Minutes of the meeting of the Board of Directors held on
26th July 2017 – 9.30 am to 1.00 pm

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

Present voting:		
Sian Bates	Chairman	SB
Rachel Benton	Director of Strategic Development	RB
Duncan Burton	Director of Nursing and Patient Experience	DB
Dr Nav Chana	Non-Executive Director	NC
Kelvin Cheatle	Director of Workforce & OD	KC
Jo Farrar	Director of Finance	JF
Chris Grindal	Non-Executive Director	CG
Jonathan Guppy	Non-Executive Director	JG
Sylvia Hamilton	Non-Executive Director	SH
Dr Rita Harris	Non-Executive Director	RH
Tracey Moore	Acting Chief Operating Officer	TM
Joan Mulcahy	Non-Executive Director	JM
Ann Radmore	Chief Executive	AR
Apologies:		
Rachel Williams	Chief Operating Officer	RW
Jane Wilson	Medical Director	JKW
In attendance:		
Amira Girgis	Associate Medical Director	AG
Susan Simpson	Company Secretary & Head of Corporate Affairs	SS
Lisa Ward	Head of Communications	LW
Governors:		
Dennis Doe	Public Governor - Kingston	DD
Marilyn Frampton	Public Governor - Merton	MF
Bonnie Green	Public Governor - Richmond	BG
Robert Markless	Public Governor - Kingston	RM
Frances Kitson	Public Governor - Kingston	FK
Marita Brown	Public Governor - Kingston	MB
Cllr Margaret Thompson	Appointed Governor - Kingston	MT
Members of the public:		
Erica Farmer		EF
Philippa Bradley		PB
Staff:		
Ellen Bull	Interim Deputy Director of Nursing	EB
Kate Skov	Staffside Chair	KS
Laura Shalev-Greene	Volunteering Manager (for Volunteering Strategy item)	LSG
Olivia Frimpong	Dementia Service Improvement Lead (for Dementia Strategy item)	OF
Jonathan Grellier	Head of Improvement (for improvement programme item)	JGr
Kate Allen	Named Nurse for Safeguarding Children (for safeguarding items)	KA

		Actions
1.	**Apologies for absence**	
1.1.	None.	
2.	**Declaration of Interests in matters on the Agenda**	
2.1.	None.	
3.	**Minutes of the previous meeting**	
3.1.	The minutes of the meeting held on 24th May 2017 were confirmed as a correct record. Progress on matters arising was noted on the action log.	
4.	**Chairman's Report**	
4.1.	The Chairman noted that this was DB's last public meeting as a member of the Board. The Board recorded thanks to DB for the huge impact he had made on the Hospital.	
4.2.	SB summarised work she had undertaken internally since the last meeting. The Director of Nursing interviews had culminated in a successful appointment. Good progress had been made in appointing new consultants in Elderly Care, Stroke and Gastroenterology.	
4.3.	SB highlighted the Clinical Audit and Improvement Seminar, noting the extent of work taking place in terms of improvement and clinical excellence. She recorded the Board's thanks to Anne Jones, Head of Clinical Audit, who had recently retired.	
4.4.	The Volunteers Summer Awards presentations had taken place during the very hot weather. Despite the heat the event was as successful as ever and a fitting celebration of the contribution made by the Volunteers to the Hospital's success.	
4.5.	SB had attended the NHS Providers Quality Conference where the focus had been on adding value to patients' lives. She noted particularly the link with palliative care where the right conversations early on can add value at the end of patients' lives.	
4.6.	A number of activities with the Council of Governors had taken place since the last meeting. SB thanked Marilyn Frampton for her tenure as Chairman of the Governors' Quality Scrutiny Committee (GQSC), and for the work the Committee has done in championing patient experience and quality under Marilyn's guidance. SB also thanked Bonnie Green for succeeding Marilyn as Chairman of the Committee. A very successful joint Governor/NED meeting had been held in June 2017, where discussion focused on priorities for each NED and how NEDs and Governors can work together collectively. There had also been a joint Board/Council of Governors development session in June which had included discussion on Estates and Workforce strategies.	
4.7.	SB had been working closely with JM on the Kingston Hospital Charity campaign to improve the environment in the Elderly Care wards in line with the Dementia Strategy.	
4.8.	Externally, SB was pleased to report that work with the Chairmen of the three Acute Trusts in the area was now very much embedded. She had also had an excellent meeting with the NHSE Accountable Officer for South London and believed that collaboration within SW London was moving in the right direction. The shared managerial arrangements across the CCGs in Richmond and Kingston was also enabling a much more holistic view to be taken on collective action.	
4.9.	SB had assisted as an independent assessor for NED interviews for the Board of Croydon Health Services NHSFT. She had also attended a NHS Providers	

