality Account goals and the Corporate Objectives for 2018/19. The Board would think about long term conditions and the importance of holistic support for patients. Skin viability would feature as a common theme in an elderly and frail population. | |
| **3.** | **Declaration of Interests in matters on the Agenda** | |
| 3.1. | None. | |
| **4.** | **Minutes of the previous meeting** | |
| 4.1. | The minutes of the meeting held on 29th November 2017 were approved as a correct record, subject to recording CW as present. The action log was reviewed and progress with actions noted. RH had met with the Medical Director to discuss processes for learning from deaths and would report back to the Audit Committee after attending a Mortality review meeting. JKW highlighted the addition of a page in the Integrated report for quarterly reporting on learning from deaths. RB gave an update on SECAmb data reporting. This | |

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| | had never been routinely provided and a new flow of data was therefore required, which would take some time to achieve. | |
| **5.** | **Chief Executive's Report** | |
| 5.1. | The Board had received a report providing an overview of matters to bring to the Board's attention not covered elsewhere on the agenda. AR highlighted a number of key points. | |
| 5.2. | Good progress was being made with the extensive fire safety programme. The UTC development and expansion of Majors/Resus had also gone well. A Governor/NED visit to the latter would be arranged. | SS |
| 5.3. | AR expressed thanks to the staff for their enormous efforts during the Winter period, which she acknowledged may not yet have finished. She welcomed the Time to Change activities aimed at bringing about cultural change to enable staff to talk about how mental ill health. Both the Chief Executive and the Chairman had attended training as Time to Change champions and had been impressed at the wide range of staff from all areas who had taken part. | |
| 5.4. | A new system for car parking had been introduced and, at the same time charges for blue badge holder parking. AR acknowledged that engagement and involvement of the public, Healthwatch and the Health Overview and Scrutiny Panel had not been as the Board would have wished. There had been extensive discussion about this at the Council of Governors meeting at the end of January 2018, which had been attended by members of the public wishing to ask questions about the decision. A review of the impact of charging blue badge holders for parking was to be undertaken after three months of operation. SBr would lead the review and terms of reference were being developed for that process, which would include engagement with stakeholders. | |
| 5.5. | Reference to Deep Dives and Walkabouts was noted. JM asked whether the issues highlighted in last year's Deep Dives would be reaudited. SBr described the information flow from peer reviews and how these could be used to give assurance on actions. SBr was asked to present to QAC a summary of points made in Deep Dives the previous year as a benchmark for auditing. | SBr |
| 5.6. | The Board noted the formal return made on Q3 data for disclosures to the Freedom to Speak Up Guardian. CW had reviewed the information on the National Guardian website and noticed that there were just under 4,000 speak up disclosure across 144 Trusts, which put KHFT below average. KC acknowledged that there had been a slow start to the role for a number of reasons. There were also many other avenues for staff to use to raise issues. His intention was to focus the FTSUG role on harassment issues coming out of the Staff Survey responses. SS was working with her team on increasing awareness of the role throughout the Trust. | |
| 5.7. | AR highlighted that the STP was now called the Health & Care Partnership. She drew attention to borough level plans that would come together as the Local Transformation Board (LTB) plan. It was anticipated that the penultimate draft would be brought to the Board prior to sign off by the LTB. CG noted reference to Winter pressures being not fully finished and asked, looking forward to next year and collaboration across SW London, whether it was realistic to hope that matters would be eased next year. AR reported that a demand and capacity plan for next Winter was required by the end of April 2018. She noted that the DTOC rate had been coming down but was still at 4.5% and there was more to be done. She thought work on localities and admission avoidance at borough level was likely to produce the most traction, but there would be a cost element to this. There would be further discussion with the Board before submission of the plan. | |

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| 5.8. | AR noted the formal relaunch of Kingston Hospital Charity and its enhanced visibility across the Trust. The aim to become far more active in raising charitable funds was becoming more and more evident. | |
| 5.9. | A FAQ sheet on blue badge holder parking had been circulated to all members of the public attending the meeting, including reference to the implementation review. SB commented that the NEDs had requested sight of the terms of reference before these were circulated more widely, and that RH had been asked to take part in the reference group. | |
