King's College Hospital NHS Foundation Trust

AGENDA

Meeting	**Council of Governors**
Date	**Tuesday 26 March 2024**
Time	**16:30 – 18:00**
Location	**The Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill**

No.	Item	Purpose	Format	Lead & Presenter	Time
1.	**STANDING ITEMS**				
	1.1. Welcome and Apologies	FI	Verbal	Chairman	**16:30**
	1.2. Declarations of Interest				
	1.3. Chair's Action				
	1.4. Minutes of Previous Meeting – 5 December 2023	FA	Enc.		
	1.5. Action Tracker	FD	Enc.		
	1.6. Matters Arising	FI	Verbal		
QUALITY, PERFORMANCE, FINANCE AND PEOPLE					
2.	**KCH Financial Position Update from the CFO**	FI	Verbal	Chief Financial Officer	**16:35**
3.	**Freedom To Speak Up (FTSU) Annual Report 2022/23**	FI	Enc.	Chief Nurse & Executive Director of Midwifery / NED (NCW)	**16:50**
4.	**EDI Update**	FI	Verbal	Director of Equality, Diversity & Inclusion	**17:10**
5.	**Governor Questions**	FD	Verbal	Chair	**17:30**
GOVERNANCE					
6.	**Governor Involvement and Engagement**				**17:45**
	6.1. Governor Engagement and Involvement Activities	FI	Enc.	Lead Governor	
	6.2. Observation of Board Committees	FI	Verbal	Governor Observers	
FOR INFORMATION					
7.	**Minutes of the Sub-Committees of the Council of Governors:** 7.1. Minutes of the Patient Experience & Safety Committee (September 2023) 7.2. Minutes of the Governor Strategy Committee (September 2023)	FI	Enc.	Chair	
8.	**Any Other Business**				**17:55**
9.	**Date of the next meeting:** Tuesday 2 July 2024, 16:30 – 18:00 The Boardroom, Hambleden Wing, King's College Hospital, Denmark Hill				

Key: ***FDA****: For Decision/ Approval;* ***FD****: For Discussion;* ***FA****: For Assurance;* ***FI****: For Information*

King's College Hospital
NHS Foundation Trust

Members:	
Jane Bailey	Acting Chair
Elected:	
Dr Devendra Singh Banker	Bromley
Tony Benfield	Bromley
Victoria O'Connor	Bromley
Katie Smith	Bromley
Rashmi Agrawal	Lambeth
Emily George	Lambeth
Prof Daniel Kelly	Lambeth (Lead Governor)
Ibtisam Adem	Lambeth
Deborah Johnston	Patient
Devon Masarati	Patient
Billie McPartlan	Patient
David Tyler	Patient
Dr Adrian Winbow	Patient
Fidelia Nimmons	Patient
Chris Symonds	Patient
Jane Allberry	Southwark
Lindsay Batty-Smith	Southwark
Angela Buckingham	Southwark
Hilary Entwistle	Southwark
Jacqueline Best-Vassell	SEL System
Aisling Considine	Staff - Allied Health Professionals, Scientific & Technical
Dr Akash Deep	Staff - Medical and Dentistry
Erika Grobler	Staff – Nurses and Midwives
Christy Oziegbe	Staff - Medical and Dentistry
Tunde Jokosenumi	Staff – Administration, Clerical & Management
Nominated / Partnership Organisations:	
Cllr. Jim Dickson	Lambeth Council
Cllr Robert Evans	Bromley Council
Prof Dame Anne Marie Rafferty	King's College London
Yogesh Tanna	King's College Hospital NHS Foundation Trust
In Attendance:	
Dame Christine Beasley	Non-Executive Director
Prof Yvonne Doyle	Non-Executive Director
Nicholas Campbell-Watts	Non-Executive Director
Akhter Mateen	Non-Executive Director
Prof Richard Trembath	Non-Executive Director
Simon Friend	Non-Executive Director
Beverley Bryant	Chief Digital Information Officer
Tracey Carter MBE	Chief Nurse & Executive Director of Midwifery
Siobhan Coldwell	Director of Corporate Affairs
Roy Clarke	Chief Finance Officer
Angela Helleur	Site Chief Executive, PRUH & South Sites
Prof Clive Kay	Chief Executive Officer
Julie Lowe	Site Chief Executive, Denmark Hill
Dr Leonie Penna	Chief Medical Officer
Mark Preston	Chief People Officer
Chris Rolfe	Director of Communications
Bernadette Thompson OBE	Director of Equality, Diversity & Inclusion
Zowie Loizou	Corporate Governance Officer (Minutes)

King's College Hospital NHS Foundation Trust

Council of Governors Meeting – Public Session

Draft Minutes of the Council of Governors (Public Session) meeting held on
Tuesday 5 December 2023 at 16:30 – 18:00
Hybrid meeting: Dulwich Room, Hambleden Wing, Denmark Hill & via MS Teams

Present:

Charles Alexander CBE	Chairman (Committee Chair)

Elected Governors

Ibtisam Adem	Lambeth Public Governor
Rashmi Agrawal	Lambeth Public Governor
Jane Allberry	Southwark Public Governor
Jacqueline Best-Vassell	SEL System Governor
Angela Buckingham	Southwark Public Governor
Aisling Considine	Staff – Allied Health Professionals, Scientific & Technical
Emily George	Lambeth Public Governor
Deborah Johnston	Patient Governor
Tunde Jokosenumi	Staff – Admin and Clerical
Daniel Kelly	Lambeth Public Governor
Devon Masarati	Patient Governor
Billie McPartlan	Patient Governor
Fidelia Nimmons	Patient Governor
Victoria O'Connor	Bromley Public Governor
Christy Oziegbe	Staff - Nurses and Midwives
Katie Smith	Bromley Public Governor
Chris Symonds	Patient Governor
David Tyler	Patient Governor

Nominated / Partnership Organisations:

Cllr Jim Dickson	Lambeth Council
Ian Rothwell	SLAM Governor

In Attendance:

Rantimi Ayodele	Site Medical Director/ DCMO in PRUH & South Sites
Jane Bailey	Deputy Chair / Non-Executive Director
Nicholas Campbell-Watts	Non-Executive Director
Tracy Carter MBE	Chief Nurse and Executive Director of Midwifery
Siobhan Coldwell	Acting Director of Corporate Affairs
Paul Dossett	Grant Thornton (External Auditor)
Prof Yvonne Doyle	Non-Executive Director
David Fontaine-Boyd	Chief of Staff - Chief Executive's Office
Simon Friend	Non-Executive Director
Sara Harris	Head of Corporate Governance
Angela Helleur	Site Chief Executive – PRUH & South Sites
Zowie Loizou	Corporate Governance Officer (minutes)
Julie Lowe	Site Chief Executive – Denmark Hill
Mark Preston	Chief People Officer
Ellis Pullinger	Senior Responsible Officer Apollo Programme
Chris Rolfe	Director of Communications

Bernadette Thompson OBE	Director of Equality, Diversity, and Inclusion (EDI)
Lorcan Woods	Chief Financial Officer

Apologies:

Lindsey Batty-Smith	Southwark Public Governor
Christine Beasley	Non-Executive Director
Beverley Bryant	Chief Digital Information Officer
Prof Jon Cohen	Non-Executive Director
Erika Grobler	Staff - Staff - Nurse & Midwives
Hilary Entwistle	Southwark Public Governor
Professor Clive Kay	Chief Executive Officer
Akhter Mateen	Non-Executive Director
Dr Leonie Penna	Chief Medical Officer
Yogesh Tanna	Nominated Staffside Governor
Richard Trembath	Non-Executive Director

Item	Subject
	Standing Items
23/33	**Welcome and Apologies**
	The Chair welcomed Governors/attendees. Apologies for absence were noted as above.
23/34	**Declarations of Interest**
	There were no declarations of interests.
23/35	**Chair's Action**
	There had been no Chair's actions since the last meeting.
23/36	**Minutes of the Previous Meeting**
	The minutes of the meeting held on 30 May 2023 were agreed as an accurate record of the meeting.
23/37	**Matters Arising/Action Tracker**
	The Council of Governors noted the progress being made to implement actions from previous meetings.
	Action 30/05/23 23/23 Police Officer Presence in the Emergency Department Update:
	The Council was informed that there was a tight framework in place and the police were now required undertake a risk assessed decision about whether to remain in the ED with individuals who posed a risk to themselves and others. On-going reviews to be completed with the Site Chief Executive, the MPS and South London Maudsley Hospital (SLAM) and Oxleas NHS Foundation Trust. The Council of Governors noted that body cameras were used on security for safety and evidence purposes.
	The Council of Governors were made aware of the Patient Safety Incident Response Framework (PSIRF) briefing session which would commence in early 2024 with the Governors, following training for all Board members.

King's College Hospital NHS Foundation Trust

QUALITY, PERFORMANCE, FINANCE AND PEOPLE

23/38 Annual Report and Accounts 2022-23: Report from the External Auditor

The Council of Governors were provided with an overview of the 2022/23 Annual Audit Report with work completed on the 30 June 2023.

The External Auditors two responsibilities were to give an opinion on the financial statements and consideration of value for money arrangements. In 2022/23 the NHS had the lowest rate of auditor completion with a 95% expectation for SEL Trusts and a 75% result for KCH. The Trust had completed the audit deadline with a positive final financial statement.

The Value for Money had three components:

1. Financial sustainability.
2. Assessment of governance arrangements.
3. Improvement of economy, efficiency and effectiveness.

In summary the External Auditors (Grant Thornton) opinions on the key areas were noted as:

- **Financial sustainability** showed significant weaknesses with various challenges that included elective demand, staff costs and industrial action. The review found excellent results in monitoring financial sustainability, however, concerns in the sustainable, operational and income deliverability position to break-even, over a period of time to a large capital improvement plan (CIP) programme was a concern. Key recommendations were proposed, and the Trust is committed to address the financial challenges and to deliver on the financial arrangements that were in place.
- **The assessment of governance arrangements** showed a result of positive assurance where no significant weaknesses in arrangements was identified, minor improvement recommendations were proposed and actioned.
- **Improvement of the economy, efficiency and effectiveness** result showed positive assurance where no significant weaknesses in arrangements were identified, and minor improvement recommendations were proposed and actioned.

The Chief Financial Officer added the short, medium and long-term challenges for the Trust and the NHS was significantly exasperated, following COVID and the levels of productivity and were required to return to pre-COVID activity levels.

Governors asked whether the audit assessment indicated that there was no long-term plan. PD noted that there were a number of issues. There were some local challenges, related to the Trust's cost basis, rather than a failure to plan for the longer term. Long-term planning in the NHS is difficult as there is no clarity on funding from one year to the next. He noted that most acute Trusts are in the same position and that many have had the same recommendation from the auditors.

Governors noted that the CIP programme considerably larger than the Trust had previously delivered, and it remained to be seen whether it could be achieved before the end of the year.

The Council of Governors noted the Annual Report and Accounts 2022-23 Report from the External Auditor

23/39 Board of Directors: Reflection & Reports

Performance:

Industrial action had a profound impact for the Trust and the ability to manage services across the Trust, with significant cancelations of elective work and priority for emergency patients. The repeated pattern of industrial action created challenges for the Trust to safeguard patients, specifically patients with non-life-threatening procedures. Unfortunately, further industrial action by the Junior Doctors would be taking place from 20-23 December 2023, and again from 3-9 January 2024.

The Council of Governors the Trust's objective to ensure that no patients will have to wait longer than 78 weeks for elective work and a small number of patients waiting above 65 weeks, predominantly patients who were waiting for complex bariatric surgery that required an in-patient bed by the end of March will be impacted by industrial action and existing plans will need to be reworked.

