Public Council of Governors meeting

Wed 30 April 2025, 18:00 - 19:30

Governors Hall, St Thomas' Hospital and online via MS Teams

Agenda

18:00 - 18:00
0 min

1. Welcome, introductions and apologies

Charles Alexander

18:00 - 18:00
0 min

2. Declarations of interest

18:00 - 18:05
5 min

3. Minutes of previous meetings held on 29 January 2025 and 17 March 2025 and and review of actions

- [3a] 20250129 Public CoG Meeting Minutes vFinal.pdf (3 pages)
- [3b] 20250317 CoG Meeting Minutes vFinal.pdf (3 pages)

18:05 - 18:25
20 min

4. Patient communications

Avey Bhatia and Andrew Wilkinson

- [4] Transforming our relationship with patients - Governors Version Final.pdf (9 pages)

18:25 - 18:45
20 min

5. Update on community services

Adam Fitzgerald

- [5] Update on community services.pdf (20 pages)

18:45 - 18:50
5 min

6. Governors' reports for information

6.1. Lead Governor's Report

Katherine Etherington

- [6a] Lead Governor's Report Jan25 vFinal.pdf (3 pages)

6.2. Membership Development Working Group

Claire Wills

- [6b] 20250205 MDWG meeting minutes.pdf (3 pages)

6.3. Strategy, Transformation and Partnership Working Group

Leah Mansfield

- [6c] 20250211 Strategy Transformation and Partnerships Working Group minutes February 2025 Minutes.pdf (8 pages)

6.4. Quality and Engagement Working Group

Leah Mansfield

[6d] 20250325 Quality Engagement Working Group meeting notes 25 Mar 2025 v2.pdf (10 pages)

6.5. Council of Governor elections

Elena Spiteri

[6e] CoG elections 2025.pdf (2 pages)

18:50 - 19:30
40 min

7. Q&A with Trust Chair and non-executive directors

19:30 - 19:30
0 min

8. Any other business

COUNCIL OF GOVERNORS

Wednesday 29 January 2025, 6pm – 7.30pm
Robens Suite, Guy's Hospital and MS Teams

Governors present:	Koku Adomza David Al-basha Steve Bean Nigel Beckett Victoria Borwick Michael Bryan Emma Barslund Blackman John Clark	Felicity Conway Katherine Etherington Emily Hickson Peter Harrison Leah Mansfield Charles Mead Alison Mould	Roseline Nwaoba Mary O'Donovan John Powell Daghni Rajasingam Sheila Reddy Kendra Schneller Claire Wills
In attendance:	Charles Alexander (Chair) Ian Abbs Edward Bradshaw (minutes) Miranda Brawn Steven Davies (to item 5)	Nilkunj Dodhia Simon Friend (to item 7) Felicity Harvey Jamie Heywood Deirdre Kelly	Ian Playford Pauline Philip Elena Spiteri Alison Wilcox
	Members of the public and members of staff		

1. Welcome and apologies

1.1. The Chair welcomed attendees both in the room and online to the meeting of the Council of Governors (the Council). Apologies had been received from non-executive director Graham Lord and from governors Aya Ayoub, Nimmi Anu Sam, Brian Boag, Annette Boaz, Samantha Field, Michael Mates, Irina Munteanu, Stephanie Petit, Mercy Satoye, Helen Selvarajan, Dominic Shaw, Darren Summers and Jadwiga Wedzicha.

2. Declarations of interests

2.1. No declarations of interest were received.

3. Minutes of the meeting held on 23 October and 10 December 2024

3.1. The minutes of the previous meetings were approved as an accurate record. There were no outstanding actions to follow up.

4. New non-executive directors

4.1. The Trust had recently appointed two new non-executive directors, Jamie Heywood and Alison Wilcox, who had started in post on 6 January. They introduced themselves to governors and summarised their background, key skills and experience, and motivation for joining Guy's and St Thomas'.

5. External audit contract

5.1. The Trust's contract for the provision of external audit services was due to end in July 2025, following the audit of the Trust's 2024/25 annual report and accounts. An overview was provided about the procurement exercise that had been undertaken to identify a firm to provide these services after the current contract ended. The process had been conducted with input from staff and non-executive directors, together with a representative from the Council of Governors, and had been overseen by the Trust's Audit and Risk Committee. It was confirmed that the appointment of the external auditors was a decision reserved for the Council of Governors.

5.2. The Trust had received one bid, from its incumbent auditor Grant Thornton. The Chief Financial Officer explained that this was not unexpected, as the public sector audit market had significantly reduced in recent years. Details were provided about the discussions that had taken place with Grant Thornton about its bid. Whilst this represented a cost increase to the Trust, analysis had concluded that the cost was not unreasonable given the Trust's size and the audit work required for its subsidiary companies. An explanation was provided about the implications if governors chose not to support the proposal.

5.3. Governors were informed that, in recent weeks, Grant Thornton's partners had voted in favour of a strategic investment from international private equity firm Cinven. This was relevant given that Cinven also had a shareholding in Synlab, which was majority owner of Synnovis, the Trust's pathology partner. Governors sought clarity on whether any potential conflicts of interest were likely to arise, but were reassured that this risk was low, would be carefully monitored, and was mitigated by the strong adherence to ethical and professional standards in the external audit profession.

RESOLVED:

5.4. The Council of Governors approved the appointment of Grant Thornton for five years.

6. Council of Governor elections

6.1. Elections to the Council of Governors were being held over the coming months. There were 11 available governor seats across six constituencies, and successful governors would commence their three-year terms on 1 July 2025. Governors with terms expiring in the summer who wished to stand for re-election were reminded to ensure they submitted their self-nomination on time. Governors noted the election information and the request to inform Corporate Affairs of opportunities where the governor elections could be promoted/advertised to encourage as much diversity as possible in those members who nominate themselves for election and thereby ensure the Council of Governors reflects both the diversity of the Trust's workforce and of the patients and communities it serves.

7. Governor reports

7.1. The Lead Governor presented her report and encouraged governors to take advantage of the Trust's site visit programme that had recommenced towards the end of 2024, and any opportunities that came up to observe one of the Board committee or clinical/delivery group board meetings. Both initiatives would provide governors with additional insight into the work of the Trust and help them triangulate information they received from other sources.

7.2. The Chair of the Membership Development Working Group reminded governors about the purpose of the Group, the key objectives in the Group's action plan, and its recent areas of focus. There was discussion about the number of patient and public members the Trust had, and the difficulties that governors experienced in adequately representing the views of their constituents. It was agreed that the benefits of membership could be more clearly articulated.

7.3. At its last meeting, the Quality and Engagement Working Group had held deep dives into MyChart and missed appointments. Led by the Chair of the Group, there had been progress with moves to enable the cancellation of appointments within 48 hours in MyChart, which would ease the pressure on other communication channels. Work was also being done to review the processes around how and when patients received clinical information on MyChart to ensure they had the opportunity to discuss this with their clinician. The need to better-link MyChart with the NHS app was noted.

7.4. The Strategy, Transformation and Partnerships Working Group was focusing on each clinical group in turn. An emerging theme from the sessions was around cutting-edge medicine, and governors encouraged the non-executive directors to ensure they were helping the Trust prioritise funding for these developments, which were having transformative effects on many patients' lives.

7.5. The Council of Governors was pleased to receive a positive update about the 'making working lives better' programme, which had been established to address longstanding concerns that staff had about their environment. In particular, it was reported that new lockers would be rolled out with the

emergency department, medical assessment unit and maternity wards prioritised for receipt of these. Similarly, a scheme to improve the availability of hot and nutritious food for staff at all hours of the day had been trialled and would be rolled-out to all hospital sites later in the year.

8. Q&A with Trust Chair and Non-executive Directors

8.1. Governors queried the extent to which patients and the public should be concerned about the spread of Human metapneumovirus (HMPV) and noted that the Trust understood it had a role to play in helping respond to emerging pathogens regionally and nationally. Other governors asked about the Trust's policy on car parking charges; it was explained that, in a time of financial constraints, this was an important source of income to support the provision of clinical services. Whilst there were exemptions available to both staff and patients, the Trust encouraged staff to use public transport to get to work wherever possible, for both environmental sustainability reasons as well as the challenges of driving and parking in central London.

8.2. Following the financial update provided at the preceding Board of Directors meeting, governors asked how the Trust was planning to mitigate the risk of the current underspend against its capital expenditure budget, given any such underspend could not be carried forward into the next financial year or offset against any revenue deficit. Governors were reassured that the Trust had a robust capital planning process and that plans were in place to spend the capital, including through bringing forward schemes planned for 2025/26. Overall, the Trust was planning to invest significantly in its estate over the coming years, both on backlog maintenance and on strategic schemes, to improve patient experience and outcomes.

8.3. Some concerns were expressed by governors about the Trust's capacity and capability to treat patients with severe mental health conditions; this was an issue that had arisen following a recent governor site visit. Whilst governors recognised the work the Trust was doing with system partners to support these patients who presented in the emergency department, assurance was sought about how ward staff were receiving appropriate training, and it was recognised there were opportunities to provide this training more widely. It was confirmed that the Trust had a comprehensive range of support for doctors in residence and was a strong advocate for the career progression opportunities for these individuals.

8.4. In response to other questions received, the Council was informed that the Trust benchmarked positively with other trusts in the Shelford Group in most areas of cancer performance, and that it recognised governors' concerns that the ongoing consultation with the capital delivery team in Essentia may impact the wayfinding team which may pose risks to patients' ability to navigate the Trust's estate quickly and easily.

Action: Corporate Affairs to raise this issue with the Managing Director of Essentia.

9. Any other business

9.1. There was no other business.

The next meeting of the Council of Governors would be held on 30 April 2025

COUNCIL OF GOVERNORS

Monday 17 March 2025, 5pm – 6pm
MS Teams

Governors present:	Katherine Etherington David Al-Basha Emma Barslund Blackman Nigel Beckett Brian Boag Annette Boaz Victoria Borwick Michael Bryan John Clark	Felicity Conway Samanth Field Peter Harrison Leah Mansfield Charles Mead Alison Mould Irina Munteanu Roseline Nwaoba	John Powell Daghni Rajasingam Sheila Reddy Kendra Schneller Dominic Shaw Darren Summers Jadwiga Wedzicha Claire Wills
In attendance:	Charles Alexander (Chair) Edward Bradshaw (minutes)	Simon Friend Felicity Harvey	Anita Knowles Elena Spiteri

1. Welcome and apologies

1.1. The Chair welcomed colleagues to the meeting of the Council of Governors (the Council). The meeting had been arranged to seek approval from the Council for the appointment of a new Chief Executive to succeed Professor Ian Abbs, who would stand down later in 2025. The Chair emphasised the need for strict confidentiality of the information that was to be discussed during the meeting.

