

Council of Governors 27th July 2016

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COUNCIL OF GOVERNORS

Meeting to be held on 27th July 2016
6.00 – 7.30pm
Governors' Hall, St Thomas' Hospital

A G E N D A

1. **Welcome, apologies and opening remarks**
2. **Minutes of meeting held on 27th April 2016** attached (CG/16/14)
3. **Matters Arising**
4. **Reflection session on Board of Directors meeting** oral
5. **Non-executive director appointment – approval of appointment** To follow (CG/16/15)
Tom Hoffman
6. **Annual Report and Accounts**
Neil Thomas, Auditor, KPMG
 1. **Annual audit report** attached
 2. **Annual report and accounts 2014-15** tabled
7. **Endoscopy Service improvement** presentation
Sarah Wilding – GI and Gastroenterology
8. **Governors' reports – to note and for information**
 1. **Lead Governor's Report**
John Porter
 2. **Quality and Engagement , 10th May** attached (CG/16/16)
Devon Allison
 3. **Service Strategy, 5th July** attached (CG/16/17)
Giles Taylor
9. **Questions and answers – for information** attached (CG/16/18)
10. **Any other business**
11. **Date and time of next meeting:**

The meetings will be held on 26th October 2016, Robens Suite, Guy's Hospital

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

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Guy's and St Thomas'

NHS Foundation Trust

Council of Governors

**Minutes of the 52nd meeting of the Council of Governors held on
Wednesday 27th April 2016 in the Robens Suite, Guy's Hospital**

Present:

Devon Allison	Gyles Morrison
John Balazs	Sam Newman
Kevin Burnand	Darren Oldfield
John Burns	Diane Rekow
John Chambers	Barry Silverman
Yvonne Craig Inskip	Sue Slipman
John Duncan	Jenny Stiles
Jonathan Farley	Giles Taylor
Kate Griffiths-Lambeth	Warren Turner
Ken Hayes	Bryn Williams
Tom Hoffman	Paula Young
Tony Hulse	

Apologies:

Jasmine Ali	Matthew Patrick
Thelma Bangura	John Porter
Anita Campolini	Steve Weiner
Robert Davidson	Sonia Winifred
Jane Fryer	
Steve McGuire	

In Attendance:

Executive Directors:

Ian Abbs
Sir Ron Kerr
Anne Macintyre
Steve McGuire
Amanda Pritchard
Martin Shaw
Dame Eileen Sills
Simon Steddon

Non Executive Directors:

Robert Drummond
Frank Nestle
Girda Niles
Reza Razavi
Sheila Shribman
Priya Singh
Diane Summers
Sir Hugh Taylor (Chair)

Other Attendance:

Peter Allanson	Trust Secretary and Head of Corporate Affairs
Angela Dawe	Director of Operations and Strategic Services, Adult Local Services
Merav Dover	Chief Officer, SLIC

CG/16/12 Welcome, apologies and opening remarks

The Council of Governors noted that this would be the final meeting for Paula Young whose second term was coming to an end, John Burns who was not standing for re-election, Gyles Morrison who was leaving the Trust's

employment and Barry Silverman who would be moving out of the area and therefore ineligible to remain a public member. The Membership co-ordinator was also leaving the Trust. The Council thanked these colleagues for the contribution they had made.

CG/16/13 Minutes of the meeting held on 27th January 2016

With the additional of Priya Singh to the attendance list, the minutes of the meeting held on 27th January 2016 were approved as a true record.

CG/16/14 Matters Arising

The Council of Governors noted the progress on recruitment for a non executive director to replace Diane Summers.

CG/16/15 Reflection session on Board of Directors meeting

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

Governors asked for further information on research work on dementia testing including developments in imaging.

There were comments following the CQC report on the actions taken on the comments made on surgery practices and the WHO checklist. The Trust had responded at the Quality Summit noting that the Trust had identified a number of the issues raised at the outset of the inspection. In particular the Trust had created a new role of Chief of Surgery supported by a surgical forum that could look at issues across the service. The Trust had given feedback to CQC on the conduct of the investigation.

Concerns were expressed about the performance of the new patient transport contractors with a number of complaints about patients being late for or missing appointments. In acknowledging settling on problems on what was a large contract, the Director of Essentia said that the major road works around Elephant and Castle had made it difficult to predict journey time. The issue had been raised formally with Transport for London through the Southbank Forum. Transferring the contract to new suppliers had been difficult and the intention had always been to introduce new performance indicators gradually as problems were encountered and resolve. A number of the changes to the targets had been prompted by suggestions from governors and the transport user group. Recruitment difficulties were also affecting the performance of the switchboard which added to the challenge for patients trying to find out what was happening to their transport. It was agreed to bring a report to the next Quality and Performance Working Group meeting.

The Council noted the workforce staffing report. In response to questions, the Chief Nurse confirmed that the Trust staffed its wards safely as a matter of priority and that there was a hierarchy of recruitment using the bank first before resorting to framework agencies. As demand sometimes exceeded supply it would breach the imposed cap rather than have unsafe wards – weekend work in theatres and A&E were the most vulnerable areas. The Trust had a good track record in negotiating reduced rates with agencies. Critical care nurses were in particularly short supply and the Trust had established its own recruitment micro site to try to reduce vacancies. Nursing would remain a

shortage profession so the Trust's view remained that it was essential that it remained on the FCO list for overseas recruitment.

The problems caused by commissioning changes for health visitors and school nurses were raised. The Trust had made representations to Public Health England and the Shelford Group was considering making a joint approach. In the absence of any relief on this the Trust would press for a London wide solution to the health visitor question and was exploring a number of ways of protecting school nurses particularly on their work on early identification of illness and prevention.

Governors noted the increase in elective and emergency work. Elective referrals were increasing disproportionately from outside the Trust's immediate catchment area and the current plan allowed for 5% increase overall. Beyond that the Trust could face capacity issues. The Trust maintained a close watch on the numbers using its emergency services; the current increase matched national trends. Whilst it was difficult to control demand, the level of growth was not sustainable so taking the opportunity to work across systems including work on prevention and keeping people out of hospital could lead to changes to the way some services, including outpatients, were offered.

Governors were asked to encourage people to support the Trust's efforts to persuade TfL to reconsider its proposals for the cycle super highway and by pass bus stop outside St Thomas'.

CG/16/16

Southwark and Lambeth Integrated Care

The Director of the Southwark and Lambeth Integrated Care programme briefed the Council on the main outputs from the programme which was coming to an end. Considerable investment had been made to set out and begin to deliver a broad vision aimed at helping people to live healthier and happier lives by identifying needs earlier and taking action. Improving hospital discharge and enabling people to stay or be treated at home. Building relationships had been a major feature of the work undertaken including at the outset persuading GPs that the programme was not an attempt by the Trust to take over all services. Moving resources from hospital to community and primary care had built trust and confidence. The programme had also featured co-design with citizens and clinicians working together as well as using test and learn techniques with the aim of failing faster in order to succeed sooner.

A major success had been the development of a local care record allowing all parts of the local health care system to share records as had the establishment of GP federations with clusters of practices working together.

It had proved difficult to measure the effectiveness of SLIC objectively although KCL had commissioned an external review which had been largely positive, with particular commendation for the involvement role played by citizens.

The Director of Adult Local Services committed the Trust to building on the learning from SLIC and assured the Council that the benefits would not be lost. She suggested that the establishment of local care networks would help to build relationships through integrated service provision with the Trust's Adult Local Services Committee and the Lambeth and Southwark Strategic Partnership overseeing this work. Developing place based delivery across local systems, changing the ways clinicians work with their patients and the

focus on people with 3 or more long term conditions, of who there were more than 45,000 locally, would carry the work of SLIC forward. The aim would be to assess their care needs, agree how their conditions should be managed including by the individual themselves. There would be transformational services offered extending the local care record to include community and social care and these would link to services such as @Home, the catheter passport and the discharge locality geriatricians. Local care network governance, which would have to flex for the different arrangements in each borough would also support connecting community nursing teams more closely to their communities.

One of the CCG governors welcomed the care record which reduced the time and effort that had to go into finding hospital test and procedure results. The increasing emphasis on multi disciplinary meetings across care pathways, especially collective discussions about difficult patients was also welcomed, as were the initiatives on care at home.