South East London (SEL) is expected to reach an Emergency Care Standard target of 76%, for patients to be treated within 4 hours in the ED by the end of March 2024 and plans are in place to deliver this target. EDs in SEL are very busy and acuity is high, particularly stroke and cardiac.

The Trust's cancer position is being protected as far as possible, but there is a concern that some patients that are on routine pathways are being missed.

Finance:

The Trust's initial financial plan indicated a £49m deficit for 2023/24, but in November, the government and National Health Service England (NHSE), announced additional funding which resulted in the Trust's deficit target being reduced to just under £42m. The Trust were forecasting an end of year total of £42m deficit with the SEL system forecasting a break even position. The revised plan will be challenging and is reliant on the cost improvement plan being delivered. Work force reductions will also been needed. The Trust shows 16% productivity gap versus the Trust's position pre-COVID, with a 12% increase in the Trust's workforce. A recruitment freeze was still in place with non-clinical staff predominately affected. The Council of Governors was made aware the Trust's medium and long-term capital plan would see funding significantly reduced and the primary focus for the next year was on two major projects: Modernising Medicine at Denmark Hill (DH) and the expansion of Endoscopy at the PRUH, costing £25m which would see a 75% take on the Trust's capital budget for 2024.

The Council of Governors noted the reports.

23/40 Trust Updates: Governor Focus Areas

- **EPIC**

EPIC was launched across the Trust on the 5 October 2023, simultaneously with GSTT and was now live for the past 9 weeks, with positive live functionality and only slight teething issues. Feedback had been productive in both positive use of EPIC and challenges that continued to arise. The Trust was now at the stabilisation phase is working with staff across the Trust to help mitigate and improve the EPIC system going forward. The Senior Responsible Officer (SRO) for the Apollo Programme and the Executive members met weekly at the Stabilisation Group Meeting to discuss ongoing issues and concerns to be

addressed involved with EPIC. Digital Champion's continued to be present across the Trust to support staff members with further EPIC related issues.

The Council of Governors noted ongoing pressures for General Practitioners (GPs) to obtain patient results and patient letters via EPIC. This was recognised by the Trust and further technical issues to be resolved. Further meetings with Jack Barker, the Trust's Clinical Lead, and the GPs to take place regularly across SEL, to discuss issues concerning EPIC and access to patient records.

The MyChart portal for patient messaging is the most secure way for patients to communicate with the Trust, with patients being encouraged to use this functionality. The Trust was working with suppliers to ensure text messages received by patients were clearly stated, with the sender being the Trust. Ongoing work to streamline the text messaging process was underway.

Appointment and outcome letters were a concern with two previous periods where the Trust was required to turn off the messaging service due to technical issues, this had since been rectified by the Trust and the backlog of patient letters was cleared. The Council of Governors noted the appointment and outcome letters were available on MyChart.

The Council of Governors was assured that work continued around migration of systems such as the patient archive information and a read-only patient clinical system was available, if required.

A dedicated helpdesk and phone line concerning EPIC for patients who do not have access to MyChart was available.

The Chairman and Council of Governors agreed a further meeting to discuss and address EPIC issues raised by the Council of Governors to be arranged.

ACTION: Ellis Pullinger / Siobhan Coldwell.

The Council of Governors requested the dedicated phone number for EPIC be circulated.

ACTION: Ellis Pullinger.

- **Estates & Facilities**

Concerns was raised in relation to Haematology and the Renal & Dialysis units following the recent PLACE assessments. The Chief Financial Officer assured the CoG, the Trust had made a large investment in the backlog of project's which included risk assessment of ward areas across the Trust, acknowledging further work was required concerning Haematology and the Renal & Dialysis Unit, which had since been refurbished. The Critical Care Unit was now fully complete and the Trust's future project priorities was Modernising Medicine and Endoscopy were at the forefront of the Trust's agenda.

The Council of Governors noted the updates.

23/41 Nominations Committee Update

The Council of Governors were made aware that the Non-Executive Director (NED) appraisals had been completed.

The Council of Governors expressed their sincere gratitude to Prof Jon Cohen, whose term of office would conclude at the end of December 2023. The Council of Governors thanked Prof Jon Cohen for his invaluable expertise, knowledge and support to colleagues and long service at the Trust.

The Council of Governors approved the re-appointment of Nicholas Campbell-Watts for a further 4 years.

GOVERNANCE

23/42 **Governor Involvement and Engagement**

- **Governor Engagement and Involvement Activities**

The Council of Governors noted the reports on Governor Involvement and Engagement.

- **Observation of Board Committees**

The Council of Governors noted the Observation on Board Committees.

FOR INFORMATION

23/43 **Minutes of the Sub-Committees of the Council of Governors**

- **Minutes of the Patient Experience & Safety Committee**
- **Minutes of the Governor Strategy Committee**

The Council of Governors noted the minutes of the Patient Experience & Safety Committee Meeting, and the Governor Strategy Committee Meeting.

Any Other Business

23/44 **Council of Governors January 2024 - date change**

The Council of Governors noted the change to the next Council of Governors meeting from 9 January 2024 to 30 January 2024. An updated invite would be sent to all to confirm the arrangements.

The Council of Governors suggested the meetings be changed from 1.5 hours to 2 hours to allow for broader discussions. The Chair would discuss the proposed time change of the Council of Governors meetings with the Lead Governor.

The Chairman concluded the meeting by thanking and congratulating the Clinical and Executive teams for their hard work and commitment to the Trust in recent challenging times.

23/45 **Date of the next meeting:**
Tuesday 30 January 2024 at 16:30 – 18:00, Hybrid meeting in the Board Room, Hambleden Wing, KCH, Denmark Hill and via MS Teams.

CoG ACTION TRACKER - Updated 26 March 2024					
Date / Item Ref	**Action**	**Lead**	**Due Date**	**Status**	**Update**
ACTIONS - DUE					
05/12/23 23/40	**Trust Updates: Governor Focus Areas - EPIC** The Governors to meet with the SRO for the Apollo Programme to discuss issues raised by the Council of Governors related to EPIC matters.	**SRO Apollo Programme/Director of Corporate Affairs**	**Jan-24**	**DUE**	Session scheduled for 25/1. **Propose to close.**
05/12/23 23/40	**Trust Updates: Governor Focus Areas - EPIC** Dedicated phone number for EPIC to be circulated.	**SRO Apollo Programme**	**Jan-24**	**DUE**	24/1/: Dedication phone line and email sent to CoG. **Propose to close.**
27/02/224 24/02	**Update on the Trust's Financial Situation** A detailed chronology of financial events leading to the current financial position to be communicated to the governors for further oversight..	**Simon Frined**	**Mar-24**	**DUE**	**Update:**
27/02/224 24/03	**Ways of working – code of conduct** Advance reports to be circulated to the governors prior to the CoG meetings to gain oversight of items to be discussed.	**Jane Bailey**	**Mar-24**	**DUE**	**Update:**
27/02/224 24/03	**Ways of working – code of conduct** Further input and added value to be provided by the governors, with the possibility of future governor walkarounds to be explored.	**Jane Bailey/Daniel Kelly/Siobhan Coldwell**	**Mar-24**	**DUE**	**Update:**
27/02/224 24/03	**Ways of working – code of conduct** A patient experience point of contact and re-circulation of the patient involvement register list to be sent to all governors.	**FTO**	**Mar-24**	**DUE**	**Update 29/2:** King's Involvement Register list emailed to council of governors and a main point of contact (Erika grobler). **Propose to close.**
ACTIONS - PENDING					
Date / Item Ref	**Action**	**Lead**	**Due Date**	**Status**	**Update**
18/10/22 22/19	**Integrated Care Board/Integrated Care System** Consideration needs to be given as to how the Governors can engage with the ICB/ICS.	**Director of Corporate Affairs/Director of Communications**	**Jan-24**	**PENDING**	**Update:** Opportunites are offered as they arise. **Propose to close.**
28/03/23 1/5	**PSIRF – Governor briefing session**	**Chief Medical Officer/Director of Quality Governance**	**Jan-24**	**PENDING**	**Update:** Session on hold for the 15/2. **Propose to close.**
28/03/23 6	**Election of new governors** The Committee suggested photos of all governors to be displayed within King's Hospital.	**Director of Corporate Affairs**	**Jan-24**	**PENDING**	**Update:** Screens within Demark Hill site will display governors, to explore PRUH and Orpington options.

King's College Hospital
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FREEDOM TO SPEAK UP ANNUAL REPORT

2022/23

King's College Hospital
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Freedom to Speak Up Annual Report 2022-2023

Purpose

The purpose of this Annual Report is to demonstrate how we at King's are continuing to build upon and deliver our commitments in relation to Freedom to Speak Up, as set out in our People and Culture Plan, together with our BOLD Strategy. It is also intended to demonstrate how the actions taken, are supporting our workforce and ultimately improving the experiences of our staff and patients.

The document builds upon the progress demonstrated in the 2021 - 2022 Freedom to Speak Up (FTSU) Annual Report, which provided assurance to the Board that the FTSU culture across King's, was on the right trajectory. This year's report aims to demonstrate that FTSU has moved beyond just aspiration, to part of our real life experiences at the Trust. The next step is to build upon the strong foundations established over the last three years. We will look for new and innovative opportunities to support those who face barriers to speaking up and ensure the strategic direction of FTSU meet the needs of all our workforce. Building and maintaining faith in our speak up culture is an ongoing priority.

This report benchmarks concerns raised with our Guardian against the national profile collated and published by the NGO/NHSE (Model Health System)

Background

This year marks the tenth anniversary of the publication of Sir Robert Francis's landmark report following the public inquiry into poor care and high patient mortality rates at Mid Staffordshire NHS Foundation Trust.

Sir Robert found that NHS culture did not always encourage or support workers to speak up, and that patients and workers suffered as a consequence.

The Francis Report made it clear that whistleblowers play an important role in identifying issues on the NHS frontline. The FTSU Guardian network was established in 2016, following recommendations made by Sir Robert. The review published 20 principles and actions which included establishing the FTSU Guardian role.

The guardian network, led by The National Guardian's Office, works to influence leadership across the healthcare sector, championing the vital role of leaders in developing positive speak up cultures.

In March 2023 the current National Guardian for the NHS, Dr Jayne Chidgey-Clark said, "The Freedom to Speak Up movement has been a catalyst for positive change, but there is still much more to be done."

Guardians provide a confidential, alternative route to normal internal channels, both formal and informal. The remit is to identify and tackle barriers to speaking up, such as issues of bullying culture, poor levels of awareness and processes that place an undue burden on individuals when they raise issues, including fear of repercussions. With the aim of promoting a positive culture for all, in which the principle of psychological safety is embedded, underpins the Guardian role.

All Guardians must adhere to the values of the role, Impartiality, Courage, Empathy and Learning.

The work of the Trust Guardian is designed to give the Board critical high-level insights, as part of the ongoing conversations around topics including race, inequality, behaviours and inclusion.

Progress in 2022 - 2024

Benchmarking against National Data

The quarterly non-identifiable data submitted to the National Guardians Office (NGO) by the Trust Guardian is interpreted by NHS England (NHSE) and recorded on the Model Health System. The culture and engagement component provides a snapshot of a range of quantitative data from well-established sources, which includes the national staff survey and FTSU data. The data is used by NHSE and the Care Quality Commission (CQC) to gain an insight into the culture of an organisation. It is recognised that Trusts with a good speaking up culture predominantly have CQC ratings of good or outstanding.

