Draft Minutes of the Meeting of the Trust Board
held on 28th July 2022 at 09.30am
in Lecture Theatre 2, Kingston Hospital Surgical Centre and via MS Teams

PRESENT VOTING		
Sukhvinder Kaur-Stubbs	Chair	SK-S
Jo Farrar	Chief Executive Officer	JF
Kelvin Cheatle	Chief People Officer	KC
Dr William Oldfield	Chief Medical Officer	WO
Sylvia Hamilton	Non-Executive Director	SH
Dr Rita Harris	Non-Executive Director	RH
Dr Nav Chana MBE	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		
Samuel Armstrong	Director of Corporate Affairs & Company Secretary	SA
Denise Madden	Director of Strategy & Transformation	DM
Stephen Hall	Director of Performance & Planning	SHa
Tracey Moore	Director of Operations	TM
IN ATTENDANCE		
Irfan Mundiya	Deputy Director of Finance (for Yarlini Roberts)	IM
Tara Ferguson-Jones	Director of Communications	TFJ
Sarah Shade	Deputy Chief Nurse (for Nichola Kane)	SS
Caroline Hopper	AHP Strategic Lead, KHFT & HRCH (item 9)	CH
Rev Susan Van Beveren	Head of Chaplaincy, Pastoral & Spiritual Support Services (item 12)	SVB
Daniel Parker	Deputy Emergency Preparedness Manager (item 13)	DP
Susan Wheeler	Corporate Governance Manager (minutes)	SW
MEMBERS OF THE PUBLIC	**Via MS Teams**	
Bonnie Green	Elected Governor	BG
Jack Saltman	Elected Governor	JS
Ashling Neil-Gallacher	Elected Governor	ANG
Alison Dicks	Staff Governor	AD
Jennifer Bunn	Staff Governor	JB
APOLOGIES		
David Hawkins	Director of Corporate Infrastructure & Integration	DH
Yarlini Roberts	Chief Finance Officer	YR
Nichola Kane	Chief Nurse	NK

1.	**Welcome and Apologies for Absence**	**Action**
1.1	SK-S welcomed all present and in attendance.	
1.2	Apologies were received from Yarlini Roberts, Nichola Kane and David Hawkins.	
2.	**Patient Story**	
2.1	SS introduced the patient story video. It was noted that full consent had been given to share the video at the Board meeting, however not for publishing on the Trust website as part of the Board meeting.	
2.2	A member of staff at the Trust gave an account of the events surrounding the death of her father in 2017, which the Board noted.	
2.3	CW felt that the story underlined the importance of hospital staff observing duty of candour, and of maintaining open and honest dialogue with patients, family friends and carers. She added that duty of candour at the Trust was much improved over recent years.	
2.4	RH commented on the corrosive effect a lack of transparency and dignity had on patients and their families. This distressing story demonstrated exactly why staff should be open, as the 'not knowing' could be so debilitating.	

2.5	NC remarked on the difficulties of managing palliative care in a busy acute hospital, where staff were so focused on delivery of good care but did not necessarily have an understanding of end-of-life care and the needs of the patient and family. He felt that the story was a good example of non-patient/relative/carer centred care.	
2.6	JF offered his apologies to the family of the deceased for the distress caused by these events. JF referred to the hospital's complaints process and commented that some of the complaints he dealt with involved pages of communication, giving a technical account of what did or did not happen. He wondered whether there was a more humane and caring approach that could be adopted at the time of an incident; perhaps to engage in more dialogue so that the families and carers could get a better understanding of events as they happened.	
2.7	DR commented on the need for compassionate leadership in such cases, providing support both to the families and carers, and to the staff involved.	
2.8	WO added that there was a sense that staff avoided giving bad news. The Trust needed to support and help facilitate staff in how to give bad news. As in this case, no news was worse than bad news. He also felt that the nurses particular to this case appeared to lack senior leadership, as there were relatively junior nurses trying to manage an end-of-life situation.	
2.9	SK-S extended her sincere apologies to the family. She assumed this example had been brought to the Quality Assurance Committee to reinforce some of the lessons.	
3.	**Declaration of Interests in Matters on the Agenda**	
3.1	SK-S declared her role as Chair in Common for Kingston Hospital and HRCH. There were no other declarations of interest.	
4.	**Minutes of the Previous Meeting**	
4.1	The minutes of the previous meeting held on 25 May 2022 were approved as a correct record.	
5.	**Action Log / Matters Arising**	
5.1	**Action Log ref: 8.7** – Integrated Quality & Compliance Report (data reporting). In response to a question, it was confirmed that the target date was for final completion.	
6.	**Chair's Report**	
6.1	The Chair gave a verbal report on her activities since the last meeting. She had: • continued her priority to connect with different teams across the hospital, notably Chaplaincy, Macmillan services and the Therapies teams since the last Board meeting; • attended celebratory events – Hidden Disabilities Day, Nursing & Midwifery Day, Jubilee celebrations, Clinical Audit, and the Volunteering Awards; • engaged externally with stakeholders, including the Acute Provider Collaborative (APC), the Integrated Care Partnership (ICP), other regional chairs, MPs, the Mayor of Kingston, and community and voluntary organisations; • continued to work with the Lead and Deputy Lead Governors to support the Council of Governors in their efforts to re-engage with patients, visitors and the wider community; • noted that progress continued on the appointments of NEDs in Common, and it was hoped that confirmation on the appointment of a Primary Care NED in Common and a Workforce NED in Common would be completed soon. Work was underway to recruit Associate NEDs in Common – one leading on Digital Transformation and the other on Equality, Diversity & Inclusion; • continued to work with the CEO and the Board on the Trust's ED&I Strategy and Objectives; and • work continued with RH and colleagues at HRCH to develop the Trust's approach to compassion and kindness. The Board noted the report.	
7.	**Chief Executive's Report**	
7.1	JF presented highlights from his report, which was taken as read and noted. He thanked all staff involved in managing the recent heatwave.	
7.2	CW commented on current media coverage regarding the crisis facing the NHS in relation to staffing and hospital waiting lists, and wondered how the Trust was managing these pressures.	