1.2. Apologies had been received from Koku Adomza, Nimmi Anu Sam, Aya Ayoub, Steve Bean, Emily Hickson, Michael Mates, Mary O'Donovan, Stephanie Petit, Mercy Satoye, and Helen Selvarajan.

2. Declarations of interests

2.1. The Chair explained that the identity of the proposed candidate would be confirmed later in the meeting, at which point governors would be asked to declare any interests in the candidate.

3. Chief Executive appointment

3.1. The Trust Chair provided an overview of the thorough and comprehensive recruitment process, supported by Odgers Berndtson, that had been undertaken to identify a new Chief Executive. The process had started in January 2025 and had been guided by a steering group of non-executive directors, led by the Trust Chair, with consistent support and advice from the Trust's Chief People Officer and General Counsel.

3.2. Alongside advertising the role, Odgers had undertaken a full proactive search to identify candidates of sufficient calibre to succeed Professor Abbs. This search had covered the full breadth of the healthcare sector including the NHS, national bodies and healthcare charities as well looking into wider sectors and internationally, including the United States, Australia, Canada and Europe. The application process had been open for six weeks. Odgers had engaged with candidates throughout this time and those candidates who were potentially a strong match for this role also had the opportunity to speak to the Trust Chair. A total of 23 applications had been received for the role, of whom 14 had been called for preliminary interview with Odgers.

3.3. All applications had been subject to a thorough review against the search criteria which included leadership experience, stakeholder management skills, performance improvement, financial acumen and change and innovation capability. At the shortlist stage of the process, the steering group, advised by Odgers, determined that there were three candidates who were the strongest for appointment and that, of these, one candidate was unanimously considered to be significantly stronger against all key criteria. The Trust's non-executive directors had met in full and decided that, in the interest of ensuring confidentiality and fairness, to take this single candidate through an accelerated assessment process,

with the intention to revert to the two remaining candidates should the individual not be considered appointable following assessment.

3.4. The assessment process had involved a 'stakeholder' panel consisting of all non-executive directors except the Chair and two deputy chairs, and a final interview panel which included the Trust Chair and two deputy chairs and senior external stakeholders representing the Trust's key partners: NHS England London region, the South East London Integrated Care Board, King's College Hospital, King's College London, and King's Health Partners, together with a Board member from Cambridge University Hospitals NHS Foundation Trust. Both stages of the assessment had tested the candidate's vision, ambition, appetite for innovation and creativity, leadership approach and impact, ability to work collaboratively with system partners, and their approach for both ensuring delivery and driving improvement, alongside their personal motivation, drive and desire for the role.

3.5. Following the final interview non-executive directors met formally as the Trust's Senior Leadership Talent, Appointments and Remuneration Committee to discuss the outcome of the two panels. Two of the Trust's governors had attended this meeting as observers to independently assess the robustness of the appointment process that had been followed and the Committee's considerations of the advice from the final interview panel. One of these governors confirmed that, from their perspective, the recruitment process had been robust and that consideration of whether to appoint the candidate had been subject to rigorous debate by those Committee members. The outcome of that meeting was that those non-executive directors present unanimously agreed that this candidate should be appointed and be recommended as such to the Council.

3.6. The Chair emphasised that the unanimous agreement by non-executive directors to appoint and recommend this to the Council had been made on merit and that at no stage during the process described had any third party sought to influence the selection process.

3.7. The Chair informed the Council that the proposed candidate/recommended appointee was Amanda Pritchard, currently Chief Executive of NHS England, who had been Chief Executive at Guy's and St Thomas' for almost four years between 2015 and 2019.

3.8. The Chair asked governors to declare any interests they had in relation to the candidate. Daghni Rajasingam declared that, alongside her role as Deputy Chief Medical Officer at the Trust, she was Medical Director for Secondary Care Transformation in the NHS England South East region. Several staff governors declared that they had been employed by Guy's and St Thomas' whilst the proposed candidate had been Chief Executive of the Trust before her departure to NHS Improvement in 2019. Similarly, Felicity Harvey declared that she had sat on the Trust Board alongside the candidate between 2016 and 2019. It was agreed that none of the interests above required any of the individuals concerned to recuse themselves from either the discussion or the decision-making process.

3.9. A summary of Amanda Pritchard's curriculum vitae was presented to governors, who were given the opportunity to read this in full. The Chair then talked through the key aspects of her background, key achievements, and the skills she would bring to the Trust. He also explained the circumstances by which she had left the Trust on secondment to NHS Improvement in 2019 and that, whilst her initial intention had to return to the organisation, this had not been possible due to her substantive appointment as Chief Executive of NHS England in 2021.

3.10. A number of governors voiced their support for the appointment of Amanda Pritchard. There followed a period of discussion where governors sought further information about the process that had been run and about the candidate, which included:

- The reasons why she had resigned from her role as Chief Executive of NHS England in February 2025;
- Confirmation that there were no restrictions regarding her availability as a result of her departure from NHS England;
- The probability that the appointment, if approved, would generate a significant degree of mixed publicity, and consideration about how the Trust might respond to this; and

- Recognition that the Trust in 2025 was significantly different to the one that Amanda Pritchard had left in 2019, and the extent to which this might be problematic. However, governors were reassured that through the assessment process the candidate had recognised this and was fully committed to helping the Trust deliver its new strategy through the clinical group operating model.

3.11. Whilst governors acknowledged the candidate's strong operational skills they emphasised the importance of the Trust remaining a 'clinically-led' organisation and highlighted the benefit that Professor Abbs, as a consultant renal physician, had provided in this respect. The Council sought assurance that having a non-clinical Chief Executive would not threaten this status quo. Whilst acknowledging these concerns, the Chair explained that there had been no pre-conception about the specific qualifications of the new Chief Executive, and that the guiding principle had been to appoint the best candidate. In addition, Amanda Pritchard was fully supportive of the clinically-led model at the Trust and had worked in this model when she was previously Chief Executive at the organisation.

3.12. All governors indicated that they were content to approve the appointment of the candidate as the new Chief Executive.

3.13. The Chair outlined the agreed communication steps, which would include a message to all Trust staff followed by a press release. No details of a potential start date for the new Chief Executive had yet been confirmed.

RESOLVED:

3.14. The Council of Governors unanimously approved the appointment of Amanda Pritchard as the new Chief Executive.

4. Any other business

4.1. There was no other business.

The next meeting of the Council of Governors would be held on 30 April 2025.

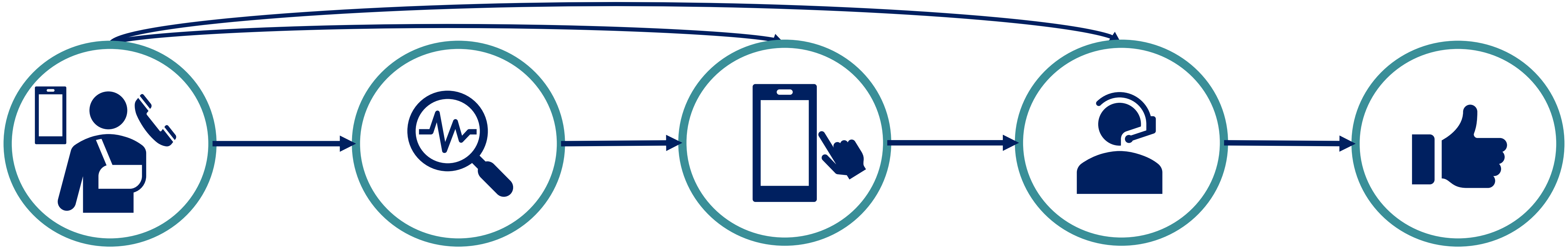
Guy's and St Thomas' NHS Foundation Trust

Transforming our relationship with patients – part of the technology-enabled innovation portfolio

Public Council of Governors Meeting – 30th April 2025

We know that patients struggle to contact the Trust, and this is a major frustration for them and their families

The typical contacting GSTT experience



Patients:

- **65%** of service contacts are patients wanting to **manage an appointment** (book, reschedule, cancel)
- **16%** of service contacts are patients looking for **appointment information**
- **11%** of switchboard contacts are looking for **Generic information**

May struggle to find information

- Searchability and Navigability are common themes on the web survey, with **21%** of 611 surveyed users requesting improved search
- **25%** of surveyed users could not find up to date contact information
- Currently no language services for our diverse population

Cannot self-schedule their care

- Despite **250,000 signups**, many of the **self-scheduling tools are unavailable** in MyChart
- Many clinics are not setup appropriately to automate appointment filling such as FastPass
- GSTT requires specialists to drive service readiness and ensure these features can be enabled

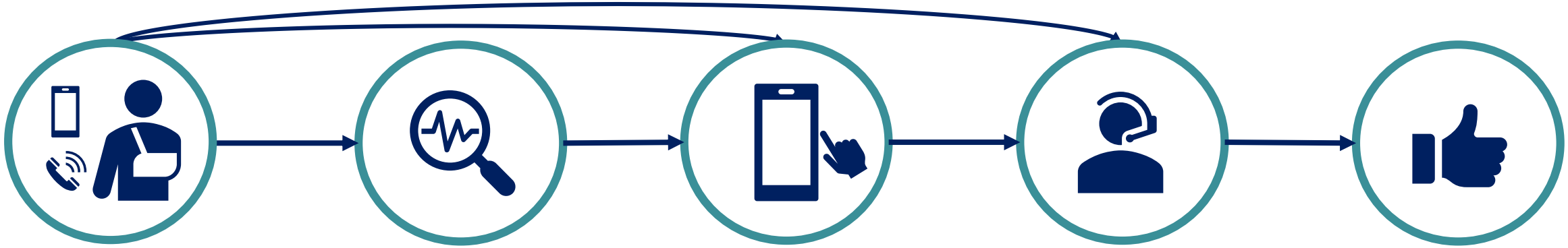
Cannot always speak to the right person

- **58%** of switchboard requests are forwarded to the service
- In services such as Dental **28%** of patients are put through to the wrong department
- **35%** of all calls in 2023 went unanswered in Service-led contact centres
- **Ease of contact 17 points below benchmark in 2023**

Are not always treated with respect[5]

- **58%** of staff feel unprepared to manage challenging behaviours
- **36%** of staff are managing other priorities
- Call handling colleagues report no GSTT training standards and only **30%** report a level of locally led induction

We want to address these frustrations and provide a new, modern, and accessible route to contacting the Trust so patients can get the support they need quickly and easily



I want to…

- **65%** of service contacts are patients wanting to manage an appointment (book, reschedule, cancel)
- **16%** of service contacts are patients looking for appointment information
- **11%** of switchboard contacts are looking for generic information

Find Information	Manage My Care	Speak to My Service	Be Treated with Respect
Quickly and easily		When I want to and to get what I need	By all members of Staff
Any time		Without long wait times	Before, during, and after my care
Any platform		Without being bounced around	In person, on the phone, or digitally
Accessibly			
In my preferred language			

