Minutes of the meeting of the Board of Directors held on
29th January 2020 – 9.30 am to 12.30 pm
Seminar Room 1, Kingston Hospital Surgical Centre, Kingston Hospital NHS Foundation Trust

Present voting:		
Sian Bates	Chairman	SB
Jo Farrar	Chief Executive	JF
Sally Brittain	Director of Nursing & Quality	SBr
Kelvin Cheatle	Director of Workforce & OD	KC
Mairead McCormick	Chief Operating Officer	MM
Jane Wilson	Medical Director	JKW
Yarlini Roberts	Interim Director of Finance	YR
Sylvia Hamilton	Non-Executive Director	SH
Dr Rita Harris	Non-Executive Director	RH
Dr Nav Chana	Non-Executive Director	NC
Jonathan Guppy	Non-Executive Director	JG
Dame Cathy Warwick	Non-Executive Director	CW
Damien Régent	Non-Executive Director	DR
Present non-voting:		
Alex Berry	Director of Integration	AB
Susan Simpson	Director of Corporate Governance & Trust Secretary	SS
Amira Girgis	Deputy Medical Director	AG
Apologies: None		
In attendance:		
Janice Price	Chaplain (patient story item only)	JP
Nicola Johnson	ACP in Emergency Department (patient story item only)	NJ
Shaun Kidd	EPR Manager (patient story item only)	SK
Dr Susannah McMorrow	Guardian of Safe Working (annual report item only)	SMM
Nichola Kane	Deputy Director of Nursing	NK
Governors:		
Richard Allen	Public Governor - Kingston, Lead Governor	RA
Marilyn Frampton	Public Governor - Merton	MF
Bonnie Green	Public Governor - Richmond	BG
Felicity Merz	Public Governor - Wandsworth	FM
CJ Kim	Public Governor - East Elmbridge	CK
Frances Kitson	Public Governor - Kingston	FK
Jack Saltman	Public Governor - East Elmbridge	JS
Staff:		
Tara Ferguson-Jones	Interim Head of Communications	
Des Irving-Brown	Deputy Director of Finance	
Clover Fernandez	Associate Director of Finance	
Public:		
3 members of the public		

1.	Patient Story	Action
1.1.	SBr began by explaining why the Board starts with a patient or staff story.	
1.2.	NJ explained that a patient arrived in A&E very unwell and upset because being admitted would mean she would miss her husband's funeral. The ED team, assisted by the Chaplaincy and IM&T teams, quickly set up a means of live streaming the funeral to a room in the Hospital where the patient could watch and feel part of the service, supported by one of the Chaplains. NJ believed that the story illustrated how care provided in the Emergency Department is holistic in the way patients are treated and cared for.	
1.3.	JP was a trainee chaplain on placement at Kingston Hospital and explained what had happened in the Chaplaincy on the day she had been asked to support the patient. JP had previously come into contact with the patient whilst the lady's husband had been on the ward. She described how the patient had connected with the funeral through singing along to the music and reminiscing about her husband. JP thought it important to recognise that chaplains have the time to sit and listen that other staff may not have.	
1.4.	SK explained his role in setting up the live stream, and how he had ensured that the experience could be made possible. He was delighted to have been part of the patient story because it demonstrated how back office functions have a role in front line care.	
1.5.	SBr thanked the team for the moving story; it had reminded her why working at KHFT was so special. She asked the Board to consider three questions: how the story had made them feel; how the Board might use the story to reflect on the agenda ahead; and whether there were any aspects Directors might want to focus on during Trust Walkabouts.	
1.6.	CW had been overwhelmed by the story for two reasons. Firstly, the Board papers had clearly evidenced how busy the Hospital had been, and yet still staff were able to go above and beyond what might be expected. Secondly, she had been delighted that the story had demonstrated that outstanding patient care was not solely the domain of front-life staff; it was everybody's business at this Hospital.	
1.7.	RH praised the humanity of the story; it had brought to life for her how team and system working, when done well, can make such a difference to patients. NC agreed that the story was a great illustration of 'putting the patient first' and an example of how the Trust demonstrates what this mean.	