The Council acknowledged the financial support given to the SLIC programme by the Guy's and St Thomas' Charity. Whilst the outcomes might be less hard edged than it would have liked, there was no doubting the positive improvements in relationships and their impact on treatment which would be a strong feature of the programme's legacy.

CG/16/17 Update: Council of Governors Elections 2016

Governors noted the closing date for voting in the elections. As Gyles Morrison would be leaving the Trust's employment there would be an additional staff governor vacancy to be filled by election as the runner up in the 2014 election had also left the Trust's employment.

CG/16/18 Governors' Reports

Quality and Engagement Working Group

The Working Group Lead drew the Council's attention to the project to improve communications with patient and patient administration and invited contributions. Governors noted the contents of the report

Service Strategy Working Group

The Group had received helpful presentations on the Trust's financial position for 2016-17 and supported the requirement for savings to be approved by the Medical Director and Chief Nurse to maintain quality and safety. The Groups was also concerned by the gap between expected activity and the current contract offer from NHS England. The Group also welcomed the briefing on the vanguard proposals and the potential benefits for each organisation whilst noting the demands being placed on the Executive team. Support for Medway continued and was delivering profitable income with the Trust able to back fill the posts of staff working in Kent. Governors noted the contents of the report

Membership Development, Involvement and Engagement Working Group

The Group was concerned that there were few staff nominations for the forthcoming elections (four candidates for 2 positions) and had agreed to consider what strategies would help to engage staff in the work of the Council more effectively. This also applied to parts of the community. Governors noted the contents of the report.

CG/16/19 Questions and answers

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

CG/16/20 Any other Business

There was none

CG/16/21 Date and time of next meeting


The meetings will be held on 27th July 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:

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Council of Governors	Guy's and St Thomas'  NHS Foundation Trust
Appointment of Non Executive Directors	27th July 2016 CoG/16/15 tabled

This paper is for:		Sponsor:	Sir Hugh Taylor	
Decision	X	Author:	Peter Allanson	
Discussion		Reviewed by:	Nominations Committee	
Noting		CEO*		
Information		ED*		
		Board Committee*		
		TME*		
		Other*		

* *Specify*

1. Summary

The original task for the Nominations Committee was to find a replacement for Diane Summers whose second term of office has ended. However, it is clear to all that the challenges facing the Board over the coming years will need considerable strength and resilience to navigate.

The combination of a strong field of candidates with the burgeoning agenda has led to the Chairman considering whether to ask the Nominations Committee to make more than one appointment. The constitution allows us to appoint up to eight non executive directors (plus the chairman). There is, therefore, in principle scope to make at least two further appointments and, for reasons set out below, potentially a third; and the Committee does indeed believe there is a strong case for making three appointments, one prospectively, from what it considers to be a very strong field.

As governors know, the Trust has just appointed a non executive adviser, David Perry, to support the development of its information and IT strategies and it is intended to make further appointments of this type. They will be designed to share the burdens and challenges but without diluting the accountability of the Board and increasing its size unreasonably to the point that discussion and decision making became unmanageable.

The Chairman would like to take a similar approach to the Trust's commercial agenda. He has, therefore, agreed with Robert Drummond, whose current term of appointment comes to an end early next year, that he will not seek re-appointment as a non executive director but will become an executive adviser to the Board with effect 1 January 2017. This will enable him to develop his current dual roles as an independent chairman of GST Enterprises Board and, the Trust's commercial advisory board; and, as he will not be a voting member on the Board, it will also help the Trust to comply with best practice advice we have received on the governance of GST Enterprises.

This will open up a vacancy on the Board for an individual with a strong finance background. One of the candidates interviewed - and with whom the Committee was extremely impressed - has extensive experience of NHS operations as a chief executive with a deep knowledge and understanding of NHS finance and experience of leadership in a commercially

successful organisation; and the Committee is proposing that he should be appointed prospectively to take up the role with effect from 1 January 2017.

A short account of the interviews that the Committee held is annexed to this paper and the recommended candidates are 1, 3 and 5.

2. Request to the Council of Governors

The Council of Governors is accordingly invited to approve the appointment of the following Non Executive Directors each for a term of four years renewable for a further four year term subject to satisfactory performance;

Felicity Harvey	(Candidate 1) – with immediate effect
Emma Duncan	(Candidate 5) – with immediate effect
John Pelly	(Candidate 3) – from 1 January 2017.

3. Report to the Council of Governors

The Nominations Committee presented its proposals for the appointment of a non executive director to replace Diane Summers to the January meeting of the Council. It sought comment on the job and person specification from the Council and the Board and appointed Odgers Berndston to advise it on the selection and search for candidates after a competition between advisers. The position was advertised in the South London Press in May as part of the selection process.

Odgers presented an initial long list of candidates which the Nominations Committee asked them to refine by meeting the candidates and reporting on their suitability for further consideration. The Nominations Committee met to consider this long list and created a shortlist of 6 candidates for interview using the key criteria in the person specification in arriving at their decision.

The panel interviewed 5 of the candidates on 21st June and 11th July 2016. The 6th candidate was unavailable for interview. The discussion with all of them was based on a common interview framework covering what it means to be a non executive director, meeting the current challenges facing the NHS, demonstrating the Trust's values understanding the needs of our local communities and patients and preparing for the role.

The Committee was grateful to Odgers for producing an interesting and high quality list of candidates and strongly recommends that the Council of Governors approves the appointments recommended.

Appendix

Candidate 1

This candidate has very recently retired as a senior civil servant in the Department of Health. She is a doctor with 10 years academic experience with KCL. As a civil servant she has worked on developing quality policy, has been director of prison health and head of the medicines, pharmacy and industry group in DH. She was director of the Prime Minister's Delivery Unit, director of the performance and reform unit at the Treasury and latterly director general of public and international health. She is a member of the World Health Organisation's independent oversight and advisory committee for the emergencies programme and a trustee of the Royal Trinity Hospice.

The interview demonstrated the breadth and depth of her experience of the NHS, the civil service and the overall political landscape affecting it. She understood local needs and issues and how to apply her commercial knowledge to helping to alleviate the current financial stresses. She was clearly comfortable in analysing and triangulating data as well as getting information from talking to people. She was a strong and appointable candidate.

Candidate 2

This person has in depth knowledge of the NHS and the local health networks having been a local NHS chief executive, consultant and coach and held non executive roles in health and health related areas.

They demonstrated that they would set high standards for the Board and the Trust, be highly effective in the scrutiny role and ask insightful questions. While the interview raised some question marks over style and approach, and the responses to the strategic issues were less persuasive than some of the other candidates, this candidate clearly has strong credentials for the role and would bring a number of positive attributes to it. Nevertheless, the overall strength of the field on this occasion meant the Committee does not recommend them for appointment.

Candidate 3

This candidate recently retired as Chief Executive of a successful specialist foundation trust having been CEO of an acute trust and finance director and chief operating officer here. Prior to that he had a commercial career that included 11 years working for Rank Xerox. One of the hallmarks of the FT he led was its commercial success.

The Panel agreed that this was a strong candidate with great affinity with the Trust, recognising that it would be a different place from the one he left, but demonstrating a good understanding of running this type of institution and the essential differences between executive and non executive responsibilities. He is recommended for appointment.

Candidate 4

From a background in PR this candidate had spent much of his career in the private sector before spending the latter part of his career before retirement in 2012 at the Food Standards Agency. His expertise is in corporate communications and corporate affairs, media handling and internal communications.

He came across to the panel as a facilitator rather than as a deliverer of innovative strategies or solutions. Clearly compassionate and values driven his lack of real board level experience in amongst strong and serious characters led the Panel to conclude he should not be recommended for appointment.

Candidate 5

After beginning her career at ITN, this individual became a print journalist with a number of roles within a major international publication where she became deputy editor. She then established an on line offshoot with a readership of around 450,000 mainly in the UK and US. She had non executive experience on the board of a FTSE 250 company (which has ended) and as trustee of a small charity.

This candidate demonstrated an enthusiasm and thirst for knowledge and information – she could be expected to pick up and pursue issues bringing newly acquired knowledge, intellectual rigour and analysis to them. She had lots of energy, had views she was prepared to express and was likely to ask demanding questions. This was a thoughtful interview and her appointment was strongly recommended by the Panel.