We have developed a multi-year programme to deliver change

	2025	2026	2027
Find Information	Contact Information Optimisation; Codesigned FAQ Chatbot	Non-clinical Language Translation; Accessibility Functionality Development	Telephony & MyChart Integration; Appointment Management via GSTT Website(s)
Manage My Care	Recruit Template Readiness Team; Prioritise & Pilot	Deliver Self-Scheduling Functionality to diverse services; Produce GSTT wide self-scheduling guidance	Service-led adoption of Self-Schedule Tools
Speak to My Service	Evaluate existing Telephony Practices; Identify Transformation Partners	Deliver Options Appraisal; Transformation of Telephony & Contact Centre Operating Model	
Be Treated with Respect	Evaluate existing Training Practices; Identify Best Practice	Deliver Options Appraisal; Introduction & Scale of Customer Excellence Training	

The GST Charity is supporting us to accelerate the first two workstreams

	2025	2026	2027
Find Information	Contact Information Optimisation Codesigned FAQ Chatbot Non-clinical Language Translation	Accessibility Functionality Development Telephony & MyChart Integration	Appointment Management via GSTT Website(s)
Manage My Care	Recruit Template Readiness Team Prioritise & Pilot Deliver Self-Scheduling Functionality to diverse services	Produce GSTT wide self-scheduling guidance	Service-led adoption of Self-Schedule Tools
Speak to My Service	Evaluate existing Telephony Practices	Identify Transformation Partners Deliver Options Appraisal Transformation of Telephony & Contact Centre Operating Model	
Be Treated with Respect	Evaluate existing Training Practices	Identify Best Practice Deliver Options Appraisal	Introduction & Scale of Customer Excellence Training

What we aim to measure and improve over the next 12-18 months

- Find Information
- Manage My Care
- Speak to My Service
- Be Treated with Respect

- Improved patient experience when contacting GSTT
- Greater proportion of successful patient interactions
- Greater access and equity for those most in need
- Improved cost to serve per patient (across all contact channels)

Ready Set Schedule: Five services have already turned on the ability for patients to self-schedule

We've seen exciting results so far from services who have launched this functionality. These tools are progressively being activated across the trust, with 43 services currently underway with implementing the guidance.

In 2025, we've seen the following benefits for services launching these tools:

22 day

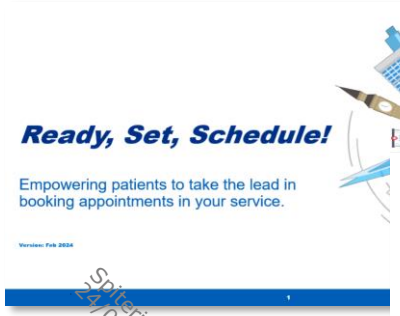
Improvement for appointments booked with Fast Pass

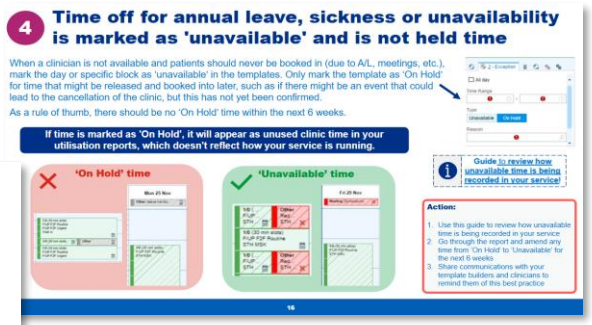
2355

Completed appointments booked by patients

89

Completed appointments that were scheduled for the same day





Using this guidance, services are now expanding this tools across difference area. The Charity funding will help accelerate this even further so more patients are able to manage their care.

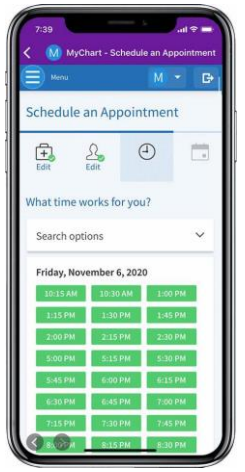
What we hope patients will experience over the next two years

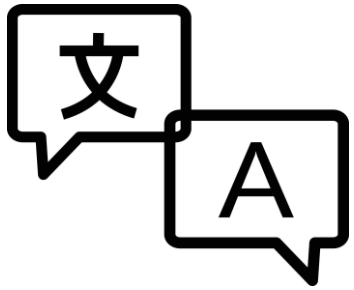
"I can find information on the website easily without needing to search or scan pages"

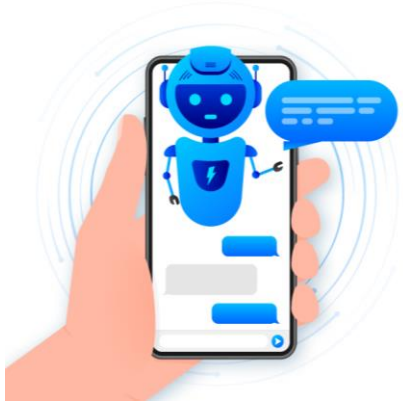
"I can book my own appointments and manage my care with MyChart"

"I can reschedule or get last minute cancellations, all without calling the Trust"

"I can search for information on the website in my preferred language"







Thank you – Questions?

Guy's and St Thomas'
NHS Foundation Trust

Update on our adult community services

Adam Fitzgerald, Head of Nursing

Dr Shaheen Khan, Clinical Director

30th April 2025

Fuller report – May 2022:

Vision for integrating primary care, and improving the access, experience and outcomes for our **communities**, which centres around three essential offers:

- **streamlining access to care** and advice for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and **ensuring care is always available in their community** when needed
- supporting more proactive, personalised care from a **multidisciplinary team of professionals** to people with more complex needs, including, but not limited to, those with multiple long-term conditions
- helping people to stay well for longer as part of a more ambitious and joined-up approach to **prevention**

Lord Darzi's report – September 2024:

- Lock in the shift of **care closer to home** by hardwiring financial flows to expand general practice, mental health and **community services.**
- **Simplify and innovate care delivery** for a neighbourhood NHS to embrace new **multidisciplinary models of care**

How can we work together to improve the health of the populations we serve?

The national political context

3 shifts needed:

- from analogue to digital
- from hospital to community care
- from curing disease to preventing disease

Commitment to a “Neighbourhood Health Service”

NHS ten year plan

[Operational priorities and planning guidance for 2025/26]

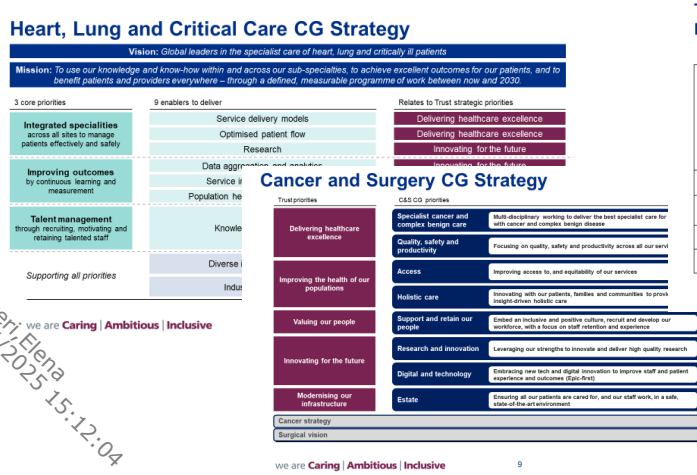
[2025/26 Neighbourhood health guidelines]

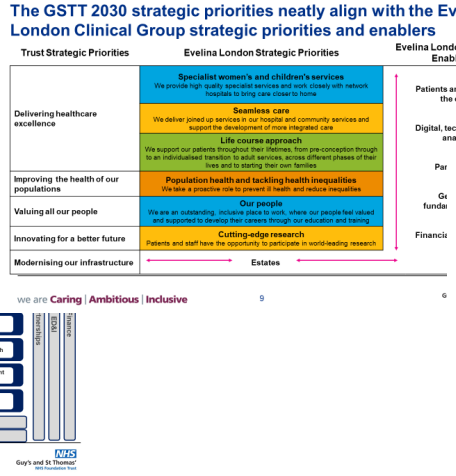
[Standardising community health services]

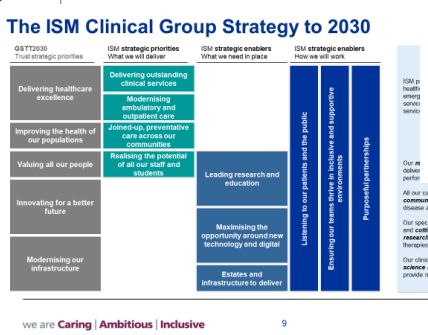
Clinical and delivery group strategies

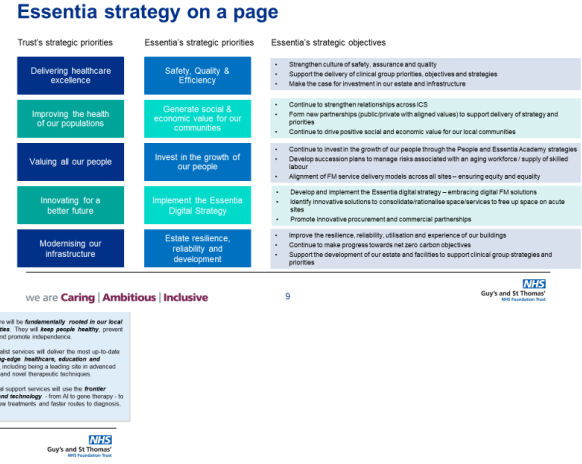
- The Trust strategy has been developed with input from our clinical groups and the Essentia delivery group as well as corporate teams.

- To both help inform and to deliver the Trust strategy, our clinical groups and Essentia have developed their complimentary group strategies to support delivery of the Trust priorities









What does this mean for our community services and the populations we serve?

NHS Confederation NHSProviders

Community NETWORK

Community health services

Community health services play a key role in our health and care system. They keep people well at home and in community settings close to home, and support people to live independently.

What are community health services?

100 million patient contacts a year

one fifth of NHS workforce

£10 billion spend of the NHS budget

Services include:

Specialist long-term condition
e.g. nursing for diabetes and cancer

Adult community services
e.g. district nursing and end of life care

Planned community services
e.g. podiatry, physiotherapy

Hospital services
e.g. bedded facilities to support treatment, recovery and rehabilitation

Health and wellbeing services
e.g. sexual health, smoking cessation

Children's 0-19 services
e.g. health visitors, school nursing

Services are delivered in different settings, such as:

Homes | Community hospitals | Community health centres/ clinics | Schools

Through different models of provision:

Working with with key partners in primary care, social care and public health.

