

Public Council of Governors meeting

Wed 29 April 2026, 18:00 - 19:30

Robens suite and online

Agenda

18:00 - 18:00 **1. Welcome and apologies**

0 min

Charles Alexander

18:00 - 18:00 **2. Declarations of interest**

0 min

18:00 - 18:05 **3. Minutes of previous meeting (28 January 2026) and review of actions**

5 min

 [1] 20260129 Public CoG Meeting Minutes_vFinal.pdf (3 pages)

18:05 - 18:10 **4. Cardio-Respiratory and Intensive Care (CRIC) service update**


5 min

Gubby Ayida

18:10 - 18:30 **5. What is population health & Why does it matter**

20 min

Ingrid Wolfe

 [5] What is population health.pdf (6 pages)

18:30 - 18:35 **6. CQC well-led inspection**

5 min

Edward Bradshaw

18:35 - 18:45 **7. Council of Governors and the ten-year health plan**

10 min

Charles Alexander

 [7] Councils of governors and the 10-year health plan.pdf (4 pages)

18:45 - 18:55 **8. Governors' reports for information**

10 min

8.1. Lead Governor's Report – Katherine Etherington

Katherine Etherington

 [8.1] Lead Governor's Report Apr26.pdf (3 pages)


8.2. Strategy Transformation and Partnership Working Group (notes from meeting on 17 February 2026)

Leah Mansfield

 [8.2] 20260217 STPWG minutes vFinal.pdf (3 pages)

8.3. Membership Development Working Group (notes from meeting on 3 March 2026)

Charles Mead

 [8.2] 20260303 MDWG meeting minutes.pdf (3 pages)

 [8.2] MDWG draft action plan.pdf (4 pages)

8.4. Quality and Engagement Working Group (notes from meeting on 24 March 2026)

Leah Mansfield

 [8.4] 20260324 QEWG 24 March Notes.pdf (3 pages)

18:55 - 19:25 **9. Q&A with Trust Chair and non-executive directors**
30 min

19:25 - 19:30 **10. Any other business**
5 min

COUNCIL OF GOVERNORS

Wednesday 28 January 2026, 6pm – 7.30pm
Robens Suite, Guy's Hospital and MS Teams

Governors present:

Nigel Beckett	Katherine Etherington	Gavin Morrison
Kathryn Blake	Emily Hickson	Alison Mould
Victoria Borwick	Leah Mansfield	Mary O'Donovan
David Bridson	Yvonne McPherson	Samuel Oloye
Michael Bryan	Margaret McEvoy	Dominic Shaw
Emma Barslund Blackman	Patrick Miller	Peter Yeh
Felicity Conway		

In attendance:

Charles Alexander (Chair)	Felicity Harvey	Ian Playford
Edward Bradshaw (minutes)	Jamie Heywood	David Shrimpton (item 4)
Miranda Brawn	Pauline Philip	Elena Spiteri
Steven Davies	Amanda Pritchard	Alison Wilcox
Jon Findlay		

1. Welcome and apologies

- 1.1. The Chair welcomed attendees in the room and online to the meeting of the Council of Governors (the Council). Apologies had been received from governors Nimmi Anu Sam, Aya Ayoub, Steven Bean, Annette Boaz, Samantha Field, Michael Mates, Charles Mead, Irina Munteanu, Stephanie Petit, Daghni Rajasingam, Sheila Reddy, Mercy Satoye, Kendra Schneller, Helen Selvarajan, Thomas Sheridan, Darren Summers, Cordwell Thomas and Jadwiga Wedzicha, and from non-executive directors Nilkunj Dodhia, Simon Friend, Deirdre Kelly, Graham Lord.

2. Declarations of interests

- 2.1. Ian Playford declared an interest in respect of agenda item 5 and would recuse himself from the meeting for that discussion. No further declarations of interest were received.

3. Minutes of the meeting held on 22 October 2025

- 3.1. The minutes of the previous meeting were approved as an accurate record. Three actions had been recorded at the last meeting, all of which had been discharged.

4. Private patients update

- 4.1. Governors received a presentation about the Trust's private patients' business from the Managing Director of Guy's and St Thomas' Specialist Care. Governors noted the locations from which private patient care was provided, the amount of income generated from these patients in 2024/25 compared to other NHS providers and independent sector organisations in London, and the Trust's ambitions to grow the business further. It was explained that ongoing NHS funding constraints meant that income diversification would increase the Trust's financial resilience and help protect the delivery of high-quality care to NHS patients in the future.
- 4.2. Governors welcomed the information provided and sought clarification over several points including around the private patient clientele, the financial margin generated, and the areas the Trust was targeting to increase income over the coming years. It was recognised that there were other commercial revenue streams, such as the pharmacy manufacturing unit, that sat outside the private patient revenue line but were reported in the Trust's annual report and accounts. Governors queried the barriers to driving a significant increase in private patient revenue and noted that further investment was needed to enable this.

5. Non-executive director reappointment

Ian Playford recused himself from the meeting for this item and rejoined for item 6.

- 5.1. The Council of Governors received a recommendation from the Nominations Committee to reappoint Ian Playford as a non-executive director for a second term of four years. The Trust Chair fully endorsed this proposal. He explained that another of Ian Playford's roles was as a non-executive director of NHS Property Services Limited, which was a landlord for many of the Trust's community facilities. This potential conflict of interest was noted but was considered sufficiently manageable so as not to prevent his reappointment. Governors supported the proposal.

RESOLVED: The Council of Governors approved a recommendation to reappoint Ian Playford for a second four-year term, from 1 May 2026 to 30 April 2030.

6. Nominations Committee terms of reference

- 6.1. The Trust Constitution requires the Council of Governors to maintain a Nominations Committee to assist the Council in carrying out functions relating to the appointment, terms and conditions and appraisal of non-executive directors. A recent review of the Nominations Committee's terms of reference, last updated in April 2024, had concluded that they remained fit for purpose and aligned with governors' statutory and regulatory requirements. Two minor changes were proposed: one relating to the receipt of a report on the fit and proper persons status of non-executive directors, and the second to clarify that the work to review the balance of skills, knowledge and experience of the existing non-executive directors would be done annually. Both amendments had been proposed with reference to regulatory frameworks published by NHS England. The updated terms of reference had been agreed by members of the Nominations Committee in December 2025 and were being brought to the full Council of Governors for formal approval.

RESOLVED: The Council of Governors approved the updated terms of reference for the Nomination Committee.

7. Governor reports for information

- 7.1. Governors noted the Lead Governor's report and the minutes from the previous meeting of the Quality and Engagement Working Group meeting held on 11 November 2025.
- 7.2. The Lead Governor explained that a group of governors was looking at the role of the three governor working groups with the intention to align them more closely with the governor triangulation meetings, the governor observation of Trust Board committees, and the quarterly Council of Governor meetings. The refresh of the groups would also to enable greater focus on the priority areas that had been agreed at the governors' away day in October 2025. It was recognised that all new chairs of the governor working groups would need to be engaged in these deliberations, and that a proposal would be brought back to the full Council of Governors in due course.
- 7.3. The Chair of the Quality and Engagement Working Group highlighted several key areas from the last meeting including the Trust's plans to increase patient-initiated follow-up (PIFU), improving patient communications whilst mitigating the risk of digital exclusion, and Martha's Rule.