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2015-16 External Audit Presentation to the Governors

Guy's and St Thomas' NHS Foundation Trust

27 July 2016

Agenda

**The contacts at KPMG
in connection with this
report are:**

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Link to your responsibilities

Headlines from our work

Financial Statements detailed findings

Use of Resources detailed findings

Quality Report detailed findings

Questions

Link to your responsibilities - why we are here today

Items you
talk about
in annual
report

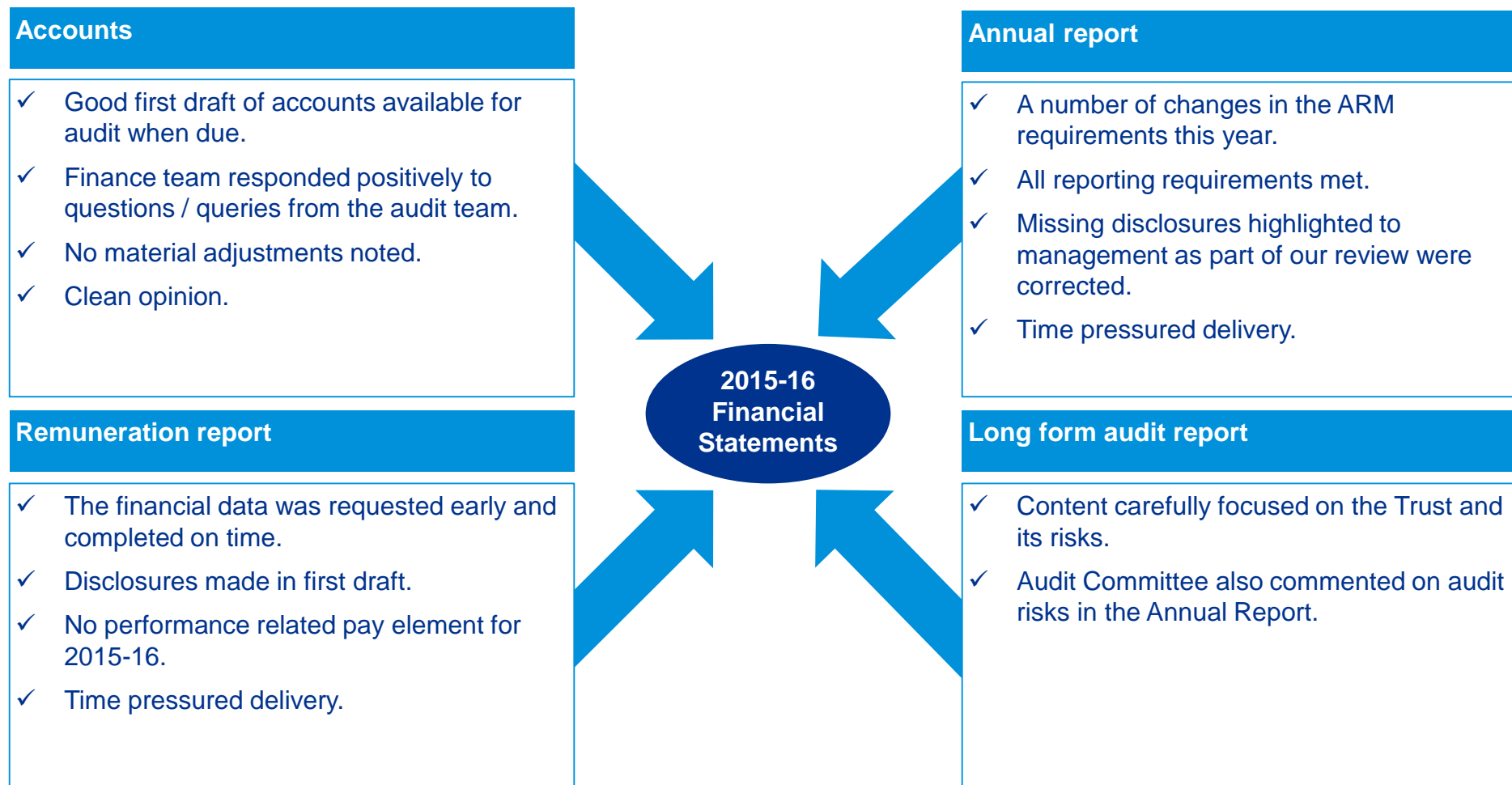
Overarching duties	
Hold the Non-Executive Directors, individually and collectively, to account for the performance of the Board	
Represent the interests of the members of the Trust as a whole and the interests of the public	
Appointment duties	
Appointing and removing the Chair and other Non-Executive Directors	
Appointing a Deputy Chair	
Appointing a Lead Governor	
Appointing Deputy Lead Governors	
Approving the appointment of the Chief Executive	
Appointing and removing the external auditor	
Decision making duties	
Decide Chair and Non-Executive Directors remuneration and allowances	
Taking decisions on significant transactions	
Taking decisions on mergers, acquisitions, separations and dissolutions	
Taking decisions on levels non-NHS income	
Corporate document duties	
Approve amendments to the Trust's constitution	
Preparing the forward plan	
Receiving the annual report and accounts	

Item you
achieve by
receiving
the annual
report

Headlines from our work

Financial Statements	<p>Unqualified (clean) opinion on the financial statements.</p> <p><i>Means we have checked that amounts the Trust says it has received and spent and money it owes and is owed are correctly recorded. We have also checked where Management has used judgement, that those judgements are well thought through and appropriate.</i></p>
Use of resources	<p>Unqualified (clean) conclusion on the use of resources.</p> <p><i>Means we have looked at how the Board works and what the Trust's main regulators, NHS Improvement and the Care Quality Commission, have said about it and found no significant concerns. This included looking at how the Trust responded to the CQC inspection.</i></p>
Quality report	<p>Limited assurance (clean) opinion on the content of the quality report.</p> <p>Limited assurance (clean) opinion given on the A&E: maximum waiting time of four hours from arrival to admission/transfer/ discharge indicator (A&E 4 hour wait).</p> <p>Qualified opinion given on the percentage of incomplete pathways within 18 week RTT (18 week RTT) indicator (2014-15 qualified opinion).</p> <p><i>Means the Trust has included everything it should have done within the quality report and presented both good performance and areas for development. No issues were found with the "A&E 4 hour wait" indicator but the "18 week RTT" indicator was not calculated in line with national guidance.</i></p> <p>Council of Governors selected indicator maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers. This indicator is not subject to a limited assurance opinion. We have concluded that if required we would be in a position to provide a clean limited assurance opinion.</p>

Financial statements detailed findings



Financial statements detailed findings

Risks we reported on in our long form audit report (audit opinion on the financial statements) were:

Recognition of NHS and non-NHS income

- ✓ Reviewed key contracts with Commissioners (£546.4m) and assessed income received against contracts (£457.0m).
- ✓ Tested NHS and non-NHS income (£45.6m).
- ✓ Reviewed key contracts for education and training income (£78.0m).
- ✓ Tested bad debt provisions (£26.0m).

Valuation of land and buildings

- ✓ Reviewed the professional valuers report.
- ✓ Re-measured a sample of spaces across the estate and identified an average 0.67% variance.
- ✓ Reviewed accounting entries regarding revaluations (£63.3m).
- ✓ Tested land and building additions (£108.6m) and disposals (£0.9m).

Opening balances

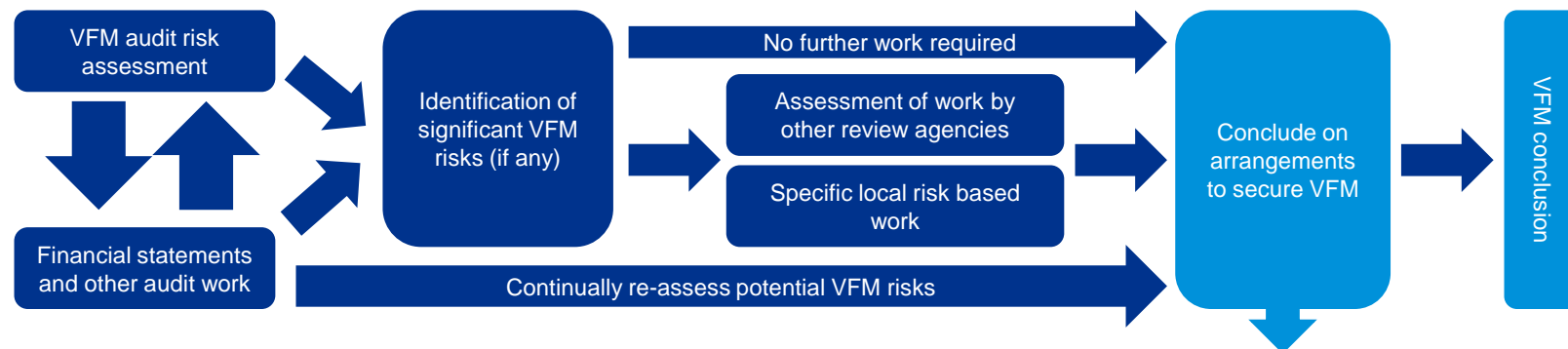
- ✓ Reviewed the Deloitte records.
- ✓ Extended our sample sizes to gain comfort over the opening balances.