50%
community interest companies, local authorities, social enterprises, private providers, GP practices, primary care networks, pharmacies

50%
NHS trusts and foundation trusts

Our community offer

- Delivered across our four Clinical Groups
- Covers the whole life journey
- Estimated 900,000 contacts per year
- Wide geography

- Opportunities provided by vertical integration of services
- Close partnership working with colleagues in primary, secondary, community care, including adult social care and voluntary sector

Examples of our adult community services

@home
Amputee Rehabilitation Unit
Community Head and Neck Team (CHANT)
Community Rehabilitation and Falls Service (CRAFs)
Community Stroke and Neurorehabilitation Service
Continence Advisory Service
Diabetes
Heart Failure Service
Homeless and High Intensity User Service
Intermediate Care for Lambeth and Southwark
Integrated Respiratory Team
Learning Disabilities Service
Neighbourhood Nursing
Outpatient Antimicrobial Therapy team
Palliative and End of Life Care
Pharmacy Services
Podiatry
Pulross - Rehabilitation Ward at Pulross Centre
Refugees and Asylum Seekers Services
Tissue Viability Nurses Service
Tobacco Dependence Treatment Service
Tuberculosis CNS Service
Weight management services

Site Administration Services

How can we work together to improve the health of the populations we serve?

Some of our strategic areas of focus

- Value based integrated care
- Neighbourhood based models of care
- Hospital @ Home (virtual ward) expansion
- Digitally enhanced care at home
- MyChart
- Population Health including Vital 5

Definition of Neighbourhood Working

What we mean by neighbourhood working

Developing INTs will be part of how we deliver care at a neighbourhood level more broadly. INTs go beyond multi-disciplinary working by fully integrating representatives from health, social care, and the voluntary sector into a single, place-based team to deliver seamless, coordinated care within a defined area. INTs will not replace existing, effective multi-disciplinary teams.

Neighbourhoods

A specific geographical area or community that resonates with residents, that local services, organisations and communities can coalesce around to address needs and improve outcomes. This is broader than INTs and includes ongoing partnerships with community groups, residents, and local stakeholders to address a wide range of community issues, including community development and systemic improvements.

Multi-disciplinary working

Representatives from different disciplines coming together to share expertise, coordinate care, and contribute their specific skills to address the needs of an individual or group. Collaboration tends to occur at key points, such as meetings, reviews, or case discussions and individuals typically maintain separate roles, responsibilities and different back-office functions.

Integrated Neighbourhood Teams

Representatives from different disciplines (e.g., health, social care, voluntary sector) working as a single team to deliver coordinated and person-centered care to individuals within a defined neighbourhood or locality. They will manage and deliver integrated clinical and operational services, provide continuity of care and work together to shared outcomes. There is an emphasis on continuous collaboration around prevention and pro-active care to improve outcomes, reduce duplication and address complex needs more efficiently. They will reach in and out of the other tiers for specialist input and care planning.

(see p.5 for further detail)

Key Areas of Neighbourhood Working

INT initial areas of focus

South East London Integrated Care System

- **As part of SEL's 'test and learn' approach, there will need to be a level of consistency across INTs** in terms of what they focus on to be able to compare success measures and demonstrate the impact of this new way of working, ensure the work aligns with SEL's strategic priorities and enable shared learning across Places about what is working and not working to facilitate continuous improvement.
- **SEL has initially identified three population groups for INTs to focus on** where the opportunity for improvement is greatest, including addressing health inequalities and improving health and care outcomes for our population. This will also enable a genuine and sustainable shift in investment across the system.

1. **3+ Long-Term Conditions**
   There are currently pilots in each place, and there is a current cost of £18m, £16 Non-Elective (NEL) admissions per year, £3-6m outpatient opportunities for diabetes alone.

2. **Frailty and those approaching end of life**
   There are examples of best practice already and a current cost of £244m* per year on NEL admissions. This also aligns with how many Places are prioritising Ageing well as a strategic goal over the next six years. This might mean pivoting virtual wards and other admission avoidance initiatives into maximising independence outside of the hospital.

3. **Children and Complex Needs**
   There is an existing model which has demonstrated reductions in GP and outpatient appointments, Accident and Emergency (A&E) attendances and NEL admissions.

- Initial INT rollouts and pilots within each Place will focus on these areas. However, there is an expectation that as INTs develop, they may identify additional specific priorities based on their local population needs.

22

Value-based Integrated Care (VBIC)

"**Value-based integrated care is the equitable, sustainable and transparent use of the available resources across primary, secondary, and community care, to achieve better outcomes and experiences for every person**"

Ad. Oxford University (2019)

OUR AMBITION

Our ambition is to design and implement an operating model for value-based integrated care, across GSTT and participating primary care partners in Lambeth and Southwark. This model will allow for greater flexibility to deliver the right care, at the right time, to improve patient outcomes and experience in South East London. Fundamental to this model are the three shifts:

- → **From hospital to community**
- → **From treatment to prevention**
- → **From analogue to digital**

Hospital @home (Virtual Wards) Context and Overview

Hospital @home (H@H) refers to an acute clinical service with staff, equipment, technologies, medication and skills usually provided in hospitals being delivered to selected people in their place of residence, including care homes.

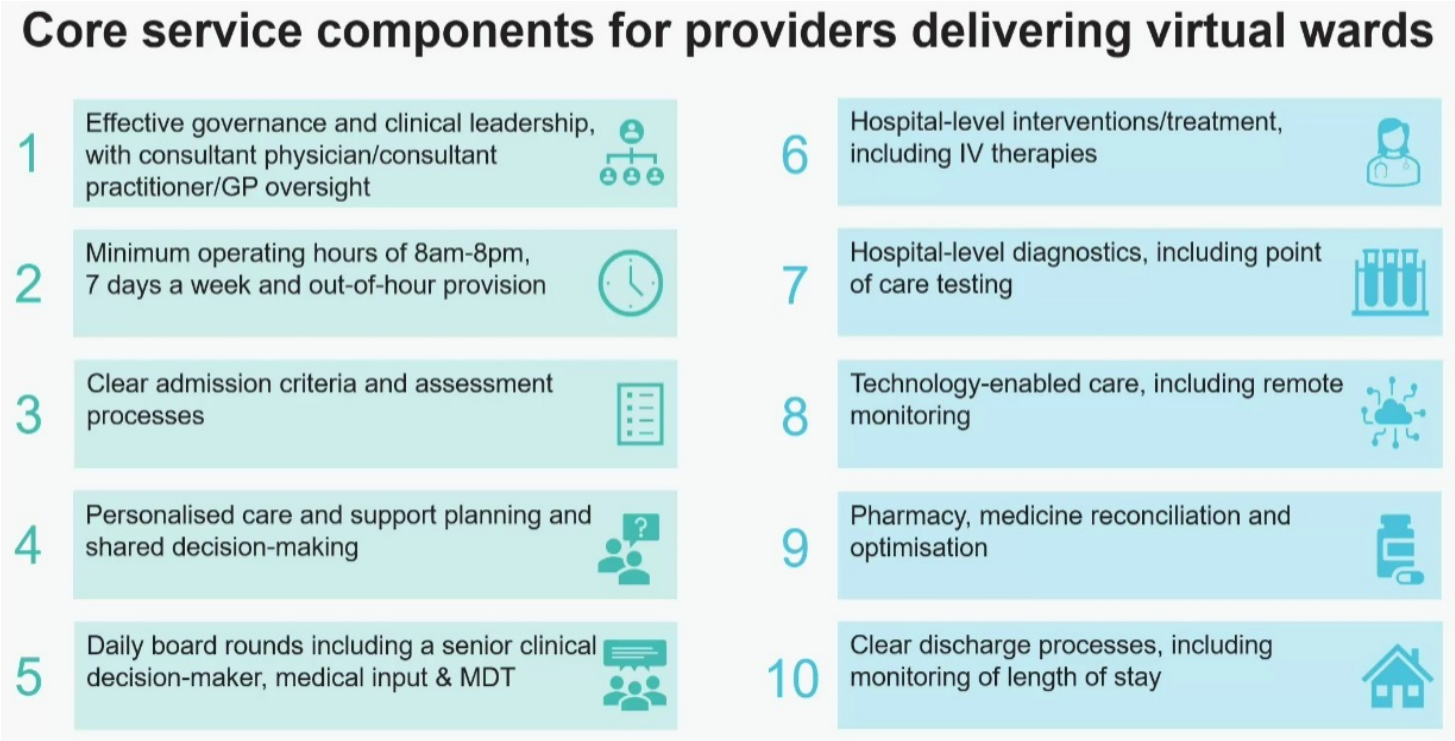
Terminology transitioning away from ‘virtual wards’

Potential to support two key areas of the system: Reducing attendances and admissions to hospital (step up) and to support reduction in length of stay in hospital (step down)

Aim for the acute episode of care to be completed in the home setting

What is Hospital @ home?

Hospital @home allows patients of all ages to safely and conveniently receive acute care at their usual place of residence, including care homes.



NHS England » Virtual Wards Operational Framework

Access to care at the right place at the right time by the right people.

Involves provision of episodic support to care for patients in their own home during an acute and crisis phase of illness and delivers an alternative to NHS ED attendance and hospital admission where appropriate

REFERRAL SOURCE

ACUTE

- Ward
- A&E
- SDEC / UEC

Early discharge

Admission avoidance

COMMUNITY

- Community Provider
- UCR
- Primary Care
- LAS (999/111)

Admission avoidance

Diagnostics

Southwark and Lambeth Hospital @home

Remote monitoring 30 BEDS

@home
82 BEDS
UPA referral: 020 3049 5751 (8am and 8pm)
EPR: For **medical** referrals from GSTT or KCH

Evelina @home
18 BEDS
8am-10pm, 7 days per week

Integrated Respiratory Team (IRT)
30 BEDS
Internal telephone referral
GSTT: 02071888636
KCH: TBC

Kings Outreach Therapy Service
10 BEDS
Internal Referral step down KCH only: WIFI phone 38530

Palliative and End of Life Care
20 BEDS
GSTT referrals: 020 7188 4754
ST CHRISTOPHER'S referrals: TBC

Pal@home Overnight
20 BEDS
Pan-London Palliative care referral form
GSTT Urgent referrals: 020 7188 4754
Out of hours: oncall palliative care CNS/ Pal@Home team

Outpatient parenteral antimicrobial Therapy (OPAT)
45 BEDS
EPIC referral and Clinical discussion with Infection consultant/SpR/OPAT CNS :
GSTT: 07871 106899 **KCH:** 020 3299 8593/7021

Point of care testing

Pharmacy

ONWARDS REFFERAL

Escalation and requires increase acute care

- SDEC / UEC
- A&E
- Ward

Ongoing therapeutic & social support

- VCS
- ICL/ICS
- Dietetics
- SLT
- Social
- Specialist rehab

P0 Home
P1 Home with help
P2 Short term beds
P3 Long term beds

Primary care

Further medical optimisation

- Mental Health Services
- Palliative/EoL
- Neighbourhood nursing
- Chronic conditions
- Outpatient services

Hospital @home Programme In Numbers

Lambeth and Southwark Virtual Wards 9 month snapshot January to September 2024 data at a glance:

H@H Next Steps & opportunities

Expanding to new services

We are working with partners across Lambeth and Southwark to explore new models of care

Remote Monitoring/Care

Technology enablement with remote monitoring is a mandatory element of the hospital at home/virtual wards. To meet the NHSE definition/criteria, the expectation in SEL is that all-inclusive activity must not separate technology enablement from remote monitoring as an eligible offer.