	JF responded that a recent staff Listening Event on the cost of living pressures had taken place. Staff were being stoic in their approach and keen to offer support to their fellow colleagues. Staff had also put forward constructive ideas on things they felt the Trust may be able to help with. It was crucial to stay focussed on staff health and wellbeing and to help address workforce stability. Regarding waiting lists, the Trust needed to ensure that it was treating patients who most needed care as soon as possible. For those anxiously waiting for care, the Trust needed to ensure that it was communicating openly with them and offering reassurance.	
7.3	SK-S added that, whilst there were significant and sustained challenges, she had been impressed with how positively and constructively staff were responding to the situation.	
7.4	DR referred to the recent heatwave and asked if lessons on responding to this would be learnt. KC responded that work-arounds had kept everyone safe and as cool as possible. He acknowledged that this would not be a one-off event, and that the Trust needed to plan for future similar events.	
7.5	TM reassured DR that the Trust had Business Continuity Plans in place for such events. It was acknowledged that some areas of the hospital were better able to manage a heatwave, so focus had been maintained on those areas that could not respond to the same degree. Areas of learning would be reflected upon.	
7.6	NC referred to the Integrated Care Board (ICB) update and sought assurance regarding the consequences of the reforms, and that there were other action-orientated plans that would make a difference to some of the challenges faced across the system. JF responded that the Trust had been working on a common set of priorities within Place for some time, with a number of areas being taken forward, for example, obesity, frailty, children and young people's mental health, and addressing inequalities. None of this had changed on 1st July 2022 when the ICB came into being. JF was confident that work that had already been undertaken would continue to gather pace, and he felt that the ICB would be an enabler to that work.	
7.7	JG highlighted the importance of the Trust's Sustainability Plan, which was different to the Trust's approach to efficiency. What were the Trust's key areas of focus? JF felt that it would be beneficial to produce a counter-factual of what the things would look like in 5-10 years' time if the Trust did nothing. Workforce would need to be examined to identify where the pinch points were likely to be, and use the analysis to think of the most impactful interventions, some of which should be implemented sooner rather than later. Funding would be available through the Integrated Care Partnership (ICP). How funds would be accessed was to be discerned. It was important to think about this over the immediate months prior to the winter period that came with all its challenges. JF confirmed that some investments may not be within the Trust, but elsewhere in the system.	
7.8	SH asked JF to elaborate on workforce statistics, particularly related to recruitment and retention, and the worrying figures on sustainability; she sought assurance that the Executive was focusing on the critical areas of prioritisation, acceleration and innovation. JF agreed that the Trust needed to progress at pace. On the back of the recent NHS pay award, the Trust needed to work through the implications of it, and to question if there was a gap that needed to be bridged. The Trust needed to be doing all it could to support its staff in the current cost of living crisis. It was a top priority to think creatively about how it could attract and retain staff and to continue working collaboratively with its partners to develop a different model.	
7.9	KC confirmed that discussions would be taking place at the Workforce & Education Committee on innovation and the pace of recruitment and retention. Many HR staff were embedded in business as usual, but some needed to be freed up in an innovative way to enable them to carry out this transformation work and accelerate change in real time.	
7.10	In response to a question from RH, KC responded that the Trust was endeavouring to vary and enlarge its recruitment base so that it could capture the necessary talent it needed. The Trust was also mindful of how best to recruit those with disabilities or mental health issues. The Diversity Champions could be of some help with this.	