Mandatory risks

- ✓ Fraud risk from revenue recognition.
- ✓ Fraud risk from management override of controls.
- ✓ We did not find any instances or indicators of either fraudulent revenue recognition or management override of controls.

Use of resources

Our approach is to consider:



WE REACHED A POSITIVE CONCLUSION, FROM CONSIDERING THE FOLLOWING:

Annual Governance Statement	Checked the content properly reflected you operations during the year we found a balanced narrative that reflects our understanding of your operations and risk management arrangements.
Work of other regulators	CQC full inspection in September 2015 resulted in a “Good” overall rating. The Trust has responded well and has implemented all actions required for the three areas identified as ‘requires improvement’. NHSI’s financial and governance risk ratings are positive. No regulatory action required.
Other work	We reviewed the: <ul style="list-style-type: none"> • 2016/17 Annual plan and underlying assumptions as well as the financial run rate position. • cost improvement schemes identified against the figure in the plan.

Quality report detailed findings



Content and consistency



National Indicators: A&E 4 hour wait 18 week wait RTT



Local Indicator: 62 Day Cancer wait

Content and consistency – clean limited assurance opinion issued

- The Quality Account was time pressured.
- A good first draft of the Quality Report was received.
- Disclosures which needed further work highlighted to management as part of our review were corrected.

A&E 4 hour wait – clean limited assurance opinion issued

- We identified some data entry issues which did not affect the indicator calculation. Improvements has been made in how the data capture systems worked following internal audit review.

18 week wait RTT– qualified limited assurance opinion issued

- We identified a few cases where the treatment date was not supported by the patient records with 2 cases not having any evidence for the referral to treatment date.
- *Concerns about the accuracy, reliability and validity of the data used to calculate the indicator NOT patient care*


62 day cancer wait– no opinion required

- Governor selected indicator which we are not required to issue an opinion on.
- *If required, we would be able to issue a limited assurance opinion due to data entry issues and concerns over the completeness of the data being used to calculate the indicator.*

Close and questions



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Council of Governors	Guy's and St Thomas'  NHS Foundation Trust
Quality and Engagement Working Group: notes of the meeting held on 10th May 2016	27th July 2016 CG/16/16

This paper is for:		Sponsor:		
Decision		Author:	Mark Tsagli	
Discussion		Reviewed by:	Devon Allison	
Noting		CEO*		
Information	X	ED*		
		Board Committee*		
		TME*		
		Other*	X	Council of Governors

1. INTRODUCTION

This report details the meeting of the Quality and Engagement Working Group, which took place on **10th May** at the Education Centre, York Road.

2. ATTENDANCE

The meeting was attended by: Sarah Allen (Patient Experience Manager), Devon Allison (Lead), Hannah Coffey (Director of Operations, Hospital Services), Yvonne Craig Inskip, Jonathan Farley, Julie Gifford (Deputy Director Strategy), Jamie Keddle (Patient and Public Engagement Specialist), Ken Hayes, Amanda Millard (Director of Patient Experience), Elizabeth Palmer (Deputy Director, Assurance and Compliance), Barry Silverman, Jenny Stiles, Priya Singh (Non - Executive Director), Mark Tsagli (Patient Experience Facilitator) Bryn Williams, and Paula Young

Apologies were received from: Andrea Carney (Patient and Public Engagement Manager), John Porter, John Burns, and Tony Hulse.

2. NOTES OF THE LAST MEETING

- It was noted that a correction should be made to paragraph 3 along with an amendment to the attendees as Priya Singh was in attendance at the February meeting. Following these changes, the notes were approved as an accurate record of the last meeting.

3. PATIENT EXPERIENCE AND PATIENT AND PUBLIC ENGAGEMENT UPDATE

The Patient Experience Manager discussed some of the highlights in the patient experience report including:

2015 National Inpatient Survey (NIP)

- Statistically significant improvement in the questions on how staff communicate with patients regarding their medication and information provided on medication side effects. The score on the quality of hospital food has also improved significantly. Other notable areas of improved performance are on discharge i.e. who to contact if patients have a concern following their discharge.
- Improvements in the NIP are likely to be flowing from a number of ongoing initiatives at the Trust – “Hello my name is” badges, nurse in charge arm bands, the Pharmacy team’s campaign on medication side effects, as well as work on hospital food by the Essentia team.
- A slight decline in scores was observed in a number of areas:
 - Noise at night – Patients’ sleep being disrupted at night by other patients still remains a challenge. Sleep packs are now being included in hospital ward packs. The impact of this is likely to be picked up in the 2016 NIP survey.
 - Sufficient help to eat meals is also another area to improve. An improvement initiative to provide support for patients at mealtimes has begun, and the impact is expected to be seen in the next survey.

Friends and Family Test (FFT)

- Inpatient - The percentage of inpatients who would recommend the Trust remains very strong, mainly in line with national scores.
- A&E - Performance not as strong when compared to the national scores. The impact of high attendance rates, and the temporary space occupied are some of the challenges facing the team and patients using the service.
- Patient Transport – ‘Recommend’ scores are stable, but there is a slight increase in ‘not recommend’ scores. It is unclear whether the new service contract in place is contributing to the drop affecting the quality of service provided.
- Maternity FFT results are in line with the National London average in January. The team are reviewing the maternity survey and developing a comprehensive action plan. Evidence of this to be covered in the next Patient Experience and Engagement report.

Governors commented:

- Regarding the Patient Transport data, Governors' suggested a caveat or 'flag' on the charts when numbers responding are small. The data can be misleading particularly when other sources of evidence show there are issues with the services concerned.

Patient Experience Manager responded:

- The NHS FFT national data analysis lags behind a couple of months. As a measure, this may not reflect the most up to date picture at the time. The FFT as a single indicator question should be considered as an early warning flag; importantly, the data should be triangulated with other sources of data, including PALS information.

The Patient and Public Engagement Specialist took Governors through the following areas of activity:

- Completion of the second Public and Patient Engagement Audit report regarding how we meet our legal duty to involve patients and public.
- Year on year increase in the number of engagement activities at the Trust.
- The Trust continuously meeting its legal obligations on consulting with patients on service delivery.
- Changes to public health budget in Southwark and Lambeth - services affected are Sexual and Reproductive Health, Health Visiting, and Preventative Health Services. Consultations regarding patient and public involvement are ongoing.
- Ongoing PLACE visits at all three sites; Guy's, St Thomas' and the Community. A number of Governors took part in these visits and the Patient and Public Engagement Specialist thanked them for their input. The full report will be published in August. Governors will be notified once this is ready.

4. Public and Patient Engagement Hub - Toolkit

Governors received a demonstration of the Patient Engagement Hub. The interactive pdf was designed in-house by the PPE Team and is aimed at providing a hands-on resource for staff (who are new to patient and public involvement) to help them plan and run their own engagement events.

The group was informed of the significant interest outside the Trust in this toolkit. There is potential for this to be expanded to other Trusts in South London but would be dependent on funding and a successful evaluation of the kit.

The lead thanked the Patient and Public Engagement Specialist for the presentation of this exciting and innovative tool-kit for staff.

5. PATIENT ADMINISTRATION:

The Director of Operations outlined the proposed programme for improving the patient administration processes. Governors were taken through the objectives, challenges and plans for bringing consistency to this.

Governors were informed that reviews from the team show that there a number of initiatives across the Directorates to improve on patient administration, however this is lacking a coordinated approach. The Patient Administration Project aims to provide the structure for the Trust's approach to improve the current administration processes.

The key objectives of this programme are:

- Getting it right first time for patients, families and carers.
- Ensuring that staff have the right skills, knowledge & support to effectively carry out their role.

Importantly, the team agreed there is the need to consistently provide excellent customer service to patients by utilising technology effectively. This should go a long way to improve the way we deliver patient administration services in the Trust and patients' experience of this.

