Minutes of the meeting of the Board of Directors held on
5th June 2019 – 9.30 am to 12.30 pm
Lecture Theatre 1, Kingston Hospital Surgical Centre, Kingston Hospital NHS Foundation Trust

Present voting:		
Sian Bates	Chairman	SB
Sally Brittain	Director of Nursing & Quality	SBr
Dr Nav Chana	Non-Executive Director	NC
Kelvin Cheatle	Director of Workforce & OD	KC
Jo Farrar	Interim Chief Executive	JF
Jonathan Guppy	Non-Executive Director	JG
Sylvia Hamilton	Non-Executive Director	SH
Dr Rita Harris	Non-Executive Director	RH
Mairead McCormick	Chief Operating Officer	MM
Dame Cathy Warwick	Non-Executive Director	CW
Jane Wilson	Medical Director	JKW
Present non-voting:		
Alex Berry	Director of Integration	AB
Tracey Cotterill	Interim Director of Finance	TC
Susan Simpson	Director of Corporate Governance	SS
Apologies:		
Joan Mulcahy	Non-Executive Director	JM
In attendance:		
Jennifer Crooks	Research and Innovation Manager (R&D item only)	JC
Dr Helen Matthews	Consultant (R&D item only)	HM
Amira Girgis	Deputy Medical Director	AG
Stella Davey	Matron, A&E (staff story item only)	SD
Amelia Harris	Lead Emergency Care Nurse (staff story item only)	AH
Governors:		
Richard Allen	Public Governor - Kingston, Lead Governor	RA
Marilyn Frampton	Public Governor - Merton	MF
Bonnie Green	Public Governor - Richmond	BG
Dr Doug Hing	Appointed Governor - Wandsworth, Merton & Sutton CCGs	DH
Jane Keep	Public Governor - Richmond	JK
CJ Kim	Public Governor - Elmbridge	CJK
Felicity Merz	Public Governor - Wandsworth	FM
Raju Pandya	Public Governor - Kingston	RP
Jack Saltman	Public Governor - Elmbridge	JS
Terry Silverstone	Public Governor - Richmond	TS
Staff:		
Jonny-Mullen Davis	Corporate Affairs Support Officer	
Members of the public:		
Louise Russell		

1.	**Staff Story**	**Action**
1.1.	SBr began by reminding the Board of the purpose of starting with a story relating to staff and patients. She invited AH and SD to speak to the Board about an experience in the Emergency Department (ED) when a teenage patient had presented with first episode psychosis, and the impact this experience had had on staff.	
1.2.	AH explained that the teenager had spent 38 hours in ED because there were no suitable mental health beds available for transfer. Deterioration in the patient's condition resulted in staff being subjected to aggressive behaviour and assault. A member of staff had been significantly affected by the experience to the extent that they had been unable to return to their role in ED. The Trust's security service had provided good support throughout, and the ways in which the Trust had responded to the patient's cultural needs had been of note. The situation had required escalation at night to the On Call Director and intervention by the Chief Executive to secure transfer of the patient to a more appropriate setting.	
1.3.	AH outlined the learning from the experience. Debriefs take place when similar events happen; the support of the security officer had been recognised with a values award; the ED team now has regular wellbeing breakfasts together to provide opportunity for mutual support.	
1.4.	RH recognised the stressful situation evident from the story, and that the team had exhibited great teamwork in caring for each other and for the patient. As Chair of the Equality & Diversity Committee, she noted that the Committee would think about the elements relating to gender and security that had come out in the story.	
1.5.	CW acknowledged the energy that is spent on keeping going when a situation is difficult and long-lasting. Steps taken to manage the patient so that their behaviour did not impact on the remaining patients in ED were explained. It was noted that the team now had more flexibility with the introduction of the Mental Health Assessment Unit, than they had at the time of this event.	
1.6.	SB had been shocked to hear of the level of violence experienced by the staff concerned. Whilst putting the right services in place for patients with mental health issues remained paramount, her focus had widened to include the duty of care towards staff caring for patients who present in such distress. She thanked the staff for the care they gave to this vulnerable young person in such difficult circumstances. An explanation was given about support available to staff who had been through that type of experience.	