	He noted that the Royal Borough of Kingston had recently held a symposium on the cost of living. There were 12,500 people in Kingston out of the employment cycle, and some of those had skills that the Trust could use so it needed to find a way to reach out to them.	
8.	**Integrated Quality and Operational Compliance Report**	
8.1	The Integrated Quality and Operational Compliance Report was taken as read and noted.	
8.2	**Safe** SS provided highlights from the Safe section of the report, and WO provided a brief summary of Serious Incidents in June 2022.	
8.3	SS drew the Board's attention to the fact that additional information on Caesarean section (CS) rates had not been included in the report. However, this would be added to future reports, with updates provided on a quarterly basis. Between January 2022 and June 2022, the Trust's CS rates ranged between 37.6% and 39.6%. She noted that this figure was above the national average, which was normally around 1 in 4. However, Kingston Hospital benchmarked itself against its peers in South West London, and the majority of those CSs were carried out in patients who were classified under the Robson Group 2 system. There had been no change in this pattern over recent years, and there were no clinical concerns within the service.	
8.4	**Effective** WO provided highlights from the Effective section of the report.	
8.5	**Caring** SS provided a summary of the Patient Experience section of the report.	
8.6	**Responsive** TM provided highlights of the Responsive section of the report.	
8.7	Given the importance of elective services recovery, SK-S wondered what sort of prioritisation the Trust was able to give to surgical pathways and theatre utilisation, and how long it would take to get back to pre-pandemic levels. TM responded that returning Isabella Ward to a surgical emergency ward had made a significant difference in the recovery of elective services, meaning that Astor Ward and Alex Ward were able to return to their former purpose of delivering 20-30 elective beds. This may revert as the Trust headed towards the winter months in order to manage admissions from ED. The elective backlog was such that the Trust needed investment over the next 8 months to reduce the numbers of those waiting. It was hoped that by March/April 2023 the Trust would return to its pre-pandemic waiting list position; however, it was difficult to predict with certainty at this time.	
8.8	**Well-Led** KC provided a summary of the Well-Led section of the report.	
9.	**Allied Health Professionals Project Update**	
9.1	CH provided a summary of key highlights from the AHP project update, which was taken as read and noted.	
9.2	NC referred to the 13 AHP roles described in the report and wondered how this mapped against the growing number of needs across the physical, mental health and social care sectors. CH responded that preventative care, where AHPs working collectively as a whole, was so important. She noted that when patients were admitted to ED, they tended to stay in hospital for longer. Patient de-conditioning was evident when waiting for a long time in ED.	
9.3	CH confirmed that the final recommendations in the report would be coming to the Committee in Common in October 2022. CH would follow through the appropriate channels of governance and take the business case to the Finance & Investment Committee.	
10.	**CQC Inspection of the Trust Dental Service**	
10.1	The paper was taken as read and noted.	
11.	**Finance Report**	
11.1	IM provided a summary of the Finance Report for month 3, which was taken as read. The Board noted the Trust's performance against the three key objectives: • I&E break-even plan for 22/23. • Deliver elective activity to achieve ERF in 22/23 of £6.9m. • Achieve Capital Delegated limit.	
11.2	JG commended the ongoing work to improve the Trust's efficiency, as it recovered from two very difficult years. It was noted that although non-recurrent savings could help in the short term, the longer term challenges would take some work to mitigate against.	