	event for the retirement of Ed Smith and had taken part in discussion about development of the culture of the system.	
5.	**Chief Executive's Report**	
5.1.	The Board had received AR's report on strategic and operational issues not covered elsewhere on the agenda.	
5.2.	AR commented on NHS England's rating of STPs and their assessment of the STP for SW London. This indicated that the SW London system was progressing towards sustainable transformation but there was more to be done. She noted that the performance table presented was an amalgamation of the performance of the four Acute Trusts.	
5.3.	AR's report had included an update on immediate actions taken on fire safety. The Hospital was in a good position, having started a programme of reviewing the whole site earlier in the year, prior to the Grenfell Tower fire, and therefore the management team had access to a great deal of useful information. The Trust was working closely with the London Fire Brigade to ensure its response was appropriate in terms of prioritisation and urgency. The Executives had taken the decision to require every member of staff to attend an intensive briefing covering response to a number of emergencies: cyber attack, terrorism and fire. A new style of evacuation sheets had also been purchased and training was taking place on their use.	
5.4.	AR drew attention to guidance issued by NHS England to help Trusts standardise and improve the way they identify, report, review, investigate and learn from deaths. The Board noted action taking place in accordance with the guidance.	
5.5.	AR reminded all present about the planned closure of Norbiton Station during August 2017. All alternative modes of transport for patients and staff had been reviewed and TM would be monitoring the impact of the closure closely for the first few days. There was a risk that the work may overrun and this may impact on patients in the group scheduled to attend in the period immediately after the planned closure. The Trust would be monitoring the situation closely.	
5.6.	Board members were encouraged to attend the Health & Wellbeing Conference in October 2017. Alastair Campbell had been engaged as keynote speaker and there would be a focus on mental wellbeing. SB noted that staff were engaging with positive enthusiasm in the wellbeing activities. KC agreed that this initiative had captured the mood and needs of the staff.	
5.7.	RH was pleased to see mental health first aid taking place and asked about the sustainability of the in-house training offer. DB explained that a grant had been received from Health Education England to roll out child and adult mental health training on a train the trainer basis.	
5.8.	A visit from the Chief Executive and Regional Managing Director (London) of NHS Improvement would take place in August 2017 and would provide the opportunity to showcase some of the excellent work taking place in the Hospital.	
5.9.	AR was delighted to confirm the appointment of Sally Brittain as Director of Nursing & Quality. Sally would join the Trust from Frimley Health, where she was Deputy Director of Nursing. The Trust would also be hosting the Acute Provider Collaborative Programme Director.	
5.10.	Council of Governor elections would take place in November 2017 and potential candidates were encouraged to seek more information.	

