

Council of Governors Meeting 26th October 2016

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COUNCIL OF GOVERNORS

Meeting to be held on 26th October 2016
6.00pm – 7.30pm, Robens Suite Guy's Hospital

A G E N D A

1. **Welcome, apologies and opening remarks**
2. **Minutes of meeting held on 27th July 2016** attached (CG/16/19)
3. **Matters Arising**
4. **Reflection session on Board of Directors meeting** oral
5. **Improving Care through Learning and Innovation – an Education, Training and Development Strategy** PRESENTATION
Amanda Price
6. **Governors' reports – to note and for information**
 1. **MeDIC** attached (CG/16/20)
Kate Griffiths-Lambeth
 2. **Quality and Engagement** attached (CG/16/21)
Devon Allison
 3. **Service Strategy** attached (CG/16/22)
Giles Taylor
7. **Questions and answers – for information** attached (CG/16/23)
8. **Any other business**
9. **Date and time of next meeting:**

The meetings will be held on 25th January 2017, 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 53rd meeting of the Council of Governors held on
Wednesday 27th July 2016 in the Governors' Hall. St Thomas' Hospital**

Present:

Devon Allison	Tony Hulse
John Balazs	Sam Newman
Thelma Bangura	Darren Oldfield
Heather Byron	James Palmer
Prof Kevin Burnand	John Porter
Anita Campolini	Vicky Rogers
Dr John Chambers	Sue Slipman
Yvonne Craig Inskip	Jenny Stiles
Robert Davidson	Giles Taylor
John Duncan	Prof Warren Turner
Jonathan Farley	Bill Williams
Linda Goldsmith	Bryn Williams
Tom Hoffman	Sonia Winifred

Apologies:

Jane Fryer	Matthew Patrick
Kate Griffiths-Lambeth	Prof Dianne Rekow
David Maurice	

In Attendance:

Executive Directors:

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

Non Executive Directors:

Robert Drummond
Girda Niles
David Perry
Sheila Shribman
Priya Singh
Sir Hugh Taylor (Chair)

Other Attendance:

Peter Allanson	Trust Secretary and Head of Corporate Affairs
Sarah Wilding	(
Anjali Joshi	(GI and Gastroenterology Team
Steve Walters	(

CG/16/22 Welcome, apologies and opening remarks

The Chairman congratulated those governors re-elected in the recent elections and welcomed the new governors – Linda Goldsmith, James Palmer, who was completing Barry Silverman's term of office, Cllr Bill Williams nominated by Southwark, Heather Byron, Vicky Rogers and David Maurice who would be attending from the next meeting.

CG/16/23 Minutes of the meeting held on 27th April 2016

The minutes of the meeting held on 27th April 2016 were approved as a true record.

CG/16/24 Matters Arising

There were no matters arising.

CG/16/25 Reflection session on Board of Directors meeting

Governors raised a number of matters following the meeting of the Board including:

Assurance was sought – and given - that there had been no serious harm events as a result of the IT problems experienced at the end of June. As no patients had suffered harm it was considered unlikely that the Trust was exposed to legal challenge as a result of the incident.

Governors were concerned about the impact of increasing referrals to the Trust on its ability to meet targets and maintain quality and wondered whether there was scope for refusing referrals for “standard” procedures from outside its catchment areas. It was confirmed that the NHS constitution made it legally difficult to turn away patients. The Trust was currently meeting its targets, though this may not be sustainable if referrals continue to increase at 10%. The Trust would continue to work with commissioners and other trusts to encourage them to solve their own problems and not pass them on. The issue for the Trust was about capacity in terms of space and staff availability.

The issue of Clinical productivity was raised. It was confirmed that the Trust did not pay the premium overtime rates described in the press. Consultants were contracted to work 40 hours per week and could work up to 48 hours. Increased activity had been met either by improved productivity or asking consultants to work outside their contracts. It was noted that non clinical activities formed part of clinicians’ workloads and changes to the way they were supported had affected this aspect of their efficiency.

The Chief Nurse confirmed that she was satisfied that asking staff to declare annually that they remained in compliance with their DBS status was likely to be a better test than repeating the assessment every three years as no-one had been disbarred as an outcome of a repeat check. The decision had the support of the local safeguarding board and mirrored the decision taken at KCH some time ago.

Finally, concerns were expressed about the turnover of nurses. The Chief Nurse said that of the 5,500 posts there were usually 500-700 vacant. There was some staff movement around the Trust but one of the characteristics of the nursing workforce was that it was young and mobile and often moved after 2-3 years including moving out of London on costs grounds. Although the Trust generally had better staffing levels per shift than others, it was working to find different ways of providing cover. It was noted that workforce issues remained high on the Trust’s risk register.

CG/16/26 Non-executive director appointment – approval of appointment

The Chairman introduced the paper tabled at the meeting. He was proposing to invite the Council to approve three appointments – two to take up post immediately and a third from 1st January 2017. In addition to filling the vacancy created by Diane Summers reaching the end of her second term, the size and complexity of the current agenda facing the Trust, which showed no sign of abating suggested that filling a previously unfilled non executive director slot would enable the Board to deal more effectively with matters facing the Trust in its own right and as a system leader.

The third position had become available as Robert Drummond would be standing down as a director of the Trust at the end of 2016 to become a non executive adviser to the Board providing independent chairmanship of the Trust's commercial interests through his chairmanship of Guy's and St Thomas' Enterprises Ltd and the Commercial Assurance Board. The opportunity was reinforced by the field of candidates sourced on this occasion was particularly strong and there were suitable candidates to recommend for appointment.

Tom Hoffman, on behalf of the Nominations Committee, then described the process followed in reaching the recommendation. After agreeing with the Council and the Board the job and person specification, the Nominations Committee had held a competitive tender for advisers and appointed Odgers Berndston to help them to find suitable candidates through a combination of search and selection. This included advertising the posts locally.

Odgers then produced a long list of candidates which was whittled down by the Committee leading to a short list of 6 candidates. Five were interviewed, one was not available, and three candidates emerged, each with skills and experience that would strengthen the Board's capability.

The Nominations Committee recommended that Emma Duncan and Felicity Harvey be appointed as non executive directors of the Trust with immediate effect and John Pelly from 1st January 2017. Each would be eligible to serve two four year terms, subject to satisfactory performance.

The Council of Governors approved the three appointments.

It was noted that the patient constituency members of the Council would need to elect one of the members to the Nominations Committee to replace Paula Young who had stood down.

CG/16/27 Annual Report and Accounts 2015-16

The External Auditor told the Council of Governors that his firm audited 54 foundation trusts supporting Governors to fulfil their role of receiving the Trust's Annual Report and Accounts.

This was KPMG's first year as the Trust's auditors and they had found the financial statements to have been presented accurately and in line with current guidance. The audit had concluded that there were no issues and that the Trust's work represented value for money, receiving a clean opinion on finance and use of resources. The finance reports had been prepared to a high standard and there were a few improvement recommendations.

The Quality Report reviewed three indicators including one which was not mandated by NHS England but chosen by the Council of Governors. This

indicator (Cancer 62 day wait target) and one of the centrally prescribed indicators on A&E performance were given a clean opinion. However, based on the limited sample of the complex RTT target the Auditors had declined to offer an opinion. This was the case in 57% of trusts in the country and reflected that it was not always possible to find evidence to support all conclusions. It was noted that those trusts with a clean opinion on this target often had new IT systems in place or spent a disproportionate amount of money on validating their data.

The Council noted the assurance they were being given by the Auditors' report and congratulated the Finance Directorate on its performance and formally received the Annual Report and Accounts for 2015-16.

CG/16/28 Endoscopy Service Improvement presentation

The Senior team from the Trust's endoscopy service presented to the Council of Governors an account of the challenges of meeting the external JAG standards for accreditation. To qualify required meeting 27 standards and 10 sub standards and St Thomas' had received its accreditation in February 2015. Guy's was unlikely to meet the single sex segregation standard in the immediate future. Although a number of possible solutions were being considered, the best would be to relocate the service.

Overall patient experience had improved through the opening of the new centre at St Thomas' which was now delivering shorted waiting times. It was acknowledged that there was still more to do in a number of areas including the telephone appointments system.