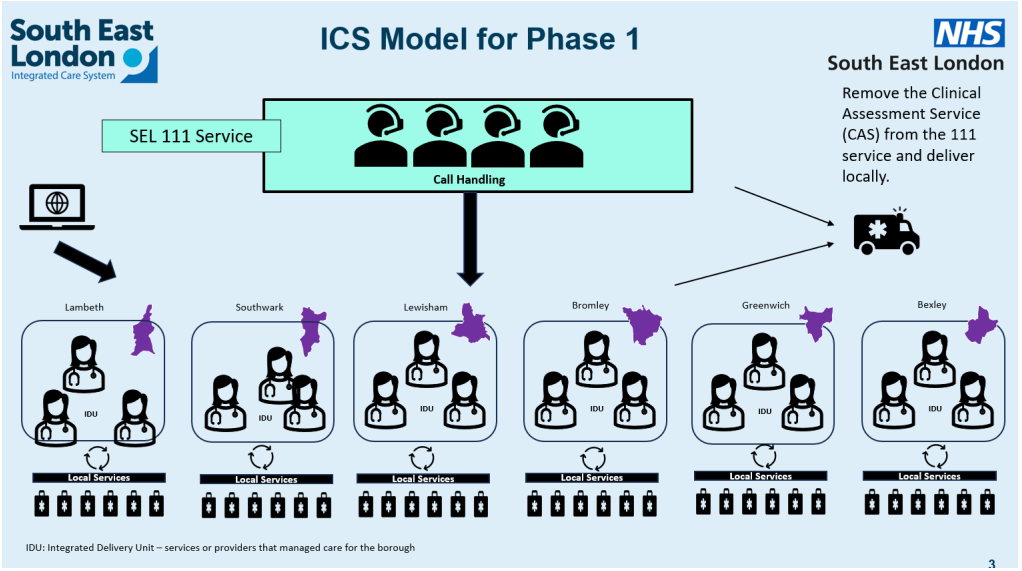
Epic build changes ongoing

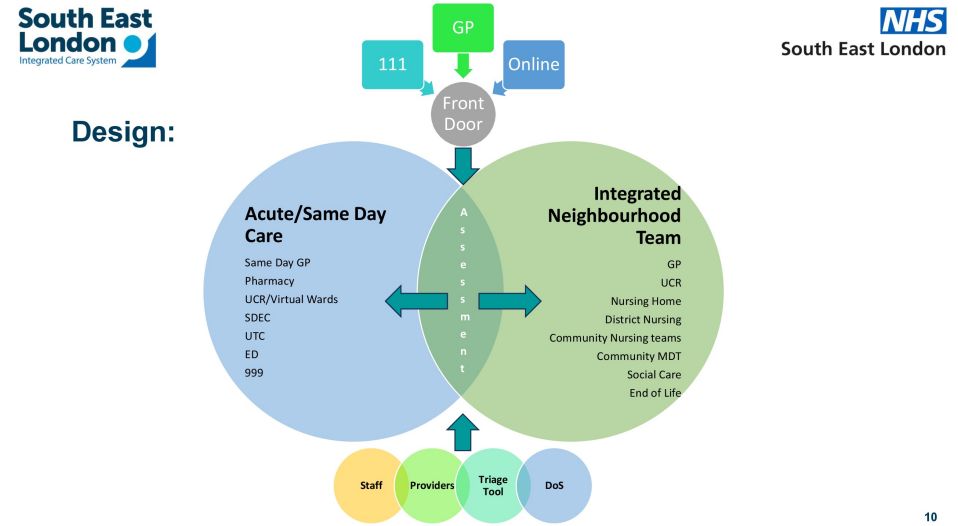
To increase productivity and improve access to data

Governance and leadership considerations

To ensure oversight of work across multiple partners and support transition to BAU

Align H@H with emerging 111/Integrated Delivery Unit / SPoA models





Thank you

Guy's and St Thomas' NHS Foundation Trust

COUNCIL OF GOVERNORS

WEDNESDAY 30 APRIL 2025

Report title:	**Lead Governor's Report**
Paper author:	**Katherine Etherington, Lead Governor**
Purpose of paper:	For awareness/noting only
Main strategic priority:	All strategic priorities
Primary BAF risk:	Risk 13: inability to attain organisational excellence could impair ability to deliver strategy
Key points of paper:	A report from the Lead Governor to acknowledge what the Governors have achieved over the last three months and to outline plans for the next three months.
Paper previously presented at:	N/a
Recommendation(s):	The COUNCIL OF GOVERNORS is asked to: 1. **Note** the Lead Governor's Report

1. Overview

1.1 After a few turbulent weeks for the NHS nationally and for Guy's and St Thomas' more locally, I think it is important to reflect on the role and responsibilities of the Council of Governors. In our duty to seek assurance that the Trust Board of Directors is meeting the needs of patients and staff, I think we should all keep in mind the pressures the whole NHS is under. This reminds us of the scale and importance of the Guy's and St Thomas' name and brand. In the changing landscape, we must support the Board to ensure that what comes next is fit for purpose and serves the needs of those around us, and also how we can thrive through this adversity and set an example for other trusts.

1.2 I would like to thank all governors for their role in the recruitment of Amanda Pritchard, accommodating an earlier meeting to ratify the decision of the non-executive directors and for their understanding surrounding the sensitivity of the process. This was a key appointment for the future of our Trust. I would also like to thank Alison Mould and Leah Mansfield in representing the Council of Governors in the meeting in which the non-executive directors made the decision to appoint Amanda. I am sure all governors will warmly welcome Amanda back to the Trust.

1.3 Since we last met, we also learnt that Lawrence Tallon would be leaving the Trust to become Chief Executive of the Medicines and Healthcare Products Regulatory Agency (MHRA). This is a fantastic addition to their team, but a huge loss for Guy's and St Thomas'. I know all governors will wish Lawrence well in his new role and we look forward to working with Steven Davies in his new appointment as interim Deputy Chief Executive Officer.

1.4 A key job this spring is the matter of governor elections with voting opening on Tuesday 22 April and closing on Monday 19 May 2025. I am looking forward to seeing who this new round of elections brings us and wish the best of luck to all of those who are standing for re-election - including myself!

1.5 I would like to encourage all governors to participate in Trust site visits now these are up and running, with dates and venues available through the monthly communications newsletter. Thank you to all those who have attended these visits and provided feedback, some of which was shared with the Board at the recent Quality and Performance Board Committee meeting. Please contact Corporate Affairs and book yourself into one of the planned visits in the upcoming months.

1.6 I would also like to reiterate the importance of governor feedback and challenge. We had an excellent Triangulation meeting in April which allowed us to meet Professor Graham Lord and Alison Wilcox in a more informal setting and understand what they are excited for in their relatively new roles. This meeting also demonstrated how the Council of Governors can seek assurance for specific items we

personally believe are important and understand how we can support the Trust to instigate changes. Thank you for all of your questions and your continued engagement. I also encourage anyone who would like to raise concerns or queries with me via email to be shared anonymously at these meetings. Finally, while healthy challenges are very much encouraged, I think it is important for us to remember what we can and cannot do as a Council. Please consider your questions and the forum in which they are presented, if in any doubt please speak to myself, Alison or Corporate Affairs.

1.7 Finally, I would like to encourage colleagues to consider being a governor observer on the People, Culture and Education Board Committee and Cancer and Surgery Clinical Group Board, and to be an active member on the following groups:

- Vulnerable Personas Assurance Committee
- Nursing & Midwifery Research Council
- Nutrition Committee
- Trust Learning and Disability Committee

1.8 Sitting on these groups gives a unique insight to particular areas of the Trust and is a good opportunity to learn more about our staff, patients and trust overall. If you would like to learn more or put yourself forward, please contact Corporate Affairs.

1.9 Thank you for everyone's continued commitment to the Council of Governors and to the Trust more broadly. I look forward to continuing to work with you all in the new financial year.

Guy's and St Thomas' NHS Foundation Trust

COUNCIL OF GOVERNORS
MEMBERSHIP DEVELOPMENT WORKING GROUP

Wednesday 5 February 2025
5.30pm – 7.00pm, MS Teams

Governors in attendance:	Claire Wills, Chair	Leah Mansfield
	Alison Mould	Nigel Beckett
	Charles Mead	Peter Harrison
	Daghni Rajasingam	Victoria Borwick
	Felicity Conway	
Trust staff in attendance:	Edward Bradshaw	Elena Spiteri

1. Welcome and opening comments

1.1. The Chair welcomed colleagues to the meeting of the Membership Development Working Group (the Group) and reminded governors about the purpose of the Group. A visual was shared that aimed to depict how foundation trust members were currently informed and involved, and how governors were informed and involved.

1.2. Governors expressed their appreciation for the documents and insights shared, acknowledging the crucial role of visuals in effectively communicating information. They recommended involving the Communications Team to create professional visual materials that highlight membership benefits, promote the role of governors, and explain how to engage with governors. Additionally, these materials could showcase the valuable skills members can acquire by taking on the role of a governor. The importance of differentiating between staff members and public/patient members in the slides was emphasised, in order to highlight the benefits of being a staff member.

ACTION: The Chair of the MDWG and the Membership Office to work with Communications team to develop visual materials that emphasised the benefits of being a governor (with a separate visual for staff governors).

2. Minutes of previous meeting

2.1 The minutes of the meeting held on 5th November 2024 were agreed as an accurate record.

3. Review of action log

3.1 The Group noted the updates that had been made to the action log.

4. Update from patient/public sub-group regarding membership engagement

4.1. An update was received about the work that had been undertaken in the patient and public sub-group, where three key objectives had been identified, which broadly aligned with the objectives of the working group more widely:

1. To increase governor engagement
2. To increase member recruitment
3. To pursue 'quick wins' to quickly enhance governor engagement and member recruitment

4.2. The following initiatives had been identified to achieve these objectives:

- Increase the frequency of governor stalls at hospital sites, and to include Royal Brompton and Harefield hospitals in this schedule;
- Hold stalls at town halls and local colleges/universities;

- Host an annual 'Ask the Governor' session for foundation trust members;
- Provide governors with membership cards and encouraging them to take them on site tours and to their local networks;
- Placing membership cards in GP practices and with the Trust voluntary services and PALS team;
- Encouraging governors to join GP practices Patient Participation Groups (PPGs);
- Undertake a membership survey to obtain feedback from members about their motivations for joining the Trust and how they want to be involved; and
- Provide governors with more performance information to help them act as advocates for GSTT.