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

- 8.1. Governors queried how the Trust was considering the impact of its estates strategy on local residents. It was explained that there would be a presentation on the estates strategy at the next meeting of the Strategy, Transformation and Partnerships Working Group on 19 February that would give more insight into this topic.
- 8.2. There was discussion about the drivers of the high demand for the Trust's services that had been referenced at the preceding public Board meeting, and about the challenges that remained in ensuring

a consistently efficient discharge process for patients going from the Trust into social care. The Trust's programme to improve patient flow was looking at this and at other aspects of discharge, some of which, for example concerning patients in the Trust's care who lived outside London, were acknowledged to be more complex than others.

- 8.3. One governor had noticed that anti-microbial filters had not been attached to all of the taps in one of the ladies' lavatories in the Guy's Cancer Centre, and queried whether the prevalence of immunocompromised patients in the Centre meant that all taps should be fitted with them. The Trust explained that there was an ongoing programme of work to optimise water safety which was the subject of significant scrutiny from executive management, and that this specific issue would be investigated.

ACTION: The Trust would report back on its policy around fitting anti-microbial filters to taps, particularly in the Guy's Cancer Centre, and follow up on the specific issue raised.

- 8.4. Clarity was sought about how the Trust was proactively identifying people with health needs in south east London to support the shift from treatment to prevention. People experiencing homelessness living in temporary accommodation was highlighted as an area where there was likely to be an enhanced level of unmet health needs. This led to a discussion about how the Trust was using population health tools, the importance of health inequity, and the role of integrated neighbourhood teams in this work. It was agreed that this should be the topic of a future presentation to governors.

ACTION: A presentation on population health, health inequity and the role of integrated neighbourhood teams to be provided at the next Council of Governors meeting in April 2026.

- 8.5. Governors commended the Trust for the improvements in its cost controls, noting that, whilst the Trust remained in financial deficit at the end of December 2025, it was slightly ahead of its plan. Some concern was expressed about the level of savings that had been generated non-recurrently, and how this would add to the financial challenge the following year. There was discussion about the financial risks the Trust would face in 2026/27, including the move away from block contracts with commissioners, the wider economic uncertainty, and the significant cost improvement programme (CIP) target. The Trust's productivity programme was recognised as a critical enabler of the Trust's ability to meet its financial plan, and governors noted that the programme was undergoing refreshed internal branding to galvanise the workforce and inject more energy into its operations.
- 8.6. One governor suggested that, to help the Trust improve its diagnostics performance, consideration should be given to giving patients access to diagnostics equipment across its whole estate, including in the Trust's private patient centres. The Chief Operating Officer stated that the Trust used its assets intensively, seven days a week, and although moving patients between sites was often challenging, consideration would be given to this suggestion.
- 8.7. Governors noted the latest developments with the children's Cardio-respiratory and Intensive Care services, which were to temporarily move from the Royal Brompton Hospital to St Thomas' Hospital later in the year. It was agreed that time would be found at a subsequent governor meeting for a fuller discussion of this matter.

9. Any other business

- 9.1. There was no other business. The next meeting of the Council of Governors would be held on 29 April 2026.

What is population health? And why does it matter?

What is population health?

It's... a clinical speciality

Population health as a clinical speciality, often termed Clinical Population Medicine (CPM) or public health medicine, blends epidemiology, public health, and individual patient care to improve health outcomes for defined groups.

An approach

A population health approach uses data-driven insights to understand risks, reduce inequalities, and inform personalised, preventative care.

It is applied to inform the development of services, or interventions, for a defined population, based on an understanding of population needs and utilisation of evidence.

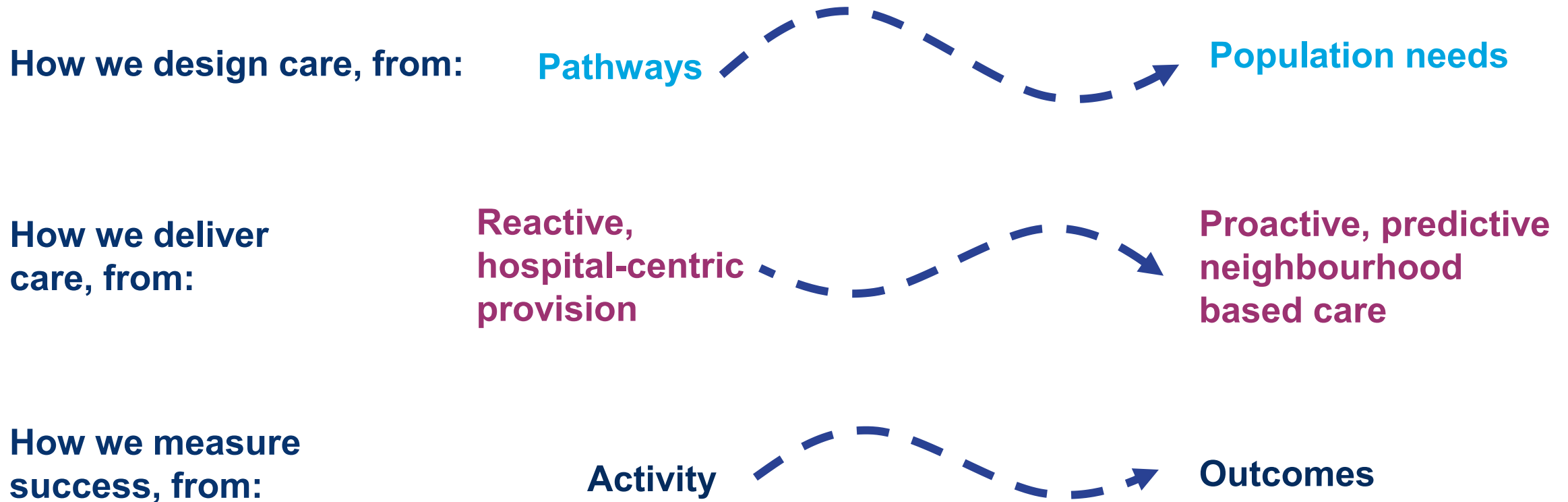
And... an outcome

"the health outcomes of a group of individuals, including the distribution of such outcomes within the group"

Therefore, we often talk about improving population health, and reducing inequalities, as our intended outcomes

Why does population health matter?

The current model of healthcare delivery is focused on managing illness, rather than creating health and is resulting in unsustainable demand on healthcare services and worsening health outcomes. A population health model, aims to change this by shifting:



What are we doing across the Trust to deliver our ambition to ‘improve the health of our populations’?