QUALITY AND PERFORMANCE		
6.	**Integrated Quality and Operational Compliance Report - June 2017**	
	<u>Safe</u>	
6.1.	DB introduced the commentary on the Safe domain and explained that from next month performance data would be provided on Ecoli. The Business Intelligence team was working on inclusion of Quality Account objectives so that the regular report would include milestones and give greater visibility on performance against agreed metrics.	
6.2.	DB highlighted discussion at Quality Assurance Committee (QAC) on medication incidents, which were receiving national attention. A deep dive was to be undertaken so that the Board could have proper visibility on methods and approaches to this.	
6.3.	The Board noted improvement in vital signs observations; this was good progress and reflective of work done in the NEWS Group.	
6.4.	Safer Staffing figures for June showed a decrease in Nursing agency expenditure against rise last month. There had again been delays in getting visas and this had been escalated to NHSI. An influx of new recruits was expected in July/August with130 due to start. SB asked whether there were any signs that the Trust was losing recruits as a result of delayed visas. DB did not believe so and, as a result of the Trust's good relationship with the overseas provider, good levels of recruitment were being maintained.	
	<u>Effective</u>	
6.5.	DB emphasised that performance on mortality remains good and that there were positive signs from the focus on Sepsis. Over the last few weeks a full time nurse post for Sepsis had been approved for adult work and a part-time nurse post in Paediatrics. IT solutions were also being explored. The Sepsis Group would be discussing plans the following day and would report progress to QAC in August 2017. NC confirmed that QAC had asked for assurance that staff were able to recognise signs and escalate appropriately.	
6.6.	The Board was pleased to note that Hand Hygiene remains good. The percentage of readmissions following emergency admission had risen and the management team was looking into root causes. DB was asked for his reflection on why there was now consistent assessment of dementia patients; he believed this was due to continuous focus on reminding staff what needed to be done.	
	<u>Caring</u>	
6.7.	Response to complaints was good. The trend on numbers of complaints was still reducing and this corresponded to improvements in Friends and Family Test (FFT) scores. A contract had been agreed with an FFT provider which will give the ability to deploy a text option to A&E and outpatients. This was expected to lead to an increase in the response rate, give better data on patient experience and release nursing staff to concentrate on care. The Patient Experience Committee (PEC) had been consulted on the procurement and there would be options to cater for diverse needs. SB commented that she had been impressed by a conversation with a matron who was looking forward to the system being able to produce live data for her to work with.	
6.8.	JM asked whether there was any significance in the spike for Hospital acquired VTE. DB believed this was a good sign that the system put in place through the Serious Incident Group was supporting the identification of Hospital acquired thrombosis. He thought the data was showing better identification rather than increased cases and the upward trend was likely to continue until it reaches a point of stability.	

	Responsive	
6.9.	TM described a positive picture for Cancer and 18 weeks performance. The A&E trajectory for June 2017 had been achieved. For Q1 A&E performance was just below 90% as a result of the highest ever number of attendances in May 2017 impacting on performance for that month. However, across the A&E Delivery Board area the Q1 trajectory had been achieved and it was this figure that qualified for STF funding. TM noted that collaborative working had improved and she hoped this would continue.	
6.10.	SB asked why attendances had increased so significantly in May 2017. AR explained that analysis across borough, age group and cause had identified no clear reason for the spike. JM congratulated the team on achieving the Q1 trajectory and for their continued hard work.	
	Well Led	
6.11.	KC identified vacancies and turnover as the key issues for the Board to note. The Vacancy rate was 11.02 % against a target of 5 %, which was a concern but similar to the same point last year. It was thought this was due to a time lag between setting budgets in April and moving ahead with recruitment. He believed the pipeline would lead to the fill rate improving later in the Summer. Turnover at 17.59 % mirrored national, London and local trends. Brexit was having an impact in turnover of EU staff but more significant was churn in the lower bands where pay was the principal issue. KC was now a member of the Social Partnership Forum, which included national NHS employers and unions. It remained to be seen whether pay review bodies would take a different approach in response to current issues.	
6.12.	KC highlighted Sickness Absence as excellent and a sign that health and wellbeing initiatives were taking effect. As this was linked to Workforce savings it was important that the rate stayed low.	
6.13.	It was suggested that it would aid understanding to show the previous year as a comparator for the Workforce data, and that a forward view may also be helpful. It was agreed that the Workforce Committee should undertake a deep dive to see whether anything more could be done locally for staff in the lower band range.	**KC**
6.14.	DB noted, in response to previous concerns about the impact of bursaries on student nurse numbers, that intelligence from the Universities showed applications had not been affected. He had agreed to increase numbers of student nurses at the Hospital from September 2017.	
6.15.	Mandatory training rates were disappointing but including the Response to Emergencies training in the figures would have a positive impact. RH commented that low attendance at mandatory training could be a sign of staff under pressure. KC emphasised the need to load as much into induction as possible so that staff were well-prepared for work and he believed putting induction onto an e-learning platform would help. DB agreed, noting that mandatory training attendance fluctuated with seasons as it was easier to release staff outside the summer holiday period.	
6.16.	AR was due to meet with the newly elected MPs and was asked to flag the impact of the pay cap and EU changes.	
7.	**Finance Report**	
7.1.	JF gave a summary of financial performance in Month 3 and welcomed the good news that the Trust had qualified for STF funding at the end of Q1. Pay expenditure was broadly on plan in month but there had been overspends in non-pay that needed further investigation to understand the variances. Support for the Trust's improvement programme and sector based procurement initiatives were showing as overspends but would be offset by savings. The	