4.3. The Trust Secretary explained that, in common with membership offices in foundation trusts nationally, the Trust's membership office was small and that with limited capacity it would be important to focus on initiatives that would have the biggest impact.

ACTIONS: Membership office to identify which of the initiatives above could be taken forward, and report back at the next meeting on progress.

4.4. There was discussion about how more governors could be encouraged to undertake more site visits and speak to patients and visitors during these – both to promote membership but also to hear about the feedback in order to represent this to the Board of Directors. It was agreed that time at each governor triangulation meeting should be ringfenced to hear feedback from site visits, as a key way of 'triangulating' the other information received by governors. It was also suggested that governor feedback should be communicated at the Quality and Performance (Q&P) Board Committee meeting.

ACTION: Trust Secretary to speak to the Chair of the Q&P Committee to explore opportunities to provide governor feedback as part of the meeting.

5. Update from staff sub-group regarding membership engagement

5.1. Whilst an equivalent sub-group for staff governors had not yet been established, steps would be taken to promote awareness of membership through clinical groups and corporate services.

ACTION: Claire Wills, Staff Governor to coordinate a staff governors sub-group and report progress to the next working group meeting.

5.2. The key issue discussed was to ensure that staff knew that they were members, and the implications of membership.

ACTION: Membership office to develop communications to help Trust staff understand their role as a foundation trust member and how they can opt out if they wished.

6. Patient and Public Engagement (PPE) – reflections on new strategy

6.1. Working group members reflected on the new PPE strategy that had been presented at the recent public Board meeting. Whilst some disappointment was expressed that no representative from the Trust's PPE team was in attendance, it was noted that the PPE team was prominent in the Quality Engagement Working Group (QEWG), which provided comprehensive insights, data, and opportunities for in-depth exploration of specific activities related to patient experience and engagement.

6.2. It was noted that a key tenet of the PPE strategy was to "Build stronger relationships with our Foundation Trust members" and that the team would work with governors to implement the Trust Membership Plan and actively promote opportunities for involvement to our members. In discussion it was clarified that, whilst there is a degree of overlap between the PPE team and the membership office, both have distinct roles and responsibilities. For example, the PPE team focuses on gathering patient voices from specific cohorts based on illnesses or treatments, which may not involve the Trust members. However, the PPE team is open to supporting membership development efforts, with considerations on the "how, what, and when" of implementation.

6.3. It was noted that members, having already shown interest, should be prioritised for engagement before expanding outreach to non-members. The importance of collaboration between teams to test and refine this approach was highlighted.

6.4. Trust members were agreed to be a 'captive audience' for general involvement activities run by the PPE team and the patient experience team, and work should be done to explore whether more of these activities could be directed to members.

ACTION: Membership office to contact Head of Patient Experience and Head of Patient and Public Engagement to understand how more of those activities could be directed to Trust members.

The next meeting would be held on Tuesday 20 May 2025.

Guy's and St Thomas' NHS Foundation Trust

GUY'S AND ST THOMAS' NHS FOUNDATION TRUST
STRATEGY, TRANSFORMATION & PARTNERSHIPS WORKING GROUP
TUESDAY 11 FEBRUARY 2025

Title:	**Strategy, Transformation and Partnership Working Group (STPWG)**
Responsible executive:	**Leah Mansfield, Patient Governor**
Paper author:	**Jed Nightingale, Strategy Business Support Manager**
Purpose of paper:	For information
Main strategic priority:	All
Key issues summary:	A report on the Working Group's discussion on the following: • The science behind the new CFTR modulators, the rollout and benefits of 'Kaftrio' therapies and information surrounding the trials held at the Royal Brompton Cystic Fibrosis Centre. • The 2025-2030 Heart, Lung and Critical Care Strategy.
Paper previously presented at:	None
Recommendation(s):	The COUNCIL OF GOVERNORS is asked to: Note the key discussion points at the Strategy, Transformation and Partnership Working Group (STPWG)

Guy's and St Thomas' NHS Foundation Trust

GUY'S AND ST THOMAS' NHS FOUNDATION TRUST
STRATEGY, TRANSFORMATION & PARTNERSHIPS WORKING GROUP
TUESDAY 11 FEBRUARY 2025

Governors in attendance: Leah Mansfield (Chair), Victoria Borwick, Alison Mould, Felicity Conway, Daghni Rajasingam (part)

Trust staff in attendance: Jed Nightingale, Jennifer Morris, Piers McCleery, Andrew Jones, Lawrence Tallon

Apologies: Elena Spiteri, Peter Harrison, Stephanie Petit, Felicity Harvey, Emma Barslund Blackman, Claire Wills

1. Welcome, introduction and apologies

1.1. The Chair welcomed everyone to the Strategy, Transformation and Partnership Working Group, including new Governors. Apologies were noted.

2. Declaration of Interest

2.1. There were no declarations of interest.

3. Previous meeting report and matters arising

3.1. A query was raised about re-introducing an 'Observer' role for this meeting i.e. if a governor or presenter is unable to attend, somebody else is available to potentially step in and follow the notes so that there is continuity across meetings.

3.2. The minutes of the previous meeting of the Group were approved as true of record.

3.3. Action point on paragraph 7.1 has been completed, these reports has been delivered.

3.4. Action point on paragraph 7.2 has been completed, a report has been provided by Felicity Conway.

3.5. Action point on paragraph 7.3 has been completed and reported by Daghni Rajasingam within the recent Council of Governors meeting.

4. Cystic Fibrosis Care in the CFTR (cystic fibrosis transmembrane conductance regulator)-modulator era

4.1. Dr Andrew Jones, Centre Director for the Department of Cystic Fibrosis (CF) at the Royal Brompton, presented an explanation of the condition of cystic fibrosis and the new therapies that have been introduced in CF in recent years.

4.2. CF is a recessive genetic condition, that requires two CF genes one from each parent to be inherited There are a lot of different CF mutations that affect approximately 10,000 people across the UK. The CF gene codes for a protein called the 'Cystic Fibrosis Transmembrane Conductance Regulator' (CFTR). Mutations in the CFTR gene are the cause of the cystic fibrosis disease. Normally, the CFTR protein sits at the cell surface to maintain normal salt and water levels in cell surfaces in the lung and gut.

4.3. CF is a multi-system disorder. It can cause issues in different areas of the body as follows:

- In lungs it causes increased mucus in the airways which can lead to increased infections if not treated.
- In the skin it can be recognised by patients having excessively salty skin.
- In the liver it can cause biliary cirrhosis, 'fatty liver', gallstones or hepatic steatosis.
- Cystic fibrosis-related diabetes can occur within the pancreas. About 1/3 of people with CF will have this diabetes, which is not categorised as type 1 or 2 but is an entity unto itself.
- In the bowels it can cause distal intestinal obstruction syndrome.
- In men, the vast majority are infertile due to the absence of vas deferens.
- Within the joints, it can cause arthritis to a certain degree or even osteoporosis.

4.4. There are six classes of mutations of CF, three of these are detailed as follows:

- Class one: The DNA has a premature stop mutation whereby the gene code tells all systems to stop reading the DNA. No functional CFTR protein is created as a result so there is nothing for modulators to work on with this type of mutation
- Class two: This is the most common. Protein is made but it is not the right shape. This is a trafficking defect and very little or no protein makes its way to the surface as a result

- Class three: CF protein does make its way to the surface but it won't 'switch on', therefore water cannot get through the salt channel. This is a defective channel regulation issue.
- Classes four to six mutations do have protein present that works but not effectively. This can either cause CF in itself or CFTR-related disorders that are more minor than CF.

4.5. The first drug to treat CF was developed in 2008 – Initial trials showed that people were benefitting quickly. The drug became available in 2012, having great benefits for people, but was only suitable for about 4 or 5% of the affected population.

4.6. Approximately 91% of the UK's CF population carry at least one F508del mutation. The goal, therefore, was to look to finding a solution for F508del correction. It was never likely one drug would fix everything due to the array of mutations. Therefore, a company called Vertex developed 'combination modulators' to try to tackle this. The first tolerated drug available for people with the 508 gene improved lung function by 3-4%. This did keep people stable, also decreasing infection rates by a third on average. Prior to these modulators being available, people would take antibiotics intravenously or via tablets a few times a year. Despite improvements, due to the nature of CF, this modulator only worked on approximately 50% of the population.

4.7. Vertex developed next generation modulators named 'Kaftrio'. One study GSTT were involved in was having a huge difference. Lung function in patients within two weeks of starting on the drug rose by 13-14%. This study carried on for a further year where infection rates were seen to reduce by two thirds, making Kaftrio twice as effective as the earlier drug, SymKevi. Kaftrio had a strong effect on the protein, being beneficial to approximately 90% of the population.

4.8. Some benefits of Kaftrio are as follows:

- A significant reduction in the number of infections seen in patients
- A significant reduction in the number of deaths (nobody has died in clinic from CF since 2022)
- The vast majority of people waiting for transplants have been taken off the list as they no longer require one
- Median life expectancy for people with CF is about 64 years
- Interestingly, the Kaftrio drug has tripled pregnancy rates in female patients with CF. A maternal health clinic has therefore been set up separately to account for this
- Everything related to CF contributes data to the national registry

4.9. Some negative effects of Kaftrio are as follows:

- 10% of the population are currently not eligible for modulator therapy
- Inpatients are mostly made up of people not on modulators
- Side effects of the drug mean some people are unable to stay on this drug. This includes effects on mental health, for example
- Nationally, this is an expensive medicine
- There is a perspective in the wider medical profession that CF is 'sorted' and there is not a huge future in it. This is untrue

4.10. Vertex are developing their own technology similar to Covid vaccinations. GSTT have been involved in these studies and recruited some patients. This can only involve patients not eligible for modulators and is ongoing with the hope there will be a treatment available that works for these patients. There are also new modulators being developed which have once a day administration rather than twice a day.