1.8.	JF was proud of the Trust's response for this patient. The story showed what a difference it makes when we focus on what matters and do everything in our gift to make it happen. He noted the connectivity with patient care that S had felt in facilitating the event.	
1.9.	JKW echoed JF's comments, adding that the way in which the IM&T team is integrated with clinical services in the Hospital is unusual and noteworthy. She had also been moved by JP's compassionate response.	
1.10.	For DR the story had emphasised the impact of high quality team work. This event had brought together individuals from different teams who were not connected to each other every day. Through innovative thinking they had achieved something extraordinary in a very short space of time. JG agreed that this element of the story was illustrative of the Trust's values being lived in a tangible way – the Kingston way.	

1.11.	SB expressed her pride in the organisation. She thanked the team for their compassionate demonstration of what it means to work at Kingston Hospital. This had been a story of true focus on the individual and provision of loving care.	
2.	**Apologies for absence**	
	There were no apologies for absence. SB welcomed YR and AG to the meeting. It would be the last Board meeting for JKW as Medical Director and SB would mark the occasion at the end of the meeting.	
3.	**Declarations of interest**	
	None to declare in relation to this meeting. A later agenda item covered the Chairman's declaration of interests relating to her appointment as Chair in Common at Hounslow and Richmond Community Health NHS Trust (HRCH) from 1st February 2020.	
4.	**Minutes of the last meeting and matters arising**	
4.1.	The minutes of the meeting held on 27th November 2019 were agreed as a correct record.	
4.2.	Progress with the action log was noted. AG provided a verbal update on 7 day services in Orthopaedics, as requested following the report received at the last meeting. AG had worked closely with Surgery, Orthopaedics and Urology to address the slight variance from target reported and the services were back on track. This had been in the context of some very good performance overall. JKW noted that benchmarking against national figures showed that London does better on 7 day services than the rest of England, although a slight drop in performance evident from the Autumn data returns was indicative of overall pressure.	
5.	**Chairman's Report**	
5.1.	SB highlighted to the Board that an increase in demand was evident across the suite of papers received for this meeting, and yet the Trust was still able to deliver the outstanding care demonstrated by the patient story.	
5.2.	Much of her work in the period since the last Board meeting had been around collaboration and integration. She was certain that this would ultimately make a difference to patients. There had been more focus on 'Place' in recent weeks and she was hopeful that taking up the Chair in Common post would result in some exciting developments for the benefit of the local population.	
5.3.	The Chairman had experienced exceptional care at the Hospital for a close family member over the Christmas period and she was thankful for the commitment and dedication of staff and volunteers who make such a difference to patients at that time of year.	
6.	**Chief Executive's Report**	
6.1.	JF presented his report providing the Board with information on strategic and operational matters not covered elsewhere on the agenda. He corrected a statement in the report regarding RTT performance. Since writing the report, validation of the data showed that the Trust had achieved slightly below the target in December at 91.16%.	
6.2.	However, performance overall remained strong and the Trust was one of two trusts in London to maintain performance over the Christmas period compared with the previous year. The latest call with RM Partners had noted the Trust's strong cancer performance and there were requests to learn from the Trust on	

	managing cancer pathways and on Urgent and Emergency Care. He was proud to see the Trust providing leadership in these critical areas.	
6.3.	JF welcomed the appointment of SB as Chair in Common with HRCH. He had already begun to work more closely with his counterpart at HRCH and looked forward to further collaboration.	
6.4.	The Board noted submission of the annual return for the Premises Assurance Model (PAM), compliance with which had been audited by two of the Executive Directors prior to submission. The report acknowledged the contribution of Kingston Hospital Charity to the development of the estate and facilities that support patient care.	
6.5.	An update was provided on the planning application for development on land sold by the Hospital adjacent to Coombe Road. The Trust had brought to the attention of the developer and the planning authority feedback received from staff, governors and local residents.	
6.6.	The report highlighted a number of initiatives relating to mental health, including the opening of two recovery hubs providing out of hours support. SB asked why the Surbiton facility referred to the hub being accessible only until the end of February. It was explained that the hubs are part of a trial and once the pilot is completed the opening times will be adjusted to suit demand.	