- The FTSU Guardian continually benchmarks King's against national, Shelford and London acute trusts. The statutory reporting categories are:
    - Total Number of cases (each quarter)
        - Received
        - Raised anonymously
        - With an element of: patient safety/quality; bullying or harassment; worker safety or wellbeing: and/or other inappropriate attitudes or behaviours
        - Where disadvantageous and/or demeaning treatment as a result of speaking up is indicated.

NHS Staff Survey

- The NHS Staff Survey includes a sub section of four questions used as an indicator of the speaking up culture in an organisation.
- At a national level, the FTSU sub-score demonstrated a marked fall of 1.5% for feeling confident to raise concerns relating to *clinical practice* (following 2021 when there was a marked improvement). King's saw a 2.2% decrease on the 2021 results.
- The decrease was 0.5%, in relation to feeling confident that the trust would address any clinical concerns raised.
- In relation to speaking up about *anything that concerns me,* the response for King's saw a positive increase on 2021 results of 0.6% and a 0.8% increase in confidence that the trust would address the concern, however King's continues to remain in the lowest 25% of trusts nationally and in comparison to other Shelford Groups trusts. The table below demonstrates this.
- This highlights the paramount importance of ensuring actions taken following concerns raised, is fed back to all staff and lessons learned. One of the biggest barriers to staff speaking up at King's is the perception that nothing changes. Challenging and addressing this viewpoint is an ongoing priority for the FTSU Guardian and senior leaders at the Trust.
- In response to the Staff Survey results, Sir Robert Francis, with the Patients Association, wrote a letter to Steve Barclay, the Secretary of State for Health and

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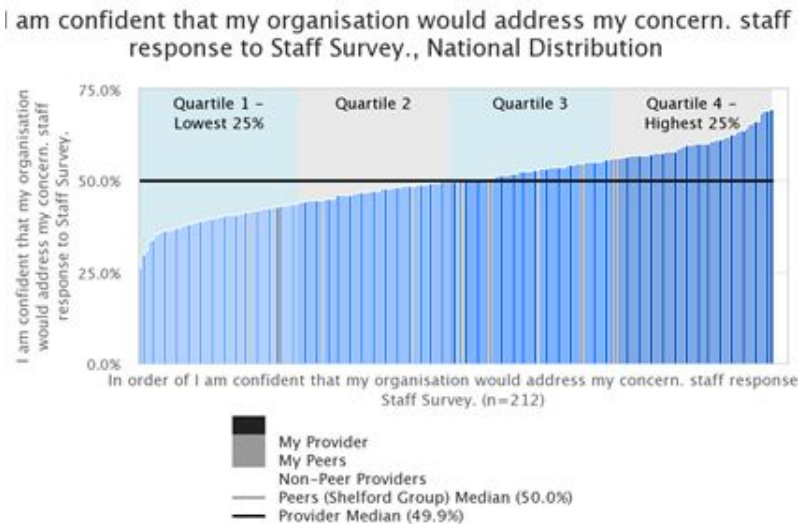
Social Care stating, "What we are witnessing across the NHS is the Mid-Staffs scandal playing out on a national level."

The table below compares King's to its peers (Shelford Trusts) and the National median.



Model Health System

- The total number of speaking up cases reported to FTSU Guardians by workers as disclosed to the National Guardians Office per 1,000 WTE, is an Indicator of the use of the FTSU Guardian route for speaking up, and the scale of reporting in comparison to the size of the organisation. Compared to our peers (Shelford), only Imperial College Healthcare NHS Trust reports a higher caseload at 5.69 per WTE, compared to King's 4.89 per WTE.
- As can be seen in the table below, King's continues to remain in the top 25% of trusts for reporting concerns and on a 12 month rolling average is the highest reporting Shelford Trust. This continues to be a positive indicator of an increased confidence in staff to speak up.
- An important part of a speaking up culture is having assurance the processes are supporting staff to speak up. The rolling year on year increase in people contacting the Guardian is a positive indicator and gives a degree of assurance.
- The crucial action going forward is to ensure lessons learned are communicated and improvements made as a result of those workers speaking up.

The chart below shows the 12 month rolling average for cases reported (King's is represented by the vertical black line)

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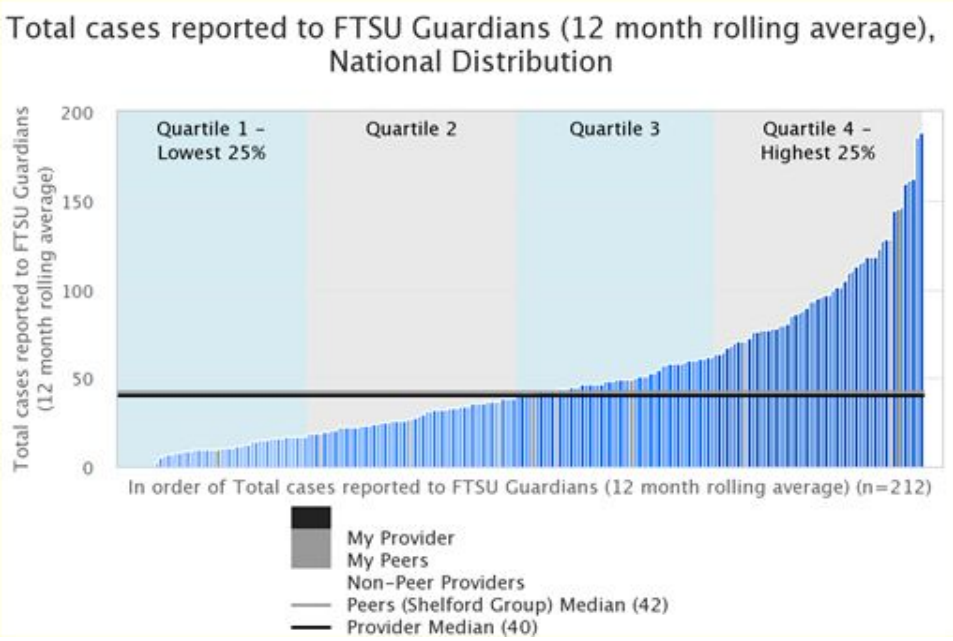

Source: The Model Health System

Breakdown of cases reported for 2022-2023

- From 1 April 2022 to 31 March 2023, 290 new cases were raised with the FTSU Guardian. This is compared to 194 cases for the previous year, representing an almost 50% increase.
- Over the last three year period we have seen an almost year on year doubling of cases and whilst this may show increased awareness and trust in the process, it also highlights how crucial it is to communicate the lessons learned and changes made as a result of speaking up.

Year	Number of cases	Increase on previous year
2020 - 2021	148	17.4%
2021 - 2022	194	32%
2022 - 2023	290	49.48%

- The main reason staff are reluctant to speak up is the belief that nothing will change. We need to continually challenge this perception and ensure that investigations are completed in a timely way and all those who have raised concerns are updated and kept informed of progress (within the boundaries of confidentiality)
- The primary objective of the FTSU Guardian over the last 2 years has been to raise awareness and accessibility for all workers. The success can be evidenced by the increase in case numbers, requests for training and listening sessions and other data sets such as exit interview data.
- The 2 questions asked in the leavers survey are:
    1. I was well informed about how to raise a concern via the Trust FTSU Guardian?
    2. It was easy for me to raise a concern via the Trust FTS Guardian?

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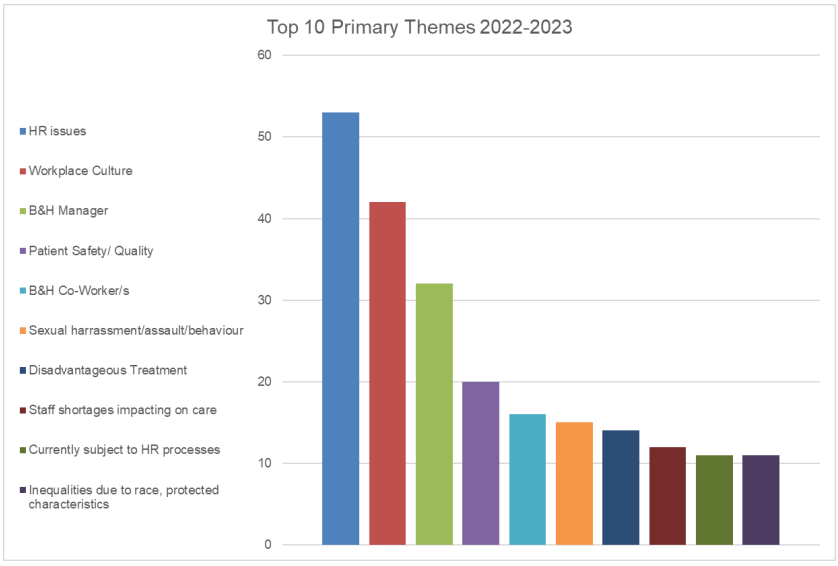
- There has been a year on year increase in the percentage of staff answering they agree or strongly agree to both questions.
- The number of staff answering that they are unsure has reduced from 36% to 20%.
- The access to a non-pay budget has ensured FTSU promotional materials are visible and accessible to all workers, therefore contributing to increasing awareness.
- Going forward, the strategic direction of FTSU will be focussed on identifying and supporting staff who face barriers to speaking up. This relies on robust data collection.
- Time lines for investigations vary from 2 weeks to 2 years. This adds additional stress and lengthy silent timelines can impact on the wellbeing of those who raise concerns. A review of time frames for investigations will be a priority to ensure trust in the FTSU process is maintained.

What are people speaking up about?

Freedom to Speak Up is about being able to raise concerns about anything which gets in the way of doing a great job. That means also being able to speak up about ideas for improvement. Feeling able to make suggestions is an indicator of psychological safety.

- It is vital that our workers have confidence that when they speak up, their concerns will be listened to and properly heard. In some cases, people just want a safe place to talk about an issue, seek advice or put a marker down, in case what has happened is repeated.
- As can be seen from the top ten themes identified below, three of the top four relate to behaviours: allegations of bullying, micro aggressions, poor culture and incivility.
- As bullying, harassment and inappropriate behaviours is a statutory reporting requirement, it will be discussed in more detail later in this report.
- Patient safety/quality and disadvantageous treatment are also statutory reporting categories and will also be discussed in detail later.



HR related concerns

- What this year has highlighted is the importance of ensuring FTSU is not used as a route to bypass other processes, such as HR.
- Staff need know the most appropriate escalation route through which to raise their concerns.
- As can be seen in the chart below, HR related issues was the main reason people contacted the FTSU Guardian. 53 cases specifically related to HR matters, with an additional 11 staff contacting the Guardian when they were undergoing HR processes. This accounts for over 22% of the total cases raised. In 2021/22, only 7 cases specifically related to HR issues, therefore there has been a significant increase in HR concerns.
- 46 of the cases were directly referred to the employee relations team for investigation
- In the 2021/22 annual report, the FTSU Guardian discussed the benefits of working closely with the pastoral support lead for ER. Due to staff changes, this has been a challenge to deliver in the last year.
- Every person seeking the support of the FTSU Guardian has a right to expect to receive a high quality service, be listened to without judgment, safe in the knowledge that what they are saying will be taken at face value.
- Even though the concern may come under the remit of HR, it is important for the FTSU Guardian to initially listen to what is being raised, to ensure there are no aspects of the issue that may come under the remit of FTSU. This can massively impact on the capacity of the Guardian.
- There is also anecdotal evidence that staff believe that HR is a management tool and some of the processes lack compassion. According to subjective data collected by the Guardian, some staff feel unsupported and unheard during HR process and as a consequence, prefer to contact the Guardian for advice and support. This poses a challenge, as direct involvement in HR processes is outside of the boundaries of FTSU as the Guardian must maintain impartiality.
- This year has seen an increase in managers contacting the FTSU Guardian, due to unresponsive/untimely HR processes. 3 managers specifically spoke about feeling intimidated by staff when trying to follow HR processes and feeling unsupported.