4.11. The following points were discussed:

- The treatment is expensive Kaftrio dominate the market
- There are fewer inpatients nowadays due to the positive developments within CF. Despite this, patients are still regularly seen – especially those with CF diabetes, for example
- There are a number of limiting factors as to what can be achieved in CF with patients who suffer from other conditions related to their cystic fibrosis diagnosis. Examples include those at slightly higher risk of cardiovascular disease, those with high cholesterol or those who suffer from certain cancers
- Investigating the effect of the Kaftrio drug on pregnancy rates is time-consuming but will present valuable data around the use of modulators throughout pregnancy
- A lot of people with CF will now be having near-normal life expectancy so the role within the field of CF for doctors is changing
- Nebulisers are effective for the respiratory issues that CF causes. At present, there are no plans for nebulisers to be available for anything other than respiratory-related CF as, if given systemically, the drug doesn't get to the most damaged part of the lung. However, if inhaled, it is much more likely to do so
- One challenge is treatment adherence as there is a long-standing issue in CF on how to encourage people to carry on taking their medication
- The MRNA technology available from the Covid vaccination development process has accelerated technology advances in CF significantly

- Certain antibiotics are taken via a dry powder inhaler. Staff in the Brompton are strong believers in the efficacy of these but some people dislike them as they can make people cough. Physios and patients are being taught how to inhale these properly to counter this, though

5. Heart, Lung and Critical Care (HLCC) Clinical Group Strategy

5.1. Piers McCleery, Director of Strategy for HLCC, presented on the HLCC strategy development.

5.2. The strategy has 2 main areas of focus; the aspiration to be UK, European and global leaders and a need to add value for all patients. The merger between Royal Brompton and Harefield (RBHH) and GSTT has established a benefit of scale and, subsequently, has helped build up the reputation of the organisation as a provider of excellent care within some very precise treatment areas, specifically within heart, lung and critical care. This underpins both the vision and the mission of the strategy, highlighting the ways in which we can become a global leader in these specialist areas of care.

5.3. There are three core capabilities within the strategy:

- Integrated specialties: bringing the best of RBHH together with the best of GSTT in cardiovascular, respiratory and critical care. When you integrate those, you create the scale that drives the depth and breadth of knowledge across all our subspecialties within all of our sites
- A commitment to continuous improvement contributing to research, quality improvement and ways to constantly transform and improve our services
- A systematic approach to attracting, training, motivating and retaining talent (staff) and then encouraging those staff to contribute back by sharing their knowledge

5.4. In order to deliver the three core capabilities, there are seven supporting capabilities:

- Service improvement models
- Population health – system leadership
- Data aggregation and analytics
- Research
- Service delivery archetypes
- Optimised patient flow

- Knowledge management

5.5. There are also two 'resourcing' capabilities:

- Diversifying where we get our income and funding from
- How we partner with industry

5.6. These capabilities are broken down into further detail around what their purposes are, how they are going to be built on and how they will then be put into action. Engagement has been undertaken with approximately 60 to 100 of the most senior clinicians across the clinical group to determine if this is the right content and whether this is the right way of framing it.

5.7. Next steps, include production of a user-friendly version of this content and an implementation plan.

5.8. The following points were discussed by attendees in the Q&A:

- A question was raised as to whether this approach had been shared across the other clinical groups. It was noted that the critique of the other strategy teams is helpful and that this particular strategic approach that Piers has outlined works well for HLCC because it is about specialist services and tertiary services whereas some of the other clinical groups have a mixture of specialist and community services. Therefore, this USP may not work as well across ISM, for example, but it has some synergy with cancer and surgery
- One strength of the clinical group model is that, because GSTT is so big and services within the groups are so diverse, the clinical groups can have a slightly different flavour of strategy within the overarching Trust strategy. There is a slightly different archetype for each group as a result, especially for ISM. ISM focuses more on localised care whereas HLCC and cancer and surgery are more about specialised care. Evelina straddles both – local care for children and also a number of specialised areas
- As an organisation, we want to grow the health service whilst still being able to invest and attract the best kind of talent, industry and research funding. We also need to continue to invest in areas of specialisation, striving to be somewhere that the industry wants to fund and that attracts the most ambitious talent
- The wealth of data we now have at our fingertips from Epic has huge potential. We have teams who are improving ways of dealing with unstructured data. Neurolinguistic programming, for example, is used that has the ability to take this unstructured data and turn it into structured at scale and at speed. There is also a role for data science companies to help us on this journey to apply clever machine learning to this data to drive greater clinical insight

- In the future, we are looking to have a single clinical leader across all sites to harmonise practices and protocols, reduce costs and ensure quality. There should be no difference in the way a case is assessed across different sites, for instance, and there is a drive to ensure this consistency across all the directorates. In theory, regardless of what kind of patient you are, you would be able to have your surgery at any one of the sites where these specialised services are offered depending on your locality rather than having to travel to a specific site. It will enable greater flexibility in the future

6. Updates for committees attended by Governors

6.1. Reports from other committees are taken as read, due to these being received recently, and are available on AdminControl to read in further detail.

6.2. Felicity Conway will send through a new report on the Quality and Performance Board and is currently liaising over the final details of this. Felicity also visited the Refugees and Asylum Seekers service in North Dulwich and will be writing up a report about this. Next week, Felicity is visiting the Adult and Disabilities Continuing Care site and a report on this is to come.

6.3. Leah noted that a form should have been received from Elena to structure these reports.

7. Any other business

7.1. There were no items of AOB.

The next Strategy, Transformation and Partnership Working Group meeting will be held on Tuesday 13th May at 5:30pm-7pm.

GUY'S AND ST THOMAS' NHS FOUNDATION TRUST
QUALITY AND ENGAGEMENT WORKING GROUP
TUESDAY 25 MARCH 2025

Title:	**Council of Governors Quality and Engagement Working Group Meeting Notes, 25 March 2025**
Governor Lead:	**Leah Mansfield, Working Group Lead**
Contact:	**Andrea Carney & Sarah Allen, Working Group Secretariat**

Purpose:	For information
Strategic priority reference:	TO TREAT AS MANY PATIENTS AS WE CAN, SAFELY
Key Issues Summary:	A report on the Working Group's discussion of the following: **1.** Quality & Safety updates: update on quality priorities for 2024/25 and developing 2025-26 Quality Account priorities **2.** Quarterly reports on Patient Experience and Patient and Public Engagement For Information only: • Reports / updates from committees recently attended by Governors (brief verbal updates, as necessary)
Recommendations:	The GROUP is asked to: **1.** Note the key discussion points at the Quality and Engagement Working Group meeting on 25 March.

GUY'S AND ST THOMAS' NHS FOUNDATION TRUST
QUALITY AND ENGAGEMENT WORKING GROUP

TUESDAY 25 MARCH 2025~~TUESDAY 25 MARCH 2025~~

QUALITY AND ENGAGEMENT WORKING GROUP MEETING NOTES

PRESENTED FOR INFORMATION

1. Introduction

1.1. This paper provides notes from the Council of Governors Quality and Engagement Working Group (QEWG) meeting held online on Tuesday 25 March 2025.

This meeting was attended by: Prof. Koku Adomdza (Public Governor), Sarah Allen (Head of Patient Experience), Nigel Beckett (Staff Governor), Andrea Carney (Head of Patient and Public Engagement), Felicity Conway, (Staff Governor), Oliver Cook (Trust Senior Quality & Compliance Lead), Anna Grinbergs-Saull (Senior Patient and Public Engagement Manager), Leah Mansfield (QEWG Chair), Charles Mead (Patient Governor), Paula Nunez Fernandez (Quality and Assurance Manager), Daghni Rajasingam (Staff Governor), Elena Spiteri (Membership and Governance Co-ordinator), Mark Tsagli (Patient Experience Specialist), Claire Wills (Staff Governor).

1.2. Apologies were received from: Alison Mould, Brian Boag, Jadwiga Wedzicha, Roseline Nwaoba.

1.3. Leah Mansfield, Chair of the Quality and Engagement Working Group, welcomed attendees and opened the meeting.

2. Agenda Item 2: Notes from the last meeting and matters arising

2.1. The notes were approved as an accurate record of the last meeting held on 3 December 2025.

2.2. Matters arising – actions update and questions raised by Governors after the last meeting:

- Questions on the Patient and Public Engagement Strategy to be covered in the agenda for this meeting.

3. Agenda item 3: Quality & Safety updates: update on quality priorities for 2024/25 and developing 2025-26 Quality Account priorities

3.1. The Trust Quality and Assurance Manager presented an overview of the 4 published Quality Priorities for the 2024/25 financial year and the proposed priorities for 2025/26 financial year. Governors noted the following updates on the progress of the 2024/25 quality priorities:

- Surgical Safety:
  - The establishment of the Trust Surgical Safety Group to review safety checklists and share best practices across the Trust. An away day was held in December 2024 to agree on the process and improvements required.
  - Simulation sessions planned with surgical and interventional teams to test the checklist process.
  - The policy and template for Local Safety Standards for Invasive Procedures (LocSSIPs) is being developed and expected to be approved by Trust Surgical Safety Group (TSSG) and Trust & Assurance Committee (TRAC).
- Martha's rule implementation progress to date (Core elements 1, 2 and 3):
  - Element 1: The Trust has met the requirement that all staff must have 24/7 access to a rapid review from a critical care outreach team if concerned about a patient's condition.
  - Element 2: This requirement that all patients, families and their carers have access to the same rapid review from the critical outreach team has also been met for adult patients through

the introduction of the well-established 'Call if Concerned' project. A similar initiative has also been launched for Evelina and Maternity services.

- Element 3: Requirement for a structured approach to obtaining information relating to patients' condition directly, at least dailyis yet to be met. Governors noted that this is due to the challenges of consistently documenting this approach across the Trust. A quality improvement project has been set up to identify the most appropriate method to implement this.

- Diagnostic Results:
  - Embedding processes to ensure diagnostic results are reported, reviewed and responded to in Epic. Assurance checks have shown the majority of radiology results have been actioned; the focus is to continue auditing specialities with high volumes of acknowledged in-basket results.
  - The team have also widely circulated tip sheets to guide and support staff to access a speciality dashboard and monitor compliance. There are plans underway to develop a Trust-wide dashboard using data in Epic to support improvement plans.
- Contacting the Trust:
  - A Charity bid has been approved for work to commence in quarter 2 among two specialist areas focussing on:
    - a) using a wide variety of digital communications to support and improve how patients contact the Trust and
    - b) self-managing care using MyChart through utilising self-scheduling tools.

3.2. Proposed Quality priorities for 2025/2026:

- The Trust Quality and Assurance Manager then presented the proposed 2025/26 Quality priorities. It was noted that these have been shared at the Trust Risk and Assurance Committee (TRAC) for feedback. It is also expected that the priorities will be presented at the Quality and Performance Committee (QPC) in April.

- Governors noted the following:
  - Patient Safety – there will be increased oversight of key operational safety metrics to ensure compliance with metrics relating to administrative safety. There will also be a focus on

providing support for positive behaviour to reduce instances of violence and aggression towards staff.

- Clinical Effectiveness –
  - Implement a structured approach to obtaining information relating to the patient's condition directly from patients and families daily as part of fully embedding Martha's rule. Patient Early Warning Scores (PEWS) have been proposed as one way of doing this. PEWS is a national tool which combines measurements such as blood pressure, heart beats with a clinical assessment to provide a final score to help assess the patient's condition.
  - Improve processes for the development, review, approval and publication of clinical guidance to align with best practice and devolving approval to Clinical groups where guidelines apply to very specialised services.
- Patient Experience – improve the experience of patients through better communications and providing a variety of ways to contact the Trust.