CG/16/29 Governors' Reports

Lead Governor's Report

The Lead Governor commented on the Accountability Session which had covered a number of interesting issues and provided an excellent forum for governors. Similarly, the recent joint meeting of all KHP governors had been successful and it was hoped would be repeated in the same format. He hoped that there would be a good attendance at the Annual Public Meeting on 15th September.

He welcomed Adeola Ogunlaja who had joined the Trust as Membership Co-ordinator in the Trust Secretary's Office and who would be providing support to the Governors.

He noted that attendance at the Governors' Away Day had been disappointing especially given the content of the agenda. He had suggested that MEDIC give some thought to the programme for future away days.

Quality and Engagement Working Group, 10th May

The Working Group Lead said that the group had discussed patient administration, end of life discussions and the national inpatient survey, welcoming in particular the good outcomes in communications with patients. The Council noted the death of Kate Granger who had initiated the "#Hello my name is..." campaign that the Trust had wholeheartedly embraced.

Service Strategy Working Group, 5th July

The Working Group had suggested it wished to retain an active interest in the partnership arrangements being put into place following the end of SLIC report and had commented on the need to secure community engagement. The Group had also noted the plans for the STP and the Chief Executive's involvement.

CG/16/30 Questions and answers

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

CG/16/31 Any other Business

There was none.

CG/16/32 Date and time of next meeting

The meetings will be held on 26th October 2016 in the Robens Suite, Guy's 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
Membership Development, Involvement & Communications (MeDIC) Working Group Report – 27th September 2016	26th October 2016 (CG/16/20)

This paper is for:		Sponsor:	Membership Development, Involvement and Communications Working Group	
Decision		Author:	Adeola Ogunlaja (Membership and Governance Co-ordinator)	
Discussion		Reviewed by:	Peter Allanson (Trust Secretary and Head of Corporate Affairs); Not reviewed by WG Lead	
Noting	X	CEO*		
Information		ED*		
		Board Committee*		
		TME*		
		Other*		

* Specify

1. Welcome and apologies for absence

The meeting was attended by: Matt Akid (Head of Media and Corporate Communications); Peter Allanson (Trust Secretary and Head of Corporate Affairs); Yvonne Craig-Inskip (Public Governor); Kate Griffiths-Lambeth (Lead, Public Governor); Adeola Ogunlaja (Membership and Governance Co-ordinator); James Palmer (Public Governor); Vicky Rogers (Staff Governor)

Apologies: John Balazs (Stakeholder Governor); Heather Byron (Patient Governor); Linda Goldsmith (Public Governor); Tony Hulse (Staff Governor); Gyles Morrison (Staff Governor); Sam Newman (Staff Governor); Girda Niles (Non-Executive Director); Darren Oldfield (Patient Governor); John Porter (Lead Governor, Public)

2. Notes of the meeting held on 16th February 2016

The minutes from the meeting on 16th February 2016 were agreed as a true record of the meeting by all attendees.

3. Matters Arising

- i. The Trust Secretary and Head of Corporate Affairs advised that the turn out at the 2016 Council of Governors election was disappointing especially among FT staff members. It was agreed that greater awareness needed to be raised among staff, though the Trust Secretary and Head of Corporate Affairs advised the group that Staff Governors have made considerable efforts to engage with FT staff members.

The Head of Media and Corporate Communications advised that Staff Governors could be more visible within the Trust. He suggested setting up a stand once a month to promote the role and value of Staff Governors.

Vicky Rogers (Staff Governor) informed the group that she has had conversations with Bryn Williams (Staff Governor) regarding staff engagement initiatives such as regular open door sessions.

The Trust Secretary and Head of Corporate Affairs proposed that the Membership and Governance Co-ordinator facilitates a meeting with Staff Governors to discuss how staff engagement activities can be improved. Staff Governors can present their ideas to the group at the next meeting.

4. Draft Membership Exit Survey

Kate Griffiths-Lambeth (Lead, Public Governor) introduced the draft membership exit survey. She stated that there has been a decrease in membership and an exit survey could be useful in understanding the reasons for declining membership numbers.

Question 3 in the exit survey asks why members are choosing to cancel membership. There was an agreement among the group members that there needed to be a question to measure the satisfaction in current engagement and communication activities such as the GiST magazine and Members' Health Seminar.

There was also an agreement that the text needed to be simplified and more personal rather than third party language. It was also noted that a name was needed on the sign-off to make the survey more personal. Perhaps the Trust Secretary and Head of Corporate Affairs' name can be included instead of membership office.

It was suggested that the survey can be created on SurveyMonkey which will be useful in analysing results. The Head of Media and Corporate Communications agreed to work with the Membership and Governance Co-ordinator on this.

The Membership and Governance Co-ordinator thanked members of the group for their feedback and informed that she will share the amended exit survey questions with Yvonne Craig-Inskip (Public Governor) for any further comments.

5. Draft Membership Communications and Engagement Strategy and Plan

The Trust Secretary and Head of Corporate Affairs introduced the draft Membership Communication and Engagement Strategy. He informed that the Membership and Governance Co-ordinator had been working on the strategy with the Head of Media and Corporate Communication and the Patient and Public Engagement (PPE) Team to ensure that it reflects the objectives of the Trust's PPE strategy. The Trust Secretary and Head of Corporate Affairs advised members of the group to agree key activities which they think will help achieve the objectives of the strategy.

The Membership and Governance Co-ordinator drew attention to the PPE strategy objectives included as an appendix within the Membership Communications and Engagement Strategy. She stated that of importance is to note objective 16: develop plans to ensure the constitution of the Foundation Trust membership is representative of the populations served by the Trust, and objective 17: develop mechanisms that maximise the involvement of members in Trust activities. Current analysis from our membership database shows that membership is not representative amongst the three main categories: age, gender and ethnicity.

There was agreement that age and ethnicity were key areas to focus on. Diversity in these areas is needed within our membership in order to be truly representative of the local population, which will in turn lead to diversity within the Council of Governors. It was suggested that a selling point for younger members to consider becoming Governors is to promote the opportunity for personal development and Governor experience.

James Palmer (Public Governor) advised that links with King's College London and South Bank University should continue to be fostered as there are potential opportunities to recruit younger clinical students. Although it was noted that engagement could be difficult due to constant changes during placements.

The Trust Secretary and Head of Corporate Affairs informed that he had worked with Green Park Interim and Executive Search in the past on recruitment. Green Park has a wealth of experience in ethnic minority recruitment and it would be beneficial to reach out for advice on suitable recruitment approaches. It was agreed that membership recruitment would focus particularly on increasing the number of ethnic minorities. Other under-represented groups, such as younger people, will be subsequently addressed.

Actions agreed by the group were that advice would be sought from Green Park regarding a low cost project. The group also considered recruiting in local GP surgeries - the Membership and Governance Co-ordinator will email the Primary Care Liaison Manager for information on upcoming Patient Engagement meetings at local GP surgeries. An email can also be sent to Governors for information on any events at their local GP surgeries which they can attend to promote Trust membership.

The group agreed that membership leaflets should be displayed internally at the PALs desk and at clinics such as the Sickle Cell Clinic. Kate Griffiths-Lambeth (Lead, Public Governor) volunteered to take some membership leaflets to disseminate around the local community.

The Trust Secretary and Head of Corporate Affairs reminded the group that there had been informal meetings with both sets of Friends of the hospitals. These had been stalled pending the merger of the two groups. This was now in its final stages so reopening the discussions about how to act together could be arranged. He agreed to check with the new chairman when this would be appropriate


Ideas discussed to improve communication with members were to encourage members to share their email details to increase the use of electronic communication. The Membership and Governance Co-ordinator informed that the evaluation forms at Health Seminars are quite useful in capturing this information. Another useful idea would be to create a 'mop-up' survey to circulate with the next GiST mailing to encourage members to provide their email information. This may also be useful in addressing the gaps with the data we store on members. Members of the group agreed for the 'mop-up' survey to be sent with the GiST mailing in November.

6. Any Other Business

Kate Griffiths-Lambeth (Lead, Public Governor) informed that in the light of the small number of governors attending the meeting she would raise this at the next Council of Governors meeting.

7. Dates of next meeting

The next meeting on the 1st November 2016 had been postponed and would take place on 29th November 2016.