Our Population Health Hub team provides public health, data, evaluation and systems expertise to support the Trust to deliver this goal.

It does so by directly informing service design of clinical services; developing the infrastructure to enable population health informed care, and, supporting and upskilling the workforce and leadership in the Trust, to move towards population health-based delivery.

Changing how we deliver services, with our partners, based on population need




Such as, through Integrated Neighbourhood Teams, CHILDS & Integrated care models with North Lambeth PCN

Improving our population health data and generating new insights



Joining up data from across the local healthcare system, to provide actionable insights, at a patient and whole population level

Upskilling & enabling our workforce



Training staff in population health, and, supporting staff to work in different ways

Embedding population health and equity principles in how we operate



Supporting the delivery of the organisation's goals, through a population health and equity lens eg. equity in performance measurements

What is the impact that we can have, through designing and delivering care, using a population health approach?

An example from CHILDS

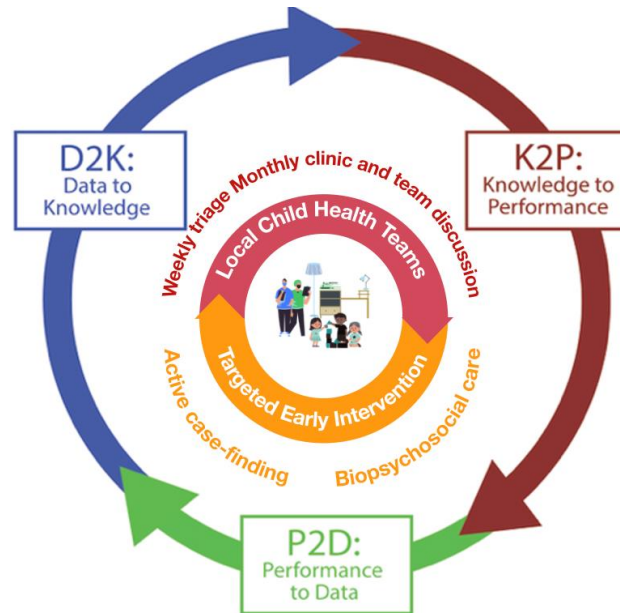
Better health outcomes

Delivering preventative care for the person, not just treating the disease



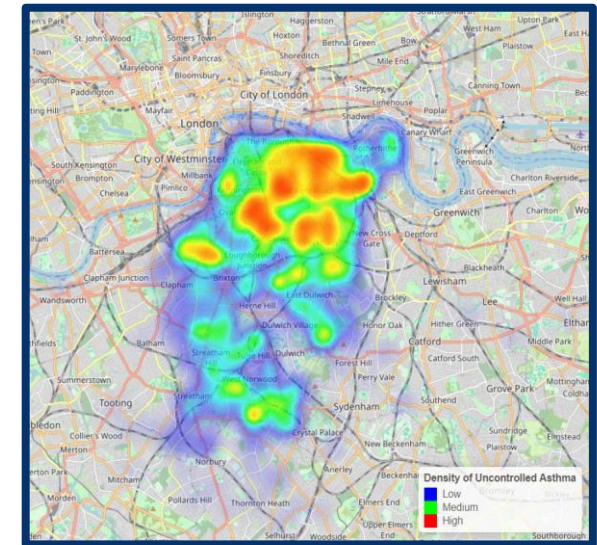
Informed healthcare delivery

Data-driven, personalised care



Reducing inequalities

Targeting high and unmet needs



What does this really mean for our local populations and patients?

An example from CHILDS



Hassan, a young boy with asthma and eczema, from a non-English speaking Somali family

Proactive identification and outreach

Early intervention

Biopsychosocial approach to care

The nurse noted damp and mould at home, and was empowered to intervene

Advocacy

The nurse helped Hassan's family escalate housing issues leading to improved living conditions in a new home

Impact

Hassan's asthma and eczema improved significantly, he stopped coming to A&E, and his overall wellbeing was enhanced



NAME OF MEETING (DROPDOWN)

WEDNESDAY 29 APRIL 2026

Report title:	Councils of governors and the 10-year health plan
Sponsor:	Charles Alexander, Trust Chairman and Chairman of the Council of Governors
Report author:	Edward Bradshaw, Director of Corporate Governance and Trust Secretary
Main strategic priority:	All strategic priorities
Primary BAF risk:	Risk 11: Organisational excellence
Key points of report:	<ul style="list-style-type: none"> • The Council of Governors plays a key role in representing stakeholder views and holding non-executive directors to account for the performance of the Trust. • The government’s ten-year health plan proposes removing the statutory requirement for councils of governors. • Legislation to enact this change is being drafted, though the timetable remains uncertain, and if passed, most governor powers would be removed or transferred to the Department for Health and Social Care (DHSC). • Until any law changes, councils of governors must continue fulfilling their legal duties. • The Trust is working with partners to consider possible future approaches for incorporating patient, public and staff voices into its activities and decision-making; it will work collaboratively with the GSTT Council of Governors to create any future model, and will maintain transparency and regular engagement with governors throughout this transition.
Previously presented at:	N/a
Supporting material:	N/a
Purpose of report:	For awareness/noting only
Recommendation(s):	The COUNCIL OF GOVERNORS is asked to: 1. Note this paper.

1. Background

- 1.1. The Guy's and St Thomas' Council of Governors plays a vital role in representing the views of patients, public, staff and partners to the Board of Directors, and holding the non-executive directors to account for ensuring the Board incorporates these views in its decision-making.
- 1.2. On 3 July 2025 the government published a 10-year health plan for England.¹ A significant provision in this plan was the intention to remove the statutory requirement for NHS foundation trusts to have councils of governors. Page 81 stated:

We will remove the requirement for foundation trusts to have governors. While governors have provided helpful advice and oversight for some foundation trusts, we expect the next generation of NHS foundation trusts to put in place more dynamic arrangements to take account of patient, staff and stakeholder insight. This should include systematic measures of patient reported experiences and outcomes.

2. Current situation and timeline

- 2.1. Before this proposal can be enacted, a new health Bill must become law. The Department of Health and Social Care (DHSC) is currently drafting this legislation and intends for the Bill to become law by 1 April 2027. There is, however, some uncertainty with this timetable, linked to the need for Parliamentary time. It is possible that timescales may be extended or that the legislation fails to pass at all. If the Bill passes as proposed, all references to governors will be deleted from statute, at which point it is currently anticipated that most current powers of councils of governors will either be removed or transferred to the DHSC (as shown in Appendix 1). The requirement for foundation trusts to maintain a formal membership will also likely be removed.

3. Activities during the interim period

- 3.1. Until the law officially changes, the legal functions and powers of councils of governors remain in force. This includes all routine activities such as council meetings, non-executive director appointments, and elections and inductions for new governors. Councils of governors must remain legally constituted and quorate. Whilst some trusts with upcoming governor elections are considering postponing these, the next scheduled elections at Guy's and St Thomas' are not until spring 2027 (for appointments starting on 1 July 2027), by which time we anticipate there will be considerably more clarity on the situation.