1.7.	JF was concerned about the length of time this vulnerable patient had been stranded in ED. He asked whether the story had been used as a case study for the system to understand the issues. MM reported that the case was used as a case study in the recent mental health concordat.	
1.8.	SBr thanked AH and SD for sharing their experience with the Board and noted that there were threads running throughout the day's agenda which linked to the themes of the story.	
2.	**Apologies for absence**	
	Noted as above. SB welcomed JF to his first Board meeting as Interim Chief Executive.	

3.	**Declarations of interest**	
	None.	
4.	**Minutes of the last meeting and matters arising**	
4.1.	Minutes of the meeting held on 27th March 2019 were approved as a correct record. Content of the action log was noted and all actions closed.	
5.	**Chairman's Report**	
5.1.	The Chairman gave a verbal report summarising her main activities since the last meeting. She welcomed the agreement of JM to stay on as Audit Committee Chair until the end of September to allow the search for a new non-executive director to be extended.	
5.2.	The Board had held a good development day in May, concentrating on acknowledging the excellent year end performance and strategic discussion on integration.	
5.3.	It was noted that annual performance appraisals for non-executive directors had now been completed and had been reported to the Nominations & Remuneration Committee of the Council of Governors (CoG).	
5.4.	The Chairman had met with the clinical chair of the Kingston CCG and the acute chairs in SW London and had attended a meeting of London chief officers and chairs. The topics for discussion had been population health, integration, the changing environment of the NHS and the pace of change needed.	
5.5.	SB had been delighted to attend a recent event devoted to research and innovation at the Hospital. She had been delighted to see how this was helping patients, and also attracting staff to join the organisation.	
5.6.	The improvement event held the day before the Board meeting had demonstrated that improvement methodology is starting to come through as the way things are done at KHFT, which was exciting to see.	
5.7.	The Executive team had hosted a meeting in May for Governors focusing on the end of year performance; given the strength of performance in 2018/19, it had been decided to share this information early with governors rather than waiting for the AGM. SB had also met with a number of governors individually since the last meeting, and was happy to do so whenever asked.	
5.8.	SB had been delighted to attend the Mayoral civic service as Cllr Margaret Thompson (a member of the CoG) was welcomed as Mayor of the London Borough of Kingston. This multi-faith event had been a great way to bring the community together and focus on kindness and caring for each other. Cllr Liz Green had visited the Hospital and had been full of praise for what she had seen.	
5.9.	The Chairman had attended the Anstee Bridge graduation. The output of Anstee Bridge's work with young people and KHFT staff celebrating NHS 70 - a waiting room full of creative work about the NHS and the young people's learning - would be visiting the Hospital shortly, and later kept for posterity at Kew Archive.	
5.10.	SB commended the 'Homeward Bound' showcase event. The final videos had demonstrated true co-production and will support improving the discharge process.	
5.11.	SB had attended the annual adult memorial service, and had also attended the	

	Death Café. She welcomed the conversation around preparation for death.	
6.	**Chief Executive's Report**	
6.1.	JF presented his report providing the Board with information on strategic and operational issues not covered elsewhere in the agenda.	
6.2.	It was noted that operational demand has continued to be challenging, and that the Executive team was working with partners through the A&E Delivery Board to address the challenge together.	
6.3.	The Private Patient Unit was now running as an integral part of the Hospital, known as Kingston Private Health. Part of Coombe Wing had been refurbished and there were plans to continue this work in the coming months. The Coombe Road development site disposal to Advanced Living had been concluded and a planning application was expected in the Autumn. The Trust was planning to vacate the site by September 2020.	
6.4.	Issues for staff around NHS pensions and taxation complexities had come to the fore over recent months. The issues are national and require a national solution. A pension workshop had been held to support staff in navigating the complexities and further support around this issue would be prioritised.	
6.5.	Health and Care Partnership Plans had been produced for Richmond and for Kingston. The Executive team looked forward to working together to shape delivery of the plans locally. Senior leaders from health and care had met to talk about a shared vision and what the goals might look like as a 'place'; a follow up meeting was to be held at the end of June.	