The programme will focus on three key areas:

- Recruitment & Education: Training programme to ensure staff have the right skills and support, and help them feel motivated to carry out their role.
- Roles and Structure: Standardise administrative roles & functions for staff involved in this process e.g. reception staff, staff involved in patient bookings, Ward Clerks, Medical Secretaries, Patient Pathway Coordinators, etc.
- Systems, Process & Technology: Standardise the patient administration process (to include all elements of outpatient and inpatient process). Achieve consistency in the Trust's communications to patients, in effect, having a "single point of contact" for patients.

Governors were invited to attend and share experiences at the Patient Administration Strategy workshop planned for May/ June with other stakeholders. The half - day workshop will be aimed at agreeing the vision, scope, and structure of how the patient administration programme will work.

Action: QEWG lead to forward names of interested Governors to Amanda Millard and Hannah Coffey.

6. QUALITY OBJECTIVES 2016-2017:

The Deputy Director of Assurance and Compliance gave an update on the Quality priorities for 2016-17:

- Patient Safety: No CQUIN payments received last year and this year, but the aim is to achieve the CQUIN standard for services irrespective of financial benefits.

- Patient safety: Dementia remains a high priority of the Trust. The plan is to achieve 90% full screening of patients at risk of dementia.
- 2015-16 objectives included achieving zero Never Events. The Trust failed to achieve this. However, this remains a focus for the Trust with plans to fully embed the 5 steps of the WHO surgical safety checklist in different settings. The plan is also to make sure everybody is using the checklist and this is embedded throughout the organisation.
- Always Safe Campaign: A campaign running for the next 2 weeks at the Trust, this focuses on drawing attention to and learning from reported incidents. There will be a series of events, drop-ins, reporting of incidents, awareness raising of reporting incidents, and shared learning to help drive down Never Events.
- Clinical effectiveness: These objectives are related to the digital hospital programme. The objectives are yet to be finalised with the overall plan subject to approval from the Board. Once completed, specific targets will be included in the quality priorities.
- Patient Experience: Strong focus on nutrition and pain management. The Nutrition strategy was recently approved to deliver 2016/2017 objectives.
- Focus on continuously improving the Trust response to complaints. There are challenges around timeliness, and the complexity of complaints. The central team operate with high caseload but the aim is to get the central team to assist directorates in providing high quality and timely responses.
- Focus on improving medicines management and information about medicines at discharge.

7. REPORTS FROM COMMITTEES

- **Quality Committee:** No report was submitted.
- **Adult Local Services Committee:** The report was tabled. Proposed priorities for Adult Local Services Programme in 2016 were presented and discussed. In summary, the focus on improving the emergency care pathway for patients with complex needs and developing local care networks. A presentation and discussion was given by Angela Dawe and Jane Stopher on the ongoing work by Lambeth and Southwark strategic partnership towards progressing local care networks.

- IT improvements: IT was not on agenda for this meeting. Members were informed that this is usually a problem but at the Lambeth CCG meeting on May 4th, a GP referred to the benefits the IT improvements had brought and others agreed.
- **Nutrition Committee:** No report was submitted.
- **Children's Services Committee:** The report was tabled. Key points included:
 - The Children's service seeing enormous activity. Patient numbers have doubled in 10 years. There has been significant progress on the capital expansion including expansion of the Neonatal Unit. Progress has also been made on a number of initiatives including the campaign on how to recognise a deteriorating child.
 - Entrepreneurial actions at the Evelina include: The Outpatient Parenteral Antibiotic Therapy Service (OPAT), The Children's Assessment and referral Service (CARS) which allows GPs to access expert pediatric advice; Children's Hospital @home launched February 2016.
 - Children's Short Stay Unit is due to open in August 2016. This will improve emergency care pathways for children and help hospital inpatient bed capacity.
 - Becket House lease has not been signed yet. This should provide office space so that capacity can be released within the Evelina for clinical use.

End of Life Committee: Governor attending the committee informed the group of a committee meeting in January chaired by the Chief Nurse and comprising a variety of representatives including: midwives, pharmacists, consultants etc. The committee is currently exploring priorities, so in its early days.

Governor representatives are working with the Patient Experience team on how to get feedback from carers on their experience. They are exploring issues on when bereaved relatives and carers should be asked for feedback and what format the research might take.

The Governor attending drew the group's attention to her involvement in the planning group of a 'death café' in October. The aim of this group is to look at how to plan for death, what happens after death, what happens to bereaved families, etc.

The lead Governor thanked the Governors' representative and noted End of Life Care is an agenda item for the year, so it will be revisited.

8. MATTERS ARISING

- Regarding the 62 day cancer wait target that is consistently being missed by the Trust, the QEWG lead noted that as requested a letter had been sent to the Trust Chairman registering Governors' concerns about this.
- The Patient and Public Engagement Specialist informed the group that the Cancer Reference Group had not discussed or commented on the Trust performance regarding the 62 day wait target.
- The QEWG lead informed the group of John Burns' decision not to seek re-election as a Governor due to problems with being able to hear at meetings. She also apologised to Governors, and particularly, to John for the challenges with the lack of an effective system. The lead also took the opportunity to thank him for all his contribution to the committee and wished him well.
- The lead recommended a film - 'Kate's story' - by Dr Kate Granger in relation to issues around planning for death to enrich governors understanding on End of Life Care. The video is available on her website.

9. ANY OTHER BUSINESS


- Governors to let the QEWG lead know of any preference for the order of items on the agenda for future meetings.
- The Patient Experience Manager informed the group that the Patient and Engagement Specialist was moving to a new role at NHS England. The group thanked him for his work over the past three years.

10. DATE OF NEXT MEETING

Tuesday, 13th September, Globe Theory Room. Education Centre, York Road.

END

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Council of Governors	Guy's and St Thomas'  NHS Foundation Trust
Service Strategy Working Group report – 5th July 2016	27th July 2016 CG/16/17

This paper is for:		Sponsor:	Giles Taylor, SSWG Chair	
Decision		Author:	Dan Price	
Discussion		Reviewed by:	Giles Taylor, SSWG Chair	
Noting	X	CEO*		
Information		ED*		
		Board Committee*		
		TME*		
		Other*		

* *Specify*

1. Attendees:

Giles Taylor (Chair), John Duncan, Devon Allison, John Porter

Sheila Shribman (Non-Executive Director), Angela Dawe (Director of Operations and Strategic Development – Adult Local Services), Julie Gifford (Deputy Director of Strategy) and Dan Price (Strategy Manager) attended from Guy's and St Thomas'.

Apologies were received from Ian Abbs, Martin Shaw and Jackie Parrot.

2. Notes of the previous meeting and matters arising

2.1 The notes of the meeting held on the 12th of April were approved as a true record.

3. Southwark & Lambeth Strategic Partnership

3.1 Angela Dawe started the presentation by highlighting how the Lambeth and Southwark Partnership was still in its early days as it only started in April but was building on the achievements of South London Integrated Care (SLIC). Angela pointed out that this fits in the section within Shaping Our Future Together which focuses on our outward-community facing services. Working with partners in this area to improve the quality of care we provide is a key element of the Trust's ambitions and is what the Strategic Partnership is all about. As such it's critical that the Trust take a leadership role in the partnership, and Ron Kerr is currently chairing the partnership until an independent chair is recruited.

3.2 As part of the presentation Angela played [this video](#) which features Helen Charlesworth-May and Merav Dover discussing the closure of SLIC. The video discussed the challenges and its successes of SLIC, including that Southwark and Lambeth were one of the few areas in the country that saw the stabilisation of the A&E demand rather and large scale increase seen in other parts of the country.

3.3 The main aims of the new partnership is to develop and establish the Local Care Networks, linking the Local Care Record across the health and social care system and continuing to build upon the engagement of citizens that SLIC

started. This would feed into developing a population health management approach which is already being supported by a CQUIN. In addition the partnership wants to build on the infrastructure and ensure that the Children and Young People programme is fully integrated.