| 5.10. | The Chairman opened the meeting to questions from the public on the car parking element of the Chief Executive's report only. | |
| 5.11. | RA asked whether AR would confirm that the present situation could be reversed and what steps the Board would take to ensure consultation took place in similar situations in future. AR responded that 'consultation' has a legal definition and a change in the operation of the Hospital does not require consultation to take place. The Health Overview & Scrutiny Panel was also clear on this point. AR reiterated that the Trust had not discharged the involvement and engagement aspects clearly and would be seeking to remedy this through the implementation review. In response to the question on reversing the decision, her expectation was that the decision would be reviewed for unintended consequences, as requested by the CoG, but the financial context of the decision would not have changed. An estimate of £250k raised from BBH charges had been made and this could be deployed in a number of ways. Some would go to fund developing and maintaining additional BBH spaces, some would be spent on additional security and management of the car parks. Any remainder would go into patient care. | |
| 5.12. | JR noted that £250k did not seem a huge amount given that it may create additional spending on patient transport. She asked whether the decision would be reversed if the amount raised was outweighed by added patient transport costs. AR indicated that she believed that £250k was a significant sum given the Trust's financial challenges. The evaluation review would include an assessment of impact on the patient transport system but this would be in the wider context of the financial consequences of running car parking and providing equal access. | |
| 5.13. | JR asked about conversations with the Council about parking on Galsworthy Road. AR noted that the Hospital continued to have a good relationship with the Council on parking issues, but that the solution for Galsworthy Road rested with the Council and not the Hospital. | |
| 5.14. | JR noted that current BBH patients would be involved in the review and suggested that the reference group might include independent groups including carers. AR agreed that a range of views was needed and that the Director of Nursing & Quality would look at the best way to achieve this. | |
| **6.** | **Chairman's Report** | |
| 6.1. | The Chairman gave a verbal report on her activities since the last meeting. She had been pleased to be invited by NHS Providers to present a case study on 'Developing and Effective and Compassionate Board' and this had produced fruitful discussion on compassionate, inclusive and effective leadership at all levels. | |
| 6.2. | In terms of engagement she had met with all Acute Chairs in SW London and had chaired the Acute Strategic Oversight Group. | |
| 6.3. | The Chairman commended the members of the joint Board/Council of Governors working party on governance and believed the new mechanisms to be introduced could be regarded as best practice. | |

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| 6.4. | SB was pleased to report that the Trust continued to attract high-quality new consultants. She had assisted recently with interviews for posts in Paediatrics, Radiology and Acute Internal Medicine. | |
| 6.5. | The Chairman echoed the Chief Executive's praise for the hard work of staff during the Winter period, which she described as exceptional. | |
| **QUALITY AND PERFORMANCE** | | |
| **7.** | **Integrated Quality & Operational Performance Report** | |
| 7.1. | The Board had received the report for December 2017. Executive Directors presented key messages under each of the CQC domains. | |
| 7.2. | JKW said that KPIs for 'safe' were predominantly good and she believed that multi-disciplinary group working was key to this. She praised the work of the Infection Control team and noted that positive impact that Point of Care Testing for Flu had had, particularly this year when there had been more Flu in the community than the previous year. JKW had highlighted four cases of MSSA bacteraemia during December 2017; although this was not reportable she thought it important for the Board to be aware of it and to know that a thorough investigation was taking place. | |
| 7.3. | CW asked whether electronic prescribing was likely to reduce incidents. JKW responded that management of medicines was a broader suite of issues than in this report and she would want to see reporting of incidents stay high. There was no value for money data within medicines management reporting but it had alerted to particular issues to be addressed through changes to the system. JKW noted that the Trust has a Medicines Safety Pharmacist and that trends were reviewed through the Medicines Safety Group. Any issues highlighted through this review would be discussed with the Quality Improvement Committee. | |