<u>Workplace Culture</u>

- Seventeen cases were specifically raised as workplace culture, but in total, 42 cases related to an aspect of workplace culture. Of those, 52% had a direct impact on patient safety/quality of care.
- In the last year the requests for the Guardian to facilitate listening sessions has increased significantly. The majority of requests have been made by senior managers/leaders. 3 requests were made in response to anonymous letters received by Triumvirates, specifically highlighting poor workplace cultures.
- The areas requesting listening sessions were:

    1. Cancer services (PRUH)
    2. Acute Speciality medicine (DH)
    3. Theatre (cross site)
    4. Renal
    5. Maternity

- All listening sessions are confidential and staff comments are anonymised.

- In all the listening sessions, staff shortages, staff being moved to other wards to cover, staff feeling overwhelmed, are cited as leading to poor communication, behaviours, attitude and lack of team working, which ultimately impacts on patients.
- Midwifery and nursing staff are the main staff group to raise poor culture as a concern.

Sexual Harassment/Behaviour

- This year 15 cases related to sexual behaviour. This is the first time such concerns have been raised.
- This increase mirrors the national picture and a great deal of work is currently underway, both internally and externally to ensure local and national processes are aligned and responsive to these concerns. The FTSU Guardian works closely with the Guardian at London Ambulance Service (LAS), who are working in partnership with NHSE to publish guidelines.

Staff shortages impacting on care

- As previously discussed, staff shortages have been raised as a primary reason for contacting the FTSU Guardian.
- In 2021/22 only 4 cases were directly related to staff shortages. This year 12 concerns have been raised, 2 by Healthcare Assistants, 4 by midwives and 6 by nurses.

Inequalities due to race

- This year 11 cases relate to inequalities due to race, protected characteristics. This compares to 3 in the previous year. 8 were raised by administrative and clerical staff and 2 by doctors. The 2 by medical colleagues, specifically relate to age discrimination. Other concerns relate to staff feeling discriminated against due to disabilities, for example 2 relate to dyslexia.
- The increase appears to correspond with the publication of the disability passport and flexible working awareness.
- The equality pay gap accounts for 4 cases.
- Several of the cases related to requests for flexible and home working.
- 4 cases specifically allege racism, which is a reduction compared to 2021/22, when 15 cases cited racism as the primary reason for contacting the Guardian.
- The FTSU Guardian continues to work closely with the network chairs and several cases have been as a direct result of the network chairs and EDI team advising staff to contact the Guardian.
- Protected characteristics can have a significant impact on confidence to speak up. People with certain protected characteristics have been historically marginalised and subjected to discrimination, prejudice and exclusion. People who belong to these groups may have experienced limited opportunities to voice their concerns and fear facing negative consequences if they do.
- The FTSU Guardian is now collecting demographic data. However, a full year of data is not available for this reporting period, as a consequence any comments would currently be subjective and not evidence based.

King's College Hospital NHS Foundation Trust

Statutory reporting categories

Cases with an element of patient safety

- At a national level 19.1% of cases have an element of patient safety. At King's, this is 24%. The primary reason someone contacts the FTSU Guardian may not be patient safety, however patient related concerns are identified during the discussion. An example of this is an HCA who felt bullied by her colleagues. She was reluctant to ask for help with a patient and went to find another colleague to help her. Whilst she was away, the patient fell and injured himself. Although patient safety concerns may not always be initially evident, this is a clear example of how workplace behaviours and culture can impact on patient outcomes.
- In 2021/22, 39 cases had an element of patient safety, which represented 20% of the total raised. Of those, 10 were the main reason for contacting the Guardian. This year 78 cases had an element of patient safety, with 20 being the primary reason for contacting the Guardian.
- Nationally, King's is in the top 25% of trusts for reporting cases with an element of patient safety, (Model Health System) and is the highest reporting Shelford Trust by a significant margin.
- Of the cases with an element of patient safety, 32 were raised by nursing staff and 20 by midwifery staff.
- Examples of patient safety/quality concerns include:

    1. Poor skill mix - mainly in maternity, due to the high establishment of band 5 midwives and more senior midwives retiring (this is a national challenge)
    2. Failure to follow IPPC policies
    3. Poor communication, leading to impact on patient care
    4. Staff shortages impacting patient care, such as patients not being mobilised
    5. Poor stock control resulting in essential equipment and supplies not being available when required
    6. Failure to gain informed consent
    7. Lack of suitably qualified staff for certain procedures
    8. Concerns over competence of a colleague.
- All the above concerns are under investigation or resolved at the time of writing. Lessons learned (within the boundaries of confidentiality), will be fed back trust wide in the FTSU communications strategy in 2023/24.
- The FTSU Guardian meets regularly with the Director of Quality Governance and is a core member of the Patient Safety Incident Response Framework (PSIRF) Steering Committee.

Cases with an element of bullying and harassment

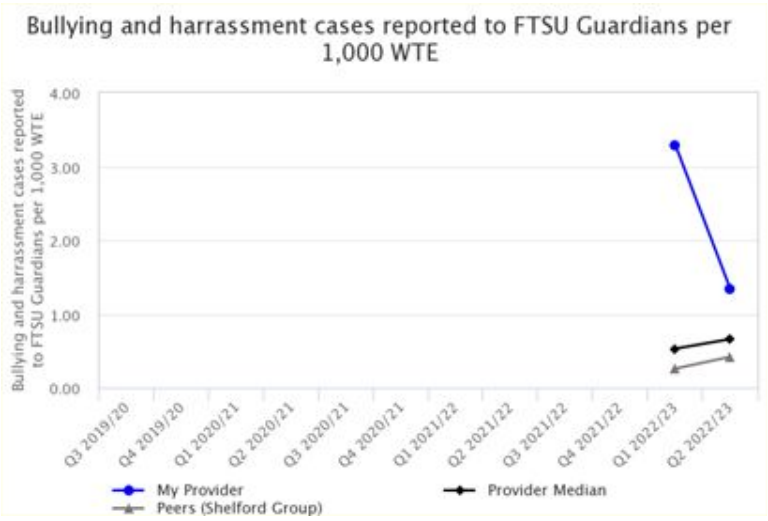
- Nationally, 32.3% of cases relate to allegations of bullying and harassment, a 2.2% increase on 2021/22. As with the national picture, bullying and inappropriate behaviours outweighs other concerns at King's.
- At King's, 99 cases had an element of perceived bullying and harassment, which represents 34% of the total cases. However, although above the national average, it is a marked decrease on 2021/22, when 47% of cases included a perception of bullying and harassment.
- According to the Model Health System data, King's is on the lower margin of the top 25% of trusts for bullying and harassment (per WTE), which is a significant

improvement on the previous 2 years. The chart below evidences the downward trend in cases with an element of bullying and harassment.

- Sub themes relating to bullying and harassment include:

    1. Feeling marginalised - the majority of these cases relate to staff speaking in different languages, particularly Filipino (evident across all sites)
    2. Individual bullying of another person by a colleague
    3. A perception of bullying by a manager
    4. Workplace/team culture issues
    5. Behaviour of a senior manager, impacting on others

- What has also been seen as an increasing theme this year, is managers who feel bullied by a team member.



Source: The Model Health System

Cases with an element of worker safety

- Worker safety is a new reporting category introduced in April 2022, as a direct consequence of the pandemic.
- Nationally, 13.7% of cases had an element of worker safety. At King's just 1.38% of cases specifically relate to worker safety concerns.
- The low numbers is likely to be due to the strong staff wellbeing team at King's.
- The FTSU Guardian is a member of the Wellbeing Action Group, so any potential risks to staff wellbeing are addressed promptly.
- Violence and Aggression concerns are recorded as a separate category at King's, with 6 cases being reported this year, mainly by nursing staff. Anecdotal evidence is available to highlight how these incidents have a direct impact on staff wellbeing.
- The FTSU Guardian works closely with the Director of Nursing for Vulnerable People, to ensure incidents are dealt with immediately and staff given the support needed.

Anonymous reporting

- The number of workers at King's choosing to remain anonymous when reporting concerns in 2021/22, represented 16% of the total raised. This was an improvement on 2020/21 when the figure was 23%. This improvement continues with only 5% of concerns being raised anonymously. This is a very positive indicator of trust in the FTSU process.
- The caveat to anonymous reporting, is that all themes from listening sessions are recorded anonymously and not included in the caseload data.
- Truly anonymous concerns are rare and sometimes difficult to address without specific details. Most contacts who initially raise concerns anonymously are willing to share their identity, once trust has been established.
- Most are happy to share their identity with the Guardian however, but not their line manager or senior leader. This is mainly due to fear of detriment or reprisal.

Cases relating to detriment/disadvantage

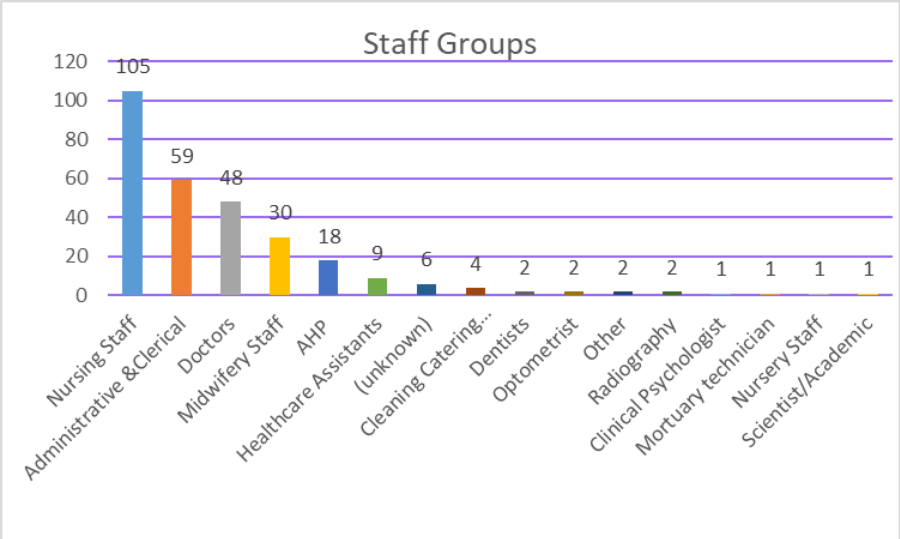
- Nationally, detriment was indicated in 4.3% of cases. In 2022/23, King's had 5 cases where a staff member felt they had suffered detriment/disadvantage as a result of speaking up. This represented 1.72%, which is below the national average and, a good indicator that this behaviour is not acceptable and will not be tolerated.
- King's compares favourably to other Shelford Group Trusts, with Imperial College NHS Trust at 3% of the total cases and Oxford University Hospitals NHS Trusts 5%. Manchester University NHS Foundation Trust reports that in 16% of cases staff report suffering detriment as a result of speaking up.
- The caveat to this may be a staff reluctance at King's to speak about disadvantage.
- Anxieties about detriment usually relate to a fear that seniors will damage an individual's career prospects or promotional opportunities.
- The NGO prefer to use the term disadvantage, rather than detriment. Reprisal if present can be very subtle, whilst also damaging.

Who is speaking up?