6.6.	JF was pleased to report that the Trust had received confirmation of a change under the Single Oversight Framework from Segment 2 to Segment 1. This indicated that the trust was at the lowest level of risk in the eyes of the regulator, and was a reflection and endorsement of strong performance over recent years.	
6.7.	CW asked about the affordability of the NHS pension for lower paid staff, and how many people opt out. KC responded that 900 of the Trust's staff are not members of the NHS pension scheme. Deductions are made into NEST for those who have requested this and some may have private pension schemes. He explained that there are now three versions of the NHS pension scheme. The purpose of the recent workshop had been to explain how people can migrate between those schemes and how it might impact on their tax liabilities.	
QUALITY AND PERFORMANCE		
7.	**Integrated Quality & Operational Compliance Report**	
7.1.	The Board had received the report for April 2019 and Executive leads presented the summaries under the CQC domains.	
	<u>Safe</u>	
7.2.	SBr presented the summary reports on falls, pressure ulcers, serious incidents and infection control, highlighting the importance of the End PJ Paralysis initiative for reducing falls and ongoing actions taking place to deal with management of pressure ulcers. She reported that the safer staffing data was now consistently good. SBr had no concerns to raise with the Board.	
7.3.	CW welcomed improvement in the Paediatric NEWS data. She noted that the Quality Assurance Committee (QAC) had had a detailed presentation on post-partum haemorrhage at the last meeting and asked when the Board could expect to see a difference in the PPH and C-section rates. It was thought that	

	allocation of additional time and the arrival of a new member of staff would make a difference and it was agreed that the QAC would these KPIs under review. RH asked what had made the difference to the Paediatric NEWS scores. SBr attributed the improvement to weekly auditing.	SBr
	<u>Effective</u>	
7.4.	JKW presented the summary reports on mortality, sepsis, dementia screening and Clinical Audit. She gave a brief explanation of the roles of the Medical Examiner Officer and the Medical Examiner. She was confident that arrangements to meet the new requirements were progressing well and highlighted that the Learning from Deaths role will remain separate.	
7.5.	The latest Sepsis data had been included in this report and was showing improvement. JKW reported that the work of the Deteriorating Patient Group was going well.	
7.6.	JKW commended the Trust's contribution to all the national audits that should be undertaken. She asked the Board to note that the performance of the Trust in clinical audits is good, and that areas for improvement are picked up through the Quality Improvement (QI) programme.	
7.7.	NC expressed congratulations on achieving improvements in the Sepsis data and asked whether the Trust was likely to achieve the one hour target for inpatients. JKW explained some of the complexities of recording the data for inpatients which made this difficult. She thought it important to note that picking up abnormality in NEWS scores on the wards is closing down deterioration. On behalf of the Board, SB thanked AG for her leadership on Sepsis; she had been delighted to see the results improve on this important measure for urgent care.	
7.8.	CW asked whether there was anything to learn from the readmissions data. MM thought it important to note that admissions had gone up and therefore there was a correlation on readmissions which meant the latter should not be looked at in isolation.	
	<u>Caring</u>	
7.9.	SBr presented the summary reports for complaints and friends and family test (FFT), noting the volume of data available overall.	
7.10.	RH linked the improvement in Paediatric NEWS scores with increased focus, and asked whether the new patient experience co-ordinator was expected to have the same impact on FFT in Paediatrics. SBr thought this would help and explained that the Paediatric team had worked on the best way to collect data for this cohort. She also gave an update on work between Paediatrics and ED on safe staffing.	
	<u>Responsive</u>	
7.11.	MM presented the summary reports on cancer, RTT and diagnostics, and A&E performance. Cancer performance remained excellent; a new measurement to be reported from next month would result in a drop in reported achievement due to the new methodology.	
7.12.	MM gave a detailed explanation of the issues underpinning A&E performance. There had been a significant increase in attendances and analysis of the data showed that 33% of attendances resulted in advice and guidance rather than admission. Despite the trend of increased attendances, the Trust was still 18th of 152 acute trusts in the country and was performing well for length of stay and patient flow. Following a recent MADE event involving system partners, the	

	growth in stranded patients had begun to reduce. There was commitment to extending the rapid response team to 10.00 pm.	