| 7.4. | CW noted from the Safer Staffing data that Blythe, Isabella and Sunshine Wards looked low and asked whether there was any correlation with other safety indicators. SBr apologised that there were some errors within the data in this section of the report. However, staffing on the wards was reviewed daily and all were running safely. | |
| 7.5. | Under 'effective' JKW reported that mortality indices were good, that there was an improvement in Sepsis screening and that the Trust continued to work on achieving the screening of over 90% of eligible patients for Dementia. The Board was pleased to note the assurance provided by the National Hip Fracture Database Annual Report. | |
| 7.6. | The rising trend in readmissions was discussed and JKW explained early indications from analysis of the data. Emergency readmissions following emergency admission covered small numbers of patients, which exaggerated trend. Readmissions from patients discharged from CDU appeared to contributing to the % increase. These tended to be older patients with respiratory or abdominal issues and JKW believed this may demonstrate immaturity in the system of admissions avoidance. Looking at these patients in more detail may help to increase success of admissions avoidance. SB asked that a further report be made to the next meeting of the Board. | JKW |
| 7.7. | The Q3 report on learning from deaths had been included in the report for the first time. JKW explained this was based on the national template and reported the number of deaths rather than % as had previously been the case. She emphasised that in the care system most people die in hospital and there is always in an increase in the Winter. She drew out that the adjusted mortality rate remains low. One Structured Judgement Review had been completed of three begun in Q3 and this had concluded that the death was unavoidable. JM | |

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| | asked whether maternity deaths were included in these figures. JKW responded that the learning from deaths did not include deaths under 18 years of age and that maternal mortality is so rare it would not be visible in this dataset. She emphasised that the Trust is below the national figure on maternal mortality. | |
| 7.8. | SBr report on the 'caring' domain. She was pleased to report that the complaints response rate within 25 working days was much improved. She had also taken comfort from the fact that the reopened complaints rate was low. She believed this reflected that the quality of the response was not affected by timeliness. SBr noted that there was an early indication that January's response rate would dip slightly, possibly reflecting the operational pressures within the Hospital. | |
| 7.9. | It was noted that the Friends and Family Test was now recorded electronically in the Emergency Department and this had significantly increased the response rate. A drop in satisfaction rate was not unexpected over the Winter period and it was pleasing to see some of the very good comments made. Electronic collection of data had the advantage of allowing managers to respond in real time. The Board was asked to note that introduction of texting mechanisms for patient feedback in Outpatients may lead to a better response rate but worse performance. RH had been surprised at the Paediatric response rate and SBr agreed that the response rate should be driven up in that area. | |
| 7.10. | JG observed that 1 in 3 complaints related to communications and asked for clarification on what this covered. SBr explained that complaints were rarely about face to face communication; these complaints were usually about Outpatient appointments changing, multiple letters or timings of communications. | |
| 7.11. | TM presented the 'responsive' section of the report, noting that the overall Referral to Treatment target had been exceeded in December 2017 despite a number of areas falling short on individual performance. | |
| 7.12. | TM confirmed that the Cancer target had been met in December 2017, emphasising that this was only achieved by paying very close attention to management of pathways. RH was unclear what an incidental finding on 100 day Cancer breach meant. It was explained that the patient had been referred as symptomatic, investigations had been undertaken and imaging had shown something else. | |
| 7.13. | TM acknowledged the impact of Winter pressures on A&E performance. Activity had now reduced but achieving the target remained challenging. Ambulance breaches had increased and the team was focusing on improving ambulance handovers. The fact that the Trust has a dedicated ambulance handover area was seen as good practice; nevertheless the team was focusing on what more could be done. SB requested that the outcome of this work be reported to the Board. | TM (MM) |
| 7.14. | In the context of RTT performance, CW asked about the impact of the Trust assisting with reducing the waiting list at St George's. It was explained that acceptance of any patient in a delayed position would impact on KHFT performance but it was the right thing to do to offer care and get their treatment under way. | |
| 7.15. | SB asked about the clinical benefits arising from the investment in Majors and Resus. TM summarised these as being the ability to offload from ambulances and to carry out initial assessment more quickly. | |