¹ [NHS England » Fit for the Future: 10 Year Health Plan for England](#)

4. Next steps

- 4.1. **The Trust is working with peer organisations**, including with the trusts in the Shelford Group, to consider how, if legislation is passed to remove councils of governors, the Trust can continue to receive strong patient, public and staff voices into its activities and decision-making. One possibility is that the Trust may choose to keep its membership database for future engagement, provided members are informed of the change in legal basis for holding their data.
- 4.2. The Trust is committed to a culture of collegiate working and transparency during this period, and will:
- Provide regular updates to governors as the situation develops and as more clarity or guidance is available, and build in time for discussion of these developments; and
 - Commit to working collaboratively with governors to create a new model – if required – to receive patient, public and staff voices within a non-statutory framework, taking into account any further national direction that may be issued.

5. Recommendations

- 5.1. The Council of Governors is asked to **note** this paper.

Appendix 1: Possible distribution of governors' powers

Council of Governors powers and functions	Likely scenario post 1 April 2027
Holding the board to account for its performance, via the non-executive directors (NEDs)	This role, which has historically also been part of the regulatory/oversight roles of NHSE and previously Monitor and the Trust Development Authority, will be moved into the Department for Health and Social Care (DHSC). CQC will continue to have a quality regulation role.
Represent the interests of FT members and the wider public	To be removed – but the government expects FTs to introduce 'more dynamic arrangements to take account of patient, staff and stakeholder insight'.
Appointment and removal of NEDs including the Chair	Moves to DHSC
Decide the remuneration, allowances and terms and conditions of all NEDs	Moves to DHSC
Approving significant transactions as defined in the FT constitution	To be removed
Approving organisation-led mergers, acquisitions, dissolutions	To be subsumed into DHSC's oversight role, noting that NHSE, Monitor and TDA historically reviewed transactions
Approval of appointment of the CEO	To be removed
Appointment and removal of the external auditor	Change in practice to that undertaken for NHS trusts and ICBs
Receipt of the FT's annual report and accounts, and the auditor's report on them	Moves to DHSC
Amendments to the constitution	Moves to DHSC
Approval of any proposal to increase the trust's income from non-NHS work by more than 5% in a financial year	Moves to DHSC
Expressing a view on board's forward plans, in advance of submission to NHS England	To be removed – review of plans moves to DHSC as part of its oversight role

COUNCIL OF GOVERNORS
WEDNESDAY 29 APRIL 2026

Report title:	Lead Governor's Report
Paper author:	Katherine Etherington
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

- 1.1. April sees the start of the new financial year and 2026/27 is set to be another successful year for Guy's and St Thomas' and the Trust's Council of Governors. Firstly, I would like to welcome Julian Kelly as the new Chief Strategy and Transformation Officer. It is an exciting time to join the Trust and I know everyone in the Council is excited to work with Julian and support all aspects of transformation.
- 1.2. At this month's governor triangulation meeting we were joined by non-executive directors Deirdre Kelly and Alison Wilcox and it was a privilege, once again, to hear their views on the challenges and opportunities facing the Trust. It is also reassuring to hear that while there are some issues that both the Council and the non-executive directors raised, these are known and being addressed. Thank you to all those who joined us and participated in the discussion.
- 1.3. I have enjoyed reading the reports from governors' attendance at various Board committee and clinical group board meetings. It was interesting to read in Leah Mansfield's report from the Transformation and Major Programmes Board Committee that the Productivity Programme has transitioned from planning into delivery, with an estimated £30 million savings opportunity. This really is a positive step towards frontline productivity, which is a national directive. Yvonne MacPherson's report from the People, Culture and Education Committee included the update that Kate Tilly is the newly appointed Director of People Strategy and Transformation. The Council of Governors looks forward to seeing Kate and the team continuing the great work to support the Trust's workforce and maintain and improve an open and patient-centred culture. Yvonne also updated the council on the work being done by the Learning Disability Committee. I was encouraged to hear that 85% of the Trust's staff have undertaken Oliver McGowan training, a training module that helps staff understand how to support and care for patients with a learning disability or autism. This is an incredibly important piece of training for staff and has a real impact on patients with a learning disability or autism.
- 1.4. Thank you to those governors who attended site visits in the last quarter. I found Felicity Conway and Margaret McEvoy's report from their visit to Dermatology Day Care insightful. Joined by non-executive director Jamie Heywood, they met with Mustafa Zubair, Deputy General Manager, and Ann Bowrin-Soyer, Deputy Head of Nursing, who told them how the department had reduced their weekend 'did not attend' (DNA) rate to 1%, which I thought was truly outstanding and really should be celebrated!
- 1.5. As you will have seen in April's monthly communication, we have a few seat vacancies in the Heart, Lung and Critical Care Clinical group End of Life Steering Group, End of Life Care Committee and Nursing & Midwifery Research Council. We are also seeking a governor representative for the Trust Vulnerable Persons Assurance Committee. This is a statutory and regulatory committee covering both adult and children's safeguarding. The committee also holds strategic responsibility for Mental Health and End of Life Care.

- 1.6. As you know, the site visiting programme, stalls and seminars are all ways that you can engage with your fellow governors and those you represent. I know the Children's Cardio-Respiratory and Intensive Care (CRIC) service is a key area of governor interest, so if you would like further information or a visit, please do reach out to Corporate Affairs.
- 1.7. You will have also seen that Corporate Affairs recently published an updated Governor Handbook for 2026/27. I would encourage you all to take a read, and if you have any questions or feedback you wish to share with me, please do reach out.
- 1.8. This year I expect we will see some big changes in the NHS and it will be great to support GSTT in their mission to continue to be a leading Trust in terms of innovation and development.
- 1.9. Finally, on behalf of all the governors, I would like to thank Leah Mansfield for her time and commitment as chair of both the Strategy Transformation and Partnerships Working Group and Quality and Engagement Working Group. I am sure those governors who have been able to attend one of her meetings will have become more knowledgeable about our Trust and its challenges and successes. I know Leah is continuing as a representative on some of our committees and Alison and I look forward to continuing to work alongside Leah.

**COUNCIL OF GOVERNORS
STRATEGY, TRANSFORMATION & PARTNERSHIPS WORKING GROUP**

**17 February 2026, 5.30pm – 7.00pm
MS Teams**

Governors: Leah Mansfield, Chair	Sheila Reddy
Charles Mead	Steve Bean
Daghni Rajasingam	Kathryn Blake
Felicity Conway	Yvonne McPherson
Katherine Etherington	Tommie Sheridan
Alison Mould	Margaret McEvoy
Nigel Beckett	Gavin Morrison

Trust staff: Jackie Parrott	Sara Hanna (item 5)
Andrew Asbury	Marilyn McDougall (item 5)
Nina van Zyl	

1. Welcome and apologies

1.1. The Chair welcomed colleagues to the Strategy, Transformation and Partnerships Working Group, including new governors. Apologies were noted.