7.13.	NC noted that, despite unprecedented access to primary care, the 'worried well' still chose to come to the Hospital, and asked what more could be done to discourage this. MM explained that an audit was being undertaken to establish if patients had already presented to their GP and if so what had caused them to move on through the system. An analysis of which elderly ED patients were known to the system had revealed that 50% were already known to community partners. Presentation to ED late in the day could indicate that the system had not responded as anticipated.	
7.14.	JKW commented that the most common symptoms for the middle age bracket were abdominal and chest pain, and diseases with these symptoms were not common in that age group. She suspected that the symptoms may indicate stress or poor mental health as the underlying cause and therefore attendance at A&E was not the right pathway for those patients. JKW endorsed the approach MM was taking to get to the nub of the issues.	
7.15.	SB asked for a sense check in terms of the impact of continued pressure in the Hospital on staff. MM observed that staff were tired, but this was not impacting on patient care. On the front line, staff remained upbeat. SBr had been clear with her teams on taking their breaks, and that regular meetings should continue as an opportunity there to let off steam.	
7.16.	CW had had some great feedback from staff about the actions of the Executive team in supporting staff. The Board agreed that refocusing attention on staff health and wellbeing should be prioritised and the Health & Wellbeing Steering Group was asked to take this forward.	KC
	<u>Well Led</u>	
7.17.	KC presented the summary reports on workforce KPI's, noting that in comparison with national sickness rates, the Trust was consistently a strong performer in the top 10%. Turnover and stability were still challenging; some posts had been identified as being constantly in churn and there was an opportunity to rethink the construct of these roles alongside considering pay and reward overall.	
7.18.	Statutory and Mandatory Training remained a high priority area and KC was pleased to report that all infrastructure work was now complete on digitising the process so that staff can record and track their own compliance. The work to give all managers access to data for their teams through the ESR portal was well under way. RH asked whether non-compliance might be linked to pressure on the Hospital. SBr explained that the nursing, midwifery and allied health professional workforce had been allocated time in their rostering to complete the training so pressure should not make a difference.	
7.19.	The Board discussed progress on improving stability in the lower pay bands and in Admin & Estates, noting discussions taking place on rotation of roles across SW London and use of the apprenticeship levy to invest in training and development. TC commented on discussions around the strategy for delivery of the Estates functions.	
8.	**Finance Report**	
8.1.	TC presented the report for April 2019, and also highlighted the 2018/19 outturn as this had not been reported publically to date. It was noted that the Trust had met its control total for 2018/19 and delivered the full cost improvement plan	

	(CIP); thereby receiving full provider sustainability funding (PSF) of £8m and benefiting from a two for one payment of £10m from the land sale. In addition a bonus PSF of £5m had been awarded, bringing total PSF in the year to £23m. The Trust reported a £20m retained surplus, allowing room for investment in coming years. It was further noted that the External Auditors provided an Unqualified Opinion on the accounts.	
8.2.	The Month 1 financial position was on plan. Income was slightly higher on the block contract than would have been under PBR. New schedules had been introduced to allow the Finance & Investment Committee (FIC) to monitor the impact of the block contract on a monthly basis. CIP for the year was £9m, profiled towards the end of the year.	
8.3.	TC explained that the Debtors position was significantly higher as a result of PSF not yet received and was expected to reduce in month 4 when payment was due. The Trust was on plan with a capital programme of £25m for the year.	
8.4.	JG asked TC to give a fuller explanation about the block contract as this may be a new concept for some. TC explained the term in the context of how tariffs had been applied previously, whereas under the block the emphasis was on working collaboratively as a system to manage demand, and facilitate change in pathways that might otherwise have been financially punitive. In short, a change in approach which enabled the hospital to work on activity reduction (e.g. in outpatients) without loss of income. She also outlined how the Trust and the commissioners planned to manage resources in relation to system funding, working together to use the resource in the best way for the needs of the population. JG added that the Board should recognise the hard work that went into making the system change that will be of benefit to patients.	
ANNUAL REPORTS		
9.	**Research and Innovation**	
9.1.	The Board had received a report setting out the proposed Research and Innovation (RI) Strategy for 2019-22. JKW introduced the agenda item, highlighting the stated goals of the strategy: to allow all patients and staff to be part of research by embedding a culture of research excellence throughout the whole trust supported by a highly skilled knowledgeable workforce; and to support and develop world class research in collaboration with our partners to improve the current and future health of our population.	