| 7.16. | KC presented the section of the report on Well Led, adding further context from January data just received to suggest that the downward trajectories on sickness and turnover were seasonal and would recover. He highlighted very | |

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| | good performance on key metrics, the vacancy rate being half that of other Trusts. He believed the focus on staff health and wellbeing and flu prevention was bearing fruit. | |
| 7.17. | The turnover rate for January was 16.5%, equal to last year at the same point. Turnover. 1% of that figure related to EU staff. Although the overall rate was not far above target, KC acknowledged high pockets of turnover in lower band Admin & Clerical roles, in a number of service lines and tending to be younger people. He explained a number of initiatives being explored to address these issues. | |
| 7.18. | KC reported on the launch of the new e-learning induction programme; there was more to be done on the secondary level of mandatory training. This second stream would roll out in April 2018 under ESR and would give better access via a national programme. JG asked what could be learned from what other Trusts were doing on mandatory training that enabled them to be more successful. KC noted that many of the issues were to do with systems: recording, follow ups and reminders were better. He also thought that the primary induction process had not previously had enough focus and this would be improved with the introduction of the new process. AR added that the new induction process included the introduction of probationary periods and other activities to target reducing turnover in the first 12 months. SB encouraged NEDs to discuss plans for training, development and progression with Nikki Hill, recently appointed as Deputy Director of Workforce. She had done so and had received some very positive assurance on progress. | |
| **8.** | **Finance Report** | |
| 8.1. | The Board had received the Finance Report for Month 9 and noted its contents. JF highlighted the key messages from the Executive Summary, explaining that the Finance & Investment Committee had considered the content of the report in detail a week ago. | |
| 8.2. | The Board formally noted the reforecast year end position submitted to NHS Improvement, which was a deficit of £6.2m (£7.1m away from the control total). JF drew the Board's attention to a number of factors underpinning this position. No STF funding had been accrued in Q3, although he was still expecting to receive the A&E element of Q2 with Q3 monies. All trusts had been asked to treat Winter Resilience funds in the same way as STF. | |
| 8.3. | The current position on capital was noted, with JF reminding the Board that the largest element of this was fire safety works. He believed that capital would get back to forecast during Q4. The Theatres work had now been completed and the outcome was very impressive. | |
| 8.4. | The Board acknowledged the challenging financial position indicated, and that this would continue into 2018/19. Planning guidance had been released within the past few days and JF would interpret this for the Board. JF had been in regular communication with his CCG counterparts during the current year and in planning for the future. | |
| 8.5. | JM asked for a summary of the level of borrowings and the cost to the Trust of those borrowings. JF would report this later on the agenda alongside the FIC report. | |
| **9.** | **Safe Staffing** | |
| 9.1. | SBr presented an update on her report to the previous meeting, asking the Board to agree thresholds for trained nurse staffing on general wards at KHFT. She explained that the proposals had been tested during the period that the Trust had operated Silver Command, and that these proposals only affected inpatient medical and surgery wards. | |

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| 9.2. | CW asked whether the 1:8 ratio included specialist ward management roles. It was explained that the ratio includes the nurse in charge, who is supernumerary, but did not include nurse specialists. CW referred to new reports on various areas of staffing published by the National Quality Board and asked whether these gave ratios for general areas. SBr confirmed this; the details would be included in the next Safe Staffing report to the Board. | |
| 9.3. | SB noted that there were no recommendations on minimal staffing levels but asked whether benchmarking within the Directors of Nursing network indicated that the proposals were within the expected range. SBr referred to research discussed by DoNs that indicated higher ratios impact on patient experience and safety. SBr had operated with the ratios proposed before and believed these were a good safety measure, noting that there is a difference between safety and quality. | |
| 9.4. | The Board agreed that the minimum number of trained nursing staff to each bed should be 1:8 during the day and 1:10 at night on the general wards within Kingston Hospital NHS FT, with a minimum of two trained nurses on duty at any one time on inpatient wards. The process for escalating and monitoring staffing levels in the maternity services was noted. | |