12.	**Organ Donation**	
12.1	SVB gave a presentation on the work being done at Kingston Hospital to support organ donation, and gave a summary of her role as Organ & Tissue Donation Committee Chair. The Board noted the report, which was taken as read.	
12.2	JG asked what the potential supply of organ donors was at Kingston Hospital, and how did it compare to its peers. It was noted in response that the Trust remained at a NHS Blood & Transplant Level 3 category. For its small size it delivered a significant contribution to the overall UK donation outcome. WO added that the categories did not take into account how many patients were seen in ED. The Trust performed very well in comparison to others with how many transplants it offered per number of attendances. WO suspected the Trust was operating in Category 1.	
12.3	SK-S noted the outstanding referral rate and acknowledged the great deal of teamwork behind the scenes, particularly Chaplaincy and the role of the nurses in facilitating this with dignity and compassion to those involved in each case.	
12.4	JF assured SVB of the Trust's commitment to support the work of Organ Donation within the Trust and help to overcome some of the challenges presented in her report.	
13.	**Emergency Preparedness Resilience and Response (EPRR) Annual Report 2021-22**	
13.1	DP provided a summary of the EPRR function and provided highlights from the EPRR Annual Report, which was taken as read and noted.	
13.2	JG called out the personal resilience and leadership of DP and ML, which had been exemplary.	
13.3	JG commented that the NHS was going through significant organisational change and, in that context, was the Trust clear about the chain of command and how the lines of communication would work, so that the Trust could be confident that its EPRR system would be effective in a wider context. DP responded that controls were well embedded within the Trust. The EPRR team held regular meetings with the EPRR team in London. The department was well versed on the new integration of the care system, and had regular contact with the Surge Hub to coordinate how they would work together in the event of a major incident.	
13.4	TM commented that the devolution of responsibility to SW London was still evolving, so the Trust still received directives from NHSE.	
13.5	DR asked if the points of assurance were self-assessed by the Trust or if they were audited by NHS EPRR. DP confirmed that every NHS organisation RAG-rated themselves and sent this to the national team. The Trust was then independently audited by NHSE.	
13.6	DP informed the Board that monthly training sessions were held in the Trust. Emergency Plans were also periodically examined to ensure that they remained fit for purpose. A post-training report was drawn up and any improvements were noted for policies and procedures, including the Business Continuity Plans. Training also took into consideration the wider impact of a major incident throughout Surrey. Lessons learnt from other healthcare providers were shared via NHSE.	
14.	**Finance & Investment Committee Report**	
14.1	JG presented the FIC report, which was taken as read and noted.	
15.	**Quality Assurance Committee Report**	
15.1	CW presented the QAC report, which was taken as read and noted.	
16.	**Audit Committee Report and Terms of Reference**	
16.1	DR presented the Audit Committee report, which was taken as read and noted. The Terms of Reference were approved by the Board.	
17.	**Workforce & Education Committee**	
17.1	SH presented the WEC report, which was taken as read and noted.	
17.2	RH asked for clarification on how the NEDs would fulfil their roles and responsibilities across the various HRCH / KHFT committees and sub-committees. JF suggested that as part of the work underway to identify where the NEDs/NEDs in Common would have responsibilities, and where the roles and relationships might be, it would be helpful to refer to the list of specific roles / responsibilities the regulators required the Trust to have.	

18.	**Equality, Diversity & Inclusion Committee**	
18.1	RH presented the ED&I Report, which was taken as read and noted.	
19.	**Seal Register Report**	
19.1	The Board noted the use of the Trust seal.	
20.	**Information Governance Deputies**	
20.1	The Board approved the appointment of Kevin Fitzgerald as deputy SIRO, overseen by David Hawkins who would act in a deputising SIRO role across both Trusts, and Amira Girgis as deputy Caldicott Guardian.	
21.	**Items Discussed in Private**	
21.1	The paper was taken as read and noted.	
22.	**Forward Plan**	
22.1	The Forward Plan was taken as read and noted.	
23.	**Any Other Business**	
23.1	There was no other business.	
24.	**Questions from the Public**	
24.1	Question from Jack Saltman, KHFT Governor. *I have just heard that Covid infections are up 7% on last week and are now at their highest for a long time. But when I am questioned by some of the people I represent about how we are coping I have no answers: How many people are now occupying KH beds? How many are in Intensive Care? How many deaths have we suffered from the virus? How many staff have had to take time off as a result of Covid? Are we getting extra money from Government to help us cope? How has this increase in Covid affected our efforts to catch up on the backlog of elective surgery and visits to specialist clinics? Does the Board feel we should get this information?*	
24.2	JS confirmed that most of his question had been answered during the course of the meeting. However, he felt that the Council of Governors could be kept better informed regarding some of the elements in the CEO's Report.	
24.3	JF stated that the prevalence of Covid-19 cases within the hospital, and its impact, had been relatively minor in comparison to previous surges and in the context of other hospital pressures.	
24.4	SK-S referred to a recent meeting she had had with the Lead and Deputy Lead Governors, who had fed back that communications with Governors was much improved. BG concurred with this comment and added that the Chief Nurse and Medical Director also provided regular updates to Governors.	
24.5	WO suggested that, as per common practice in other hospitals, Governor questions and answers could be published on the website. TFJ welcomed any ideas on this, and suggestions would be triangulated with SA. **ACTION** TFJ to review how the Trust communicates with Governors.	**TFJ**
24.6	Although it happened a number of years ago, BG sought assurance from CW that some of the issues raised in the Patient Story had been adequately responded to. In response, CW confirmed that the most appropriate course of action would be to take this to the Quality Assurance Committee, and that feedback would be brought to the Governors Quality Scrutiny Committee.	
	DATE OF NEXT MEETING	
	The next Board meeting will take place on Wednesday 28 September 2022.	
	RESOLUTION TO MOVE TO CLOSED SESSION	
	In accordance with Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960, the Board approved 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".	

Part 1 of the Trust Board meeting closed at 12.25pm