9.2.	HM explained how the strategy had been developed. She reported feedback from staff and patients in support of research and innovation underpinning the patient care the Hospital provides. HM explained how an increase in the volume of NHS research had been achieved over the past four years and how the strategy was designed to take the Trust forward.	
9.3.	HM described the RI team as a core department within the Hospital, able to integrate research fully into all aspects of clinical care and a hub of excellence which can reach out to the community outside the Hospital. She noted that public and patient involvement had been key to the development of research at KHFT. However, surveys had shown that, whilst 89% value the opportunity to participate, 69% do not realise what opportunities there are and this would be addressed in the strategy.	
9.4.	The key elements of the proposed strategy were outlined, including working with academic partners at Kingston University to attract funding and answer research questions which support local population priorities. HM emphasised that	

	increasing research activity leads to increased funding and broadening of funding sources.	
9.5.	JC explained how the department had grown to meet the needs of the increase in activity through a variety of sources of income, and what this meant for patient care. She believed the department was good at exceeding expectations and was very lean in comparison with other trusts. With 48% projected growth proposed in the strategy, there was a need to consider how to maintain the same excellence. The intention was to incorporate research volunteers into the team, embedding public and patient involvement, and to continue the use of apprenticeships as part of the model.	
9.6.	JKW drew the Board's attention to the infrastructure and how positioning the research and innovation team in the Education Centre had helped bring things central to the organisation. She supported the idea of a Clinical Trials/RI hub in a patient-facing location in order to increase awareness and accessibility.	
9.7.	RH commended the RI team for the presentation and the strategy. She asked what support there was for staff to encourage more to build RI into their job plans. In her response, HM focused on the type of research being carried out at KHFT, which was more patient-focused than academic. A wide range of principal investigators had been supported across the Trust and in SW London KHFT had been at the forefront of promoting non-consultant investigators.	
9.8.	NC asked whether research focused on linear disease-based interventions or whether it could support networked and more complex models of care. HM thought the Trust's approach was in line with this objective, having grown organically to meet the needs of the community. The starting point was to look at what outcomes were important for SW London.	
9.9.	JF thanked HM and JC on behalf of the Board, recognising the achievements described in the journey from small beginnings to a sustainable and self-financing service. He believed there was merit in exploring with system partners whether there were opportunities for sharing more widely.	
9.10.	JG had found the presentation inspiring and asked whether enough was being made of the good news stories. JC acknowledged that more could be done on this, and it was addressed specifically in the strategy. She noted that the Trust was recognised as one of the best recruiters because of patient engagement.	
9.11.	SB thanked HM and JC for a well-timed presentation and confirmed the Board's endorsement of the strategy. She saw RI as an absolute essential in relation to the Trust's stated aim of transformational change, putting patients first, co-production, staff development and system working. She asked that the team find a way to accelerate the pace in order to meet those goals.	JKW
10.	**Medical Appraisal and Revalidation**	
10.1.	The Board had received a report providing assurance regarding the Medical Appraisal and Revalidation process and an update on plans for improving the process.	
10.2.	AG presented the report, explaining that the process had been seen to date as a regulatory tool rather than a QI tool but now that compliance was where it needed to be the next step would be to shift that perception. The Executive team would review whether additional administrative support would be needed to achieve this.	
10.3.	NC asked whether more generic training and development needs were being identified beyond speciality needs. AG responded that the focus was on the	

	individual at present, and therefore was speciality based. However, she would like to develop appraisal training so that appraisers have a clearer picture of what output is expected and how each appraisal might feed into common learning goals.	
10.4.	JKW believed the appraisal process for doctors had developed into a very robust system and that now was the right point at which to start thinking of value added in terms of potential development opportunities.	
10.5.	The Board acknowledged the work that had gone into ensuring the process was operating correctly and the potential of the process to lead to even higher standards of medical care.	