2. Declarations of interest

2.1. There were no declarations of interest.

3. Minutes of previous meeting

3.1. The minutes of the meeting held on 16 September 2025 were approved as an accurate record.

4. Previous meeting report and matters arising

4.1. No action points from the previous meeting were raised.

5. Cardio-Respiratory and Intensive Centre (CRIC) services update

5.1. The Medical Director of Evelina London Women's & Children's Group, Sara Hanna and Marilyn McDougall, Clinical Director for CRIC services briefed governors in detail on the planned temporary move of inpatient cardiac and respiratory services from the Royal Brompton Hospital to the Evelina London Children's Hospital on the St Thomas' site.

A note was sent to Governors on the 22nd January regarding the proposed temporary service changes. In addition a briefing paper and letter to patients and families were shared with Governors in advance of the STPWG meeting. These materials covered the history and context, clinical reasons why it was not possible to continue the two site inpatient provision, clarified which services would be remaining at the Brompton site, where inpatient services would be moving to, some information on the geography of patients currently being admitted to the Brompton site and the patient and public engagement processes being followed with relevant commissioners.

5.2. More detail was provided in the meeting about concerns raised by clinical leaders that running these critical, highly specialist services across two sites was becoming increasingly difficult, particularly for the children's heart surgery team. The service employs five dedicated children's heart surgeons (the correct number for the annual surgery volume). However, providing consistent 24-hour on-call cover for both urgent and planned operations across the two locations places excessive and unsustainable pressure on the team. The children's heart surgery team have raised concerns that they are not able to continue to work under this pressure beyond spring 2026. When children's cardiac surgery moves

to the Evelina London then there will be insufficient inpatient activity to maintain a paediatric intensive care unit (PICU) to support respiratory in patients and the decision after extensive conversations with the clinical teams was that all inpatient services should move.

- 5.3. Governors were also advised that national standards required hospitals providing children's congenital heart disease (CHD) services to meet stringent national standards, which included the co-location of CHD services with other essential services including children's general surgery, gastroenterology and nephrology services. Evelina London Children's Hospital offers access to these services in one place, enabling the Trust to meet the national standards, which was not currently possible while inpatient services were split across the two sites.

The Trust is implementing this as a 'planned temporary change' under the direction of NHS England to resolve these immediate clinical sustainability and standards compliance issues. Crucially, this temporary change is not a decision on the long-term configuration of the service and does not replace the formal process required for a permanent service change.

The temporary move of all cardio-respiratory inpatient services to the St Thomas' site, is being done in a planned, careful way to avoid a sudden, disruptive change to patient care. Around 40 inpatient beds would be provided, matching the number currently available to children at Royal Brompton. To minimise disruption, several key services would remain at the Royal Brompton and Harefield sites in the short term, including children's heart and lung outpatient clinics, day-case procedures that do not require anaesthetic or sedation, outpatient imaging services and ongoing clinical research and trials.

To accommodate the services before the expanded Evelina children's hospital building was complete, the Trust was refurbishing an adult ward in St Thomas' Hospital (Edward Ward) to accommodate children's heart services, and converting an existing children's ward in the Evelina London to accommodate paediatric lung patients.

Discussion and questions focused on the following:

- The use of Edward Ward and the discussions that had been held with clinical teams about the facilities and location.
- The potential additional pressure on the St Thomas's and EL sites.
- The longer-term intention to locate the service in a new children's development on the St Thomas' site and when would this be likely, noting that plans had previously been paused.
- The need for further clarity of language around 'engaging and informing' stakeholders about the 'temporary' service change as opposed to 'engaging and consulting' on permanent service change.
- The concerns that had been raised by respiratory consultants at Royal Brompton Hospital and the Trust's engagement with them.
- There could be spare capacity on the Royal Brompton Hospital site which could help to relieve pressure on other sites.

6. Estates strategy refresh and mapping

- 6.1. The Essentia Managing Director provided an update on the development of a Trust-wide Estates Strategy.
- 6.2. The Trust's acute estate currently totalled nearly 500,000 m² and had a substantial maintenance backlog. A new 3D digital estate model had been developed to enable a real-time assessment of the estate's condition and utilisation. Workplace utilisation was around 40%, with a number of expiring office leases.
- 6.3. The Trust's approach to development of the estates strategy would be based on clinically-led demand and capacity modelling over 5, 10, 15 and 20 year periods. The strategy recognises national shifts towards community-based care, while noting the high costs of the community estate.
- 6.4. A programme was under way to improve staff workspaces and communal areas, including locker provision, rest areas and addressing overcrowded clinical offices.

6.5. The group discussed the following points:

- The expected national changes to how NHS community properties are owned and managed, and the security issues at community sites.
- The success of the 'Making Working Lives Better' programme for staff facilities, including improvements to rest areas. It emphasised the need to balance efficiency with effective clinical workspaces. Great Dover Street was noted as a successful example of an improved environment leading to better utilisation.
- How the PLACE (Patient-Led Assessment of the Care Environment) assessments were feeding into the development of the estates strategy.
- The progress that had been made in removing long-standing 'dead legs' in plumbing and non-essential sinks in Borough Wing to reduce infection risk.

7. Report updates from committees attended by Governors

7.1. Felicity Conway reported that community staff continue to highlight safety concerns when visiting patients' homes. The Quality & Performance Board Committee was now focusing on this.

8. AOB

8.1. Governors extended their thanks to Leah Mansfield for her leadership and commitment as Chair of the Working Group over recent years.

The next meeting will be held on 19 May, from 5.30pm to 7.00pm, on Microsoft Teams.

**COUNCIL OF GOVERNORS
MEMBERSHIP DEVELOPMENT WORKING GROUP**

**Tuesday 3 March 2026
5.30pm – 7.00pm, MS Teams**

Governors in attendance:	Charles Mead	Kathryn Blake
	Alison Mould	Leah Mansfield
	Felicity Conway	Margaret McEvoy
	Gavin Morrison	Steve Bean
	Victoria Borwick	Yvonne McPherson

Trust staff in attendance:	Edward Bradshaw	Elena Spiteri
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1. Welcome and apologies

1.1. The Chair welcomed members and thanked attendees for joining the meeting of the Membership Development Working Group ('the Group' or 'MDWG'). Apologies were noted from governors unable to attend.

2. Minutes of previous meeting

2.1 The minutes of the previous meeting were approved as an accurate record.

3. Declarations of interest

3.1 No relevant interests were declared.

4. Action Log

4.1. The action log was reviewed. Of the 19 actions, 18 were confirmed as having been closed. One action, from May 2024, remained open. It was agreed that this action should be reviewed considering the outcomes of this meeting to assess whether it has been superseded or if it should be retained.

ACTION: Charles Mead to review action 2 following the meeting and decide how it should be treated.