	Productivity & Improvement Board (PIB) had looked in detail at workforce and pay related Cost Improvement Plans (CIPs). Capex was slightly behind plan for 2017/18 but was currently under review in the light of fire safety requirements.	
7.2.	JG commented on excellent progress in developing CIPs and asked what that investment had helped the Trust to realise. JF gave a brief summary.	
7.3.	SB asked what progress had been made with assessing the mid-year financial health of the whole sub-region and its affordability. AR outlined discussion with CCGs on what will be done differently to drive sustainability, reminding the Board that it had been agreed to focus attention on the sub-region for quality and finance.	
8.	**Inpatient Survey**	
8.1.	The Board had previously received the Picker results in embargoed form but the CQC had now published their report. This cut the data slightly differently from the Picker report seen earlier but still reflected positive improvements. The Board had noted that Kingston was the most improved of all Hospitals in the Picker report, which correlated with data coming through from FFT.	
8.2.	DB explained the bottom up approach to responding to the survey. Picker had led a workshop with patient and staff representation. The action plan had also been discussed at PEC. The substantial improvement achieved was thought to be due to a more granular approach to action planning which achieved buy-in at ward level. RH and SB echoed DB's reasoning and hoped staff at ward level felt proud of the quantum leap achieved.	
9.	**Winter Planning**	
9.1.	TM introduced her report, reflecting on management of winter 2016/17 and setting the scene for the next stage of planning. Activity analysis revealed an increase in attendances by patients aged 80 years+ of 6.83%.	
9.2.	Guidance on Winter from NHSE and NHSI had been received in recent weeks and TM drew attention to expectations on the performance trajectory, occupancy rate and DTOC rate. If the growth trend continued at the same rate the Trust would need additional beds for which there was no physical capacity within the Hospital. Therefore there was a need to mitigate the risk of requiring those additional beds.	
9.3.	TM explained the strategy for 2017/18 would be achieved through better collaborative arrangements with colleagues, focused through the A&E Delivery Board (A&EDB). The Trust's Winter Plan would be contained within the A&EDB's plan. TM believed that mitigation would be supported externally through the Frailty Team, continuation of GP hubs, better communication with care homes and progression of trusted assessor and discharge to assess programmes. Internally, the 'medically fit for discharge ward' trialled in 2016/17 would continue and the urgent care stream was due to come on line at the end of October 2017. The planned expansion of majors and resus would assist in managing surges of ED activity better. The 'plan for each patient' initiative had started with trials on two wards and the plan was to extend this if successful.	
9.4.	RB reported on a comprehensive bed audit that had just taken place with partners. This showed that, at the time of the audit, 46% of patients did not need acute care and 80 of these patients could have been at home. She believed this reinforced the importance of the workstreams TM had been describing. SB asked what assurance there was that discharge to assess would be implemented, having failed to achieve this previously. It was thought that arrangements for collaborative working with colleagues, including inreach on the Hospital site, were much stronger than before. Oversight by the A&EDB was also key to success. AR noted that the current position was as predicted by RB two years ago, and that the context in which conversations were taking	