| **10.** | **Mental Health in the Workplace** | |
| 10.1. | The Board had received KC's report summarising the measures being taken to support staff with mental health problems to 'thrive at work', the benchmark being the Stevenson/Farmer review report. The aim was to change the organisational climate so that mental ill health is an acceptable topic of conversation. | |
| 10.2. | KC outlined the work of the Health and Wellbeing Steering Group (HAWB) and the various strategies it was leading to raise awareness. As with any cultural change, the challenge would be to be sure that change was embedded. The Trust was collaborating with Kingston University on supporting back to work and taking the 'Time to Change' pledge had provided the opportunity for publicity. KC was talking to SW London & St George's Mental Health Trust about the possibility of fast-tracking support for staff when needed. | |
| 10.3. | KC welcomed the arrival of the Staff Wellbeing Chaplain, saying KHFT is the only trust to have taken this route. In her first few months in post the Chaplain had estimated that 80% of her workload was focused on mental ill health and stress related issues. KC reminded the Board that the free confidential helpline for staff included a counselling resource for staff and families. | |
| 10.4. | KC believed that the Trust had achieved the basis of a good response to the 'Thriving at Work' report but that there was more to be done. RH acknowledged that the mainstream staff groups could access a number of sources of support and asked about night shift or harder to reach groups. KC responded that some of the Mental Health First Aid Champions worked night shifts and that the employee assistance programme can be accessed 24/7. He acknowledged that communications could be better and looked forward to the launch of the new Intranet which would have a dedicated Health and Wellbeing section. | |
| 10.5. | SB thanked KC for a helpful report enabling the Board to understand fully the components of the Trust's response. She highlighted the importance of the managers' training programme and toolkit. | |
| **STRATEGY AND POLICY** | | |
| **11.** | **National Workforce Strategy** | |
| 11.1. | The Board had received a report introducing the national workforce strategy designed by Health Education England (HEE) and the Trust's proposed | |

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| | response to the consultation on it. KC put the report into context with feedback from a national event at which the strategy had been discussed. He asked for comments from the Board for further discussion at the Workforce Committee meeting in February 2018. | |
| 11.2. | AR had been struck by data discussed earlier in the week which showed that in the period 2010-17 there had been a 25% increase in consultant staff but only 1% in nursing. She believed that the greatest impact on productivity came from harnessing the contribution of all team members but this did not come out from the report. She also highlighted that the next most disruptive change is the use of Information Technology and yet this was not addressed. There were also local retention issues that do not lend themselves to a national response and the granularity of that discussion was lost in the national report. | |
| 11.3. | SBr noted that 1/3 of nurse training places were not taken up and that this would have a national impact. Locally, KHFT had been very proactive in engaging with another University, which would bring in a further 60 student nurses. However, to have a lasting impact these would need to be retained once qualified. | |
| 11.4. | RH asked how the Board should help people to think about changing roles and expectations. CW thought the Board would want to seek assurance that, in relation to the enormous challenges in this area, the right structures and processes were in place for early consultation with those whose roles would have to change. KC believed that within the Trust there were rigorous processes in place through the Workforce Committee to the Board, but in SW London the link with national strategy has not been possible. He believed that new leadership in the patch would now bring this to the fore. | |
| 11.5. | CW asked what engagement there had been with Trade Unions and whether more could be done now to ensure that plans did not meet obstacles later on. AR noted that the Trust had good relationships with full time TU officials and that KC had been putting time into TPF representation of staff and leadership. JKW was not convinced that training bodies for doctors were aligned with the issues and that conflicting pathways made this difficult to resolve. | |
| 11.6. | JM asked whether the staffing position had been extrapolated. KC noted that the extrapolated position at SW London level was more relevant than the national figures as it showed the breakdown of occupational groups and where the gaps are for the future. | |
| 11.7. | KC summarised the Board's concerns about the strategy lacking connectivity with health and care partnerships work and with IT. The SW London Workforce Board would look to align more closely with the national targets in a pragmatic way making sense for providers. | |