6.7.	JF was pleased to report that the visit of the Duchess of Cambridge to the Maternity service had been a great success, and it was equally pleasing that the home birth team had won Team of the Year award at the London Festival of Maternity and Midwifery Conference.	
6.8.	JF invited SBr to give a verbal report on Corona Virus. SBr explained that there were no cases in the UK and no UK citizens abroad had contracted the virus. The risk was considered to be low. Emergency plans, relevant policies and infection control measures had been reviewed, including scenario testing, and additional equipment had been ordered as a precaution.	
6.9.	The Board thanked the Chief Executive for a strong report and for the additional infection control assurance.	
	QUALITY	
7.	**Integrated Quality & Operational Compliance Report**	
7.1.	The Board had received the report for December 2019 and Executive leads presented the summaries under the CQC domains.	
	<u>Safe</u>	
7.2.	SBr reported that pressure ulcers were a matter of concern and she had included in the narrative what had been done to investigate and find root causes. She had also met with CW to review the areas of concern and had appreciated the independent view. CW commended the way in which the whole team had looked at the matter in depth. She had come away from the meeting with the impression that the nursing and quality teams were fully behind finding a way to improve. CW would continue to meet with SBr to review progress. RH echoed CW's comments and supported the view that mirroring the work which had had an impact on reducing falls was the right thing to do.	
7.3.	RH asked a question about cross-infection and whether the numbers in the report were concerning. SBr thought Norovirus had been contained well and discussion with the CCG about infection in the community did not raise any matters of concern. SBr reminded the Board that the CDiff target was 8 lapses in	

	care, and that when the target changed it had been anticipated that reported numbers would increase.	
7.4.	NC asked to what extent a population health approach was being used to predict who might be at risk of pressure ulcers. SBr said the subject had been discussed with the nursing home group but for many patients hospital admission would be their first contact with a provider. It was agreed that it would be helpful to have an integrated approach to external communications on preventative measures across the community.	JF
	<u>Effective</u>	
7.5.	JKW reported that the key performance indicators (KPIs) in this domain were largely well-controlled, with readmissions the key focus. JKW described the balance between working hard to get frail elderly patients home, which was best for the patient, and coping with complex care needs. She was not aware of any patient not having been discharged effectively, nor of failures in post-surgical care.	
7.6.	RH noted the absence of data on learning from deaths. JKW reported that in December there had been 7 structured judgement reviews (c.10% of death rate which is expected practice). There had been a reduction in patients reviewed in Morbidity & Mortality (M&M) meetings due these being cancelled in order to prioritise clinical care. The Board was reminded of the introduction of the Medical Examiner (ME) process, where all deaths are reviewed by an ME. The Trust had elected to spread the role across five trained MEs, with a sixth due to start from April. Contact was made with the patients' families to see if there were any issues they wished to raise and the ME's role was to ensure the accuracy of the death certificate. The Medical Examiner Officer was looking at how to bring the data and the learning from this work through to the Board.	JKW
7.7.	NC noted the hypothesis around 30 day readmissions following elective surgery and asked whether there were any other hypotheses. JKW confirmed no other causes were obvious. Unexpected admissions were reported as incidents and these had not flagged any particular issues. She believed the Hospital operated more often on patients with serious co-morbidities and she thought some readmissions may be linked to this.	
	<u>Caring</u>	
7.8.	SBr reminded the Board that the year on year increase in complaints was a positive indicator and brought the Trust more in line with expectations. She noted that within the complaints there had been three alleged assaults by staff. She had sought assurance on these cases and, whilst she could not share this in public, she would provide comment for the Board in the private session.	
7.9.	SH noted that the Board was seeing complaints from Kingston Private Health patients for the first time and asked what level of complaints was to be expected from private patients. SBr thought private patients might raise different concerns but suggested that the Board returns to this in more detail once there is more data.	
	<u>Responsive</u>	
7.10.	MM reminded the Board that the four constitutional standards are delivered from the same resource and that diagnostics capacity issues cut through many of the pathways. She set out what was being done to manage the challenges.	