Council of Governors	Guy's and St Thomas'  NHS Foundation Trust
Quality and Engagement Working Group: notes of the meeting held on 13th September 2016	26th October 2016 (CG/16/21)

This paper is for:		Sponsor:	Quality and Engagement Working Group	
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 13th, September at the Education Centre, York Road.

2. ATTENDANCE

The meeting was attended by: Sarah Allen (Patient Experience Manager), Devon Allison (Lead), Thelma Bangura, Dr. Irene Carey (Clinical Lead – Palliative Care), Andrea Carney (Patient and Public Engagement Manager), Rachel Hill (Head of Nursing, Palliative Care), Jonathan Farley, Julie Gifford (Deputy Director Strategy), Linda Goldsmith, Yvonne Craig Inskip, Elizabeth Palmer (Deputy Director, Assurance and Compliance), Vicky Rogers, Jenny Styles, Mark Tsagli (Patient Experience Facilitator).

Apologies were received from: Heather Brown, Robert Davidson, Tom Hoffman, James Palmer, John Porter, Dianne Rekow, Priya Singh, Bryn Williams.

3. NOTES OF THE LAST MEETING

The notes were approved as an accurate record of the last meeting.

4. END OF LIFE CARE (EoLC) AT GUY'S AND ST THOMAS'

The Palliative care team led by Rachel Hill (Head of Nursing, Palliative and EoLC) and Dr. Irene Carey (Clinical Lead – Palliative Care), presented on the programme - Transforming End of Life Care in Acute Hospitals - focussed on improving the quality of EoLC in hospitals, enabling more people to be supported to live and die well in their preferred place.

Five key areas were covered in the presentation:

- Advanced care planning – aiming at working to the specific needs of patients, covering areas such as power of attorney, consent for relatives and friends to make decisions on a patient's behalf, and preferences for where/how people want to be looked after. It also includes how end of life care conversations are undertaken, how these are triggered, whether by the GP or the palliative care team.
- Electronic Palliative Care Coordination Systems – (EPaCCS): Aimed at fast tracking discharges as well as ensuring an all-round care assessment. Forthcoming initiatives include 'Co-ordinate my Care' which will provide patients the opportunity to view their medical records if preferred. The system is already available elsewhere and will enable stakeholders such as GPs, London Ambulance to access/view information about the patients they are caring for.
- Rapid discharge home – The team is currently seeking feedback from relatives about patient transition experience including emergency department admissions, fast-track discharges, and rapid discharge at the end of life. There are plans for the ongoing Carers survey to help inform/assess whether interventions are making meaningful changes and triangulating findings with other sources of feedback.
- Recognising uncertain recovery (e.g. Amber Care bundle) – Interventions like these are used when clinicians are uncertain whether a patient will make a recovery. It involves talking to patients, families, friends on plans should the worst happen. Version 4 of this tool is widely used across GSTT helping drive improvement and care for EoLC patients.

- Priorities for care of the dying person – These principles of care were introduced following withdrawal of Liverpool Care Pathway. This involves communicating, involving, and supporting families on what matters most to patients.

The team informed governors that EoLC at GSTT was rated as ‘good’ in the recent Care Quality Commission (CQC) inspection, and the Caring domain, (a CQC area of focus) was rated ‘outstanding’. The team acknowledged that despite the good work, there is still room for improvement hence the need to continuously seek improvements.

Governors welcomed the presentation and thanked the team. They made the following observations and suggestions:

- It was suggested that when dealing with patients of this group, individual needs should be taken into account and this should also guide the way communications are handled. They felt patients should be seen as individuals.
- One Governor wanted to know how much involvement the Clinical Commissioning Group (CCG) had, particularly in funding the care that people need when they are at the end of their lives. The Governor felt it was important that they were fully involved as funders of local care generally. The team responded that EoLC Steering Group meets quarterly with the CCG, so there is the opportunity for issues like this to be raised.
- With regard to information available generally, Governors also wanted to know what the levels of awareness were amongst families and relatives on the options that are available for such patients regarding EoLC. They cited evidence that when end of life conversations are initiated early enough, people and their families have better end of life experience. Governors asked if the Trust knows what proportion of patients have had an opportunity for an end of life discussion.
- Governors also asked about how children and young people with life-limiting conditions are dealt with at the Trust. The team clarified that this care is provided by a specialist team in the Evelina.
- Governors also suggested the EoLC team coordinate with the Dying Matters week event on Death Cafés next year and possibly collaborate to raise more awareness.

The team responded that there are some challenges, particularly on information awareness raising. For example cultural challenges, people not wanting to have these sorts of conversations, and general misconceptions about EoLC.

Note: EoLC presentation attached to Minutes

5. PATIENT EXPERIENCE AND PATIENT AND PUBLIC ENGAGEMENT UPDATE

The Patient Experience Manager summarised the key points from the annual patient experience report, which included:

- 2015 Maternity survey – The Trust is currently ranked third among the Shelford group. The Trust has improved in 8 key indicators since the last survey in 2013 including; choice on place of birth, communication, not being left alone, being treated with kindness, provision of information, support with breastfeeding, and women being able to contact midwives on their return home.
- 2015 Inpatient Survey – There was a marked deterioration when compared to the Shelford Group, but results compares well with other London Trusts. Areas for improvement are: noise at night, help to eat meals, privacy, and consistency of communication. A number of these will be looked at as part of the Nightingale Project – which is a nursing project looking at standardising and raising the standard of certain aspects of basic care.
- Children and Young People – A number of improvements are being undertaken. Teams are working with families to support and improve patient experience. A new self check-in system has been introduced in Ocean Ward. Governors were referred to p.9 of the 2015-2016 Quarter Patient Experience Annual Report for further information.
- Friends and Family Test (FFT) – Inpatient performance remains stable, but this also remains a challenge in A&E. The team is continuously working to improve results. The results for Community services are strong and higher than other areas of the Trust. For Maternity Services, results are consistent with London Areas, but Postnatal Ward experience is below the national and regional averages. Regarding Outpatients, the challenges continue to be keeping patients informed about waiting time.
- Acting on feedback – A number of actions has taken place in response to patient feedback. The Neonatal Unit installed privacy screens for breastfeeding mothers. Essentia has introduced new lids to keep food warm for longer, and menus now show allergen information. Other notable actions include the Nurse in Charge armband, and the embedding of the 'Hello My Name is' badges.

- Mystery shopping findings – Mystery shoppers identified areas for improvement such as frontline staff closing interactions with patients properly. Governors were informed teams are working with staff to gain a greater understanding of this. Some areas such as Therapies Directorate has undertaken staff on a programme of customer care training to improve staff skills.

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

- Completed an annual audit of patient and public engagement activities within the Trust over the past year - Overall, the number of activities undertaken have increased from 175 to 200. Governors were informed that all projects which trigger the Duty to Involve have met or will meet the Duty.
- A lower proportion of projects involved co-designing. It is believed this is due to the decreased number of capital projects at the Trust. The Patient and Public Engagement team will continue to work to support Directorates as financial pressures continue, particularly as this would require some project changes to ensure cost savings. The team will also continue to work to support staff to understand the difference between ‘involving’ and ‘co-design’ so they can engage patients appropriately.
- Lambeth and Southwark along with GSTT completed a number of public engagements to seek views of users. A public consultation of sexual health service users and members of the local community is currently underway and is due to close on September 30th 2016. Governors will be updated on the outcome of the consultation.
- PLACE Assessment – GSTT scored *above average* in a number of areas, food, privacy, cleanliness, and dementia. The Trust scored just *below the national average* on the new measure on how healthcare environment is set up for people with disability.
- Summary of the Call Quality Assessor Programme Findings – The programme has also been extended to include the Pain Management Clinic. Findings from the current report show dips in performance on how promptly staff gave information or offered actions during the call. Staff need to minimise gaps and silence during calls and improve on the way calls are ended.

Governors commented upon:

- The current arrangement for mealtimes means there is no opportunity for families and friends who want to help their relatives during meals. The Patient Experience Manager promised to raise this with the Nutritional Ward Group for discussion.
- The thinking in co-design and involvement could be utilised to help deal with persistent problems at the Trust. Essentially, how the ideas of patients could be tapped into to help solve some of the problems with contacting departments, phone numbers, numbers getting referred on etc.