11.	**Equality and Diversity (E&D)**	
11.1.	The Board had received a report on a new Equality, Diversity and Inclusion Strategy which had been drafted to reflect work undertaken over the past eighteen months and the next steps necessary for the Trust. The Board was also asked to ratify the annual equality and diversity workforce report, which had been compiled to provide data against each of the protected characteristics of the Equality Act 2010, as well as other workforce data such as recruitment and promotions.	
11.2.	KC presented the agenda item. He reminded the Board of the national infrastructure on E&D performance management, saying that these reports recorded current performance and action taken to comply.	
11.3.	It was noted that WRES (workforce race equality) scores were improved but that there was more to be done on bullying and harassment from patients and public. This was not a new phenomenon but was resistant to efforts to change. The data on composition of the workforce and how that sits in the various community strands had been helpful.	
11.4.	The E&D Committee had agreed to focus on universal themes that helped tackle issues across all the protected characteristics: leadership; equal access to training, development and promotion; staff and patient engagement and partnership. KC hoped that the detailed action plans agreed with the E&D Committee would deliver positive results in the next Staff Survey.	
	<u>Board Committee reports - Equality & Diversity Committee</u>	
11.5.	RH presented her report, as Chairman of the E&D Committee, on the main areas of discussion at the meeting held on 3rd April 2019. She emphasised that the Committee had established strategic objectives linked to Trust's overall objectives in order to be very clear on direction of travel and where to target limited resources.	
11.6.	The Committee had created a task and finish group to look at the WRES in some detail and identify specific areas to take forward for improvement. Membership included clinical and non-clinical and in the longer term it was hoped to include patient partners. QI methodology was to be used to get underneath the issues rather than impose solutions.	
11.7.	JF asked whether there was an opportunity for this area of work to be of common interest to local partners. RH agreed, and noted that the E&D Committee was different from other Board committees in that it included external members. KC added that there was a pan-London group working on WRES and that the SW London HR Directors group was looking at shared response to the issues. Bullying and harassment had a national task group.	

11.8.	TC observed that the Bands 5 and 6 stood out in the data and asked whether there had been any analysis on whether the recruitment of overseas nurses gave rise to a need to differentiate in the data between those who are attracted to the Trust of their own volition and those recruited from abroad. SBr noted the difficulties of recruiting locally and the Trust's response to this in creating a local pool through registered nursing associates.	
11.9.	SH agreed that the pressures in the workforce created a gap that had to be filled through overseas recruitment. She suggested that the underlying issues be approached through looking at case studies.	
11.10	The Board noted good progress in addressing E&D issues overall, with more to be done.	
	STRATEGY AND POLICY	
12.	**Annual Operating Plan 2019/20**	
12.1.	The Board had received the summary version of the Trust's 2019-20 Operating Plan intended for publication online, as required by NHS Improvement. The Board had approved the final version of the 2019-20 Operating Plan prior to submission to NHS Improvement in April 2019, and the plan had also been discussed with the Council of Governors in March 2019.	
12.2.	The content of the report had been well-rehearsed in various meetings of the Trust Board and Council of Governors as the plan was developed, and was approved for publication. MM noted that the operational standards referenced were the current standards and that change was anticipated in late Summer.	
	BOARD COMMITTEE REPORTS	
13.	**Quality Assurance Committee**	
13.1.	CW presented the report on discussion at the meeting held on 24th April 2019. The Board noted that the Committee had signed off the 2018/19 Quality Report on its behalf.	
14.	**Finance & Investment Committee**	
14.1.	JG presented the report on FIC meetings held on 30th April and 23rd May 2019, which had spanned the period either side of the year end.	
14.2.	The first meeting had principally focused on the success of the previous year and JG particularly wished to thank all colleagues for their part in delivering such an outstanding result. The meeting had discussed receipt of the PSF money and the need to find an effective way to communicate a complex story. FIC had sought extra assurance on approval processes and it had been helpful to hear about new steps in place to clarify approval procedures going forward.	
14.3.	The second meeting had focused on the financial position at M1 and the early impact of the new block contract on achieving that position.	
15.	**Audit Committee**	
15.1.	RH presented a report on the meeting of the Audit Committee held on 23rd May 2019 on behalf of JM.	
15.2.	She was pleased to report that the Trust had received a clean audit of the 2018/19 financial statements and described the flavour of the meeting as being very positive but without complacency. Thanks had been expressed to the teams that had produced the Annual Report & Accounts for 2018/19.	