7.11.	The Trust continued to pilot the Faster Diagnosis Standard (FDS) for Cancer and continued to perform well. More would be known about the FDS by the end of March.	
7.12.	It was disappointing to have missed the RTT target narrowly in December. This reflected dependency on diagnostics coupled with growth in demand across a number of pathways; redirection of resources to cancer pathways had taken its toll. Diagnostics capacity was a national issue. There was a shortage of people with the right skills and, whilst there was investment in training, it would take time to plug the gap.	
7.13.	MM was proud that the Trust had sustained its A&E performance but the growth in demand had absorbed diagnostic capacity. There remained challenges to patient flow but the Delayed Transfers of Care (DTOC) position was solid and Same Day Emergency Care (SDEC) was running and producing good outcomes. The Mental Health Assessment Unit (MHAU) was proving very beneficial for patients and patient experience overall.	
7.14.	CW congratulated the team for managing performance so well. She could sense this it was tough but the Trust was managing to keep performance in a good place relative to national performance.	
7.15.	SB noted the constant fine-tuning needed to service demand in each area. She had observed teams across the Hospital working seamlessly together day in day out and thanked them for their constant surveillance.	
	<u>Well Led</u>	
7.16.	KC was pleased to report strong KPIs for this period. The vacancy rate (5.59%) was remarkable as the next best in London was 8%. The Trust had proven itself good at recruiting and attracting qualified nurses, medics and AHPs. A Recruitment Hub for SW London would be led by Kingston Hospital and the challenge would be how to maintain high performance whilst working to improve it for partners.	
7.17.	Work on areas with above average turnover continued, particularly admin and clerical. Early indicators from the latest staff survey triangulated with corporate functions requiring focus.	
7.18.	The Appraisal rate was a rolling target so, whilst completion rates were not yet to target, staff survey feedback indicated that quality of appraisals is good. KC reminded the Board that 2020/21 would be the first year that appraisal is linked to pay. RH asked whether appraisers were being prepared for linking pay awards to appraisals. KC reported that policies were under development but that guidance was not yet released. There would be processes for moderation and appeals. It was important to ensure that managers were applying incremental steps fairly and not using them punitively. Outcomes would be monitored carefully for equality and diversity impact, particularly where increments were withheld.	
7.19.	DR asked whether there was an underlying story around the sickness rate in the Unplanned Care Division. KC commented that the staff survey indicated workload pressure and a strong work ethic leading to staff coming to work while sick. MM endorsed this comment, saying that often staff feel they must not let colleagues down.	

8.	**End of Life Strategy Update**	
8.1.	The Board had received an update and assurance that the Trust is delivering the key elements related to End of Life Care (EoLC) outlined in the strategy dated 2018-21.	
8.2.	NK presented a summary of the report, emphasising that EoLC at KHFT is everyone's business and incorporates the input of stakeholders and partners. She outlined the progress made in six areas: engagement and clinical ownership; identification of patients in their last year of life; maintaining high quality of care; investment in patient and carer information; support for staff; and cross boundary working. NK described the current challenges in delivering the strategy and the plans under way to overcome these	
8.3.	SB thanked NK for her report, emphasising how passionately she felt about this area of care and the positive impact it can have for patients.	
8.4.	SH had felt very proud about the thoughtful and wide-ranging approach. She asked what education was taking place in care homes so that advanced care plans are put in place. NK agreed this was an area of focus moving forward, pointing to the early steps taking place as described in the report.	
8.5.	CW had been pleased to be given insight into whether the challenges were seen as achievable or not, and asked about development of a further strategy from 2021. NK explained this was in the shaping phase and was currently high on the agenda for the EoLC group.	
8.6.	SB asked NK to explain more about recognition of dying. NK described the challenge of broaching the conversation with patients and families. There were robust training programmes in place designed to give staff the skills to have the conversation and for the next steps to be managed.	
8.7.	NC noted reference to an interoperability issue between two systems and asked how big an issue this was. JKW explained it was not interoperability but finding a solution to the current situation of requiring two separate log ins to the two systems. A solution was being tested London-wide and she thought connection through the electronic patient record was nearly there.	