QUALITY AND SAFETY UPDATE: The Deputy Director of Assurance and Compliance informed the group of the following activities:

- CQC Action Plan – Required actions and recommendations made to the Trust following the CQC inspection are underway and being monitored.
- Quality and Assurance team changes - Karen Procter and Marie McDonald have been jointly appointed to the role of Director of Assurance as a job share. Karen may attend the December 2016 meeting.
- Complaints – good progress is being made. The number of open complaints has been substantially reduced and there have been significant improvements in the timeliness of responses. Straight forward complaints are now channelled through PALS. The Complaints Team is making efforts to ensure the process is more streamlined, and that complex cases progress quickly to the Complaints Team. This arrangement so far is working well and there has been good feedback from complainants.

6. REPORTS FROM COMMITTEES

Quality & Performance Committee:

- Not discussed, to be circulated with minutes

Adult Local Services Committee:

- Not discussed, to be circulated with minutes

Children's Services Committee:

- Not discussed, to be circulated with minutes

End of Life Care Committee:

- Covered in presentation

7. ANY OTHER BUSINESS

The lead invited the group to let her know whether services provided at home should be considered as a topic for the next meeting particularly as one of the Governors (John Porter) is currently at home experiencing these services provided by the Trust.

8. DATE OF NEXT MEETING

Tuesday, 6th December, Globe Theory Room, Education Centre, York Road.

END

Appendices:

End of life care at Guy's & St Thomas' Presentation - Update to Quality and Engagement Working Group 13/09/16

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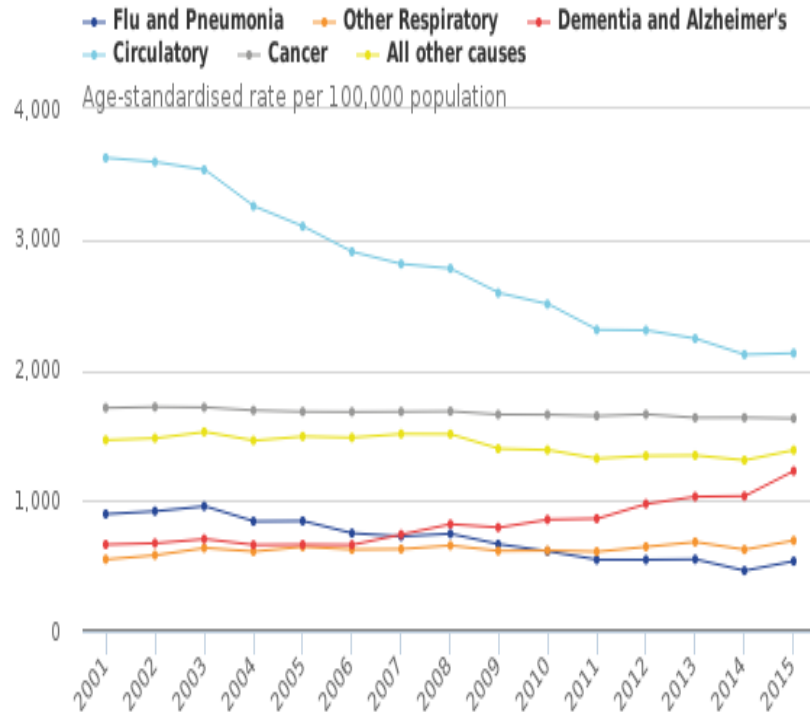
End of life care at Guy's & St Thomas'

Update to Quality and Engagement Working Group

13/09/16

Rachel Hill, Head of Nursing, palliative and end of life care
Irene Carey, consultant and end of life care lead

Death is common and rising



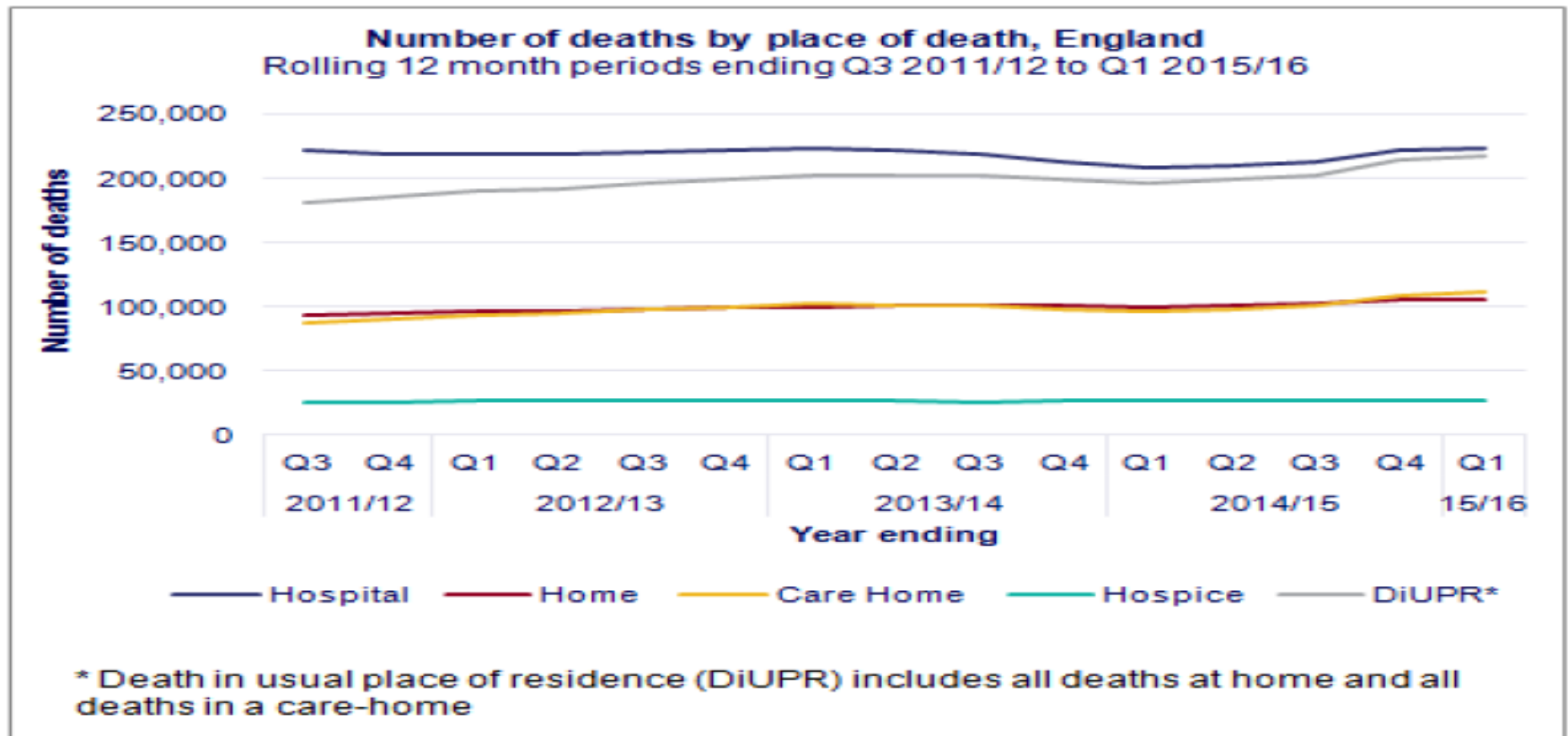
England & Wales 2015:

- 529,613 deaths
- 5.6% increase on 2014
- Rise of 20% in 20years anticipated
- ~75% deaths would benefit from palliative care

England & Wales 2014:

- Hospital 48%
- Home 23%
- Care home 21%

Proxy measure of quality of care : death in usual place of residence



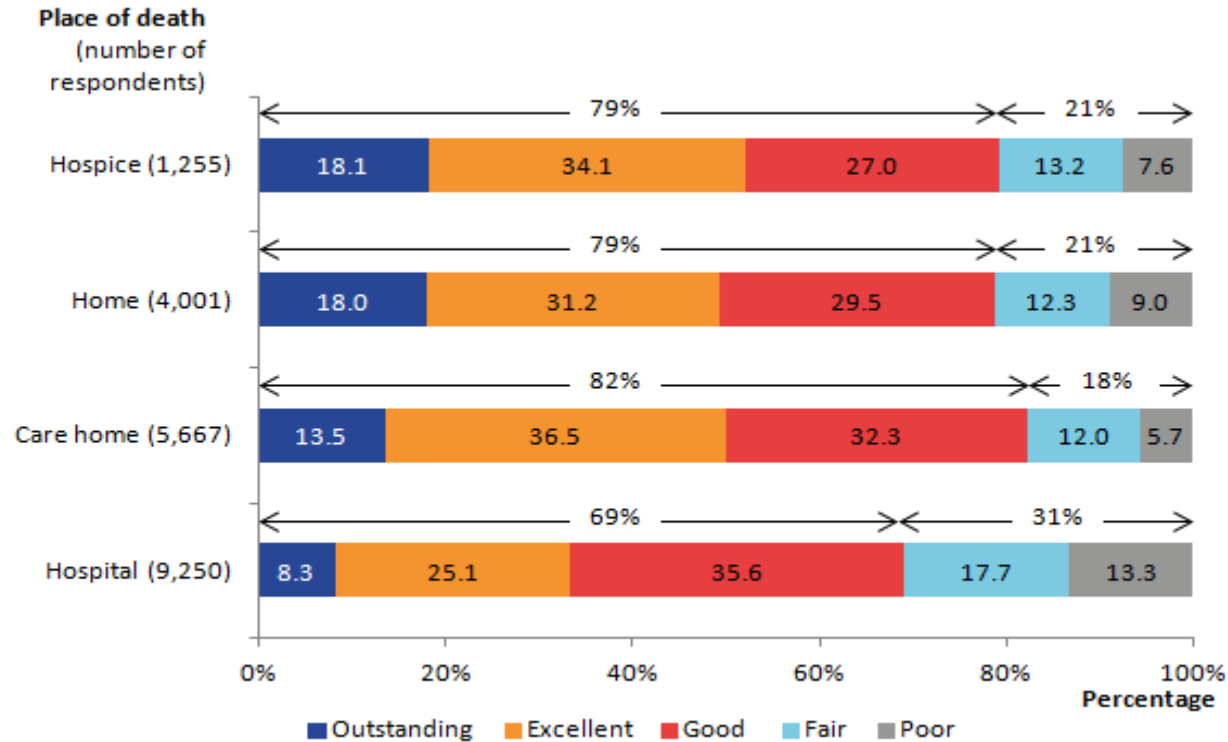
National End of Life Care Intelligence Network 2015

29% of hospital inpatients are in the last year of life.

Higher proportion over 85 years or under a medical specialty.

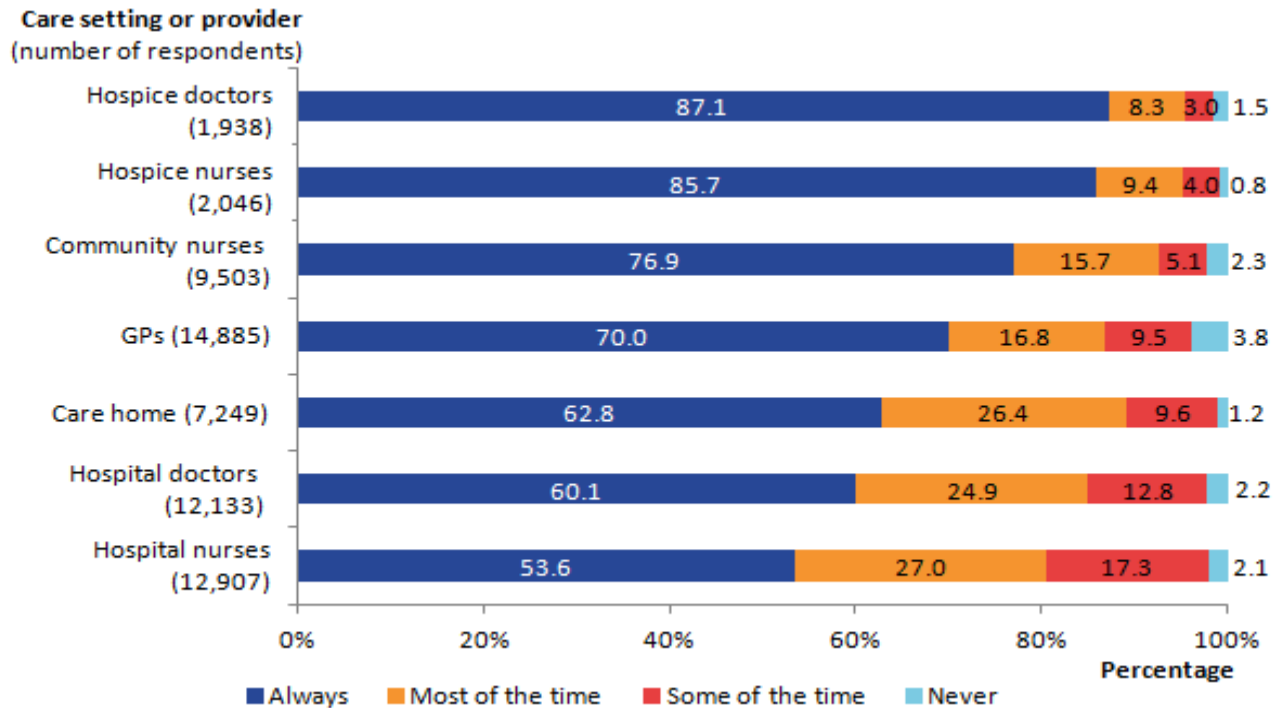
Clark D, et al. Imminence of death among hospital inpatients: prevalent cohort study. Palliative Medicine 2014; 28(6):474-479.

VOICES 2015: quality of care last 3 months by place of care



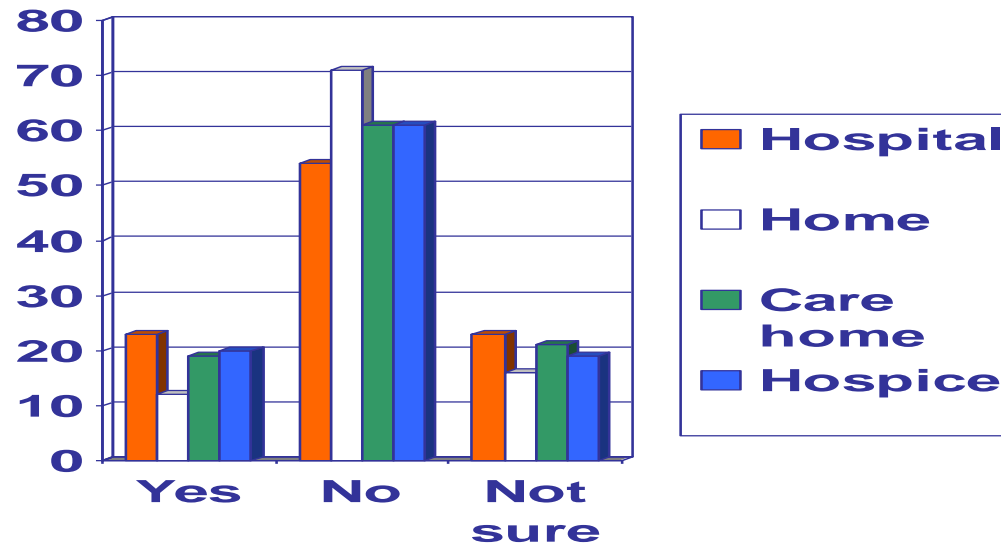
VOICES 2015:

Dignity and respect, last 3 months



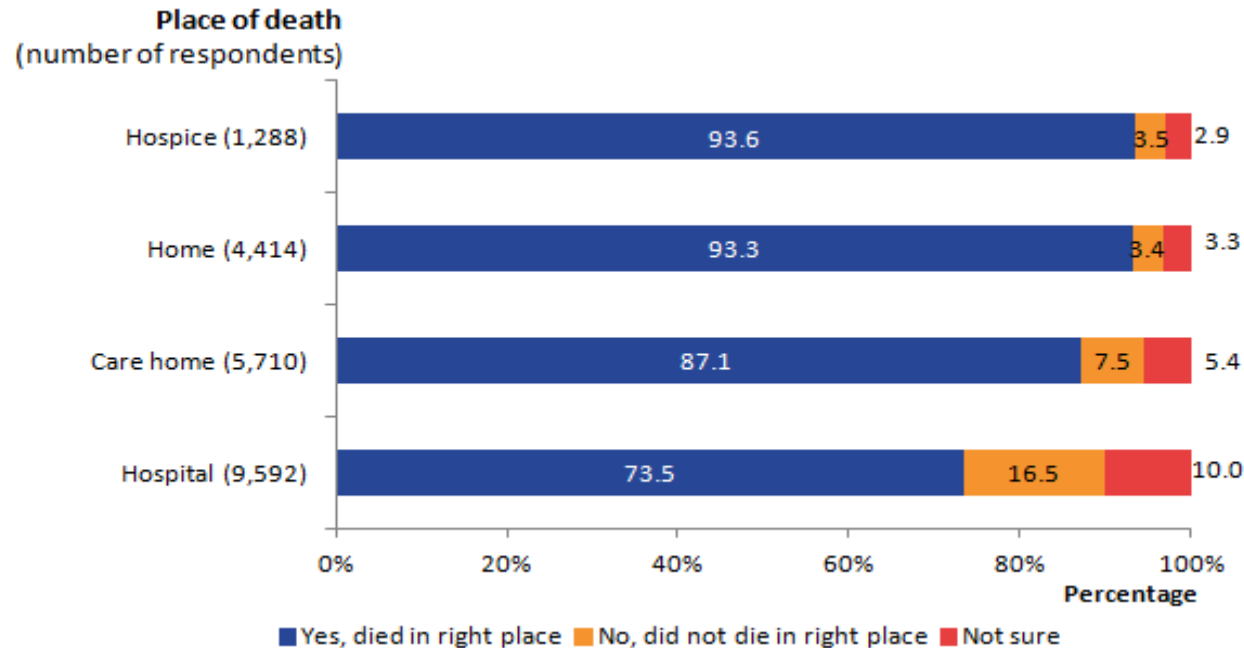
VOICES 2015:

In the last 3 months of life, were decisions made which he would not have wanted?



VOICES 2015:

Did the patient die in the right place, by place of death



Dying without Dignity

Parliamentary and Health Service Ombudsman 2015

Not recognising that people are dying and not responding to their needs

Poor communication – with people, families and each other

Poor symptom control

Inadequate out-of-hours services

Poor care planning, eg hospital to GP

Delays in diagnosis and referrals for treatment

The public's fears and concerns about
end of life and dying

**‘inherent uncertainty in
the pace of disease
progression and that
reversible and
irreversible conditions
can coexist’**



House of Commons
Health Committee

End of Life Care

Fifth Report of Session 2014–15

Report, together with formal minutes relating
to the report

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THE MID STAFFORDSHIRE
NHS FOUNDATION TRUST
PUBLIC INQUIRY

Chaired by Robert Francis QC

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Executive summary

HC 947



Dying without dignity

Investigations by the Parliamentary
and Health Service Ombudsman into
complaints about end of life care



MORE CARE LESS PATHWAY A REVIEW OF THE LIVERPOOL CARE PATHWAY

ONE CHANCE TO GET IT RIGHT

Improving people's experience of care
in the last few days and hours of life.

Published June 2014 by the
Leadership Alliance for the Care of Dying People

Publications Gateway Reference 01509

NICE National Institute for
Health and Care Excellence



Care of dying adults in the last days of life

NICE guideline
Published: 16 December 2015
nice.org.uk/guidance/ng31

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Our Commitment to you for end of life care

The Government Response to the Review of Choice
in End of Life Care

July 2016

Transforming End of Life Care in Acute Hospitals

Programme aims to improve the quality of EoLC within acute hospitals across England, enabling more people to be supported to live and die well in their preferred place.

The five enablers of the Transform programme are:

1. Advance care planning
2. Electronic palliative care coordination systems (EPaCCS)
3. Rapid discharge home
4. Recognising uncertain recovery (e.g. AMBER care bundle)
5. Priorities for care of the dying person.

'comfortable, symptom free, treated with dignity and respect and involved in decisions, surrounded by their loved ones, and ideally in a place of their choosing'

One size does NOT fit all



Advance decision to refuse treatment: ventilation, CPR, blood products

Lasting power of attorney – health and wellbeing

Advance statement of preferences: place of care, approach to care, hospital re-admission

Verbal/non-verbal: 'I wish I could be out of here'; 'I don't want to be involved in these conversations (DNACPR)'; repatriation overseas; 'I want to go home even if I die in the ambulance', 'you've got to try everything doc', 'don't tell my partner'

Triggers

Who

Where

Ongoing

Palliative care notes – assessment/MDM / Trust notes

Discharge letter

PEACE, Patient specific protocol

Coordinate my care

Transitions

Emergency department admissions

Fast-track discharges

Rapid discharge at the end of life

Currently seeking feedback about patient experience of transition

- In addition to bereaved carer feedback, complaints, compliments, patient reported outcomes

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English NHS

Future

37 in 2015

30 in
2013

3
pilots
2010

G
S
T

New South
Wales,
Australia 2013

Middlemore Hospital, New Zealand 2015

Guy's and St Thomas'

NHS Foundation Trust



Transforming End of Life Care in Acute Hospitals

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Priorities for care of the dying person

Recognise
Communicate
Involve
Support
Plan & Do

Guy's & St Thomas'

1277 beds

182,000 ED attendances

80,000 admissions

1.1 million outpatient attendances

1,000 deaths

SPC:

- >1000 hospital support team, >800 community team, >200 outpatients
- 24/7 service

Bereavement follow up -> all known to SPC, paediatrics, cardiac, ED;

Memorials -> SPC, paediatrics, renal, critical care, EB

Pain control: assessment, guidelines, education, audit.

Care Quality Commission 2016



Good

Guy's and St Thomas' Trust



Good

End of life care



Outstanding

Caring domain in end of life care

Six ambitions to bring that vision about

- 01 Each person is seen as an individual
- 02 Each person gets fair access to care
- 03 Maximising comfort and wellbeing
- 04 Care is coordinated
- 05 All staff are prepared to care
- 06 Each community is prepared to help

"I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including my carer(s)."



Home

Shared decision
making

Hospital

Outpatients

Improving
patient
and carer
experience

Pain and
symptom
management

Communication
on transfer



Current priorities EoLC

Focus on holistic care

- #hellomynames / yellow badges
- Hydration/nutrition/fundamental care
 - Spiritual/psychological support
- Namaste care
- Patient and family feedback

Education and training

- Re-launch events
 - Champions
- Staff education – profiles and prospectus

Communication on transfer / shared decision making

- Advance care planning
- Coordinate my care
- Electronic discharge letter
 - AMBER
- Emergency care and treatment planning

Attention to pain and symptom control

- Unified pain assessment tool
- Updated guidelines
 - Symptom observation chart

Challenges

Demographic changes and financial pressures

Cultural

Logistics – IT, staffing turnover, silos and working across boundaries

‘...There is no shortcut to good end of life care. We need to embed it in our clinical culture – make it everyone’s business and support everyone to do it...

Fifty years ago Cicely Saunders transformed care for the dying through foundation of the modern hospice movement. She took death out of the NHS in order to show us what good care could look like. She did not expect us to leave it there. We, now, need to move death back in to the NHS. It is time for another transformation in how we care for the dying, and we have the knowledge and power to achieve it; we can’t afford not to’

Katherine Sleeman EXPO blog 2016

Illusions of autonomy: where medical ethics and human behaviour meet

Dr Philip Berry @philaberry

End of life care is everybody's business



Council of Governors	Guy's and St Thomas'  NHS Foundation Trust
Service Strategy Working Group report – 11th October 2016	26th October 2016 (CG/16/22)

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), Devon Allison, Vicky Rogers, Kevin Burnand, James Palmer, Jenny Stiles, Linda Goldsmith, Tony Hulse Martin Shaw (Director of Finance), Jackie Parrott (Director of Strategy), Sara Hanna (Medical Director ELCH), Miranda Jenkins (Deputy Director and Head of Strategic Development) and Dan Price (Strategy Manager) attended from Guy's and St Thomas'.