	place now was therefore different.	
9.5.	JM asked whether sufficient step down facilities were available. NC explained the philosophical debate on whether step down facilities are needed at all. He believed the report recognised that more access in primary care may not have the impact required, noting that this was a discussion to be had at STP level and that elsewhere in the country there is shared ownership of commissioner and provider on step down beds.	
9.6.	JG asked whether there was to be further financial analysis on the 'medically fit for discharge' ward and what the opportunity cost was of carrying that provision. TM explained the need to look at the pros and cons of opening escalation beds vs other initiatives. It was hoped to complete this work over the next few weeks in order to report to EMC.	
9.7.	AR reported that the A&EDB plan for Winter 2017/18 would be submitted by 8th September 2017. AR highlighted discussion on how the money follows the patient through the system. JG commented that it would be helpful to expose the numbers to understand choices for the system.	
9.8.	RH had been interested to read about the partnership work but was also mindful of the need for an internal programme of culture change for the Trust. DB and AR explained some of the initiatives to provide support for nursing and medical staff on culture and practice change. SB welcomed confirmation that the Frailty Team will cover all boroughs.	
10.	**Volunteering Strategy 2017-2020**	
10.1.	DB welcomed representatives from the Volunteering team present to hear the discussion. The Board recognised that the Trust was held in high regard for its Volunteer workforce nationally and had won an HSJ award. The revised strategy highlighted the staff and volunteer focus on diversity and targeted strategic activity on known pinch points: dementia; discharge support; food and nutrition; and mental health. The Trust would continue to nurture volunteers so that the relationship is two way, and would continue to maintain strong governance to enable the Volunteer workforce to contribute positively to the organisation.	
10.2.	RH had been struck by the fact that targeted work makes a significant difference. NC welcomed the strategy and thought there was a need to do more on this nationally as a core resource for clinical teams to call on. He fed back comments from a deep dive that had taken place the previous day, noting that in some areas staff were unsure about what volunteers can and cannot do. DB noted that clear descriptions were available and would discuss this further with the Volunteering team.	**DB**
10.3.	AR linked the importance of the Volunteer workforce resource to the communication strategy; the Trust should make as much of this good news story as possible. She also thought the strategy for leadership development should make use of the opportunity; as Volunteering becomes more integrated, management at different levels becomes necessary and managers need to see this as part of their role. SB commented that judging Volunteer awards had opened her eyes to the reach of the Volunteers and their importance to new models of care. The Volunteering Strategy was approved with great enthusiasm and thanks.	
11.	**Dementia Strategy 2017-2020**	
11.1.	DB introduced the report explaining the strong history behind this strategy over the last three years. An external conference had helped build the strategy from the bottom up over five key areas of focus. He explained that the area of focus on Carers had been changed to reflect more partnership working. The strategy aimed also to build on opportunities for training and education of partners that	

	would build relationships at the same time as transferring skills.	
11.2.	SH asked how dependent delivery of the strategy was on fund-raising and how confident the Executive was those funds could be raised. DB explained that the Trust's capital plan included commitments to fund development of the environment but that some top up would be needed. The Board discussed grant-making and fund-raising opportunities. RH identified the dementia champions as fantastic drivers of culture change. The Board expressed thanks to Olivia Frimpong for work done in this area and approved the Dementia Strategy.	
12.	**Quality Strategy 2017-2020**	
12.1.	DB introduced the updated strategy presented for ratification, noting that the PPI strategy sits beneath it and that some of the dates specified would need revision to reflect the link.	
12.2.	The update of the strategy had included changes in governance structures, frameworks, and organisational structure. It was noted that Quality Improvement is a key component. DB drew attention to the fact that the Quality Improvement Volunteers Group no longer exists; an update on QI volunteers would be included in the PPI strategy, which would be refreshed for discussion by the Board at the next meeting. DB explained the role of QAC and GQSC in the PPI strategy.	
12.3.	The Quality Strategy was approved.	
13.	**Improvement Programme Update**	
13.1.	JGr attended to give a presentation on development of the Improvement Programme, asking the Board to comment on whether the content reflected the right balance between the proposals made and the Board's ambition.	
13.2.	JGr highlighted the role of the improvement programme in the journey to achieving outstanding in 2022. He believed leadership behaviours were key to a change in organisational culture. He gave examples of encouraging improvement on the front line, an assessment of where the Trust is now and the importance of building improvement into daily life.	
13.3.	In response to a question from CG, JGr explained that the ability to achieve the goals of the programme was dependent on the Board's appetite for the scale and pace of travel. He believed the current resource could be a constraining factor if the Board wished the pace to accelerate. AR noted that bandwidth was a constraint and that there needed to be a balance between internal and external support.	
13.4.	RH noted that having leadership that is adaptive and flexible is crucial to improvement, and asked what were the biggest constraints. JGr said there was a perception that staff do not have time to pause and understand problems. Leadership training was helping staff to prioritise and giving people a clearer view of how daily work can contribute to improvement. JF observed that the leadership in change programme was both active and supportive. KPMG was helping to accelerate skills transfer.	
13.5.	NC reflected on a conversation with nursing staff during a recent deep dive where there was frustration over how different elements of the system come together on discharge planning. He asked how the improvement programme prioritised where support could make the greatest difference. JGr explained the mechanism for raising an issue for prioritisation.	
13.6.	RB highlighted the importance of analytics in helping the improvement programme to move forward. In response to a question from JG, JGr commented on Agile Change as a methodology. SH asked whether job design and how that relates had been factored into discussion. JGr believed it had not	