8.8.	SB found the EoLC group meetings to be both vibrant and challenging. She agreed that EoLC was everybody's business, and was gratified to see that Emergency Department staff were participants in the group, actively thinking about people at the end of life who may come through ED. She thanked NK for her passionate leadership in this area.	
9.	**Safe Staffing**	
9.1.	The Board had received an update on the progress made with the implementation of the Developing Workforce Safeguards, as well as assurance around safe staffing within nursing, midwifery, medicine and allied health professionals. Progress made to ensure future plans are in place to sustain the position was highlighted.	
9.2.	NK described the report as extremely positive and drew out key highlights. It was a significant achievement to have no vacancies for qualified midwives and a fully staffed Neonatal Unit. Sickness rates for Health Care Assistants (HCA) and Maternity Support Workers had also improved significantly. She was pleased to report that the Trust was continuously looking at how to provide patient care in different ways with different skills mixes and praised the innovative working taking place across the Trust.	

9.3.	NK drew the Board's attention to HCA turnover, which remained high. Across London there was difficulty in recruiting Nursing Associates. Speech and language therapy was now on the skills shortage list; whilst this was not an issue for the Trust at present this would need to be monitored.	
9.4.	RH asked about ongoing work to change overseas recruitment and also why the vacancy rates seemed to be so different between the Unplanned and Planned Care Divisions. It was explained that the latter was due to a difference in roles between the two divisions. KC thought it was difficult to predict what the new policy on international recruitment would be post-EU Exit. The NHS Chief People Officer had talked about taking an ethical national view rather than having local policy.	
9.5.	As Maternity Safety Champion for the Board, CW highlighted how unusual it was that there were no vacancies for midwives. She thought the Board should be aware that investment in maintaining midwifery ratios had been really important in encouraging a positive culture in Maternity services. It was no accident that the Home Birth team had won a best team award as Kingston Hospital was a place where midwives could offer choice and had a chance to practice how they want to practice.	
9.6.	SB drew links between HCA turnover and SBr's comments about experience levels of nurses in relation to pressure ulcers. She saw the work that HCAs do as essential to patient care and allowing nurses to work at the height of their skills. A recent report from Healthwatch had asked if the Trust could increase ways in which it demonstrates how much it values the work of HCAs. NK noted that demands on HCAs had increased and there was a need to undertake a deep dive into the ratios of HCAs. She had been discussing this with the Heads of Nursing as part of business planning for 2020/21. SB suggested there may be synergy with community HCAs and an opportunity to create more of a career infrastructure as had been achieved so successfully with other roles. The deep dive might also help to understand how much of HCA turnover was due to staff passing through the role prior to medical training.	
9.7.	JKW noted that the Guardian of Safe Working report would cover safe staffing for junior doctors. In the consultant body, availability of Care of the Elderly consultants was the greatest concern. There was a national shortage and would be a pressure area for the Trust through maternity leave in the team.	
	SUSTAINABILITY	
10.	**Finance Report**	
10.1.	YR presented the report for Month 9 of 2019/20. The summary scorecard was new this month and was welcomed by Board members. YR emphasised that the Trust was forecasting delivery of the 2019/20 control total and will secure PSF funding.	
10.2.	The Finance & Investment Committee had undertaken a detailed review of the M9 report. YR presented highlights as: • Income YTD favourable, which was encouraging but due to non-recurrent and winter funding. • Pay variance YTD slightly under due to phasing of contingencies and M9 adverse because costs for increased demand were coming through. • CNST Maternity rebate had been received. • FIP delivery was broadly in line with plan but with non-recurrent schemes.	

10.3.	The Finance team was working with all Divisions and Corporate areas to maintain focus on achieving the control total. The Trust had been invited to submit a request for additional capital funding.	
10.4.	The 5 year system plan had been submitted in November. Planning guidance was yet to be received regarding next year. YR anticipated that a submission would be required in early May. The Trust continued to work with system partners on transformational schemes for 2020/21.	