3.3. Governors welcomed the presentation. In response, governor discussion raised the following points:

- Surgical Safety – Governors recognised from the presentation that this priority had not been carried over to 2025/26 and sought reassurance from the Quality and Assurance Team on whether any detailed information could be shared on monitoring of the success of this metric.
- Governors also raised their concerns about the potential for messages from patients to clinicians in 'inbasketing' on Epic being missed, due to the volume of messages received by clinicians. Inbaskets were not the only method by which clinicians received information. In response, the Trust Quality and Assurance Lead reassured Governors that there is an Improvement Working Group across both GSTT and King's College Hospital that meets monthly to review 'in basket' and resource management incorporating good practices / learnings from other Trusts using Epic.
- Speeding up the clinical guidance approval process –. The Quality and Assurance Lead responded that a pilot project to devolve some of the approval processes to clinical groups and directorates is already underway. This is also expected to standardise the approval process and make it simpler

for staff. The Lead further advised that the team is looking to review the quality checking of clinical guidance documents before final approval and publication to ensure that document owners have identified appropriate monitoring and/or auditing arrangements.

- The importance of ensuring that the wording in the Quality Priorities is clear and easy to understand. Governors felt that the Patient Experience priority needed re-wording. The Quality and Assurance Lead welcomed the suggestion from Governors and agreed these would be reviewed as the priorities are published externally as part of the Trust Quality Accounts.
- Questions regarding performance objectives, separate from a quality objective, on improving communications with patients. To address these queries, it was recommended that the programme team delivering the 'Contacting Us' programme, invited to attend a future Working Group meeting.
- Concerns about waiting times for appointments following referral, and the impact of delays on patients. The Quality and Assurance Lead advised that it is likely colleagues in the Administration and Operational Safety Board would be monitoring this. The Lead proposed to send some outputs of the program and share some visual representations of the impact of this work with Governors.
- Governors would like further information about how success will be measured for all the 2025/26 priorities, the additional resources that are going into this work, and what the key milestones are.

Actions requesting further updates/information:

- Assurance that actions put in place for measuring Surgical Safety have been achieved.
- Provide the Working Group with information on appointment waiting times and cancellations from Administration and Operational Safety Programme Board.
- Invite the team from the "Contacting Us" programme to provide a presentation at a future QEWG meeting
- Understand how the success of the 2025/26 priorities will be measured, what additional resources are going into this work, and what the key milestones are.

4. Agenda Item 4: Patient and public engagement updates (papers attached)

4.1. Item 4a: The Patient Experience Quarter 3 report. The report was circulated with papers in advance of the meeting. The Head of Patient Experience noted the following:

- Friends and Family Test – Patient satisfaction and overall experience scores are very good across most settings of care. Most scores are above 90%, with the exception of the Emergency Department (ED) where this is around 80%. ED performance is, however, comparable to other Trusts. Maternity scores are down slightly but varied throughout the quarter. The Trust generally performs satisfactorily in relational aspects of care, with significant challenges related to waiting times and delays.

- Two national survey results were reported in the last quarter: National Urgent and Emergency Care survey (UEC) 2024 and the Maternity Survey 2024. The Trust performed very well in the UEC Type 1 Services (Consultant-led) and was rated by the CQC a positive outlier status nationally. Results for the Maternity survey were slightly below expectations following improvements made in 2022 and 2023. The team have been making significant improvements since this survey and many of the areas for improvement are being taken forward as part of the Maternity Services 'Good to Outstanding' Improvement project.

- The Head of Patient Experience concluded the update by drawing attention to ongoing improvement work that some teams are undertaking around informing patients about waiting times in clinics, intentional rounding (updates to patients), ongoing work to improve noise at night with trials in Savannah ward and in Evelina where noise masking projects are being undertaken. Governors' attention was drawn to the full report circulated which spells out fuller details of these improvement projects.

Action: Governor suggestion for the Maternity Services team to attend the working group to share a perspective of quality and safety within the service.

4.2. **Item 4b**: The Patient and Public Engagement Q3 (2024-25) report was circulated in advance of the meeting. Attention was drawn to the PPE Strategy that has now been reviewed and ratified by the Trust Board. The next steps will be to draw up materials for internal and external publication, expected in the next quarter. The team plans to seek patient and public feedback on the public summary before publication. Governors interested in taking part in the review were invited to contact the PPE team..

Action: Governors to contact the PPE team to express an interest in reviewing the PPE strategy public summary.

5. Agenda Item 5 Reports/updates from committees recently attended by Governors

5.1. The Chair noted the written summary reports shared in advance of the meeting. No verbal updates were given.

6. Agenda Item 6: Any other business

- None raised. Governors to be contacted in due course about the next Working Group meeting date.

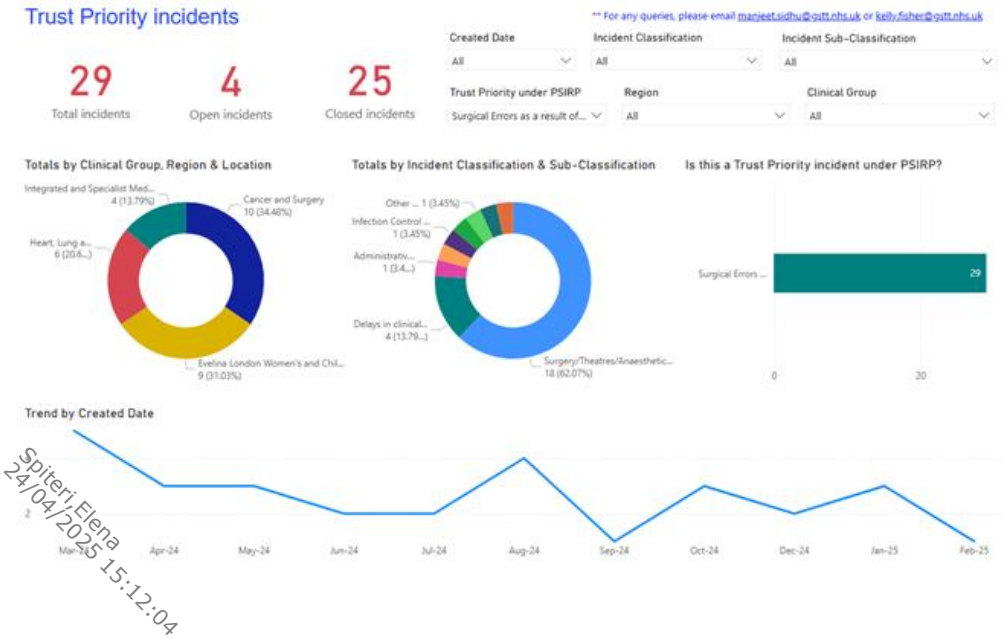
7. Actions

3.3a	**Assurance that actions put in place for measuring Surgical Safety have been achieved and what the measure indicate regarding Trust performance.**
3.3f	**Provide the Governors Working Group with some information on appointment waiting times cancellations.**
3.3.g	**Request that representatives from the "Contacting Us" programme attend the Working Group to provide a presentation on the planned work of the programme.**
3.3h.	**Understand how the success of 2025/26 Quality priorities will be measured, what additional resources are going into this work, and the key milestones.**
4a	**Request from the Chair that Maternity Services team attend the Working Group to share a perspective of quality and safety of maternity services within the Trust.**

Annex 1: response provided to points raised by governors at the meeting of 25th March

3.3a. Assurance that actions put in place for measuring Surgical Safety have been achieved and what the measure indicate regarding Trust performance.

Although surgical safety will not be carried forward as a quality priority for 2025-26, the surgical safety improvement work will continue via the improvement plan with oversight of the Trust Surgical Safety Group (TSSG). A working group to review and improve surgical safety processes within EPIC was achieved and TSSG will continue to implement the proposed changes within relevant services. A copy of the groups Terms of Reference and improvement plan will be circulated with the notes for information. A screenshot from the Learning for Improvement Group is included below which shows tracking and reporting of incidents linked to the surgical safety improvement plan.



3.3.f. Provide the Governors Working Group with some information on appointment waiting times and cancellations.

This work is part of a wider programme of work being overseen by the Administration and Operational Safety Programme Board. Inviting representatives of the programme to present at a future working group meeting will enable governors to receive a more detailed update on this area of work.

3.3.h. Understand how the success of 2025/26 Quality priorities will be measured, what additional resources are going into this work, and the key milestones.

Colleagues from the Quality and Assurance Team will provide further detail about how the 2025/26 priorities will be measured and key milestones in the next meeting. The proposed priorities for 2025/26 represent improvement work which is underway with no additional resource identified.

Guy's and St Thomas' NHS Foundation Trust

COUNCIL OF GOVERNORS

WEDNESDAY 30 APRIL 2025

Report title:	**Elections to the Council of Governors - 2025**
Board sponsor:	Charles Alexander, Trust Chair and Chair of the Council of Governors
Paper author:	Edward Bradshaw, Director of Corporate Governance and Trust Secretary
Purpose of paper:	For awareness/noting only
Main strategic priority:	All strategic priorities
Primary BAF risk:	Risk 13: inability to attain organisational excellence could impair ability to deliver strategy
Key points of paper:	• Elections to the Council of Governors are being held during spring 2025, with new governors elected to the Council formally commencing their three-year terms on 1 July 2025. • The nominations window closed on 27 March and there are 66 nominations for the 11 available governor seats. Each of these seats is being contested. The voting window opened on 22 April. • This paper provides a brief update to governors regarding the status of the elections.
Paper previously presented at:	N/a
Recommendation(s):	The COUNCIL OF GOVERNORS is asked to: 1. **Note** this paper.

1. Overview of election timetable and nominations received

1.1. There are 11 governor seats across six constituencies that have come up for election this year. All posts will start on 1 July 2025 and elected governors will serve a term of three years. The election timetable is as follows:

ELECTION STAGE	2025 DATES
Notice of Election / nominations opened	Thursday 27 February
Nominations deadline	Thursday 27 March
Summary of valid nominated candidates published	Friday 28 March
Final date for candidate withdrawal	Tuesday 1 April
Notice of Poll published	Thursday 17 April
Voting packs despatched / election open	Tuesday 22 April
Close of election	Monday 19 May
Declaration of results	Wednesday 21 May

1.2. The following nominations have been received:

Constituency	Seats available	Nominations received	Status
Guy's and St Thomas' patient class	3	21	Contested
Patient carer	1	2	Contested
Public constituency area 1 (around Guy's and St Thomas' Hospitals)	3	14	Contested
Public constituency area 2 (around Royal Brompton and Harefield)	1	8	Contested
Public constituency area 3 (Rest of England and Wales)	1	8	Contested
Guy's and St Thomas' non-clinical staff	2	13	Contested
	11	66	

1.3. Each constituency is contested, and on average there have been six nominations for each available governor seat. Whilst no firm data is available, the individuals who are standing for election appear to represent a diverse group in terms of age, gender and ethnicity.