5. Strategic discussion: purpose and impact of the governor role

5.1. The Group Chair set out the purpose and format of the meeting. This was to take stock across the group's three recurring themes: member development, governor engagement, and patient experience, via three open questions which had been circulated in advance. Each topic was allotted around 20 minutes, with the goal of surfacing practical ideas the Chair could turn into a forward agenda.

6. Topic one: Why did you become a governor, and what would help you fulfil that purpose?

6.1. Across the discussion, governors expressed strong personal motivation to serve, often rooted in long-standing connections with the Trust, lived patient experience, professional NHS backgrounds, or a desire to contribute meaningfully after major life events. Many saw the governor role as a way to advocate for patients, apply professional expertise for public benefit, and stay connected to the NHS or to services that had supported them or their families.

6.2. However, most reflections highlighted a common challenge: while governors are committed and skilled, many feel it is not always clear how they can best make a difference. A number of themes emerged:

- A desire for clearer routes to impact: Governors want mechanisms that enable them to see how their work leads to tangible improvements, rather than feeling peripheral or confined to passive oversight.
- Stronger connection with patients and communities: Many felt they lack direct, structured opportunities to hear patient voices and understand real-world experiences. They expressed interest in more purposeful engagement via forums, surgeries, or targeted listening activities.
- Better focus and cohesion across the governor body: The Council of Governors is broad and diverse, with varied motivations and backgrounds. Governors noted the need for a clearer collective purpose, shared priorities, and more structured collaboration.
- Greater clarity about the expectations and limits of the role: Several governors described initial uncertainty about how to use the role effectively, particularly in comparison to governance roles in smaller organisations. Clearer guidance, induction, and ongoing support were seen as important.
- More opportunities to apply specialist skills: Many governors have deep professional experience (clinical, managerial, financial, legal, community) and want to deploy those skills in ways that provide meaningful assurance and constructive challenge.
- Development of member-facing activities: There was strong support for expanding the scope of member seminars and using them not just for information-giving, but as a platform to understand member priorities and support broader community wellbeing.
- Interest in targeted “deep dives”: Small, time-bound workstreams focused on specific service issues or patient experience themes were seen as a promising way to generate actionable insights and demonstrate impact.

6.3. Governors were reminded of the statutory remit of the governor role, but encouraged to identify practical ways of adding value beyond this. There had been similar discussions at the October away day and the survey that had been completed by around 18 governors beforehand, and the pack would be re-circulated to complement the current discussion. It was suggested that governors should ask NEDs for pointed suggestions on where governors can have the greatest impact.

6.4. There was a brief straw poll on holding a quarterly governor-only focus session (no NEDs) led by the Lead Governor team to improve cohesion and focus of the governor group. Most supported the idea in principle; some governors asked for clear objectives/structure before proceeding, given the number of governor meetings already held.

ACTION: Charles Mead/Alison Mould to raise the prospect of a governors-only meeting with the Lead Governor.

7. Topic 2 – How well do we represent members, and how could we do better?

7.1. The Group Chair said that governors are well-intentioned and well-briefed but lack focus/cohesion and insight into what members want. He proposed researching member interests to sharpen representation.

7.2. There was support for a wider lens that includes staff experience and staff surveys. One governor urged earlier, forward-looking challenge: asking NEDs about 2–3-year plans before they’re finalised, so governors’ perspectives can influence direction, not merely observe or “rubber-stamp.” Another governor cited examples of executives benchmarking elsewhere (e.g., turnaround times, EPIC implementation), suggesting governors should ask NEDs how they validate executive benchmarking and options appraisal, and to evidence claims of improvement.

7.3. On external learning and networking, it was noted the Lead Governor has links to a national lea governors WhatsApp group; current national focus includes a response to proposals about abolishing governors. For GSTT, the sense was that GSTT governors already do more than many trusts, but scale and complexity limits a small-trust “community” feel.

8. Topic 3 – Practical ways for governors to interact directly with patients

8.1. The Chair highlighted two practical avenues:

- PLACE audits (half-day patient-led environment audits) at St Thomas' and Guy's, encouraging all governors to attend one of the biannual sessions; and
- Patient Experience Groups within each Clinical Group: exploring a formal route for governor involvement at that level (the Chair had already started conversations in ISM).

8.2. On attendance and engagement, there was variable attendance (historically lower for stakeholder governors; this year lower among some staff governors). Corporate Affairs was planning to issue supportive letters (as done in prior years) reminding governors of expectations and offering help, while acknowledging valid reasons (e.g., illness). There was debate about mandating more meetings; the consensus leaned toward maximising the value of existing sessions, supporting quieter/newer governors (e.g., buddying), and ensuring staff governors know they can take protected time to attend.

ACTION: Trust Secretary to send a reminder to staff governors regarding their utilisation of special leave to undertake their governor duties.

8.3. It was flagged that meeting formats can inadvertently favour the same frequent speakers; one governor favoured structured formats (e.g., round-robin sections) to equalise airtime, especially at away days. There was a suggestion to use existing structures better: working groups, triangulation meetings with NEDs, relevant community/patient group meetings, and staff forums, plus ensuring staff governors and line managers understand time-off arrangements.

8.4. Governors asked whether the Trust holds a directory of patient groups (patient partners, advisory groups, PPIE groups, project-specific panels). The current understanding is there is no single compendium; numbers are large and diverse.

ACTION: Trust Secretary to pursue this question and report back on what exists and what could be compiled.

8.5. Governors also asked for a question template to help governors frame assurance-seeking questions effectively in committees and public sessions.

ACTION: Trust Secretary to identify resources in place to support governors to ask questions and hold to account and circulate details of these.

9. Summary and next steps

9.1. The Chair reiterated his aim to convert today's ideas into an action-oriented agenda, including triaging the proposals into (a) quick wins, (b) feasible with push, (c) not feasible/needs reframing, and will bring that back to the MDWG promptly, well ahead of the April Council of Governors, so that clear proposals can go into the MDWG workplan and the Council pack. He asked the Trust's Membership Officer for prompt minutes to maintain momentum.

9.2. The upcoming member seminars were noted. The Trust's Membership Officer would share a list of seminar topics and dates, to which the Chair would add suggestions.

ACTION: Chair to work with Corporate Affairs to identify a date/time for the next meeting.