	but would take this into consideration.	
13.7.	JM asked whether there were any areas where the Trust could revolutionise processes. RB noted that KPMG had been asked to help with prioritisation of such cases. SB thanked JGr on behalf of the Board and looked forward to further discussion.	
14.	**Communications Strategy Update**	
14.1.	As the new Executive lead for Communication, KC introduced the report received. He explained that both the Website and the Intranet were key to delivering a number of priority projects, e.g. training delivery. LW was therefore looking to create a digital assistant role to provide specialist support.	
14.2.	LW summarised Communications team activity in 2016/17. There had been a major push on positivity and she was pleased to report that this had resulted in much greater input from staff on things to highlight and celebrate.	
14.3.	LW reported that progress had been made on stakeholder and partnership engagement, although there was still scope for more. She highlighted a key role for governors in helping to engage with key people outside the Trust.	
14.4.	SB asked what the timeline would be to communicate externally the message on 'Our Hospital, Our Future'. LW explained that the initiative had been given internal focus for the first few months but a section on the Website was to be launched the following week. SH noted that the Communications team was small and asked how they intended to prioritise delivery of the remainder of the strategy. The Board recognised that moving towards digital messaging would make best use of the resource available, however SB reminded that there had been strong indication from governors that they would wish to assist in conveying messages to people outside the digital sphere.	
ANNUAL REPORTS		
15.	**Safeguarding Children**	
15.1.	DB presented the annual report and introduced Kate Allen, the Trust's nurse lead for child safeguarding. DB drew to the attention of the Board the increasing number of children and young people with mental health issues and the important work the Trust was doing around this. He also highlighted the work being done to help staff deal with families where it is difficult to maintain a relationship with parents whilst also raising concerns.	
15.2.	RH commented that it was good to recognise that vulnerable adults have children, and to have an understanding of the impact of digital lives on young people in general, not just around cyber bullying. She asked whether there was training for administrative staff to understand the issues. DB said that all staff have safeguarding training as part of induction. KC suggested that leadership training should acknowledge the issues raised in this report.	
15.3.	The Board discussed whether any further action was needed in response to this report. AR would follow up with commissioners on CAMHS investment and where this had been deployed. DB commented that the Chair of the Adults Safeguarding Board had been invited to attend a future Board meeting; last year the Board had heard from the Chair of the Children's Safeguarding Board and this had been a useful exercise. The Board acknowledged that mental health can impact on physical health and vice versa and expressed thanks for the work taking place in this complex area. The content of the annual report was noted and the annual declaration approved for publication.	**AR** **DB**
16.	**Safeguarding Adults**	
16.1.	DB presented the annual report, commenting that the volume of work in this area continued to grow. He highlighted the section of the report covering learning disabilities and asked that Board members taken note of the work on	

	mortality review. SB recalled the patient story at the last Board meeting and appreciated the link between that story and the work described in this report. DB drew attention to a number of improvements during 2016/17, particularly in terms of link nurses and electronic documentation. RH welcomed the alignment of child and adult safeguarding.	
16.2.	The Board heard that Sarah Loades was leaving her post as Safeguarding Lead and acknowledged her contribution to the understanding of safeguarding within the Trust. The content of the annual report was noted by the Board.	
17.	**PALS, Complaints and Incidents**	
17.1.	The Board had received the annual report. As this had been discussed in detail at both Patient Experience Committee and Quality Assurance Committee there were no further comments and the content was noted.	
18.	**Health & Safety**	
18.1.	JF presented the annual Health & Safety report, noting the positive impact of Gilly Ede who had joined the Trust as Health and Safety advisor during the year.	
18.2.	JF highlighted the section on risk management, which was undergoing a thorough review, and that incident reporting had increased whereas health and safety KPIs were relatively flat.	
18.3.	SB welcomed the focus on fire safety through the Health & Safety Committee, as well as targeted reporting through the Executive Management Committee. AR added that training on Response to Emergencies had been introduced since this annual report was written.	
19.	**Information Governance**	
19.1.	JF presented the annual report for 2016/17, drawing attention to the outcome of the voluntary inspection by the Information Commissioner and recommendations from the audit. The Board noted the content of the report.	
BOARD COMMITTEE CHAIR REPORTS		
20.	**Quality Assurance Committee**	
20.1.	NC gave a verbal report on the meeting held on 20th July 2017. The Committee had reviewed divisional updates and the Integrated Quality and Compliance Report. The Committee had also had an in depth discussion on Sepsis and on the increased response rate and decrease in complaints in the Emergency Department.	
20.2.	NC commented that Committee members had been impressed by the report given by the Radiology department on moves to improve equipment and patient experience within the service. He noted the strength of a multi-disciplinary team working together.	
20.3.	The Committee had also received a report on progress against the CQC action plan, noting that in preparing for the next visit there were plans to invite NHSI and peer review colleagues from another Trust to help prepare.	
20.4.	The QAC forward plan included a deep dive into Medication management. A planned deep dive into Dentistry had not taken place as planned due to staff being unavailable at short notice, but it was hoped that the Governors Quality Scrutiny Committee would take the deep dive instead. The QAC had received a report from the latest meeting of the GQSC.	
20.5.	NC expressed thanks to DB, JKW and AG for helping him to prepare for his first meeting as QAC Chairman.	