Apologies were received from Ian Abbs, Sheila Shribman, Bryn Williams, Kate Griffiths-Lambeth, Jane Fryer, John Balazs, John Porter, Sonia Winifred, David Maurice, John Duncan

2. Notes of the previous meeting and matters arising

2.1 The notes of the meeting held on the 5th July were approved as a true record.

3. Business Planning 2017/18 & 18/19

3.1 Jackie Parrott started the presentation with a recap of the Sustainability and Transformation Plan (STP) process: that the country had been divided into 44 geographies to produce a long term plan for the area. GSTT are part of the south east London (SEL) STP and are considered a national exemplar, largely because we have built on the work of Our Healthier South East London. Jackie also gave an overview of the newly launched Single Oversight Framework and its implications for how the Trust will be regulated by NHS Improvement.

3.2 Martin said that for the next draft STP submissions on the 21st of October, the controls totals were still being worked through as many of the financial assumptions in the plan did not include factors that will affect all organisations. This would be issues like capital development implications, loan repayments and education costs. The wider issue of how funding that moves across geographies, for example specialised services and that we get several hundred million from other STP areas in London, still needs to be dealt with. There were also challenges about how responsibilities for STPs control totals versus for single organisation control totals were handled.

- 3.3 One of the issues affecting the financial position in the SEL STP is the increasing volumes that the Trust is experiencing. The latest volumes were included in a resubmission of draft plans the day of the meeting. In previous plans we had assumed activity growth of 3% per annum, but for this plan we are increasing to 6%. This is then having a cumulative impact on subsequent year's plans.
- 3.4 Martin then broke down some elements of the financial challenge within the STP. The £232m of collective productivity gains are something that the Trust feels it should be pursuing irrespective of any other factors. The financial challenge is creating a complex situation, and even if all the savings identified thus far were achieved, there would still be a £300m gap. This is due to factors like specialised commissioning mentioned earlier and isn't easily fixed within the STP. Martin is working with others, including CCGs, to inform and influence central government on these issues to try and get to a resolution.
- 3.5 Currently the Trust is meeting its financial targets for this year. Compared to last year the Trust was in a much better position financially, however there is more of a challenge on access standards this year due to the growth of demand. This demand is variable across London and anecdotally we think demand is shifting to us. Nationally conversations are happening about rationalising where clinically appropriate.
- 3.6 Fit for the Future was the Trust's approach to securing some of the savings required, with Hannah Coffey appointed as the Improvement Director leading the programme. The view of Fit for the Future was that while it would release savings now the larger goal was to develop a culture and methodology that would lead to bigger savings in the future.

During questions and discussion the following was highlighted:

- That the quality section of the new Single Oversight Framework was aligned to the CQC domains and inspection to reduce regulatory burden. There are two new domains; strategic change and governance and leadership which were being worked through with NHS Improvement.
- Governors expressed concerns that any of the proposals might include e-follow ups to appointments and that this might affect the quality of care provided. Martin assured the governors that the Trust is taking clinical advice on this issue.

- The STPs are looking to transfer funding towards community based care. This is dependent on the continuing increase the capacity in primary care and community care.
- Education cost pressures is one of the areas which isn't factored into the STP plans. The Trust may have to make a hard decision in the future about what education provision is offered, but it's difficult to be clear on what that looks like as the whole way that education is financed is in a state of flux.

4. Evelina London Children's Healthcare

4.1 Miranda Jenkins and Sara Hanna presented an update on the strategy for the Evelina London Children's Healthcare.

The presentation went through the services provided in the hospital and the community and how they worked together.

4.2 Miranda provided a strategic context for the Evelina; the demand within central London, the networks out into south east England and that England's has poor health outcomes for children nationally. Locally part of this is driven by the fragmentation of services in south east England, which means that services are provided in the same way that the rest of the country is able to.

4.3 The presentation outlined the vision and ambition of the Evelina which is split into four parts; Local services in a Local integrated network, Specialist services in a Regional Clinical network, the specialist hospital, Academic Department with a national/international profile. There have been multiple developments in all of these agendas, particularly in children's community services.

4.4 Academically the Evelina is a top performing research organisation. This will be built upon through the development of a children's clinical research facility and because KCL have created a new children's and women's division which will support the Evelina's vision for research. The recent successful BRC bid also specifically included a children's theme.


4.4 Sara Hanna gave an overview of the Evelina's quality priorities for the coming year. The Evelina has a culture of continuous improvement and it is always difficult to pick priorities but the team highlight that maintaining and improving staff morale will be vital.

During questions and discussion the following was highlighted:

- A lot of discussion focused on the Evelina 2 business case which is in early stages of development. How St Thomas' House is dealt with in terms of maintaining the educational covenant was a critical pathway. The team had been engaging with KCL on this issue and thinking through the sequences of moves required. Clinical engagement has been a cornerstone of the development of the plans for the Evelina 2 case as the team knows that is the only way to make sure that the facility would work effectively.
- The concept behind the developments is to bring specialist services together to build economies of scale and increase the quality of service provision for children, as is done in other parts of the country. This can be seen as expansionist, but is the model of care for elsewhere in the country. This is in sync with national policy as the high specialised services spend on children's services means that commissioners are looking to rationalise services. Other providers are thoughtful about this, and not negative in terms of the need to provide better quality of care through centralisation.
- This aligned with the strategic networks as the Evelina believes it is better to provide care as locally as possible where clinically safe. As such, over three quarters of the general paediatrics clinics have moved into the community.
- The capital for the Evelina 2 case is not yet in place. Martin Shaw pointed out that the Cancer Centre had been in a similar situation and yet that is now funded and built. This is now being discussed and linked with wider estates thinking that applies to the whole Trust.

5. Any other business

5.1 There was no further business and the next meeting was confirmed for 17th January 2017, 5.30pm to 7pm at York Road.

Council of Governors	Guy's and St Thomas'  NHS Foundation Trust
Questions and Answers	26th October 2016 CG/16/23