10.5.	JG expressed gratitude for the work that had gone into ensuring a system approach was taken to addressing the financial challenge this year. It was excellent news that the Trust was on target to achieve the control total. This year had presented a tough challenge that could not have been resolved without a collaborative approach across the system.	
	ANNUAL REPORTS	
11.	**Guardian of Safe Working**	
11.1.	The Board had received the annual report of the Guardian of Safe Working. SMM gave a presentation summarising the key points from her report.	
11.2.	Since the previous report, SMM had worked with F1s and F2s as those groups had had a low reporting rate. She was pleased to report that the latest data – October 2019 to January 2020 was showing an increase in reporting from those groups.	
11.3.	SMM flagged that General Medical and Trauma & Orthopaedics were hotspots for exception reporting. She believed this was due to rota gaps in both areas impacting on the ability to fill shifts. By contrast, the A&E rota also had gaps but exception reporting was low due to the extra workload being taken on by senior clinicians. She was working with that team to see where there was learning to be shared with other areas.	
11.4.	SMM gave assurance that the Trust is coming into line with the changes made to the Junior Doctors contract in 2018 and no fines had been levied in the year. The target of achieving Educational Supervisor response time within 7 days was not being achieved; compliance was improving but could perhaps be improved by changing reporting to Clinical Supervisor level and this was being looked into.	
11.5.	SMM concluded that Junior Doctors are generally working safely in terms of their working hours and patterns at present. She made a number of recommendations for further action.	
11.6.	Discussion took place on use of 'fatigue and facility charter' funds to improve facilities, as well as provision of hot food out of hours. SMM outlined plans for improvements to the Junior Doctors' Mess and provision of satellite areas for overnight and weekend rest. SBr asked whether there was any reason why use of the satellite mess in Obstetrics should be limited to doctors as a shared space could open up more opportunities. SMM would investigate and discuss with the Junior Doctors Forum.	JKW
11.7.	JG commented that including all non-training grade doctors who share the rotas would seem sensible as a means of ensuring safety. Concentrating only on the junior doctors was more about measuring compliance with the contract.	
11.8.	Social media comment around staff working out of hours becoming dehydrated was noted, and a question asked about the extent to which this applied to KHFT. SBr had been assured that there are water fountains throughout the Hospital. The nursing staff were more organised about planning and taking breaks than	

	the medical staff so there were issues to resolve around culture rather than provision of water.	
11.9.	The Board thanked SMM for her helpful recommendations and report. KC was asked to follow up on the issues around bank shift payments and inclusion of all doctors in the reporting mechanisms.	KC
12.	**Emergency Preparedness**	
12.1.	MM presented a report to the Board on the 2019-20 Emergency Preparedness, Resilience and Response (EPRR) Assurance outcome and the Trust's declaration and self-assessment against the NHS Core Standards 2019-20.	
12.2.	DR asked how prescriptive the check points were behind the ratings. MM described the tests as prescriptive, with evidence submitted of having acted on the requirements. She cited the recent internet outage in Kingston as a good example of how the Trust responds to, and recovers and learns from, major incidents.	
12.3.	JG asked in relation to Coronavirus how the Hospital moves from general preparedness to actual response. MM explained that the Mass Casualty Plan would apply and had been tested so as to be ready should a real response be needed.	
12.4.	The Board noted the level of EPRR assurance achieved, areas of good practice and key priorities for the next 12 months.	
13.	**RM Partners**	
13.1.	The Board had received the RM Partners evaluation report for information and NK presented key highlights. It was recognised that funding of the Vanguard had benefited earlier diagnosis at KHFT.	
13.2.	The Board found the broader view of the report provided useful context around the cancer performance, of which the Trust was very proud, as well as assurance on the impact of investment on patient care.	
BOARD COMMITTEE REPORTS		
12.	**Quality Assurance Committee**	
12.1.	The Board noted content of discussions at the meeting of the Committee held in December 2019.	
12.2.	CW drew out evidence of the impact of volume of work on the Hospital and the importance of collaborative working to find solutions. The deep dive into Rheumatology Outpatients transformation work had underlined that getting it right would need a QI focus and transformation in collaborative way. This applied equally to transformation of Outpatients in other specialities.	