- As with the previous reporting periods, nursing staff continue to be the staff group who speak up the most. Last year, 35% of cases were raised by nursing staff. In the current reporting period of 2022/23, there has been a slight increase to 36.21%.
- The NGO are currently reviewing the staff categories as midwives and nurses are nationally reported as one staff group. Recent high profile reports such as Ockeneden, has resulted in an increase in midwives speaking up. At King's, midwives and nurses have always been recorded as separate professional groups. In 2021/22, midwife related concerns increased by 400%. This increase has continued, with 30 midwives raising concerns this year compared to just 10 last year. The FTSU Guardian has been facilitating listening sessions for the last 12 months and maintained a visible presence in maternity.
- Administrative and clerical concerns have increased from 32 in the previous year to 59 this year. Of those, 21 cases related directly to HR issues. 8 were in relation to inequalities due to race, protected characteristics. As previously discussed, many relate to flexible and home working issues.
- Doctors are nationally one of the least likely professions to speak up. This particularly relates to junior doctors. This year has seen an increase in concerns raised by doctors. In 20/21, only 2 doctors spoke up, this increased to 13 in 21/22. 2022/23 has

seen 48 doctors speaking up. A substantial increase, implying greater awareness and confidence to speak up.

- Junior doctors account for a significant proportion of those. This is most likely due to the close working between the Guardians of Safe Working and the FTSU Guardian. This includes joint training sessions, to raise awareness of both services.
- Allied Health Professionals have accounted for the second highest reporting group for the previous years. However, the majority of their concerns have now been resolved, as a consequence there has been a reduction in AHPs accessing FTSU in the last 6 months of 2022/23.



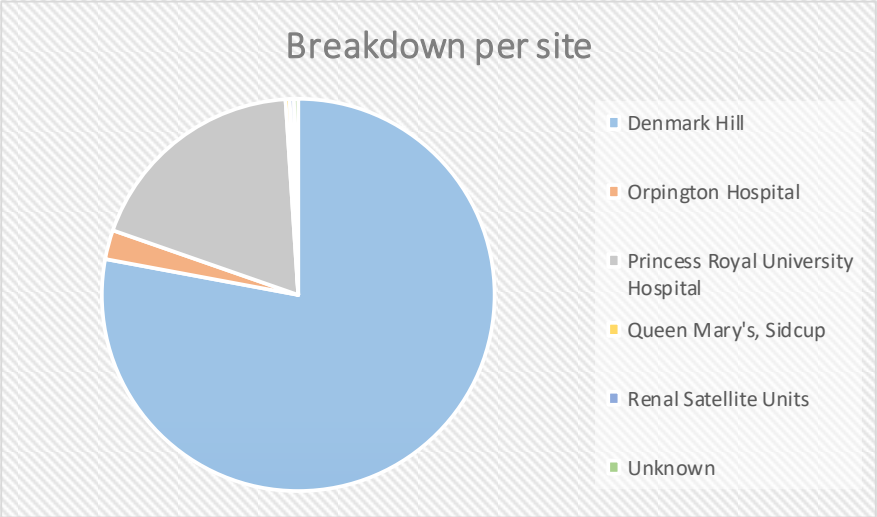
Professional level of those speaking up

- In 2021/22, of the 194 concerns raised, 163 were made by workers (the NGO refers to 'workers' rather than 'staff', as FTSU is available to anyone engaged in working activity at a trust). A further 27 were raised by managers and 4 were 'unknown'.
- In 2022/23, 219 workers, 62 managers and 5 senior leaders raised concerns. The increase in managers speaking up is 129%. This correlates with the increase in managers raising concerns in relation to HR issues and feeling intimidated by staff.
- A priority identified in the last annual report was for the FTSU Guardian to support managers to create a safe environment for staff to speak up about anything that concerns them.
- Managers play a vital role in fostering a responsive speak up culture and the psychological safety of workers. That is why it is essential that they are supported to listen and respond effectively.
- Speaking up begins with a conversation, usually with a line manager. How the manager then reacts has a significant impact on the perception of whether speaking up is welcomed. This is why the Guardian has invested a great deal of time in the last 12 months supporting managers.

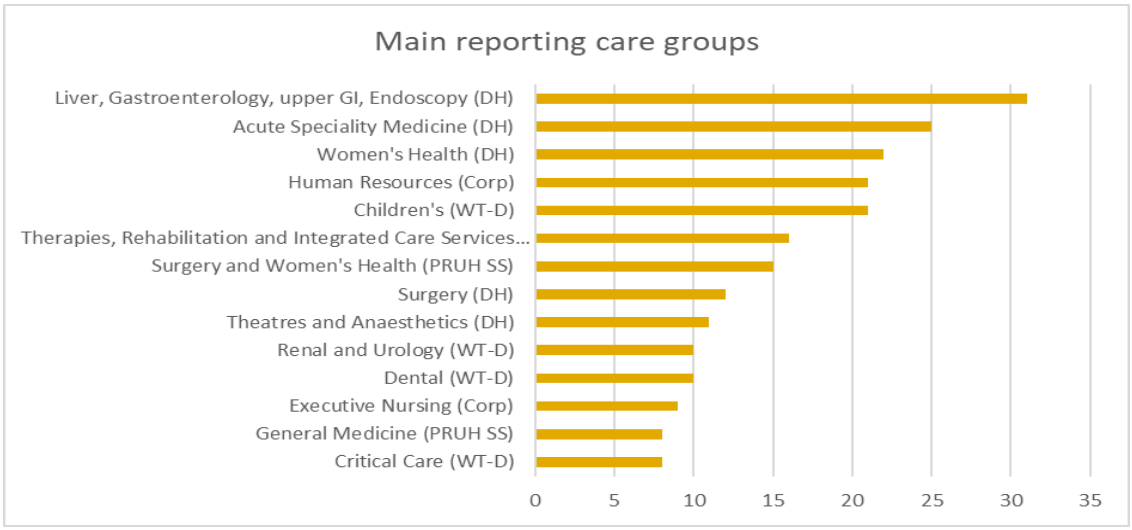
- This may account for the increase in managers raising issues, possibly due to contact with the Guardian. Managers are voicing concerns that they are facing increasing challenges, both from staff and what is expected of them.
- This is the first annual report to record that some clinical senior leaders are accessing the FTSU service.

Breakdown for sites

- As in previous years, the majority of concerns are raised by staff based at Denmark Hill, but with a slight drop from last year, when 81% of cases were Denmark Hill. This year it was 78%.
- The PRUH and South Sites account for 22% of cases, which is an increase from 13% in 2021/22.
- This can also be attributed possibly to the visible presence of the FTSU Guardian being predominantly at the Denmark Hill site. The planned recruitment of a deputy Guardian, based at the PRUH, should support a more visible presence on this site for 23 - 24.



Breakdown by care group



- As can be seen from the table above, Liver and Gastroenterology raised the most concerns in 2022/23. There are ongoing investigations in progress in these services, which relate mainly to culture and behaviours.
- Concerns in Acute Speciality Medicine have been in relation to staff shortages impacting on the delivery of patient care.
- Women's Health across both sites has increased significantly in this reporting period. The total from DH and PRUH, makes Women's Health the highest reporting care group. The increase has coincided with the outcome of the CQC inspection in 2022, and subsequent findings. As previously discussed, midwives have been raising concerns regarding culture and staffing skill mix.
- As well as an increase in issues of a HR nature, this year staff within HR have also been raising concerns. All of these are currently under investigation.
- In 2021/22, Children's services accounted for 8% of concerns. This year they account for 7%. Several have been in relation to therapy teams wanting to come under the remit of children's services, rather than therapies. This is to ensure a more productive service provision.

Method of contact

- 24% of contact with the Guardian is direct, either in person or by personal work email.
- 32% of contact is by the FTSU inbox.
- 5% of contact is through the network chairs or other professional teams such as HR and EDI.

Addressing barriers to speaking up

- The disproportionate impact of the pandemic on black and minority ethnic health workers has highlighted how vital inclusion is for worker safety and wellbeing. Inclusion is essential for a healthy speak up, listen up and follow up culture. Being heard increases a sense of belonging.
- Addressing barriers to speaking up is an ongoing priority for the FTSU Guardian and leadership team. Working in partnership with the EDI team and staff networks is a key thread in the daily activity of the Guardian.

- The National Staff Survey results have highlighted a national concern that certain staff such as white males and those with disabilities face significant barriers to speaking up. Addressing this is essential.
- One of the biggest barriers to speaking up is the belief that nothing will ever change. We continue to challenge the *'what's the point'* attitude, by demonstrating the difference speaking up has made to our staff and patients.
- Fear of retaliation is another barrier to speaking up. Although this evidence is currently anecdotal, going forward, the FTSU Guardian is collating this to present in the next annual report.
- Our aim is to ensure all workers at King's, regardless of background, identity or circumstances feel valued and know that their contribution matters.
- Understanding barriers and how they can be overcome, is a core focus of both the National Guardian's Office and the Trust.

King's Ambassadors

- The King's Ambassador Scheme was launched in February 2023. The scheme incorporates FTSU, with King's Ambassadors signposting to the FTSU Guardian and raising awareness of FTSU in their working environment.
- The FTSU Guardian delivers training and supervision to all ambassadors in respect of speaking up.
- All King's Ambassadors have met the NGO training requirements for the role.

Training

- The increase in requests for training has continued this year, with the FTSU Guardian frequently delivering bespoke training to teams across all sites.
- The Guardian delivers training to preceptorship nurses and midwives, as well as students.
- All international staff receive training and awareness sessions from the Guardian.
- FTSU is part of the induction programme for all staff (this is currently being reviewed by the Guardian).
- Despite the NHSE/NGO e-learning package, Speak up, Listen Up, Follow up modules being available on LEAP, the uptake remains poor. The CQC and NGO recommend this training to be mandatory.
- The Follow up Module was specifically developed for senior leaders. The training aims to promote a consistent and effective FTSU culture across the NHS. The module asks leaders to be reflective and curious, with practical suggestions to improve the speaking up culture in their organisation. This was completed by the Board in October 2022 in a session facilitated by the Guardian.

Access to Senior Leaders

- The FTSU Guardian has direct access and support from all the senior leadership team, the CEO, Non-Executive Director for FTSU and the Executive Directors.
- Monthly diarised meetings with the CEO and quarterly meetings with the Executive and Non-Executive Directors for FTSU, the Chair and CEO ensures the strategic direction of FTSU is on course and has Board oversight.

Looking Forward to 2023/2024

The priorities for the next year will be to continue to build on the progress made in the last 3 years and since a substantive Guardian was appointed at the Trust.

Key priorities

1. Undertake a strategic review of the FTSU culture at King's
2. Create a feel safe to challenge communication strategy, in partnership with HR and other relevant stakeholders, ensuring communication messages and routes are fully inclusive
3. Make training mandatory
4. Continue the ongoing support and training for middle managers across the trust, to ensure they feel confident to listen and act
5. Clinically led local projects to focus on the impact of workplace culture on patient safety and staff wellbeing
6. Review the timelines for investigations to be completed and feedback given to those who raised the concern
7. Trust in the process and a belief that speaking up is worthwhile requires a robust feedback mechanism and lessons learned communicated trust wide
8. Work with partners including HR and EDI, to safely share high level information to triangulate intelligence
9. In-Phase module to be launched for confidential case management.
10. Increase voluntary data collection regarding demographics and protected characteristics, to identify and evidence if specific groups of staff face particular barriers.
11. Ensure the Raising Concerns policy aligns with the new NHSE policy (to be completed by November 2023)
12. More visible FTSU presence on the PRUH and south sites.

The Board is asked to consider and endorse the content of this report and the priorities for 2023 - 2024.

