Guy's and St Thomas' NHS
NHS Foundation Trust

Council of Governors

Minutes of the 50th meeting of the Council of Governors held on Wednesday 28th October 2015 in the Governors Hall, St Thomas' Hospital

Present:

Devon Allison
Kevin Burnand
John Burns
Anita Campolini
John Chambers
Yvonne Craig Inskip
Jonathan Farley
Kate Griffiths-Lambeth
Ken Hayes
Tom Hoffman
Tony Hulse
Gyles Morrison
Sam Newman
Darren Oldfield
Robert Park
John Porter
Barry Silverman
Jenny Stiles
Giles Taylor
Warren Turner
Bryn Williams
Sonia Winifred
Paula Young

Apologies:

Jasmine Ali
Thelma Bangura
John Duncan
Steve McGuire
Frank Nestle
Diane Rekow
Steve Weiner

In Attendance:

Executive Directors:
Ian Abbs
Anne Macintyre
Martin Shaw
Dame Eileen Sills
Simon Steddon

Non Executive Directors:
Sir Ron Kerr
Sir Hugh Taylor (Chair)
Girda Niles
Robert Drummond
Sheila Shribman
Diane Summers

Other Attendance:

Peter Allanson	Trust Secretary and Head of Corporate Affairs
Diane Spillane	Governance Support Manager
Alastair Gourlay	Director of Asset Management

CG/15/34 Welcome, apologies and opening remarks

The Chairman noted that during his absence on leave, the vice chair and executive vice chair would be available to deal with any issues that arose. There was also likely to be an announcement of an additional appointment for the executive vice chairman which would not affect or interfere with his commitments for the Trust.

Both stakeholder governors who had been appointed by the local CCGs had stood down because the CCG was obliged to withdraw them. A review of the regulations covering CCGs following the 2012 Health and Social Care Act had revealed that a lay governor of a CCG, which both were, could not be a director, employee, member or governor of an FT even if they were governors by virtue of being nominated by the CCG. Council expressed its regret and thanked both members for their contribution to the Trust having been both supportive and challenging and also taken on extra responsibilities. The names of their successors were awaited.

CG/15/35 **Minutes of the meeting held on 22nd July 2015**

The minutes of the meeting held on 22nd July 2015 were approved as a true record. It was noted that the appointment of KPMG as auditors to the Trust, approved at the July meeting had been brought forward and would take immediate effect.

CG/15/36 **Matters Arising**

None were raised.

CG/15/37 **Reflection session on Board of Directors meeting**

Governors raised a number of questions and issues following the meeting of the Board, including:

- The likely impact on the Trust of the caps on external agency and bank spend. There was a short consultation on setting caps for bank and agency workers with an expected implementation date of 23rd November covering agency supplied staff, the staff bank, contractors and self employed staff. The proposal was to set a cap from November with adjustments in February and April 2016 with a maximum payment allowed of basic salary for the job plus 55% which had to cover fees and employment costs. By March 2016 nursing agency spend had to be 6% of nursing costs – it was currently 7.2% in the Trust and it would be permitted only to recruit from framework agencies so tow used by the Trust would have to be moved through the accreditation process at some speed to comply. The cap also covered medical staff including junior doctors. This was worrying given the current mood caused by the contract negotiations in play. Overall the Trust expected to comply with these changes and the Board would be accountable for reporting on a shift by shift basis. This seemed unreasonable for a trust of this scale and would potentially overwhelm the centre with information. More information about the effects of this would be given to the Board in January.

- Cost improvement plans – governors suggested it would be worth asking patients for their ideas on how to reduce cost, improve efficient and eliminate waste.

- Clinical trials – governors said they would welcome a presentation on the Trust's research and clinical trial participation especially given the success recently reported.

- The Trust also said it would consider the advice given by Public Health England on sugar consumption. A new nutrition strategy for patients and staff had just been approved.

- Digital strategy – having invested in a number of new technologies and the challenge was to ensure they were being fully exploited and the benefits from transformation properly realised. Going paper free should be possible and it was noted that the renal service had done so five years ago. The Executive Team was discussing how to make sure that the ambitious investment programme produced real transformational benefits for patients and staff and how to put digital at the heart of the Trust and not simply as a part of an IT project.

- Outliers – the problem of patients being put into wards away from the speciality looking after them continued to pose problems and inefficiencies. One general medical ward was currently closed but was expected to open as it became possible to staff it safely. As part of the preparations for Winter this was acknowledged as a partial answer but the challenge of using the bed stock more efficiently had been picked up and benchmarks applied to help manage referrals more efficiently.

- The benefits locally of taking part in the vanguard programme with Dartford and Gravesham – the Trust had a long history of working collaboratively with other trusts, including Dartford and Gravesham. Centrally, the NHS was looking to larger trusts to help support local health economies and build on clinical synergies. Geographically, Dartford and Gravesham would help the Trust develop network and tertiary services into Kent. Being a part of this would enable the Trust to retain control of its own affairs and access discretionary funding to support innovation for the benefit of local and more widely dispersed patients.

- Teenagers and the needs of the 18-24 age group, noting that they often disappear from their GP's vie. This subject had been discussed by the Children's Services Committee which had recognised the need to improve hospital and community services for this group. This was an area to be acknowledged to the CQC as requiring further work and progress.

CG/15/38 **<u>NHS Update</u>**

NHS Update

The Chairman suggested there were three areas of particular relevance to the Trust and its future – the money, strategy and the system.

i) The money

In terms of context, the NHS was the least costly and arguable most efficient health system in the developed world. Less per head of GDP was spent on it than most comparable EU counterparts and half of what the USA spent per head of population. The part of the US system funded from taxation (about 50%) had spending levels similar to the UK.