13.	**Finance & Investment Committee**	
13.1.	The Board noted the update from the Finance & Investment Committee meetings held on 19th December 2019 and 23rd January 2020	
13.2.	JG highlighted that the Committee was increasingly seeing system-wide business cases and this had brought about a helpful and thorough debate around governance. JG expressed thanks on behalf of the Committee to DIB for all she had done in the Finance team and wished her success in her new role.	

14.	**Workforce Committee**	
14.1.	The Board noted the update from the Workforce Committee meeting held on 15th January 2020.	
14.2.	SH drew the Board's attention to the continuing work on reducing turnover in Admin & Clerical staff. Cohort recruitment had started and the need to engage with medical staff to ensure workforce design principles were clear and relevant had been recognised.	
14.3.	SH commended Nikki Hill, Associate Director of Workforce for the difference she had made to apprenticeship provision within the Trust and the exciting proposal for the Trust to become an apprentice training provider for the wider community.	
15.	**Equality & Diversity Committee**	
15.1.	The Board noted the main areas of discussion at the Committee meeting held on 3rd December 2019.	
15.2.	RH highlighted work with the Learning & Disability Collaborative, which had raised awareness across the workforce as well as for patients.	
15.3.	RH reminded the Board reverse mentoring and how this could bring about cultural change. It could be applied to any population feeling less powerful and unequally treated, not just race, and she was delighted the Board had committed to introducing reverse mentoring into the Trust.	
15.4.	RH noted the launch of Rainbow badges within the Trust, and that this had been initiated by junior doctors.	
16.	**Audit Committee**	
16.1.	The Board noted the main areas of discussion at the Committee meeting held on 10th December 2019.	
16.2.	DR drew two points to the attention of the Board following his first meeting as Chair of the Committee: the integration of governance of the Private Patients Unit with the Trust; and a strong compliance report received on Safeguarding.	
16.3.	DR reported that he had met with the auditors as part of his induction. The meeting had provided good assurance on the processes in place and the auditors had been complimentary about the Trust's management.	
CHARITABLE FUNDS		
17.	**Charitable Funds Committee Terms of Reference**	
17.1.	The Board reviewed and approved the amended Charitable Funds Committee Terms of Reference and approved the appointment of an additional Non-Executive Director to the Charitable Funds Committee effective from 1st February 2020. DR would join the Charitable Funds Committee from that date.	
GOVERNANCE		
18.	**Register of Sealing**	
18.1.	The Board had received a report documenting use of the Trust seal since the last report to the Board in September 2019.	

19.	**Board Assurance Framework (BAF)**	
19.1.	SS reminded the Board that the purpose of the BAF is to assess the controls in place to manage risks to delivery of strategic objectives, and that it is closely linked to the Trust Risk Register where all risks scored 12+ are recorded.	
19.2.	The Risk Register Overview highlighted the four top risks for the Trust remained the same as for the previous report. SS identified new commentary under breakthrough objectives 1 and 4 in particular.	
19.3.	Board members noted the content of the BAF, and agreed that the overview was aligned both to the focus of Board agendas and to their understanding of the Trust's current position.	
20.	**Chair in Common - Conflicts of Interest**	
20.1.	SS presented legal and regulatory considerations regarding the Chairman's appointment as Chair in Common with Hounslow & Richmond Community Health NHS Trust.	
20.2.	It was noted that the Trust's Constitution, and the provisions of the NHS Act 2006 on which it was based, permit directors to have conflicts of interest where these have been authorised by the Board. The Board accepted that the Chairman's role as Chair in Common for KHFT and HRCH represented a potential conflict of interest, and approved the basis on which this potential conflict of interest had been accepted and would be managed.	
21.	**Items Discussed in Private**	
21.1.	The Board noted in the public domain an outline of the matters covered in private since the last meeting in public.	