| 11.8. | JG observed that the strategy document appeared to be superficial in comparison with the technological, system and societal change needed. He asked whether there was an opportunity to speak loudly as a group because ultimately the problems would rest with the providers, not HEE. AR suggested the four SW London Acutes might agree a joint response and KC noted this for discussion with the SW London Worforce Board later in the month. | |
| 11.9. | KC thanked the Board for their input to the conversation, which he would take to the Workforce Committee. He would circulate the final consultation response to the Board for information. | KC |
| **12.** | **Quality Priorities 2018/19** | |
| 12.1. | The Board had received a report summarising the process for selection of the Quality Priorities for 2018/19 and proposing the selected priorities for approval. SBr acknowledged that it had proved difficult during 2017/18 to monitor and | |

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| | report on progress in a meaningful way in-year and that regular updates would be made to the Board on compliance and progress in the coming year. | |
| 12.2. | RB commented that the Quality Priorities were much more closely aligned to the Corporate Objectives than in previous years. | |
| 12.3. | The Board approved the proposed Quality Priorities for 2018/19, thanking the Council of Governors for their input to the selection. | |
| **13.** | **Corporate Objectives 2018/19** | |
| 13.1. | The Board had received a report providing the draft corporate objectives for 2018/19 for approval, noting that further refinement of the measures relating to CO4 and 5 will be necessary following publication of the latest Picker staff survey results and CO6 will be finalised after further work on pay and conditions. RB outlined the process taken to reach this point in the drafting of the Corporate Objectives, including input from the Council of Governors Strategy Committee on referencing staff accommodation and continuing focus on BAME staff. | |
| 13.2. | CW made a general point on terminology and asked whether references to the Nursing Workforce could be extended to Nursing and Midwifery as some midwives were not nurses. SBr confirmed she was happy to accept this clarification. | |
| 13.3. | The Board approved the Corporate Objectives for 2018/19 as presented. | |
| **14.** | **Risk Management Strategy** | |
| 14.1. | SBr presented the refreshed strategy which she believed set out with clarity the process in operation within the Trust. The strategy had been updated to reflect the changes to committees within the governance structure and posts within risk management and quality governance team. JM welcomed the strategy and looked forward to greater visibility of risks at Board level as described within the document. | |
| 14.2. | JG asked how the Board might gain assurance that the content of the strategy had been registered on the front line. SBr described a variety of ways in which assurance can be gained that the front line to Board and junior to senior staff conversations are taking place. She also described how risk assessment and management is addressed in mandatory training so that the Board can be assured that people are aware of what they need to do. Her own observations indicated that staff know it is part of their job role and talk about risk regularly; this was reflected in staff meetings, data for the wards and ongoing conversations. She acknowledged the need to increase capacity in training and development around risk to ensure that there is more consistency in the quality of delivery. | |
| 14.3. | The Board approved the Risk Management Strategy as presented. | |
| **ANNUAL REPORTS** | | |
| **15.** | **Emergency Preparedness** | |
| 15.1. | The Board had received a report on the 2017/18 Emergency Preparedness, Resilience and Response (EPRR) Assurance outcome and the Trust's declaration and self-assessment against the NHS Core Standards for 2017/18. TM summarised feedback from the EPRR assurance visit. | |
| 15.2. | TM described local work on business continuity, for which there had been a substantial programme work which had been audited by KPMG. JM asked if this work had included processes to cover any emergency situation in the event of computer failure and TM confirmed this was the case. | |

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| 15.3. | The Board noted the level of EPRR assurance achieved, the results of the self-assessment and the actions taken to date to address issues of concern. | |
| **16.** | **Medical Education** | |
| 16.1. | The Board had received a report on a review of Medical Education at KHFT, which was introduced by JKW. GMC attended to give a presentation summarising the highlights and key challenges, following which she answered questions from the Board. | |
| 16.2. | CW noted that 54% of trainees did not proceed and asked whether these were then lost to the system. GMC believed that the majority did not leave medicine but it was often the case that F3 trainees needed time to reflect on the future and many took a break at that time. | |