- 3.4 The partnership was launched on the 1st of April with the same statutory bodies but also including the voluntary sector and developing GP federations and citizens group. A public pledge to demonstrate commitment to the partnership has gone to the boards of all of the participating organisations and has been signed.
- 3.5 One of the proposals will look at how the partnership will include citizens and ensure their voices are heard in all decision making. As such a citizen's workshop is being set up, at short notice, to discuss this and Jenny Stiles will be attending from the Governors. There is likely to be further opportunities for Governors to be involved. Angela will be presenting on the work of the LCNs at the Council of Governors away day.
- 3.6 Angela outlined the governance structure for the partnership and how that would ensure that there was both the reciprocity of involvement at the right level amongst all the partners and ensure appropriate citizen involvement and engagement. It was highlighted to the working group that this is still early days and there is a lot of work in train on the governance and infrastructure of the partnership.

During questions and discussion the following was highlighted:

- In terms of the sustainability of this work that the major programmes of SLIC had been mainstreamed by commissioners. The commissioners are clear that they want to change the form of contracting and the introduction of the CQUIN on co-ordinating care this year is the first step in doing this. There is appetite to work across the whole system to look at outcome based contracts, and there is already an alliance based contract of this type for Mental Health and Housing providers in the area.
- The citizen's forum is independently supported outside of GSTT and the new partnership recognises the need to support the citizens. They are actively considering how to use the links with Governors in the engagement exercise, including in the Children and Young People's programme.
- A concern was raised that the community engagement will drop off without the investment of a central team, especially if the citizen voice isn't integrated fully into the decision making processes. It was noted that individual

teams will be engaging the public too and there might be some financial support available for those individual teams when they are engaging in the community for this work.

- The Adult local services programme has been and is continuing to consider the workforce implications of SLIC and the Strategic Partnership with Amanda Price and the clinicians. There is appetite to look at new competencies and roles across Health and social care. This is a slow process, but new roles have already been created and it was acknowledged that there is a need to show case what we've already done.
- It was recognized that this work would have to align with that of the Sustainability and Transformation Plan in South East London. The Trust believes that they should be able to do so as they have the same overarching goal, but the focus was likely to be different as the STP is aware that local solutions will be needed to meet local needs.

4. Sustainability and Transformation Plan

4.1 Julie Gifford started her presentation by reminding the governors that the Trust had already submitted its one year operational plan and had known it would have to submit a five year plan which would be based on a location – the South East London Sustainability and Transformation Plan (SEL STP).

4.2 Amanda Pritchard has been chosen as the overall Senior Responsible Officer for the SEL STP. There are two other representatives leading the STP from different parts of the geography and parts of the Health and Social Care system. Our STP governance is based on the Our Healthier South East London work which has been running for two years. A local authority Oversight and Scrutiny committee has also been set up for the region.

4.3 The financial challenge facing the SEL STP is over £1bn which will be addressed through five main programmes. It was noted that the Sustainability and Transformation funding that has been allocated to the Trust can only be accessed through being part of the STP. There is still detailed work to be done to determine the precise potential for financial savings and ensure there isn't any double counting. The Directors of Finance have been heavily involved in this work to identify the opportunities, and the Trust has a large presence in the non-clinical productivity workstreams.

- 4.4 It was also clarified that looking at End of Life Care benefits will be picked up in the programme of work that focuses on the Local Care Networks. Particularly as this readily fits within the same agenda as the long term health conditions and health needs 'Christmas tree' of resource intensity. The view is that much of the work in this programme will support both issues and increase the quality of the care provided.
- 4.5 On specialist services a number of opportunities are being considered. Governors discussed the drivers for these changes and it was agreed that how these are presented and managed would be a key factor in the success of the implementation of any changes. Much of the specialised services will be looking to create a system where as much care is done as locally as possible while ensuring that the low volume, highly specialised, work is undertaken in a safe environment. Workforce was also raised as an issue if there was any service reconfiguration, but Julie Gifford pointed out that there are staffing gaps which could be filled, but the public aren't aware of this because they are covered using agency and other ways. The strong message that was coming out that SEL STP is that we need to be efficient when the growth of demand for services is huge.
- 4.6 It was confirmed that Amanda Pritchard will be sitting on a pan-London specialised commissioning board to consider issues arising from specialised services flows across London, and we will be involved in the tier one providers board too. The Trust was advocating that a similar board needed to set up for Kent, Surrey and Sussex as similar issues arise there and this was something that the relevant STPs were interested in. The agenda for the board is yet to be determined but conversations were underway.

During questions and discussion the following was highlighted:


- Governors thought that there was a view that there was a lot of unmet demand in the geography which this work may uncover. Some demand modelling has already been done for specific areas of work, like Orthopaedics, but it was noted that some wider work may need to be done. Angela informed SSWG that some interventions like the falls/fractures initiative is helping to manage this demand though. Alternatively some consolidation of specialised

services could result in increases in quality which will resolve some of the demand issues, like Orthopaedics, but detailed thinking on this is still to be done.

- Governors were concerned that all of this work falls on a small number of people. The board have raised the concern but recognised that while it was good to have the Trust's top people in the centre of the decision making process, it was stretching the organisation – and the board would continue to monitor this.
- The STP is funded, as it is based on the OHSEL governance which was funded.
- The governors were keen that the STP included work to encourage patient enablement and mobilisation to empower patients to provide their own care.

5. Any other business

5.1 There was no further business and the next meeting was confirmed for 11th October 2016, 5.30pm to 7pm in the Globe Theory Room at York Road.

Council of Governors	Guy's and St Thomas'  NHS Foundation Trust
Questions and Answers	27th July 2016 CG/16/18

This paper is for:		Sponsor:	Corporate Affairs	
Decision		Author:		
Discussion		Reviewed by:		
Noting		CEO*		
Information	X	ED*		
		Board Committee*		
		TME*		
		Other*		

* *Specify*

1. Summary

This report provides a list of queries which have been raised by governors. Answers are included or are ongoing and will be provided to governors once available.

Note: *Governors are asked to send any queries to the Membership and Governance Co-ordinator or Peter Allanson and not directly to directorates. We will log questions and ensure they are properly handled.*

2. Request to the Council of Governors

The Council of Governors is invited to note the report.

3. Detail/Commentary

The following questions have been raised by governors. Answers are included or are ongoing and will be provided to governors once available.

Note: Governors are asked to send any queries to Peter Allanson and not directly to directorates. We will log questions and ensure they are properly handled.