Membership Development Working Group Action Plan

DRAFT FOR DISCUSSION

No	Area	Objective proposed by MDWG	Proposed action	Proposed owner	Next steps
1.1	Member Engagement	Expand the scope of member seminars to include opportunity for governors to understand members' interests and needs.	No action proposed. The Membership Office sends follow-up emails after each seminar to gather feedback and invite members to share their interests for future sessions. Therefore, seminar topics are already based on suggestions from members and governors, with a focus on prevention, new treatments, and the latest developments and innovations.	N/a	N/a
1.2	Member Engagement	Hold member seminars on: <ul style="list-style-type: none"> • NHS Oversight Framework segmentation results • Annual results • Strategic plan 	Hold regular members' seminar on the latest NHS Oversight Framework results. Seminars not proposed for: <ul style="list-style-type: none"> • Annual results – these are presented at the Annual Public Meeting held each September. • Strategic plan – as many current members' health seminars are based on elements of the Trust's strategy and operational plan. 	Membership Office	Trust Secretary to discuss feasibility with senior colleagues internally.
1.3	Member engagement	Hold governor-to-member 'town hall' meeting in person.	Suggestion agreed. To be led by governors, held in Governors' hall. Governor task and finish group to be established to consider practicalities, objectives etc. Pilot session to be arranged, with benefits monitored.	Governors (with support from Membership Office)	Membership Office to seek expressions of interest for a governor task and finish group.
2.1	Governor Engagement	Clearer collective purpose on objectives.	<ul style="list-style-type: none"> • This was discussed in part at the governors away day in October 2025. The outcomes/agreements from that session will be recirculated. • Session on governor role and purpose to be added to July 2026 governors away day. 	Governors (with support from Membership Office)	To be discussed with Lead Governor.
2.2	Governor Engagement	Greater guidance about expectations of governors and limits of the governor role.	No action proposed. There is sufficient existing guidance available to governors about their role, including: <ul style="list-style-type: none"> • Governor 'awareness' sessions held prior to elections • Governor introduction meetings • Governor 'core skills' training run by NHS Providers • Governors' handbook (reissued annually) • Monthly newsletter 	N/a	N/a
2.3	Governor Engagement	Assess and advertise required	Section 8.13.2 of the Constitution states governors' tenure of office can be terminated by the Trust if they fail to attend any meeting of the Council of Governors for a consecutive period of twelve months or alternatively for	Governors (with support from	To be discussed with Lead Governor.

No	Area	Objective proposed by MDWG	Proposed action	Proposed owner	Next steps
		time commitment of governors	<p>three successive meetings of the Council of Governors. However, the Constitution does not set out a mandatory time commitment expected from governors, nor is there one in statute, so the Trust is unable to introduce any such requirements.</p> <p>In the guidance provided to governors (referred to in 2.2) the Trust gives its view of how governors can best use their time to make the most of the role.</p> <p>Ahead of the October 2025 away day the Trust ran a short survey for governors, around 18-20 of whom indicated their available time commitment. This session could be re-run at the July 2026 away day if required.</p>	Membership Office)	
2.4	Governor Engagement	Governor-only quarterly meetings, chaired by Lead Governor.	<p>Suggestion agreed, subject to further consultation with the wider Council of Governors. Currently, governors only have 30 minutes each quarter without any Trust colleagues 'in the room'. Governor-only time is important to:</p> <ul style="list-style-type: none"> • Support independence and assurance – it allows governors to test their understanding of issues and reflect honestly on what they've heard from the Board without feeling inhibited. • Build collective capability and confidence – governors can develop a shared view, support newer members, and improve their effectiveness as a body rather than as individuals. • Enable open discussion of sensitive matters – such as Board performance, culture, concerns raised by members or the public, or whether further engagement or escalation is needed. • Help governors prepare more focused questions and feedback for the Chair and Non-Executive Directors, strengthening scrutiny rather than weakening relationships. • Encourage ownership of the role – governors are better able to act as the voice of members and the public when they have space to reflect free from Trust influence. 	Governors (with support from Membership Office)	To be discussed with Lead Governor.
2.5	Governor Engagement	More opportunity to apply individual skills	<p>Suggestion agreed. There was a session at the October 2025 away day about how governors could 'add value beyond the statutory duties' but this was not discussed due to time availability. Governors to consider whether this session needs to be re-run.</p> <p>Governors to make suggestions to Trust about ways in which they can apply their individual skills for the benefit of the Trust.</p>	Governors	To schedule at a future triangulation meeting or governors away day in July 2026.

No	Area	Objective proposed by MDWG	Proposed action	Proposed owner	Next steps
2.6	Governor Engagement	More 'deep dives' by governors.	The Quality and Engagement Working Group, Strategy, Transformation and Partnerships Working Group, and Council of Governors meeting provides opportunity for these deep dives. Chairs of the working groups need to ensure that the agendas are closely aligned with the governors' main priority areas (as agreed at the October 2025 away day). Proposed session at the July 2026 away day to review these priority areas to ensure they remain appropriate.	Governors	Chairs of working groups to take forward.
2.7	Governor Engagement	Governors to attend Integrated Delivery Boards (IDBs) as observers	Trust Secretary to discuss further with colleagues in the Integrated and Specialist Medicine and Evelina clinical groups.	Trust Secretary	Trust Secretary to discuss further with colleagues in ISM and Evelina clinical groups.
2.8	Governor Engagement	Research decrease in Staff governor involvement to identify ways of increasing it.	<ul style="list-style-type: none"> Lead Governor to arrange session with staff governors to understand any issues and provide support. Trust Secretary to write to staff governors to re-emphasise that staff governors have an allowance of time to devote to governor business. 	Lead and Deputy Lead Governor. Trust Secretary	To be discussed with Lead Governor.
2.9	Governor Engagement	Shaping the voice of patient, public and staff voice from 2027/28. The future of the governor role.	<ul style="list-style-type: none"> Initial update on this to be provided by the Trust Chair at the Council of Governors meeting on Wednesday 29 April. Next steps to follow, but will require a task and finish group consisting of governors, Corporate Affairs, other Trust staff (including the patient and public engagement team). Governors to be kept updated at forthcoming public CoG meetings. 	Trust Secretary	Update at CoG on 29 April
2.10	Governor Engagement	Expand governor involvement in other GSTT meetings by encouraging executives to ask for governor attendance.	The Membership Office already sends out messages to staff across the Trust to explain the role of governors, the value they can provide, and encouraging staff to consider asking for governor representatives at their meetings. Membership Office to continue to do this.	Membership Office	N/a
3.1	Patient Engagement	Governor participation in clinical group patient panels	Membership Office to engage with clinical groups and central patient experience team to explore feasibility and, if accepted, determine approach, rules etc.	Membership Office	Membership office to engage with clinical groups and patient experience team.
3.2	Patient Engagement	Patient surgeries/focus groups conducted by governors.	No action proposed for now. It is suggested that the Membership Office's resources are focused on other areas for now – including the 'town hall' idea proposed in section 1.3. Governors have access to significant amounts of patient experience data, so the added value of these surgeries/focus groups is unclear. In addition,	N/a	N/a

No	Area	Objective proposed by MDWG	Proposed action	Proposed owner	Next steps
			our experience of governor involvement in hospital stalls is that most governors are unlikely to participate.		
3.3	Patient Engagement	Governors as volunteers (mystery shoppers, MyChart volunteers)	Proposal accepted in principle. Membership Office to discuss with Patient Experience team.	Membership Office	Membership Office to discuss with Patient Experience team.
3.4	Patient Engagement	Governors to attend Patient Participation Groups (PPG)	Patient and Public Governors to enrol in their local GP practice's Patient Participation Groups to hear and understand patient representatives' views re GSTT at first hand.	MDWG to discuss and assess appetite and availability of Governors	Charles/Elena to add to next MDWG agenda