22.	**Forward Plan**	
22.1.	Content of the plan for public meetings of the Board for 2020 was noted.	
	QUESTIONS FROM THE PUBLIC	
23.	RA thanked the Board for a powerful patient story in which individual initiative had been so important. He asked about HCA exit interviews and whether these gave any insight into why turnover in these roles was higher than in others. KC explained that there were different reasons for taking up the role, and that 100 day surveys were conducted to see how new recruits were finding the role. The focus at present was to work to ensure that HCAs feel part of the team.	
24.	RA was concerned about the position on diagnostics and asked whether enough was being done to plug the gaps. MM confirmed that the Trust was doing everything possible in her view. There were no trusts in London able to support with echo capacity, and if there were, patients were not always willing to travel. Capacity had been outsourced as far as possible and clinical reviews with GP partners had been undertaken to look at triaging referrals and revising end to end pathways. Training was being provided to increase the number of staff available but the training took 2 years to being fully skilled so this was not a quick fix.	
25.	JS asked whether the analysis of people presenting at A&E and their reasons for being there had concluded. MM identified that the greatest increase in attendances was in working age adults, and that the principal reason was convenience: inability to access a GP at a time they would like coupled with A&E opening hours. The local population appeared to be fully aware of all the services available, including Out of Hospital, 111 and clinical hubs, but still	

	choose to attend. Work was now taking place on reducing Ambulance conveyances as it had been found that currently 10-12 patients conveyed per day do not require acute care.	
26.	FK asked whether there was anything to be done about how HCAs see themselves and the value of their role to the organisation. SH noted that the HCA experience had parallels in other organisations where there could be learning about building self-esteem in those at the lowest end of the structure. SBr explained that prizes and awards at the Nursing & Midwifery Conference had been given across the spectrum of roles in order to foster inclusivity; however she would consider what else could be done.	SBr
27.	FK had read that 25% of leavers have less than a year's service, and asked whether this was across the board or only in certain service lines. KC explained that the Stability index at 87.5% is high in comparison to peers. However, it was thought that Bands 2&3, both clinical and non-clinical, would account for the highest number of early leavers. SH suggested that the Workforce Committee might do a deep dive to understand the issues further.	
28.	FK had never heard of pressure ulcers before becoming a governor and had agreed that prevention through movement and hydration were important messages to get out into the community. She asked whether governors might be able to help with this? JF agreed there was a role for effective communication and engagement with the community on prevention and was working with the Interim Head of Communications to flesh out the Communications & Engagement Strategy so as to understand what it really means for the population and working with partners.	
29.	MF asked how far the Outpatients transformation projects had progressed in terms of different projects. From the NED perspective, CW knew that Outpatients transformation is a very large programme looking at a range of issues and revolved around getting the right people at the right place at the right time. However, GP patterns of referral would not change overnight so progress might not be immediately obvious. JKW reported that some specialities had made more progress than others. The deep dive on Rheumatology had shown that referrals had increased more than in other services. Learning from the deep dive showed the need to increase the ability to help patients with long term conditions to manage their condition themselves. Some GP practices were more linked in to be able to do this than others, and SW London Pathology was working to increase links to other areas.	
30.	BG echoed earlier comments on the value of the patient story; she had been taken by JG's response on how the story demonstrated staff living the values. BG welcomed the neonatal audit and was pleased to see the results coming out so well, particularly with parents involvement. On pressure ulcers, she was concerned that half of the increase was in Levels 3 and 4, and looked forward to hearing more on that.	
31.	BG had been interested to hear the discussion about readmissions and commented on her own experience caring for a family member discharged soon after surgery. SBr outlined the work taking place to provide support around discharge from soon after patients are admitted. She recognised the difficulties for patients and their families, but into context that it is better for patients who can be safely discharged to recover at home. The Discharge Volunteers had been a great success in helping people to prepare to go home and there was also work taking place to draw together sources of care and support in the community.	

32.	SB concluded the meeting with a public tribute to JKW, retiring as Medical Director at the end of March after 10 years in the post. SB noted that JKW had been a champion of improvement and transformation, and praised her openness, transparency, honesty and commitment to learning. She had been instrumental in developing the organisation as a learning organisation and fostering a non-blame culture.	