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
Pedestrian access to the Guys site is becoming increasingly hazardous, particularly for those of limited mobility. I suggest that a small group is formed to include a governor to beat the bounds and to look at improvements such as marked pathways and better signposting. The group should also look at more revolutionary solution including the positioning of wheelchairs at access points.	16/0019 2016-09-25 (John Porter)	A meeting will be arranged with the Projects and Estates/Essentia team with a few Governors to understand concerns and talk through some of the works around the Guy's site and actions in place, followed by a walk around the site. (19-10-2016)		
I have a couple of questions arising from the sexual and reproductive health services consultation which I am keen to query with the clinical lead and GM: <ul style="list-style-type: none"> Is there a commitment to transfer the long-standing specialist LGBT ('after 5') clinic from Lloyd clinic to one of the 3 remaining clinics? Is there data available showing the sexuality of users vs attendances by clinic? I am keen to understand whether the closure of the Vauxhall Riverside clinic (and others) will have a significant impact on the LGBT community; With the proposed expansion of the SH:24 	16/0018 2016-08-30 (James Palmer)	The new service model will deliver a higher quality service to MSM in terms of the skill mix in each clinic. The After Five clinic and Male clinic at Vauxhall are not being moved but instead they will be absorbed in the new clinic model. Burrell street is increasingly popular with the LGBT community and the community services have too as their proficiency and service offer has improved. We track the age, gender and sexuality of all attendees and the single biggest draw for LGBT patients is a service that can effectively manage their needs. In addition to highly skilled doctors and nurses the new model has health advisors in		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
<p>online testing service, is there any consideration to extend availability beyond Lambeth and Southwark residents? If not, the current proposal looks to significantly impact upon the ~40% users from outside these boroughs, reliant on the 'open access' provision of testing services. As a suggestion, would the trust consider expanding SH:24 to the GSST's other 3 key boroughs (Wandsworth, Lewisham and Westminster)?</p> <p>I would be grateful if you could forward these on for their attention. I plan to attend the public meeting on 22nd September, so I am happy to discuss then, if easier. I would be grateful if the data request could be considered beforehand though.</p>		<p>every clinic session to support complex patients. SH:24 is already available to non Lambeth & Southwark residents via our click & collect service that can be accessed on the Burrell Street website or http://testtoday.org.uk</p> <p>(31-08-2016)</p>		
<p>I would like to ask what procedure GSTT has for helping patients when GSTT has lost the patients notes?</p> <p>This arises because someone I know was put on the waiting list for a knee replacement in Dec 2015. Since then she has been sent 2 pre-op letters, one in April and another for May, on neither occasion could the operation proceed as the notes were not available. She is in considerable pain despite being on 3 pain killers. During the summer she is getting out a bit ie to Waterloo Action Centre but this is very difficult. She is worried that with the colder weather she will be housebound again</p>	<p>16/0017 2016-08-23 (Jenny Stiles)</p>	<p>Some Surgeons and/or Anaesthetist will not operate without original health records. Health Records can be unavailable for a variety of reasons – most frequently they have not been tracked which means when they are needed they cannot be found. If a records has been “missing” for a year a new health record is created</p> <p>(12-09-2016)</p> <p>The Health Records team carried out a thorough search of the library on the date the complaint was received and also searched the Ophthalmology department. The complaint was then forwarded to the Acting Directorate General Manager of Medical</p>		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
<p>as she was last winter. She lives alone. She has asked why her notes cannot be reconstructed from those sent to her GP and been told that GSTT does not do this. However she has also been told that the operation cannot proceed unless the doctor operating has a full set of paper notes in front of him/her. The patient has made a formal complaint. The complaints officer has confirmed that the notes remain missing. He is going to find out what the procedure is in these circumstances. . It seems to me something which would be of interest to the Governors too.</p>		<p>Specialties. A response was received from him on 22nd July to say the staff in the Ophthalmology department were still searching for the records. The Health Records team physically searched the following areas:</p> <ul style="list-style-type: none"> • Ophthalmology Outpatients Health Records Library • Orthopaedics department • Florence Ward • Pre-Operative Assessment-Tower Wing • Surgical Admissions Lounge • Urology department • Neurology department • Eye Day Case Unit • Ophthalmology Secretaries Office • Ophthalmology Research office • Pre-Operative Assessment – Gassiot House <p>The Health Records team were informed that the pre-assessment nurses would not see the patient without her original Trust notes.</p> <p>A temporary folder was created by the Health Records team on 14th September after the consultant agreed to go ahead with surgery using the information available on EPR.</p> <p>The Health Records team are currently waiting for</p>		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
		<p>confirmation from the Orthopaedics team whether pre-assessment will go ahead with a temporary folder. They will also confirm if the anaesthetist is happy to proceed.</p> <p>A temporary health record can only be created by the Health Records team after exhaustive searches have been made to locate the original Trust health records. On creating a temporary health record it is ensured that the most up-to-date information is obtained from electronic health record systems and placed into the temporary health record.</p> <p>The patient's records have been logged on our missing health records database and the tracking of the records will be monitored on a weekly basis for movement. If after a 12 month period the records are still missing, it will be necessary to create a new health record to the best of the Trust's ability.</p> <p>Records are deemed to be missing for a variety of reasons e.g. Inaccurate tracking, misplaced within departments.</p> <p>(23-09-2016)</p>		
I wonder whether the below is something we can support either as a CoG or raise up to the Children's Services committee given it has impacted the clinical process and patients?	16/0016 2016-07-28 (Heather Byron)	<p>The Head of Nursing for Children's Medicine & Neonatology responded as follows:</p> <p>I have some insight into this, as this must originate</p>	Further update has been sought.	

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
<p>Problem Statement: The lab is facing some lapse in service from the Royal Mail around a business delivery service that is in place for the prompt delivery of newborn screening / monitoring blood spot tests. Whilst this hasn't yet a systemic problem, talking to the lab and the dietitians, there have been a number of incidents which clearly causes concern both from the perspective of delay to patients on results but also any potential risk / harm resulting from tests which do not arrive or cant be read in the lab.</p> <p>Context / Risk: It is hard to quantify the scale of late delivery of the risk to newborns / patients as the lab never knows exactly how many newborn screening / monitoring blood tests are being sent in. However, we know the implications of a late results, especially in the newborn screening where in many of the conditions being screened for require immediate intervention / treatment. Its concerning that we may not receive a sample and isn't clear whether there are robust processes in place across the community network to identify promptly if a newborn test results hadn't been returned and therefore a further test taken. I fear, more often than not, it would be missed for some time, which could have medical and/or quality of life implications.</p> <p>Whats next: There are a number of things</p>		<p>from the paediatric metabolic service - she worked in this team for many years, & is well used to the challenges of bloodspot screening, ongoing monitoring & Royal Mail.</p> <p>Just in terms of assurance with regards to delays in NBBS after birth, the national “fail safe” system does provide some reassurance and ensure if a sample is mislaid or significantly delayed a baby would have a repeat sample taken in a timely way. I will look into the other issues raised with the teams involved and will feedback progress around these points.</p> <p>Thank you again for sharing this with us. (26-08-2016)</p>		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
<p>which could happen to support the labs in dealing with the problem so that the service becomes reliable and they are spending valuable time chasing RM.</p> <ul style="list-style-type: none"> • develop a simple, consistent escalation process to Royal Mail (admin driven not lab driven) so that we are consistent in our escalations and have a clearer audit behind us of the issues encountered (this could be a simple form on the portal for example) • as part of the wider Royal Mail relationship drive some escalation discussions (the sense is that in isolation this isn't 'important enough' to deal with by the RM. • review whether Royal Mail is the right partner to be responsible for the delivery of such important blood samples or whether a commercial agreement should be made with another party (whilst on the surface the 'cost' of the RM business reply service may seem competitive, I wonder when you look at the total cost including the courier costs to bring post from RM to GSST, it may not be... not to mention the slightly unreliable nature of the service. <p>I am very happy to support any next steps, but wanted to share with you for your guidance as to whether this is something we are at liberty</p>				

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
to raise awareness to and have the possibility to help resolve?				
There are document or communications review groups that look at written information that is shared to patients. If there is an opportunity to get involved, I would be happy to offer my time as I am in full agreement with the point that Tony made in the meeting that the way patient letters are written leaves a lot to be desired. Equally, I think there is a lot we could do to make 'information sheets' more engaging and easy to understand.	16/0015 2016-07-22 (Heather Byron)	In September, all Governors will be given the opportunity to join groups which they are interested in. (22-07-2016)	Governors have been informed of vacancies in the CoG Working Groups and Board Committees including: <ul style="list-style-type: none"> • Adult Local Services Development Committee • Cancer Services Development Committee • Quality and Performance Committee Governors have also been informed of the opportunity to join the Patient Information Group.	
How do we get engaged to be part of the 'mystery shopper' process?	16/0014 2016-07-22 (Heather Byron)	In terms of mystery shopping if the governor concerned would like to contact my colleague, Mark, who manages the mystery shopping programme he can talk them through what is involved. Our next training course will be in early December. We recruit twice a year. Mark's email address is mark.tsagli@gstt.nhs.uk . (22-07-2016)		
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	16/0011 2016-06-22 (John Porter)	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		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
have on the operation of the FT.		Trust when compared to other similar service providers. This output forms part of the continuing cost improvement plan.		
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	16/0009 2016-06-22 (Jenny Stiles)	<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 highway here. Have been meeting TfL to discuss sensible alternatives and thus avoid litigation <p>We have tried to be clear that we are neither anti</p>		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
		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. (22-06-2016)		
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?	16/0008 2016-06-22 (Devon Allison)	<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. 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 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>The Head of Fundraising attended the recent Board of Directors Away Day and gave a presentation. There is now a commitment to give fundraising a greater priority but the practical terms are yet to be agreed.</p> <p>The Executive Team is considering how to develop the Trust's fundraising activities.</p>	

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
		<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>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</p>		

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		position overall. Indeed many Trust officers are leading STP groups working in collaboration with other local providers. (22-06-2016)		
<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</p>		

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		<p>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> <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>		
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	16/0003 2016-02-05 (John Porter)	<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</p>		

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integrated care across the community and what this community is and will be.		<p>that will require funds or delegated powers require the approval of all three FT Boards of Directors. 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>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 contributing to them by participating in any established Working Group (such as was the case for developing the 'Smoke free' policy) 	<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 • Low calorie options are available throughout the retail outlets • Healthier food options are available daily & are cheaper in price 	<p>The Nutritional Care Strategy was launched on the 20th September 2016 which sets out how the Trust aims to provide our patients, their families, carers and staff with high quality and nutritious food, drink or specialist nutrition.</p> <p>The Nutritional Care Strategy can be found on the Trust website: http://www.guysandstthomas.nhs.uk/resources/our-services/nutrition/nutritional-care-strategy-2016-final.pdf</p>	

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<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 environment <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</p>		<ul style="list-style-type: none"> • 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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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.				
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	2014-04-29	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.	A further response/update has been sought.	

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