**COUNCIL OF GOVERNORS
QUALITY AND ENGAGEMENT WORKING GROUP**

**Tuesday 24 March
5.30pm – 7.00pm, MS Teams**

Governors in attendance:	Leah Mansfield, Chair	Samantha Field
	Steve Bean	Charles Mead
	Nigel Beckett	Margaret McEvoy
	Kathryn Blake	Yvonne McPherson
	Victoria Borwick	Daghni Rajasingam
	Felicity Conway	Sheila Reddy

Trust staff in attendance:	Sarah Allen	Elena Spiteri
	Oliver Cook	Mark Tsagli
	Anna Grinbergs-Saull	Jeanette Rhodes
	Charles Martin	Holly Wharton
	Aimee Porter Smith	

1. Welcome

1.1. The chair welcomed attendees to the Quality and Engagement Working Group meeting.

2. Minutes of the previous meeting and matters arising.

2.1. The minutes of the meeting held on 11 November were approved as an accurate account of the meeting.

2.2. Governors noted updates made to the actions from the previous meeting.

Action: Epic benchmarking insights and learning to be shared in a future report.

3. My Chart: patient and public engagement

3.1 The Trust's Programme Manager for Transformation provided an update on My Chart optimisation and patient engagement in the programme.

- 55% of all outpatients in GSTT and KCH are now signed up to My chart. (Over 890,000 patients). Work continues to encourage patients to sign up.
- Patients and carers have been involved throughout the programme. To support increased sign-ups, patient engagement delivery has focused on:
 - Digital inclusion and initiatives to address digital inequality
 - Demographic insights to understand the demographics of patients who are not using MyChart
 - Targeted patient engagement activities to co-design communications and campaigns.
- As well as informing the design of the app, patients have been involved in continuous improvement of the MyChart app since its launch. Patient views collected through involvement activities, patient experience feedback, complaints and helpdesk enquiries have driven improvements to:
 - Reporting and sharing results with patients
 - Appointment cancellation – allowing patients to cancel appointments up to 1 minute before the appointment time
 - Accessible routes to access the app (SMS, email)
- The programme team has worked with the Trust PPE team to establish a joint Digital Patient Panel for GSTT and KCH. The panel includes 60 people aged 16 and over and will help design and improve digital services, including MyChart. Additional panel members may be recruited later in the year.
- The programme team has also worked with Clear Community Web, to deliver community outreach to people and communities at risk of digital inequity. 56 events across 19 areas in South East London, aimed at supporting people to learn how to access and use the MyChart app.
- Further improvement and engagement activity will focus on:

- Continuing sustainable improvement to the app via the Digital Panel, helpdesks, and patient experience and digital volunteer feedback
- Working with children, young people and parents to improve sign-ups and proxy access
- Improving patient experience of receiving appointment information
- Further addressing digital inclusion
- Single sign-on using NHS app credentials
- Improved self-scheduling in MyChart.
- Exploring patient-initiated messaging.

3.2 Governor discussion noted the following:

- The importance of focusing improvement activity on letters and test result delivery and patient initiated messaging.
- The need to address ongoing patient concerns about the useability of information provided on Mychart.
- Continued patient interest in integration with other apps including NHS app and GP systems.
- The need for further clinical engagement and training to ensure clinical teams are able to use all Epic functions effectively. To support the sustainable delivery of additional messaging and results functions.
- The impact of MyChart on DNA rates. Recent analysis is to be reported to the MyChart management group in April 2026. Early outcomes suggest that MyChart role out is having a positive impact.
- An interest in further targeted engagement activities, particularly with patients aged 80 and over. There have not been specific activities for this cohort, other than those focused on proxy access.
- The needs and experiences of adult patients with a learning disability and neurodivergent people, particularly regarding DNA rates and safeguarding. Tools to better support vulnerable adults and patients with complex needs are being developed.
- The importance of considering digital poverty alongside digital inclusion.

4. Quality Assurance. Trust quality priorities: update:

The Trust Quality and Assurance Manager, Senior Quality and Compliance Lead and Head of Risk and Quality Assurance provided an update on the Trust quality priorities for 2026-27.

4.1 Two priorities from 2025-26 have not been carried forward:

- Administrative safety: the aim to develop a monitoring dashboard has been achieved
- Clinical guidance: the main objectives to improve our processes for development, review, approval and publication of clinical guidance has been achieved.

4.2 The Quality priorities and objectives for 2026-27 are

- Patient safety: reducing instances of verbal and physical violence and aggression (carried forward from 2025-26), improving procedural safety
- Clinical effectiveness: implementing Martha's Rule component 1, data-led approach to transforming outpatient care, maximise the functionality of Epic
- Patient experience: improving patient experience through the "Contacting Us" programme

4.3 In discussion, Governors asked questions regarding

- The use of research or national approaches to addressing violence and aggression, and if there are opportunities to learn from the way other Trust's have approached a common challenge.
- Whether dementia and delirium (DaD) could be considered within the violence and aggression objective, to ensure patients experiencing DaD are reflected in monitoring.
 - The scope and wording of this work is under development and there will be opportunities for staff to contribute.
- How the implementation of advice and guidance to GPs is being monitored to ensure it is effective and supports patients receiving the right care, and how this is monitored through Epic.
 - It was agreed that this would be discussed further at a future meeting.

Action: Advice and guidance implementation and monitoring to be added to a future meeting agenda.

5. Patient and public engagement and patient experience updates

5.1. Quarterly reports for Patient Experience and Patient and Public Engagement were circulated in advance of the meeting. The Head of Patient Experience and Senior PPE Manager took questions and comments.

5.2. Governors raised comments regarding:

- The impact of the “Contacting Us” programme and investment in communications methods on patient experience.
 - The programme, funded by GSTT charity, and a number of other initiatives are underway but impact data is not yet available. This will be reported to Governors when there is sufficient data.
- Improvement programmes taking place in Maternity services to respond to patient experience reporting.
 - The Maternity Good to Outstanding programme is developing widespread improvement plans. A further update will be provided before the next QEWG meeting.
- The range of volunteering activities noted in the patient experience report, and whether more information is available on the demographics of Trust volunteers.
 - This information is regularly reported to NHS England and will be provided at the next meeting.
- The depth and quality of patient involvement taking place across the Trust. Governors noted a perceived increase in activity and notable impact on services and patients.

Actions:

- **“Contacting Us” programme updates and impact to be included in a future agenda**
- **Trust staff to provide an update on the Maternity Good to Outstanding programme.**
- **Patient Experience team to include the demographic breakdown of volunteers in the next meeting report.**

6. Reports/updates from committees recently attended by Governors

6.1. None discussed.

7. Any other business

7.1. Formal thanks extended to Leah Mansfield as the outgoing working group chair. Margaret McEvoy welcomed as the new chair.

The next meeting would be held on 23 June 2026