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
Does the Trust use 360 degree appraisal?	16/0013 2016-06-22 (Devon Allison)	The use of 360 degree appraisal varies across the Trust. Nurse revalidation came into effect in April and everyone has been asked to go through the revalidation as part of their appraisal; this has allowed a much richer output and allowed people to be more honest at appraisal. This has been fed back across the Trust, and is something we need to build on. (22-06-2016)		
Given that people are living longer and approaches to work and life are changing, what are we doing to think about how we are going to equip our patients and staff for the future – people living to 100 you will no longer have the standard ‘education, working, retirement’ flow of life. Given the career paths will be different in the future, what are we thinking about the different paths and how we respond to them?	16/0012 2016-06-22 (Kate Griffiths-Lambeth)	This is a really important question; at one end it’s about having the staff there to look after the older people, but it’s about the different people coming through the workforce, for example the millennials. With the younger workforce you need to consider how to keep people interested, and prepare for the changes to think about things differently. At the same time we need to consider how to support the aging workforce to manage their health and wellbeing and develop new patterns; allowing them to retire and return part time. A programme		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
		<p>of work has been developing slowly looking at how to create a more agile and flexible workforce to support the changes ahead.</p> <p>(22-06-2016)</p>		
<p>Governors understand, from documentation released at Board Committee meetings, that Consultants are helping to identify cost improvement opportunities for FY 2016/17 and that Lord Carter has similarly identified savings opportunities. Could the Board outline the nature of these opportunities and give some understanding of the impact they would have on the operation of the FT.</p>	<p>16/0011 2016-06-22 (John Porter)</p>	<p>The Trust commissioned PWC, following a tender process, to perform a six week diagnostic study to identify and quantify in year savings opportunities for the Trust in 2016/17. The report shows a number of cost saving opportunities over and above existing savings schemes. PWC and the Carter team have provided benchmark data demonstrating potential efficiency savings for the Trust when compared to other similar service providers. This output forms part of the continuing cost improvement plan.</p>		
<p>How do we reduce the number of DNAs, cut costs and increase goodwill and understanding of GSTT's values?</p> <p>Every message should be accurate and informative AND expressed in plain language.</p>	<p>16/0010 2016-06-22 (Yvonne Craig-Inskip)</p>	<p>Reducing DNA (do not attend rates) is something we feel is a very high priority. Not only does it reduce waste and allow us to make better use of our resources but it also creates additional outpatient appointments and so reducing waiting times for appointments.</p> <p>In May this year we introduced a piece of software called Drdoctor. Drdoctor makes it quick and easy for patients to be informed of their hospital appointments using Drdoctor SMS text messageswith details of their appointment when it is booked and a reminder a few days before the appointment date. The SMS service is conversational, so patients can reply to the messages, to change or cancel their appointment.</p>		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
		<p>All messages contain links to an online portal which in the future will provide richer information about the appointment, such as maps and what to expect on the day. Once logged in, patients will be able to use the portal to add the hospital appointment to their personal calendar, request a reschedule, choose times of appointments for partially booked clinics and complete pre-clinic and post-clinic questionnaires online.</p> <p>Since May we have switched on Drdoctor for 20% of all of our outpatient clinics and in those clinics we have already seen a 21% reduction in DNA rate. Patients who do not wish to use the new electronic system can still receive appointment information as before.</p> <p>We have reviewed our outpatient letters with a view to making them more welcoming, improving the tone and providing clear information. We are now working on an implementation plan as we have a large number of letter templates that require changing. This work will also involve rationalising the number of letter templates used across the Trust so that we provide consistent and standardised information where appropriate.</p> <p>We have developed a training package for administering outpatient appointments which will be launched in the next few months and is expected to reduce administration errors. We are also working on a solution that will provide patient</p>		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
		<p>letters by email instead of using the postal system. A wider review of our outpatient administrative processes is planned and being scoped as part of our "Fit for the Future" improvement programme.</p> <p>(22-06-2016)</p>		
<p>I would welcome a summary of how GSTT's efforts to the keep entrance to the hospital safe are progressing. I want to know what we are doing about TFL's plans for all pedestrians into St Thomas' having to cross cycle tracks - many of them from floating bus islands</p>	<p>16/0009 2016-06-22 (Jenny Stiles)</p>	<p>This is about TfL's proposal to put a cycle lane on the west side of Westminster bridge and a by-pass bus stop outside the hospital entrance so anyone getting off the bus has to cross the cycle lane to get into the hospital.</p> <p>Responded to the consultation</p> <ul style="list-style-type: none"> Put in formal complaint that our concerns had not been given sufficient weight – the only change made as a result is to lengthen the crossing point over the cycle lane from the bus stop Set up petition – closed with over 2,000 signatures – and been to observe the floating bus stop outside the Royal London Garnered support from Lambeth, SBEG and witness statements from a number of groups and individuals in support of a legal claim to take TfL to Judicial Review on the basis that the proposal makes insufficient reasonable adjustment for people with a permanent disability. The case makes suggestions for a number of alternative ways of dealing with the cycle super 		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
		<p>highway here.</p> <ul style="list-style-type: none"> Have been meeting TfL to discuss sensible alternatives and thus avoid litigation <p>We have tried to be clear that we are neither anti cycling nor anti cycle lanes nor, in the right place, floating bus stops and are sorry our actions have been seen as such and as negative by some groups and individuals – however no-one we've talked to thinks the proposal is a good one and it seems unwise to replace a hazard with another one.</p> <p>(22-06-2016)</p>		
<p>The Great Ormond Street Hospital Children's Charity raised a record £81million in 2014/15, which has been contributed to the redevelopment of GOSH; the year before this charity raised £74 million. Is it time to create a similarly effective charity dedicated to our own outstanding Evelina London Children's Hospital?</p>	<p>16/0008 2016-06-22 (Devon Allison)</p>	<p>The Evelina London team share the view that there is significant potential to substantially increase the scale of fundraising over the next few years to support the development of our facilities, services and academic activities. This will of course require proportionately substantial investment, and we will need to consider carefully how best to do this in the context of the current combined KHP Fundraising Team.</p> <p>In 2014/15 the total expenditure of GOSH was £37.9M, of which £19.2M was spent on generating funds (this compares to c£700k fundraising spend across the whole of GSTT to raise £3-4mn). The fundraising team at GOSH has in excess of 120+ professional fundraising and support services.</p> <p>Evelina London is a comparatively young hospital and the philanthropic funding generated is currently comparable to other children's hospitals at c. £3-4m per annum and rising. There is growing</p>		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
		<p>brand recognition, and an increasing number of high profile corporate relationships, including with Kia Oval and NatWest. The fundraising team have recently secured another £0.5m in a single gift to add to the £3m gift already received for the 6th floor conversion.</p> <p>Being part of a combined KHP Fundraising function allows us to combine clinical and academic dimensions (as GOSH does), which is recognised as the most effective approach to secure transformative major gifts. It also provides a way of co-ordinating across the KHP organisations so as to avoid competitive fundraising within the partnership if possible.</p> <p>The Evelina London team believe that a dedicated expert team will be required. (22-06-2016)</p>		
<p>Nationally the leads for the new Sustainability and Transformation Plans (STPs) come from a variety of backgrounds. Amanda Pritchard, our CEO, has been appointed to lead the SE London Sustainability and Transformation Plan (STP). Is the Board content that the infrastructure of wielding influence and showing leadership in a trust wide system trumps 'minding the GST shop'</p>	<p>16/0007 2016-06-22 (John Porter)</p>	<p>Amanda was asked to lead the STP in recognition that GST is regarded as a well run, highly performing and stable organisation, capable of working with and leading partner organisations in SE London. This is evident in work that we have led and been involved in community and local services as well as specialist services for both adults and children.</p> <p>❖ This role then enables Amanda to have influence at the highest levels e.g. calls with Simon Stevens who speaks to the 44 STP leads on a regular basis. She has also</p>		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
		<p>been able to influence plans that are being developed across London particularly in relation to specialised services. GST and Amanda have been very clear of the need to join up STPs within and around London and a pan London Specialised Commissioning Planning Board has now been set up with Amanda as a member representing the SE London STP. This is critical given that over 35% of our income comes from providing these services and indeed this is where our strategic ambitions lie. In addition this role is enabling her to shape a review of specialised services across south London. The STP now provides the route to accessing sustainability and transformation funding and provides an opportunity to flag future capital funding requirements. This is the type of position that the GST CEO should be fulfilling.</p> <p>In terms of 'minding the GST shop', much of what Amanda is influencing has substantial impact on the long term sustainability of GST.</p> <p>We have a very strong, stable executive team, with many years of collective experience of leading this organisation. This team has been strengthened further by the recent creation of the new executive Director of Improvement (Hannah), through the role that Ron is fulfilling, the appointment of a Medical Director focussed on internal results</p>		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
		(Simon) and we are just out to advert for a substantive COO. (22-06-2016)		
<p>NHS England and NHS Improvement are publishing a stream of directives for the sector ranging from income controls, capital expenditure controls through to the required publication of the footprint based Sustainability and Transformation (STPs) plans.</p> <p>Does the Board see any significant diminution of its freedom of action within its Foundation Trust Constitution in this new environment? If it does, how will it protect itself and the Council Of Governors from being forced to take actions over which it has no or inadequate control?</p>	<p>16/0006 2016-06-22 (John Porter)</p>	<p>The provision of significant amounts of Sustainability and Transformation Plan funding by NHSI and CQUIN funding by NHSE gives these bodies a degree of control over the finances of Foundation Trusts. NHSI, together with the Council of Governors, holds Trust Boards to account for their governance and licence obligations to ensure service provision.</p> <p>As yet it is unclear how the numerous control totals and guidance, on for example on the usage of agency staff, will impact on the degree of freedom Trusts have to manage their own affairs. The Board will ensure Governors are kept up to date on the implications and seek Governors support to push back on NHSI and NHSE where appropriate.</p> <p>Clearly the financial position of the NHS as a whole has led to more central controls and the imposition of targets. The Trust is supportive of these initiatives where they are helping improve the position overall. Indeed many Trust officers are leading STP groups working in collaboration with other local providers.</p> <p>(22-06-2016)</p>		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
<p>The policy papers coming out of NHS Improvement make much of place-based service provision. I have seen no discussion of how our 'place' is to be defined but the definition is obviously of considerable interest to governors.</p> <p>We are aware of SLIC placing us firmly in Lambeth and Southwark. We see work on SE London which seems to move our sights Eastward. There is also talk of the southern London dimension. Our membership of course takes us across the river and also into Wandsworth. Then there is the dimension of tertiary care and in particular childrens' services.</p> <p>I hope we are not putting ourselves in a position of a fait accompli on our 'place' which does not reflect the reality of our services.</p>	<p>16/0004 2016-02-18 (John Porter)</p>	<p>The place-based system of care is an initiative developing a whole systems approach to improve the overall response to growing financial and service pressures whilst avoiding further structural changes to the NHS. The idea is for the various organisations within particular geographical boundaries to work together to ensure efficient delivery of services, rather than there being a provider <i>or</i> a commissioner response.</p> <p>Implementation of place-based systems will see the formation of Sustainability and Transformation Plans (STP) for each region. It has been agreed by commissioners that our local STP is South East London (SEL) as part of the Our Healthier South East London (OSHEL) programme embracing the South London Integrated Care (SLIC) project. The SEL STP covers the boroughs of Lambeth, Southwark, Lewisham, Bromley, Bexley and Greenwich. Our own CEO is the lead from the SEL STP to which we have been allocated. For a trust like GSTT which provides specialist services nationally and which also has secondary flows from South West London as well as Kent, Surrey and Sussex, the geography of our STP is not entirely appropriate and this has been acknowledged.</p> <p>Whilst we agree it makes sense to build upon the work undertaken as part of OHSEL we contend that the sustainability of some specialised commissioned services cannot be addressed through one geographically confined STP.</p>		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
		<p>There needs to be, amongst other things:</p> <ul style="list-style-type: none"> • a national and regional discussion and strategy for children's services ; • a south London, Kent, Surrey and Sussex conversation on cardiovascular services; and • a south east London and Kent conversation on cancer services <p>Also, service changes in other London footprints could shift activity flows and volumes that would have an impact on us. We have asked the Programme Director for OHSEL to link with his counterparts in South West London and other London 'footprints', though how London will link with surrounding STP footprints is currently unclear.</p> <p>We will keep governors abreast of developments. (31-03-2016)</p>		
<p>On KHP, could provide an explanation of the governance. How money flows in, how it is spent and under whose authority. Why no accounts are produced. How NEDs are appointed. How fund-raising across KHP partners is organised. Why no minutes of BOD meetings are produced. How CAGs are controlled and financed. What KHP role is in integrated care across the community and what this community is and will be.</p>	<p>16/0003 2016-02-05 (John Porter)</p>	<p>The running costs of Kings Health Partners (KHP) are shared equally between the four organisations: Guy's and St Thomas' (GSTT); King's College Hospital; South London and Maudsley; and Kings College London.</p> <p>The foundation trusts (FT) have not delegated authority to KHP, so any initiatives it's proposing that will require funds or delegated powers require the approval of all three FT Boards of Directors.</p>		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
		<p>Where service reconfiguration is concerned, there should be consultation of the governors of all three FTs and further afield.</p> <p>Our Chairman is minded to release KHP Board minutes to the GSTT Board, which would in turn make them available to governors.</p> <p>We shall respond further with more information generally and with regards to fund-raising. (01-04-2016)</p>		
<p>I think that there are aspects of Healthwatch's Enter and View Report that should be considered by Governors. In particular, the opportunity given by statute to Lambeth Healthwatch, for in depth examination of issues and access to management and staff, that is not available to Governors.</p> <p>If Governors did have such access, I think that the proceedings of QEWG would not only be different but also that much more productive.</p>	<p>16/0001 2016-01-07 (Barry Silverman)</p>	<p>The formal statutory position is that Healthwatch have the Enter and Watch role as set out in the 2012 legislation, which governors do not.</p> <p>However, we always try to facilitate requests from governors for access to staff, community locations and the hospitals. Whilst we would not deny governors access to management and staff here, but this always has to be by agreement (as indeed with the Enter and View and other inspection regimes) due to safeguarding implications.</p> <p>Our governors are well briefed with access to information and can use their experience from a variety of backgrounds to apply to their statutory role, which is to hold the non executive directors individually and collectively to account for the performance of the Board. We can discuss how to support your being better-positioned to do this on behalf of all patients and users.</p> <p>(04-01-2016)</p>	<p>One of the objectives in the 2016-17 Membership Development and Engagement Strategy, currently under production, is to explore and identify a range of opportunities for governors to engage with local Healthwatch and other organisations which represent the needs of our patient groups.</p>	