21.	**Finance Investment Committee**	
21.1.	CG presented the report on the June 2017 meeting of FIC. The July meeting would take place later in the day. The Committee had reviewed its terms of reference, which were approved as presented.	
GOVERNANCE		
22.	**Items Discussed in Private**	
22.1.	The Board noted in the public domain an outline of the matters covered in private since the last meeting in public.	
23.	**Forward Plan**	
23.1.	Content was noted.	
QUESTIONS FROM THE PUBLIC		
24.	DD praised the quality of the reports received by the Board on safeguarding. He asked a question about DTOC bed days and whether the STP was supposed to solve the issue. AR explained that the STP sits across six boroughs, whereas DTOCs are a borough issue and therefore the STP was unlikely to be the answer. She noted that Kingston & Richmond does not perform as well as others. SB reminded DD that the focus for the Board was on the sub-region, Kingston & Richmond and Surrey, all aligned within the SW London STP.	
25.	DD asked a second question about opportunity costs of running a ward for medically safe patients. AR agreed that the financial cost of maintaining patients in a bed once medically safe could be calculated but emphasised the impact on the patient. Evidence showed they were likely to deteriorate in Hospital when they could be at home.	
26.	FK asked a question about the improvement programme and how this could be maintained amidst staff turnover. KC responded that JGr had referred to embedding the improvement philosophy in senior staff so they can empower staff to engage with improvement as daily routine. DB and AG identified that staff would expect there to be an improvement programme in place and therefore this initiative should be seen as a positive step.	
27.	On behalf of the Council of Governors, FK expressed heartfelt thanks to DB for his work in the Hospital and for his support to the CoG.	
28.	BG asked for a definition of a medication incident. DB explained that there were many facets to this and gave some examples. BG acknowledged inclusion in Integrated Quality report of the Quality Account objectives. She noted certain Maternity KPIs moving in the wrong direction and asked whether this was a matter of concern. DB had sought assurance for the Director of Midwifery and had satisfied himself that there was nothing of concern to note. KPI 5.02, highlighted by DB, was below the rate for last year and was tracking well against London averages.	
29.	EF welcomed the many useful annual reports and strategies received at this meeting. In particular she was pleased to hear more about collaboration and learning from others. EF singled out the Dementia Strategy as being clear and beautifully presented. It was clear to her that those drawing up the strategy had listened to many views across the organisation.	
30.	PB noted the many references to IT in the meeting but that a clear data strategy was not evident. She asked whether this would come out of the performance improvement strategy. AR responded that the Board had approved the IT Strategy earlier in the year, which might have answered the question. She believed the Board had access to copious amounts of comparative data, and the issue was more about how to use it sensibly rather	

	than looking for more. RB had been asked to look at what is currently available to ensure what the Board has generates a clear a picture on opportunites and issues as possible. The IT Strategy had included a component part on enabling change in clinical practice, and joining up systems, but this could often be stalled due to data sharing agreements. The Board would receive updates on the IT Strategy to track progress.	
31.	**RESOLUTION TO MOVE TO CLOSED SESSION**	
31.1.	**In accordance with Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960, the Board is invited to approve the following resolution: "That representatives of the press and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest".**	
31.2.	Resolved: that representatives of the press and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.	