| 16.3. | JG asked for headlines of what the Trust was doing from a training perspective to address Junior Doctor morale issues. GMC explained that Junior Doctors were empowered to take control through the Junior Doctor Forum and this had been an important initiative allowing them to see how they could effect change. Developing leadership skills in the trainees was also important, building a bridge between core training and the Hospital's management programmes. | |
| 16.4. | SB observed that many of the problems affecting Junior Doctors were national or regional and asked whether the Trust was proactive enough in mitigating the issues. GMC saw no easy answer to the workforce shortages, however she was looking for support on increasing medical student places and developing the role of physician associate. She was also working on improving the initial induction period for F1s to provide more professional input to support them. SB was pleased to feed back to the Board from her experience of consultant interviews how often doctors who had trained at Kingston wanted to return. | |
| 16.5. | JKW added that the Trust had been working on supporting the administration roles that doctors undertake. This had been trialled successfully on Hamble Ward and she thought this work should be continued. SB thanked GMC on behalf of the Board for a very comprehensive report giving great assurance on the quality of medical education provided by the Trust. | |
| **BOARD COMMITTEE REPORTS** | | |
| **17.** | Audit Committee | |
| 17.1. | JM presented the report from the Audit Committee meeting on 14th December 2017 and drew out the key issues for the Board to note, including the final internal report on RTT (Data Quality) in Ophthalmology and Clinical Audit report on progress with 'red' rated audits in 2015/16. Audit Committee members had taken forward actions to follow up through Quality Assurance Committee. | |
| **18.** | **Quality Assurance Committee** | |
| 18.1. | CW presented, on behalf of the Committee Chairman, the report on the main areas of discussion at the QAC meeting held on 18th January 2018, noting the update on improvements to administration in the Royal Eye Unit, assurance on pain management and a review of caesarean section rates. She added to the commentary on the Sepsis review that assurance had been given that there were no unavoidable deaths. | |
| **19.** | **Finance & Investment Committee** | |
| 19.1. | JG presented the report on key issues for the FIC meeting on 4th January 2018, noting that there had been a second FIC meeting in the month which had taken place the previous week. | |
| 19.2. | Discussion on the Beds tender had been very helpful in helping to bring out ways to achieve stronger assurance on procurement when procuring in the | |

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| | wider system and in more complex arrangements. | |
| 19.3. | JF summarised the Trust's borrowing commitments: an ITFF loan of £10m for the capital programme; a working capital facility in two parts - £10.8m balance; a fire capital loan of £6.8m drawn down with another £1.5m to be drawn down in early part of next year. JG noted that the Trust continued to be in active discussion with NHS Improvement and that the process of forecasting was an evolving picture at the present time. | |
| **CHARITY TRUSTEE** | | |
| **20.** | **Charitable Funds Committee** | |
| 20.1. | The Board had received a report on the meeting of the committee held on 12th December 2017. JM highlighted the importance of legacies and the relaunch of the Kingston Hospital Charity in November 2017 with new logo and literature to raise awareness. The Board noted progress with plans to secure funding needed for refurbishment of Blythe and Kennet Ward as dementia-friendly wards. SB welcomed the good news that the Dementia Care Programme had received donations totalling £342k in the year to date. | |
| **GOVERNANCE** | | |
| **21.** | **Board Assurance Framework** | |
| 21.1. | The Board had received the BAF for month 9. AR noted the consequence of focus on delivery in December and January meaning work on the Estate had been put on hold. She also drew the Board's attention to a risk around availability of capital going forward. There was an emerging message that capital availability would be significant reduced in future and this may change what the Board is able to deliver. | |
| **22.** | **Strengthened Governance at KHFT** | |
| 22.1. | The Board noted the enhanced governance mechanisms to be introduced with effect from April 2018, as agreed by the joint Board/CoG Working Party and reported to the Council of Governors on 25th January 2018. A review would be undertaken after a year in operation to evaluate the impact. | |
| **23.** | **Items discussed in Private** | |
| 23.1. | The Board noted in the public domain an outline of the matters covered in private at the last meeting. One of the enhanced governance mechanisms agreed by the Working Party was to provide more amplification in this report. SB hoped that governors and members of the public found this approach helpful. | |
| **24.** | **Forward Plan** | |