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<p>NHS: Call for opt-out organ donation law across UK</p> <p>Wales has implemented Britain's first opt-out organ donation system with anyone who has lived in the country for more than a year now considered to be a donor unless they have registered a formal objection, informs The Times (Staff). Just three per cent of adults, or 85,944 people, have decided to opt-out as compared to only a third of the population registering to be a donor. The British Medical Association and the British Heart Foundation has called for the UK to adopt the policy.</p> <p>Does GSST support this campaign - or is that too political?</p>	<p>15/0020 2015-12-01 (Yvonne Craig Inskip)</p>	<p>GSTT is very supportive of organ donation: The Renal Unit has a very large living donation programme, and organ donation after death has been integrated into routine end-of-life care.</p> <p>If the government decided to introduce an opt-out system in the UK, the Organ Donation Committee would likely recommend that the Trust adopted it. (01-04-2016)</p>		
<p>As a Governor Member of the Trust's 'Smoke free Working Group' I asked whether GSST might be able to apply its accumulated work on the Smoke free objective towards a wider purpose with other Commercial Organisations. The reply was that, in relation to its peers, GSST was more at the end of the line than a vanguard for a Smoke free policy. This being so, I would like to enquire whether the Trust is already taking such action as may be available to it of implementing the Public Health England advice to Government on reducing sugar consumption.</p> <p>Therefore :</p> <ul style="list-style-type: none"> • If so, could Governors be told about the plans and have the opportunity of 	<p>15/0004 2015-10-26 (Barry Silverman)</p>	<ul style="list-style-type: none"> • Our menus operate a traffic light coding system identifying what foods are healthier than other • The menus also display information on the nutritional content of the meal • We have implemented a vending policy that ticks the boxes of all the Government Buying Standards in relation to vending & sugar content • Reduced confectionery packet sizes in line with GBS • We do not display sugar/confectionery or unhealthy items at till points • All our drink ranges have been reviewed & high sugar options have been removed 		

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<p>contributing to them by participating in any established Working Group (such as was the case for developing the 'Smoke free' policy)</p> <ul style="list-style-type: none"> • If not, will the Trust begin a proactive response to the Public Health (E) proposal in those areas not requiring Government action but which are available to the Trust now within its present powers : <ol style="list-style-type: none"> 1. sugar reduction in everyday food and drink 2. ensure the sale of healthier food in hospitals and also public bodies <p>It would be helpful if Governors could be informed of the scope of any intended response and how it might be applied to :</p> <ul style="list-style-type: none"> • hospital catering in the form of measurable targets, including alternative sugar options for patients • commercial operations and franchise anywhere on hospital premises and any timescale or targets that might be necessary in relation to present contractual obligations • the reputational powers of the Trust in encouraging other organisations in South East London and Westminster too follow its lead • protecting staff health in relation to sugar consumption – particularly Agency night staff more removed from the day to day hospital 		<ul style="list-style-type: none"> • Low calorie options are available throughout the retail outlets • Healthier food options are available daily & are cheaper in price • We are active within the Trust's Health & Well Being Committee • Trust dieticians have an active role within catering looking at improving healthy meals, snacks & vending • Commercial contracts when renewal is up will have new guidelines to meet the demand for healthier options • Actively involved with the Healthier Hospital Procurement Workshop • Working within the communities supporting the Sustainable Lambeth Action Plan 		

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<p>environment</p> <p>Noting that PHE states that, “if the UK were to meet the SACN target of 5% of energy being sugar within the next 10 years, it would save £484 million per year by avoiding deaths and preventing 204,000 dental caries,” does the Trust have any knowledge of its ‘present sugar consumption’ and is there a way of setting a reducing target in relation to it, by establishing measurable criteria and actions that would advance the PHE objective.</p>				
<p>The CEO says that there is a programme of work underway by the Medical Director to address "hospital at night concerns". What progress I wonder? I realise how difficult it is to control events at night in a busy hospital, but I have had recent experience of unnecessary noise at night in the wards</p>	2014-04-29	<p>Hospital at Night is about the clinical operating model for looking after patients out of hours. We are currently looking at the future clinical model that will be required at GSTT and the implications this will have for our workforce, given activity changes and the anticipated shift towards a 24/7 care model at a national level.</p>	A further response/update has been sought.	