Executive Director: Tracey Carter, Chief Nurse
Date: June 23

King's College Hospital NHS Foundation Trust

Council of Governors Report Template

Update from 5 December 2023 to 26 March 2024

Name	Designation	Date of Activity	Commentary	Any suggestions/comments/ learning for the consideration at the COG meeting	Items to include in the next Council of Governors Bulletin (please detail or tick ✓)
Jane Allberry	Eolc stakeholder group	5.12.23	Very interesting way of keeping up with what is going on to improve eolc. New NED Simon Friend is involved.	I think it is great that Simon Friend is attending these meetings – could NEDs more regularly attend a range of meetings to get a feel for patient issues?	
	Cancer Support Worker WG	13.12.23 and 23.1.24	I chair this WG which is part of the cancer programme – we are rolling out the Macmillan funded	Interesting idea for a patient rep to chair a WG – perhaps do more often? Also cancer	

			cancer support workers – now to be funded by the Trust	programme good at engaging with patients and carers – lessons to be learned for other specialties?	
	Patient outcomes meeting	12.12.23	Very interesting to see what work is being done to measure patient outcomes. I could only listen in as was doing other work at the same time, so missed the benefit of participation …	If I have a clash with a King's meeting I tend not to prioritise King's meetings as they are so often cancelled … important point re valuing patient/carer reps and not cancelling things they are involved in?	

	S London neuroscience patient/carer group	23.1.24	Very interesting – although depressing – presentation by Heather Campbell who leads on community rehab in SE London.	I have been part of this group since it started about 5 years ago. It struggles to get stable patient/carer participation – I am not surprised because not enough happens as a result of our input and so people move on – patient advisory groups need the Trust to use them so the Trust benefits and patients and carers think it is worthwhile trying to help.	

Name	Designation	Date of Activity	Commentary	Any suggestions/comments/ learning for the consideration at the COG meeting	Items to include in the next Council of Governors Bulletin (please detail or tick ✓)
Lindsay Batty-Smith	Southwark Public Governor	on going	End of Life Steering Committee	Lack of resources for the EoLC team. Excellent engagement across the disciplines vital to this service	Need for a NED on the EoLC steering committee
		on going	Bereavement Steering Group	Lack of resources for the team. Great engagement from many key players.	
		on going	Kings and Queers EDI Forum	promote the work of the forum through the CoG eg special event days, Pledge Initiative	Pledge Initiative to be on the Agenda
		on going	EDI Disability meetings	Hospital Passports, Reasonable Adjustments, Access	
Fidelia Nimmons	NHS Clinical Entrepreneur	6/03/2024	In this event the different innovations people from	This event is held yearly. Details came through the FTO.	

	Programme Big Pitch 2024		different health sectors shared made me realise that no matter how simple your idea is your product will get a chance to be shared with a wider audience through the NHS Insite Big Pitch.	It has inspired me to create a product for one of my ideas.	
	Therapies Waste Workshop#8 @PRUH	20/03/24	I attended this workshop as part of the King's Core Team Meaningful Involvement of Carers/patients in QI initiatives. This is a project to help identify waste in order to create fully efficient patient's pathways. I am enjoying learning with all levels of staff from the Trust.	There are many projects that are currently taking place across the trust. I appreciate the opportunity to report back on those that I have taken part in. Is it possible to at some point make a presentation to the COG on one of them?	

King's College Hospital NHS Foundation Trust

Patient Experience & Safety Governor Committee (PESC)

Minutes of the meeting held on Thursday 21 September 2023
at 09:30 - 11:30 via MS Teams

Present:

Hilary Entwistle	Public Southwark Governor / Deputy Chair (Committee Chair)
Ibtisam Adem	Public Lambeth Governor
Lindsay Batty-Smith	Public Southwark Governor
Jacqueline Best-Vassell	SEL Public Governor
Angela Buckingham	Public Southwark Governor
Nicholas Campbell-Watts	Non-Executive Director
Erika Grobler	Staff Governor, Nursing
Devon Masarati	Patient Governor
Fidelia Nimmons	Patient Governor
Katie Smith	Public Bromley Governor
David Tyler	Patient Governor

Nominated / Partnership Organisation:

Prof Dame Anne Marie Rafferty	King's College London Governor (*Joined at 10:00)*

In Attendance:

Jane Bailey	
Siobhan Coldwell	Director of Corporate Affairs
Sara Harris	Interim Head of Corporate Governance (Minutes)
Joe Hague	
Zowie Loizou	Corporate Governance
Patricia Mecinska	Assistant Director of Patient Experience
Kudzai Mika	Head of Quality Governance, Assurance & Compliance
Roisin Mulvaney	Director of Quality Governance
Karen Roberts	Head of Complaints

Apologies:

Jane Allberry	Public Governor/ Lead Governor Southwark
Tony Benfield	Public Bromley Governor
Prof John Cohen	Non-Executive Director
Aisling Considine	Deputy Chief Pharmacist/ Staff - AHPs, Scientific & Technical
Robert Evans	Public Bromley Governor
Angela Helleur	Interim Site Chief Executive, PRUH & South Sites
Prof Daniel Kelly OBE	Lead Governor
Deborah Johnston	Patient Governor
Tunde Jokosenumi	Staff Governor, Admin, Clerical & Management
Rashmi Kumar	Public Lambeth
Billie McPartlan	Patient Governor
Victoria O'Connor	Public Bromley Governor
Christy Oziegbe	Nurses and Midwives
Devendra Singh Banker	Public Bromley Southwark
Chris Symonds	Patient Governor

King's College Hospital NHS Foundation Trust

Item	Subject
1.	**STANDING ITEMS**
23/025	**Welcome and Apologies**
	The Chair welcomed members and attendees to the meeting and noted the above apologies.
23/026	**Declaration of Interests**
	No interests were declared at the meeting.
23/027	**Chair's Action**
	There were no actions from the Chair.
23/028	**Minutes of the previous meeting held on the 22 June 2023**
	The minutes of the previous meeting were approved as an accurate reflection of the meeting.
23/029	**Action Tracker / Matters Arising**
	The Committee reviewed the action tracker and other pending actions.
2.	**FOCUS ON DISABILITY**
23/030	**No items.**
3.	**QUALITY, SAFETY & RISK**
23/031	**3.1. Quality Account Priorities – Quarter 1**

Head of Quality Governance, Assurance & Compliance presented the Committee with key highlights on the Patient Experience and Patient Outcomes Quality Account Priorities carried forward into 2023/24 which were agreed as two-year priorities.

To improve the identification and management of patients with sepsis, and to improve the detection and escalation of the deteriorating children, mothers, and birthing persons – partial compliance.

- To improve the identification and management of patients with sepsis, and to improve the detection and escalation of the deteriorating children, mothers, and birthing persons – partial compliance.
- A Medical Lead for sepsis was now in post who will be championing training and supporting the identification needs around sepsis.
- For adults the 90% target had not been achieved and work was underway to improve the trajectory.
- With deteriorating patients with children, achieved 60% target and the focus was now on embedding all the improvement initiatives.
- The aim had been set for 90% target in maternity going forwards, though most of the improvement initiatives had not been quite embedded with focus on the new handover tool, with MIS escalation plans, maternity ward handovers etc.

To improve patient experience through effective communication – partial compliance

- This was quite successful and noted a marked reduction in terms of the number of patients that were unable to contact the ophthalmology service.
- The industrial action did have an impact but the key learning was to be rolled out and has been built into MyChart and ensuring that key learning has been embedded.

- In Q1, year 2 objectives focus on co-designing the ward welcome pack and ward discharge pack to improve provision of information to patients and carers in the pilot areas: Coptcoat, Brunel, Byron, Farnborough, Medical 7 and Surgical Admissions Lounge.
- Another key element was the training component in terms of how clinicians communicate with patients. The training package has been reviewed and four training sessions delivered to 60+ clinical staff including FY1, FY2 doctors and speciality registrars.

Improving outcomes for patients receiving neuro-rehabilitation – compliance

- The key focus of year one was developing the pilot quality of life questionnaire.
- The initial analysis and review of the data will be in October 2023, feedback had been received on the questionnaire from patients. The key focus will then be, depending on the analysis of the results, improvement initiatives to be rolled out going forwards.
- In year 1, the Trust co-produced a pilot quality of life questionnaire defining the outcomes that matter most to patients receiving neuro-rehabilitation.

The Committee received questions in advance from Governor (FN) in relation to sepsis:

Question 1: Considering the possibility of multiple organ failure and quick death from sepsis are we now assured that the EPR will not fail again? What contingency have we in place?

Answer: One of the incidents was as a result of a failure with APR and FN sought assurance in terms of how this would not happen again. Contingency plans are in place, EPIC (to be launched on 5 October 2023) and the functionalities may help mitigate from happening being a cloud based system. The Trust cannot give a definite guarantee that the electronic systems will not fail again, however, a business continuity plan and systems are in place to support any downtime functions

Question 2: Are we assured that we will not be relying for all solution on the new Sepsis Lead, and on EPIC? What are the backup plans should EPIC fail as the EPR failed above?

Answer: In regards to our Sepsis Lead, the role is crucial. One of the recommendations from the Care Quality Commission was the appointment of a Consultant to Lead on Sepsis for the Trust. The key element of this role really is to support the education, the training, raising awareness, not necessarily depending on the individual to carry out the works, but being a key source in terms of education and knowledge and raising awareness. One of the key focuses is improving our use of safety tools in response to sepsis. It is a multi-pronged approach with Incident reporting, live data from EPIC and the local quality MEG audit.

Question 3: Are we assured that whole departments where sepsis could occur are trained in identifying and managing the condition? That no one is left out (please see context in the next paragraph).

Answer: The Committee may have heard the sad circumstances of the death of Martha Mills in Paediatrics which has been of media interest. The Trust apologised for the failings in Martha's care and made a number of changes as a result. Martha's parents who had shown extraordinary courage in creating Martha's Rule, fully supported by the Trust. One of the keys aspect of learning for the Trust was around sepsis training which is mandatory for all paediatricians and consultants treating adults. This is an area being championed by the new Sepsis Lead and one of the key things is the review of the training needs analysis and the various levels of training that consultants need depending on their clinical roles, as well as simulation training as part of any mandatory sessions.

Question 4: Are we assured sepsis information leaflets will be available for family members who accompany patients?

Answer: As much as we would like to say we have the full assurance of the availability of the sepsis leaflets to family members who accompany patients, the Trust is still working towards achieving this. As part of the Sepsis Awareness Training Day, the Trust did purchase a number of leaflets and posters that have been circulated to most of the wards and that information is available in a standard format to all patients.

Question 5: In response to your statement: "*actively reviewing staff awareness of the sepsis bundle,*" *Question*: Are we assured that awareness of sepsis alone is sufficient to tackle this fast and deadly killer?

Answer: The Sepsis 6 bundle, which is being tested as part of the education and training is a step by step process of what clinicians need to be aware off and the signs they need to look out for. MEG, which is the quality audit tool and one of the questions asked is that staff are able to describe the sepsis 6 bundle. In August, over 90% of our staff were able to describe it, which helps to monitor staff awareness of the sepsis 6 bundle.

The Chief Nurse and Executive Director of Midwifery added the training session was set up by the Lead for Sepsis 6 (an Anaesthetist from another organisation) to highlight the national profile day around Sepsis. The Committee noted to share future national Sepsis Awareness Day events with the Governors.

Action: Kudzai Mika

Worries and Concerns is a national improvement and project that the Trust was working alongside NHSE as a pilot site. The key driver for ensuring that Worries and Concerns was included in patient assessments and care planning plays a big part in sepsis as well as seconds. The programme is to support people in terms of escalation and if the care is not meeting their needs and as part of that the Trust presented work around this at the HSJ conference.

A number of focus groups as well with patients taking on board their voices. The Freedom to Speak Up (FTSU) Guardian has been looking to continue to build on this work and support the communication in raising awareness the FTSU service which is in complete confidence to encourage staff to raise concerns.