| 24.1. | Content of the forward plan was noted. AR reported that the CQC would be visiting the Trust on 20th February 2018 for a staff engagement event. A further visit to engage with patients and the public would take place during the week commencing 26th March 2018. The Provider Information Request had been received the previous week, which was the first formal step in the process of the CQC inspection. An unannounced inspection could be expected until mid-May 2018 and a Well Led review towards the end of that period. | |
| **QUESTIONS FROM THE PUBLIC** | | |
| **25.** | BG welcomed a question raised by JM on following up on issues raised in deep dives. She looked forward to hearing more through QAC reports to the Governors' Quality Scrutiny Committee. BG believed that in the past the Trust's members had been asked to comment on the Quality Priorities and asked why this had not happened this year. SBr answered that this step had not been on the schedule used in previous years and she was not used to | SBr |

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| | doing that in previous organisations. She would look at this for next year. | |
| **26.** | As Chair of her local PPG BG was aware of a major programme to develop e-referrals, to be in place by the end of March 2018. She asked how this was progressing. JKW replied that the Trust was working towards receiving all referrals electronically by 1 April 2018 and that there was a schedule of penalties for those who do not achieve this by October 2018. The technology was in place and the project management team was working with the CCGs, GPs and throughout the Hospital on implementation. TM reported that c.85% of all services now had capacity to receive e-referrals and the team was working to complete the service directory by the deadline. AR added that there were varying degrees of comfort about where GP practices were with implementation and there had been discussion with the CCG on what the Hospital should do if a GP practice was not ready and what the implications were on penalties in that scenario. A steady but cautious pace was being taken in order to avoid unintended consequences. RA had attended a Kingston CCG meeting recently where this was discussed and he believed GPs had said they would not meet the 1st April deadline. | |
| **27.** | RM had noted that the FIP target for 2018/19 was likely to be £7.9m. He had the impression that the target over previous years had not been met and asked whether it would be possible to see the trend over 5 years to see whether the targets set were over-optimistic. JF thought FIP targets did need to be more realistic but in the context of FIP becoming more difficult the approach needed to be transformational. SB thought RM's observation was right; the Model Hospital showed KHFT to be efficient and there was an increasingly difficult decision to be made by the Board. | |
| **28.** | RA welcomed the focus on the work of the Diabetic Day Unit through the patient story. He invited the Board to attend the next meeting of the diabetes support group on 20th February 2018 at 6.45 pm. | |
| **29.** | RA referred to the introduction of charges for blue badge holders and asked whether the Trust's apparent failure to consult might be repeated in other areas of public interest and concern. AR repeated her explanation that consultation as a legal construct did not apply to the decision made. She was satisfied that she understood why engagement and involvement of stakeholders had not taken place once the decision had been made and this had not been repeated with other operational decisions. However, she had put aside time with the Executive team to review what could be learned generically. | |
| **30.** | RA was conscious that work had been done to improve discharge arrangements but was concerned that a couple of experiences had been relayed to him that suggested this did not work as well as it might. He asked whether Hospital management was on top of the issues. SBr observed that every situation is different and that there may be reasons why the process is not right every time. TM responded that patients are sometimes discharged in the evening from AAU and that there had been some isolated examples over the period of Winter pressure where later discharges had been driven by volume of activity through the transport services. She described working towards getting medically optimised patients home for assessment and agreed that there was still more that could be done to avoid late discharges. RA asked that preference be borne in mind where late discharge was being considered. | |
| **31.** | JS conveyed feedback from a recent Governor desk where a family had described an oppressive member of staff attempting to bring about a short notice discharge against the wishes of the family. SB thanked JS for his feedback, saying that any formal complaints such as these are analysed very carefully to see what can be learned. | |
| **32.** | **RESOLUTION TO MOVE TO CLOSED SESSION** | |

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| 32.1. | **In accordance with Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960, the Board is invited to approve the following resolution: "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".** | |
| 32.2. | 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. | |