The UK government spent over £100bn per annum on health and social care. The Five Year Forward View had suggested that and additional £30bn would

be needed to maintain quality over the period for which the government had pledged an extra £8bn so the service was required to find efficiency and cost savings of £22bn over the five years. It was unclear when the extra money would be made available. The NHS was pressing the Treasury to front load the additional funding to support the necessary transformation. The outcome would be signalled in the spending review in November 2015.

Equally significant was the actual spend in the NHS. Many trusts, like GSTT, were forecasting deficits with the main exceptions being specialised providers who could rely on overseas and private funds. There were also risks to budgets that Trusts have access to but which sat outside their control – Public Health England, some local authority funds etc. It was possible that Health Education England and research budgets could be at risk. Assuming that at least some of the activity covered by these organisations would continue, there would be an impact on the Trust.

NHS budgets for specialised services had generally been increased at the expense of other budgets. The action on tariff seemed aimed at reversing this and was causing problems for the Trust and other specialist providers. It was noteworthy that the Trust's largest single commissioner was NHS England.

Governors encouraged the Trust to press for better costing of specialist services including understanding that specialised equipment was expensive. It was noted that the Finance Director was heavily involved in tariff discussions but it was clear that the way forward was being driven by cost pressures rather than anything to do with the real cost of undertaking procedures. Project Diamond top up funds were intended to subsidise complexity, a practice used internationally, and now it had been removed it had laid bare the inadequacy of the tariff for very specialist work.

There were also concerns that continued pay restraint in the public sector generally and the NHS in particular would be unsustainable as the private sector emerged from a period of austerity. The impact was likely to be felt with nurses and support staff rather than with doctors though the current industrial unrest was demonstrating the power of NHS muscle.

ii) Strategy

Although the current efforts to control demand and improve public health were essential it would be unwise to assume any early significant impact to support reduced spending. Demand was in fact, rising inexorably.

Current policy direction supported service integration from primary through to other health and social care services through a democratised process of seeking and developing ideas. Locally there had been considerable involvement in this agenda.

Different ways of collaborating were being trialled; both the Christie and Marsden specialist trusts had been given vanguard status to operate as commissioners and providers on behalf of NHS England. The Trust would need to decide what its appetite was for this type of initiative together with creating groups, chains and franchises.

The use of information and information systems were key to the success of delivering new models of care bringing opportunities to reduce cost as well as transforming the way staff worked.

Governors recognised the scale of challenge in public health terms from obesity and its links to diabetes where it was felt that more could be done especially for childhood obesity. These were known local health inequalities and a whole systems approach would help meet challenging but achievable targets. Monitoring the DevoManc experiment where all LA, NHS and some voluntary sector budgets were being pooled and then distributed on a capitated basis across Greater Manchester could suggest ways forward. It was worth noting that this exciting initiative was built on the back of long term relationships and the inspirational leadership of the city's long term CEO so it might not work everywhere but would provide lessons with broad applicability.

It was recognised that late diagnosis was an enduring problem. There were doubts expressed as to whether remote and virtual consultations would speed up diagnoses but primary care, working with people at risk with perhaps volunteers in support from the community might offer a way to improve this.

iii) The System

It was apparent that NHS England wanted to lay off the risk on specialist tariff and was passing responsibility for some to CCGs and to organisations such as the Trust. As a result, CCGs were experiencing more top down management than hitherto.

Monitor and the Trust Development Authority were set to merge to become NHS Improvement. This would offer a major change in direction as Monitor in particular had been established as a regulator and not to run failing or struggling trusts. Indeed it had only recently begun to employ staff with operational experience. Applying rules across all trusts was beginning to undermine and question the future of the FT model. For now the spotlight remained on finance and governance.

CG/15/39 **Nominations Committee**

Two members of the Nominations Committee had stood down at the end of their second term of office as governors so there were vacancies for a Patient and a staff governor. The Committee worked with the Chairman on the recruitment and performance management of the non executive directors.

Paula Young was the sole nominee from the patient constituency and was duly elected to the Committee.

Gyles Morrison and John Chambers were nominated as staff representatives. Each made a short statement in support of their nomination and after a paper ballot, John Chambers was elected to the Committee.

CG/15/40 **Governors' Reports**

Lead Governor

The Lead Governor commented on the range of recent meetings. He proposed to arrange an informal meeting of governors in January and had agreed with

the Chairman to hold a short drinks reception after the Accountability Session arranged for 2nd December 2015.

Quality and Engagement Working Group
Governors noted the contents of the report

Service Strategy Working Group
The outgoing Lead of the Group commented how useful it had been to be able to triangulate the information from different sources as a governor and had found that the Trust had briefed its governors well as the operating environment had become more difficult.

SSWG had had interesting presentations on collaboration on education with KCL where the aspirations needed to be crystallised into practical plans which the Board should pick up. There had also been a helpful over view of the start of the business plan.

It was noted that the current arrangements for SLIC would expire in March 2016 and the Governors were assured that planning for the next iteration of integrated care locally was in hand and a transition plan dedicated to maintaining progress through the change under active discussion.

CG/15/41 **Questions and answers**

The Council of Governors noted the updated matrix of issues that had been raised.

CG/15/42 **Any other Business**

There was none

CG/15/43 **Date and time of next meeting**

The meetings would be held on 27th January 2016 in the Governors' Hall, St Thomas' Hospital

Board of Directors meeting	3.45 – 5.30pm
Council of Governors meeting	6.00 – 7.30pm

Signed: _____ Date: _____