The Chief Nurse and Executive Director of Midwifery, suggested to the Governors if they welcomed the proposition to hear more about the Worries and Concerns pilot which is also underpinned by Martha's rule, this could be organised at a later date.

The Governor (JBV) commended the Worries and Concerns pilot scheme and encouraged all to join the worthwhile scheme. The Chief Nurse confirmed that being an integrated system, this would flag and score those patients who were more at risk at deterioration.

In terms of patient follow ups, EPIC will be opening up access to MyChart which will be a patient portal application that effectively allows a patient individualised access to their results, their referrals and it will also streamline direct access to clinical teams. Patients will be able to directly contact their clinical team through the electronic system in order to get a response. For example, for referrals that would remain visible and uncompleted until the appointment was sent, it should improve that communication function between clinicians and patients. The remit of MyChart will sit with the Patient Experience team alongside PALS, to ensure the link between the service support patients in a more robust way. Part of the campaign is asking patients, to ensure they have understood what they are informed about but also an opportunity for them to raise any worries, concerns that they have and also bring in their family as support and a review of visiting hours.

23/032 **3.2. Integrated Quality Report**

The Director of Quality Governance presented the key highlights:

There were 3 Never Events (NE), one of which was an unfortunate incident with a patient scalded with water. A number of immediate actions were put in place: how to escalate when there is no hot water at the Orpington site (in this instance kettles were used to prepare the hot water in order to do the right thing for patients for them to be washed appropriately.)

A series of maternity never events and the outcomes from the review of all of those have been aggregated to ensure the systematic issues were fixed and liaising with NHSE to redesign some of the swabs and tampons that are used in maternity care to ensure a more robust system. For the wrong site surgery never event, the situation surrounding this was rather complex in terms of the site was marked but the prep that was used to prepare the patient just prior to insertion to the skin had been washed off. The Committee noted that there was a disconnect between the person who marked the finger and the surgeon, and in the midst, the actual marking had been washed off to disinfect the skin before insertion.

The July data showed an improvement with duty of candour documentation, noting there had been a dip with the implementation of InPhase, the Trust was now at normal levels of compliance. The Trust's still birth rates, neonatal mortality rates and perinatal mortality rates showed the Trust was below expected, a positive reflection on the care that provided by neonates.

A suggestion from the Committee was for patients with darker skin for the markings to be made more visible as it may be difficult to see. The investigation was still on-going, and a process change was the availability of the correct site marking pens. An immediate after-action review was held with all parties involved to consider a different approach which the Trust was trying to manage. The incidents which involve surgical or other invasive procedures are tracked, with thematic analysis undertaken to see if there is an issue in the process of these procedures.

The Director of Quality Governance explained that InPhase was implemented 6 months ahead of Epic so that staff could familiarise themselves with the system, to prevent staff having to learn and adapt to 2 systems in quick succession. InPhase also allows the coding system to be triangulated between different types of information with patient safety and patient experience, complaints, and legal cases. In relation to medication with agreement from the ICB, the Trust

was able to postpone the launch of PSIRF to January 2024 with GSTT; an initial soft launch would commence in November 2023.

A demonstration of InPhase to be presented to the Committee at a later date to enable better insight and understanding of InPhase with its functionalities and the dashboards.

Action: Roisin Mulvaney

The Chief Nurse and Executive Director of Midwifery confirmed that there is no national guidance for hand surgery, however, there is national guidance for knee, hip, and other procedures.

The Committee welcomed and noted the Integrated Quality Report.

4. PATIENT EXPERIENCE

23/033 **4.1. End of Life Care Annual Report 2022 - 2023**

The Deputy Chief Nurse presented the key highlights:

The report provided a review of progress against the Trust's End of Life Care (EOLC) Strategy 2022-2026 which set out the priorities for 2023-24 and data supplied from the last financial year, and noted to be the first annual report since the start of the pandemic. A new governance structure had been developed which the EOLC Committee which feeds into the Patient Experience Committee. The Trust had a much older demographic of patients that access the service at the PRUH and Orpington sites with 64% being over the age of 85 versus Denmark Hill at 43%. The age bracket at the DH ranges from 25 to 64 (part of the variation in age is around the tertiary services on the DH site and the types of patients received as a Major Trauma Centre (MTC).

The partnership and processes between the palliative care teams, bereavement and chaplaincy services is well established and concerted efforts to contact all the bereaved families within 10-12 weeks post bereavement. Further work was underway in obtaining feedback with the activities, process and through to the care of the dying patient. The Committee noted the Mortuary Service had an inspection by the Human Tissue Authority and noted some critical shortfalls, which has since been remedied. The Trust was heavily engaged with the Medical Examiner in terms of process and review around the legal aspects of death certification.

The Chaplaincy Service is a key a player in the support offered to patients for EOLC and they received about 10% of EOLC referrals for patients approaching or in their last hours of their lives. There was ongoing training for staff in terms of offering the service more broadly and not just as a request service. The last CQC inspection took place in 2019 and various actions were implemented including the 24/7 service and the integration of the patient electronic service which would be finalised with the launch of EPIC on 5 October 2023. Significant work around improvement ordering the preferred place of care setting and again the EPIC functionality would allow within in the care planning stage. The Trust received 25 complaints for EOLC and key theme identified was privacy and dignity for the dying patients and privacy for visitors in relation to their arrangements for visiting their loved ones.

The Committee received a question in advance from Governor (FN) in relation to EOLC:

Question 6: How much were you requesting? How much will the film making cost?

Answer: A joint venture with a company called Inner Eye Productions, which is a company used previously at King's to produce the film footage, but also with the Burdett Trust for Nursing Proactive Grants Programme, a charity. They had actually approached Inner Eye Productions with the proposition of EOLC and so asked the Trust to partner with them and to put in a joint proposal. The joint proposal was successful in the bid which amounted to £100,000 and the cost of the production element of the film which would be about 20 minutes long.

It is a bespoke piece of work with interviews to be held with a large number of stakeholders and staff to really understand what are the real lives, lived experiences to produce a thought provoking film as an educational tool.

The Governor (LBS) presented key highlights following a recent meeting re: EOLC about items for discussion at future meetings:

- The need for clinical staff and governors to support this initiative.
- Collecting evidence that needed to be collated, analysed and to improve the current service.
- AI and quality alerts to gather information; but there's very little support, manpower and finances
- A crucial area and culturally a societal pressures mean that most people don't talk about death
- Training opening up the subject involving chaplaincy funeral directors.
- Monthly meeting would be with Joe and colleagues.

The EOL Committee, which has been up and running for the past 18 months, which was a recommendation from the Department of Health & Social Care (DoHSC).

The Governor (LBS) stated that EOLC is *absolutely crucial to the delivering of good patient care, and a factor that would be faced by all and to ensure it a good experience for all.*

LBS requested EOLC to be itemised as a standing item on the agenda.

Action: Sara Harris

The Deputy Chief Nurse added that it is a priority and the dying patient is often thought about just in the last few hours, however, the whole process around EOLC starts the last year of life and it is around advanced care planning, having those conversations and trying to make some of those difficult conversations more comfortable because people don't often feel like talking about EOL. There are on average approximately 100 inpatients dying on each site on a monthly basis. The care package is available to those patients who have died in hospital, noting some patients have died shortly after discharge and the teams are also involved with their care and the hospital does arrange a follow up. The Committee noted that a considerable number of patients die within a community setting after discharge and would have some level of follow up from the Community Palliative Care teams who would undertake that service.

The Committee noted the End of Life Care Annual Report 2022 – 2023.

5.	**GOVERNOR FEEDBACK**
23/034	**5.1.Feedback from Governors on Activities**

This item was not discussed due to time constraints.

5.2. Quality Committee - Governor Observer Summary

The Committee Chair presented key highlights from the Quality Committee held on the 7 September 2023:

- **Martha Mills and Martha's Rule:** There is now a critical care outreach service in paediatrics in light of the death of Martha Mills. Staff are highly trained and to look after people who are deteriorating rapidly and flagged through the national early warning scores.
- **The Worry and Concern Project:** More emphasis on stressing to people quite how ill their child or their loved ones are, again another change implemented in the aftermath of the Martha Mills case.
- **Whistleblowers:** The Quality Committee raised the issue how do we respond to whistleblowers? This was in light of the Lucy Letby case and actively listening and responding to concerns raised by staff and patients.
- **Retained Swabs:** Episodes of retained swabs in maternity and the on-going investigations. A key factor was the changeover of staff, handovers and noting that there were now fewer vaginal deliveries and more instrumental deliveries. 40% of deliveries were now by caesarean section and a further 20% are instrumental deliveries.

The Committee noted the Quality Committee - Governor Observer Summary.

6.	**ANY OTHER BUSINESS**
23/035	The Governor (AB) raised the following issues:

- **Evening reception:** Raised that there was no reception cover after 18:00 on Monday 18 September 2023. The Deputy Chief Nurse confirmed that recruitment had been approved to lengthen the hours to cover a broader range of out of hours though not a 24 hours reception cover.
- **Hook in Ladies Cubicles:** Raised no hooks in the cubicles. The Deputy Chief Nurse confirmed that due to it be classed as a ligature risk and in a confined lockable area, an alternative measure would be sought. The toilets are cleaned regularly and noted on the inspection register.
- **Cancelled Appointments Communications:** Raised a patient turned up their appointment and no letter had been received. The Deputy Chief Nurse confirmed that this would not happen under EPIC.
- **Reimbursement for Transport:** Raised that the above patient who had their appointment cancelled, subsequently had difficulties in obtaining the expenses reimbursed. The Deputy Chief Nurse confirmed that the Patient Experience Team had taken on the cashier functionality, so should be a more streamlined service going forward.

Dates of future meetings via MS Teams at 09:30 – 11:30:

- Thursday 21 March 2024
- Thursday 18 July 2024
- Thursday 26 September 2024
- Thursday 28 November 2024

King's College Hospital NHS Foundation Trust

Strategy Governors Committee

Minutes of the meeting held on Thursday 7 September 2023
At 14:00-16:00 via MS Teams

Members Present:

Dr Devendrasingh Banker	Bromley Public Governor (Committee Chair)
Ibtisam Adem	Lambeth Public Governor
Jane Allberry	Southwark Public Governor
Jacqueline Best-Vassell	SEL Public Governor
Aisling Considine	Staff Governor - Senior Pharmacist
Hilary Entwistle	Southwark Public Governor
Emily George	Lambeth Public Governor
Erika Grobler	Staff Governor - Nurses and Midwives
Debbie Johnstone	Patient Governor
Tunde Jokosenumi	Staff Governor - Administration, Clerical and Management
Prof Daniel Kelly OBE	Lambeth Public Governor
Devon Masarati	Patient Governor
Akhter Mateen	Non-Executive Director
Fidelia Nimmons	Patient Governor
Victoria O'Connor	Bromley Public Governor
Christy Oziegbe	Staff Governor - Nurses and Midwives
Katie Smith	Bromley Public Governor
Chris Symonds	Patient Governor
David Tyler	Patient Governor

Nominated / Partnership Organisations:

Prof Dame Anne Marie Rafferty	King's College London (Governor)

In Attendance:

Siobhan Coldwell	Director of Corporate Affairs
Sara Harris	Interim Head of Corporate Affairs (Minutes)
Akhter Mateen	Non-Executive Director
Ellis Pullinger	Senior Responsible Officer, Apollo Programme (Item 2.)
Dr Jack Barker	Chest and General Physician (Item 2.)