15.3.	At the Committee's request, a report giving assurance on the management of fire risk had been received and good assurance presented on completion of the programme focusing on the highest risk areas. Work was expected to continue for a period of up to two years.	
	GOVERNANCE	
16.	**Governance Report**	
16.1.	The Board had received a report confirming elements of the Trust's governance structure following recent changes in the Board, and seeking approval for amendment of the Scheme of Delegation.	
16.2.	The Board confirmed the Committee membership presented in the report and noted the special responsibilities assigned to individual directors.	
16.3.	Use of the Trust seal since the last report in October 2018 was noted.	
16.4.	Membership of the Executive Management Committee agreed as a temporary measure following the recent divisional restructure had been confirmed as the permanent membership. A list of members was contained within the report.	
16.5.	TC explained the rationale behind a change in delegated authority levels. The Board approved the revision to the scheme of delegation to support the new governance structure for capital and revenue projects, with the addition of the Investment Committee alongside the delegation levels shown for the Chief Executive in the report.	
17.	**Items discussed in Private**	
17.1.	The Board noted in the public domain an outline of the matters covered in private at the last meeting.	
18.	**Forward Plan**	
18.1.	Content of the forward plan was noted.	
	QUESTIONS FROM THE PUBLIC	
19.	RA asked whether there was any correlation between the rise in attendance in A&E and people who are not registered with a GP. MM answered that there was a consistent pattern of c.25% of patients who attend not knowing the name of their GP, which could include those who could not remember their GP or who had never visited them. She referred to the earlier discussion on work with system partners to identify trends linked to GP practices.	
20.	RA asked what support was available to the staff member who had been affected by the incident described in the staff story. SBr explained the various means of support available, saying that she was aware of the support given to the individual but it would have been inappropriate to have described that in detail to the Board.	
21.	RA referred to statutory and mandatory training compliance and asked whether the Board should consider sanctions for those who did not comply. SB emphasised that the Board did share the concern about compliance with the target and it remained a focus for the Executive team.	
22.	TS was concerned that cultural differences meant security officers might not go to the defence of a member of staff if a male security officer is not considered a suitable intervention. SBr corrected this impression saying that the important	

	message from the staff story was that the Trust had respected the cultural difference and had found other ways to support staff and restrain the patient in a way that respected their background.	
23.	MF had attended the Research Seminar on 20th May 2019 and had been particularly impressed by the presentations given by two patients. She had been delighted to hear the presentation to this meeting on Research and Innovation and hoped the Board would find a way to support the further growth of research in the Trust. She was proud of what had been achieved.	
24.	FM also spoke about the RI presentation, reminding the Board that there is a body of people who are already engaged with the Hospital in the membership. She asked whether research could be promoted to this group. FM suggested that a QI project on the middle age group presenting to A&E with potential stress related issues could be relevant to the whole nation.	
25.	BG noted that Age is a protected Equality Act characteristic and expressed concern that the NHS 10 year view and transformation emphasises enhanced digital systems. She asked how the potential impact on an elderly population would be assessed. JKW agreed that impact assessment should not assume that any age group is automatically able to operate on digital platforms. She explained that the work taking place on transforming care is mindful of the need to co-design change, making sure users are involved in the design.	
26.	BG asked whether there was any detail differentiating Richmond and Kingston on A&E attendance increase. MM noted that Richmond was slightly higher than Kingston but not disproportionately so. She would be able to share more granular detail with BG if that would be helpful to her role as a governor elected for Richmond.	
27.	JK asked whether the Board had access to regular statistics on the abuse of staff by patients and public. KC and SBr outlined the data available and how it was triangulated. JK observed that there had been a connected theme through the Board's agenda of how to deal with psychological wellbeing and in her view it was right to connect those disparate pieces as responses would be similar. Board members agreed with this assessment.	
28.	TS asked whether a block contract meant block transfer of funds as work is transferred to the community. TC explained that there was a 2% tolerance on aggregated income. Anything in addition would be paid on a marginal rate whereas underperformance would not be repaid. It had been recognised that in the early stages of the transformation required, behavioural change would not be achieved if income was removed.	