Apologies:

Rashmi Agrawal	Lambeth
Lindsay Batty-Smith	Southwark Public Governor
Tony Benfield	Bromley
Angela Buckingham	Southwark Public Governor
Dr Akash Deep	Consultant Paediatric Intensivist / Staff - Medical and Dentistry
Sarah Lafond	Acting Deputy Director of Strategy
Billie McPartlan	Patient
Prof Richard Trembath	Non-Executive Director
Adrian Winbow	Patient

Item	Subject
23/25	**Standing Items**
23/26	**Welcome and Apologies** The Committee Chair welcomed members and attendees to the meeting and introductions were made. The above apologies were noted.
23/27	**Declarations of Interest** The Committee noted there was no declarations of interests.
23/28	**Chair's Action** There were no actions from the Chair.
23/29	**Minutes of the meeting held on 22 June 2023** The minutes of the previous meeting held on Thursday 22 June 2023 were approved as an accurate record of the meeting.
23/30	**Action Tracker** The Committee noted the updates to the action tracker.
23/31	**Matters Arising** The Committee noted there were no matters arising.
2.	**Apollo Session and Update**
23/32	The Committee was updated on developments with the Apollo Programme by Ellis Pullinger, Senior Responsible Officer (SRO) and Dr Jack Barker, Chest and General Physician (Clinical Lead) who were both steering the project for safe launch and implementation on the 5 October 2023. The Committee was informed by the SRO that the Trust was 27 days away from the launch. A Joint Apollo Steering Board was held last week with GSTT. Both the SRO and Clinical Lead were confident that a safe launch would take place on the 5 October 2023, noting the Industrial Actions had made the plan more complicated, however, there was a contingency plan in place to ensure all proceeded well. The Committee was updated by the Clinical Lead that staff training had advanced well, though there was a further to push to get even more staff trained. Work was on-going with transcribing drug charts to the new system as a contingency measure if there were no consultants available due to the industrial action. The Trust was currently operating an electronic prescribing within CPR and those charts need to be transferred into the new system and that detail is being worked through. It was noted that 80% of consultants did turn up for work during the last industrial action. ▪ Work was ongoing with the cardiotocograph (foetal monitoring systems in maternity), which the nurses and midwives were assisting with to mitigate. ▪ Data migration was taking place steadily, and there was a sense of real commitment and dedication by all the clinical and non-clinical teams to go live on the 5 October 2023. ▪ The issue of patient data migration was raised and noted there had been 6 rounds of testing involved and there had been no issues of compatibility. ▪ The system of future appointments was crucial and ensuring people were booked into slots from late September was progressing well. ▪ Over 40million documents had been transferred over into the new Document Archive, though not all systems would be migrated over, such as the ITU system which will go into archive. A concern was raised about a fall back plan, and the decision the Trust had taken was if it was not safe to go live on the 5 October, then the Trust would not compromise patient safety, clinical colleagues and that of the reputation of the Trust. Various decisions had been taken

through the governance structures to ensure it was an optimum launch. The Clinical Lead confirmed that at cutover, the Trust would resort to paper as a fall back measure.

In terms of benefits to patients, the benefits would be seen in time but a quick gain was that patient records would be accessible between partnering Trusts, so patients being treated appropriately and more speedily. For patients transferring in to an area, their records would not accessible by the new Trust as not a partnering Trust. The Clinical Lead confirmed this aspect was not part of the Apollo Programme and not all hospital IT systems were the same, but did confirm the transfer in process was seamless in primary care up and down the country.

The Committee noted the issues in South East London (SEL) primary care and that a different system is used by General Practitioners (GPs), who are independent of secondary care. Outside London, GPs use DocNote. The proposal was that the GPs in SEL use the London Care Record so that they have a portal similar to secondary care.

The Staff Governor - Nurses and Midwives also reiterated that the time spent with the Care Groups and their commitment was astonishing; all were driven to ensure a successful launch both operationally and clinically by all clinical and nursing teams. The Clinical Lead also confirmed that the consultants and surgeons were all aware of the different challenges they face given time constraints to ensure all the training had been undertaken within the timeframe set out.

The Committee noted the Apollo Programme update report.

3. Equality, Diversity & Inclusion(EDI) and Health Inequalities (HI)

23/33 The Committee was presented with an update on Equality, Diversity & Inclusion (EDI) and Health Inequalities (HI) by the Director of EDI.

NHS England's EDI Improvement Plan set out six "High Impact Actions" to address direct and indirect prejudice and discrimination that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce.

The most significant action for King's Executive is "High Impact Action 1", which states:

"Chief Executives, Chairs and Board Members must have specific and measurable EDI objectives to which they will be individually and collectively accountable." The Director of EDI confirmed that HI Action 1 was well embedded and there was on-going work to widen out this action to the Board, including NEDs and setting SMART objectives.

The Director of EDI highlighted that the key issues in the NHS particularly around representation and lived experience relate to Disability and Race equality and Inclusion. For Disability, King's was recently ranked 206th position out of 212 Trusts, so there is a lot of improvement required. It is an assumption that a similar National benchmarking exercise for Race will soon emerge. Our aspiration as a Trust is to learn from the "best in class" and aspire to achieve a much better performance in the areas where we are week.

Health Inequalities – Vital 5

There had been good progress with launch of the Health Inequalities programme (the steering group being led by Dr Rantimi Ayodele, Deputy Chief Medical Officer (PRUH MED Director) which has 4 key areas of focus:

1. Vital 5
2. Data Dashboard
3. Research
4. Clinical Projects

All areas have working groups with leads; however, the Vital 5 group requires a Clinician to lead the overarching working group and progress has been made in identifying Clinicians to lead these categories:

- Obesity (diabetes, heart disease and cancer).
- Alcohol (liver disease, mental health conditions and cancer)
- Tobacco (heart disease, respiratory disease and cancer)
- Mental Health (anxiety and depression)
- Blood Pressure (hypertension)

The purpose of the Vital 5 it to reduce obesity and harmful drinking, smoking cessation, controlling blood pressure, and identifying and improving poor mental health to help prevent ill health, promote good health, and improve detection, management and treatment of existing conditions. The Vital 5 initiative advocates for people, communities and organisations to make improvements in/to five factors that have a major impact on health at an individual and population level.

Fidelia Nimmons, Patient Governor proposed a few questions in advance of the meeting in relation to the EDI report, addressed by the Director of EDI at the meeting.

Page 13: **Addressing structural barriers to the career and pay progression of women by finalising a menopause policy for staff and accompanying programme of work.**

Question: Menopause is a taboo subject for many cultures. Women just do not talk about it or disclose it. Are we assured we have systems in place to overcome this so we are not cutting off some sections of the female workforce? Are there alternatives areas to menopause?

The Women's Network are promoting events around menopause, working with the REACH network to ensure conversations and approaches are inclusive, taking into account the cultural nuances. During Black History Month, Bernadette Thompson, will be hosting a panel linked to Black Women's health and we will hear from a GP who specialises in menopause; who will discuss menopause so it is transparent as it is different symptoms for individuals and in different cultures.

Page 15: **They are picked up at the airport on arrival.**

Question: Is this a rule for everyone or for only those who are not familiar with London? Will these be groups or singles pick up? Who picks them up? Are we assured we can present a friendly caring Kings' face to the new arrivals from the airport? 1st impression matters.

International recruited nurses' staff are collected at the airport which is a collaboration with King's Commercial services and King's IEN leads. The Chief Nurses' team ensures those staff recruited internationally are properly inducted and clarity given about route to progression and noting there was so much more the Trust can do better.

The Staff Governor - Nurses and Midwives concluded that international nurses are supported well once arrived in the UK, and are given an induction to the British medical system, supported with accommodation (cost of living, childcare) and are given the same level of opportunity as their British colleagues.

Page 17: **In cases of low-level misconduct**

Question: Are we assured we can define what this looks like to staff from different parts and cultures of the world? What some consider aggressive behaviour is not the same in other places. Schools use behaviour rules so you know when you have overstepped the mark.

We do have instances of where there has been 7 cases of low-level misconduct to date. Cultural nuance (cultural nuances are the differences in the way that people in different cultures think, feel, and behave) is something that will be reviewed in the New Year.

The Chief People Officer and the Director of EDI with other members of the ER and EDI team regularly review staff Employee Relations (ER) cases to ensure any sanction of disciplinary action is justified.

The same process exists for our doctors and consultants, where the ROAG (Responsible Officer Action Group) chaired by Dr Christopher Palin, convenes to discuss cases that could be potentially referred for disciplinary action to the General Medical Council (GMC) and the Director of EDI attends and feeds into the discussion at this Committee.

A cultural intelligence programme would be rolled out in due course; however, the Trust's immediate priorities are with Apollo and the winter pressures. It is predicted that this programme will commence early 2024 and the Governors will be advised accordingly.

The Committee noted the EDI and Health Inequalities report.

4.	**NED Committee Updates**
23/34	The Committee was presented with an update from Akhter Mateen, NED.

There had been fewer meetings since the Strategy Governors Committee (SGC) had last met and key highlights from the various Board Committees:

- *Audit & Risk Committee* - The Auditors were establishing their plans and the Internal Auditors are going through their reviews.
- *Finance & Commercial Committee* – As at month 4, the Trust reported a deficit of £43.7m. This represented a £12.9m adverse variance to plan. The Trust plan included a £72m of cost improvement at M4 the total schemes identified was £52.0m. The Trust realises the enormity of the pressures it faces and all areas were focussing on costs and budgets. Other factors had made the situation more complex, in terms of the consultant / junior doctors' strikes.
- The Sustainability Plan for 22-23 was reviewed and a positive result was a reduction in the carbon footprint, water consumption and in waste at the Trust. There had been significant reduction in medical gas consumption and medical gases.
- Initiatives were being put in place with air quality monitors around the Trust, creating cycle hubs where people could comfortably park their cycles, introducing EV charging points, LED lighting. Heat decarbonisation (alternatives to boilers which do not use fossil fuels) for the Trust is an area which is a slightly longer term initiative.
- International financial reporting standards would be introduced which would require all Boards and Trusts to declare in their annual reports the progress made in sustainable output. The Governors were encouraged to feedback in this important area.

The Chair enquired about the finances given the financial pressures the Trust was under for new services such as clean aeroplane, heat decarbonisation? The forecasting had been done whereby there is clinical prioritisation and a complete review of budgets to ensure delivery. The Trust was also taking initiatives in their discussions with suppliers and asking them to be

more sustainable in terms of carbon footprint, being smart in line with climate change productivity.

Prof Daniel Kelly and Jane Allberry joined the meeting at 15:00.
Ibitisem Adem joined the meeting at 15:16.

The Lead Governor was interested to hear about the strategic priorities and how can the Governors play a more active role in the debates around the finances. The NED (AM) confirmed all can contribute to the thinking process to the strategy and have input via the relevant attendance of the meetings, however, as a NED it was his role to have oversight and not manage the organisation and make executive decisions. The role of the governors is primarily around accountability and assurance.

The Southwark Public Governor (Jane Allberry) commented that all Governors should have input into setting the Quality Account Priorities (QAP) and suggested 2 priorities be considered for next year around:

1. Improving Services for Alcoholics
2. End of Life Care

The Director of Corporate Affairs confirmed that setting the QAP should happen via the Patient Experience and Safety Committee (PESC) and earlier input by the Governors was key to ensure an inclusive approach.

The Committee noted the NED Committee update.

5.	**Work Plan**
23/35	**The Committee noted the work plan.**
6.	**Any Other Business**
23/36	The Committee agreed that future meeting should all be held via MS Teams.
	Date of the next meeting
23/37	Thursday 21 March 2024 at 13:00-15:00 via MS Teams.