GSTT Public Council of Governors meeting

Wednesday 22 July 2026, 18:00 - 19:30

Robens suite and online

Agenda

18:00 - 18:00
0 min

1. Welcome and apologies

Charles Alexander

18:00 - 18:00
0 min

2. Declarations of interest

18:00 - 18:05
5 min

3. Minutes of previous meeting (28 April 2026) and review of actions

[3] 20260429 Public CoG Meeting Minutes vDraft.pdf (3 pages)

18:05 - 18:25
20 min

4. Annual Report and Accounts 2025/26

Amanda Pritchard and Steven Davies

[5] Annual Report and Accounts_CoG.pdf (1 pages)

18:25 - 18:40
15 min

5. NHS Health Bill – implications for the Council of Governors and Trust members

[6] Summary of future arrangements for patient public and staff voice following changes to Council of Governors functions FINAL.pdf (3 pages)

18:40 - 18:50
10 min

6. Governors' reports for information

6.1. Lead Governor's Report

[7.1] Lead Governor's Report Jul26.pdf (3 pages)

6.2. Membership Development Working Group

Charles Mead

[7.2] 20260512 MDWG meeting minutes.pdf (3 pages)

6.3. Strategy Transformation and Partnership Working Group

Thomas Sheridan

[7.3] 20260519 STPWG meeting minutes.pdf (3 pages)

6.4. Quality and Engagement Working Group

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[7.4] 20260623 QEWG 23 June notes (final).pdf (6 pages)

18:50 - 19:20 30 min

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

19:20 - 19:25 5 min

8. Any other business

COUNCIL OF GOVERNORS

Wednesday 29 April 2026, 6pm – 7.30pm
Governors' Hall, St Thomas' Hospital and MS Teams

Governors present:	Steven Bean	Charles Mead	Daghni Rajasingam
	Kathryn Blake	Margaret McEvoy	Sheila Reddy
	Victoria Borwick	Patrick Miller	Thomas Sheridan
	Michael Bryan	Gavin Morrison	Darren Summers
	Felicity Conway	Alison Mould	Cordwell Thomas
	Katherine Etherington	Mary O'Donovan	Peter Yeh
	Leah Mansfield	Samuel Oloye	
In attendance:	Charles Alexander (Chair)	Simon Friend	Pauline Philip
	Edward Bradshaw (minutes)	Felicity Harvey	Amanda Pritchard
	Avey Bhatia	Sara Hanna (to item 6)	Elena Spiteri
	Steven Davies	Jamie Heywood	Ingrid Wolfe (to item 6)
	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, Emma Barslund Blackman, Nigel Beckett, Annette Boaz, David Bridson, Samantha Field, Emily Hickson, Michael Mates, Yvonne McPherson, Stephanie Petit, Mercy Satoye, Kendra Schneller, Helen Selvarajan, Dominic Shaw, and Jadwiga Wedzicha, and from non-executive directors Miranda Brawn, Nilkunj Dodhia, Deirdre Kelly, Graham Lord, Ian Playford, and Alison Wilcox.

2. Declarations of interests

2.1. No declarations of interest were received.

3. Minutes of the meeting held on 29 January 2026

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

4. Cardio-Respiratory & Intensive Care (CRIC) service update

4.1. Governors received a verbal update on progress towards the temporary transfer of children's cardio-respiratory and intensive care inpatient services from Royal Brompton Hospital to the St Thomas' Hospital site, which had been mandated by NHS England. The programme had been running for several months and was in its final stages of preparation, with oversight in place across workforce, clinical governance, estates, IT, equipment, operational logistics and partner engagement.

4.2. A clinical readiness assessment had recently been undertaken, providing assurance that key risks and safety considerations had been identified and mitigated. The Trust had entered a period of pre-transfer operational planning, including a controlled reduction in activity to minimise the number of children requiring physical transfer on the day of the transfer, phased movement of services between wards, and structured staff induction and training to ensure safe service delivery from day one.

4.3. It was noted that the transfer was being managed using established tactical and escalation arrangements, with senior clinical and operational visibility during and immediately after the move. In the Trust's view, the principal risk related to staff anxiety, which increased the importance of leadership

visibility, wellbeing support and open communication to address concerns and maintain a focus on safe and effective care.

4.4. Governors sought assurance regarding contingency arrangements should demand increase during the transition period. It was confirmed that mutual aid arrangements with partner organisations were in place and that elective activity would only be adjusted when it was clinically safe to do so. Confidence was expressed that the Trust had sufficient workforce, capacity and system support to complete the transfer – planned for mid-May – safely.

5. Population health update

5.1. The Council received a presentation on the Trust's developing population health approach, noting that this work had been established as a Trust-wide function building on earlier experience within children's services. Population health was described as an outcome-focused, data-led approach to improving health and reducing inequalities by shifting the system from reactive treatment towards prevention, early intervention and proactive care based on population need.

5.2. The approach had included the use of population-level data to identify unmet need, inform service design and target interventions, with a focus on health equity and outcomes rather than activity alone. An illustrative case study relating to childhood asthma demonstrated how integrating clinical care with social and environmental interventions could reduce avoidable hospital attendance, improve wellbeing and address inequalities. This work had been supported by evaluation and learning mechanisms intended to enable continuous improvement.

5.3. Discussion highlighted the importance of robust evaluation to distinguish the impact of health system interventions from wider environmental and policy changes, and it was noted that controlled studies and ongoing research partnerships had been used to support this. Questions were raised about housing, air quality and wider economic pressures, with acknowledgement that many determinants of health sat beyond direct NHS control. The Trust's role as an advocate and partner within the wider system, including collaboration with local authorities, research partners and regional programmes, was emphasised.

5.4. Governors welcomed the work and reflected on the need for distributed leadership, organisational commitment and alignment across partners to embed a population health mindset. The initiative was recognised as ambitious, long-term and strategically significant for the Trust.

6. CQC well-led inspection update

6.1. An update was provided on regulatory engagement with the Care Quality Commission (CQC). It was confirmed that service-level inspections had commenced, with a well-led inspection to follow later in the inspection cycle. The timing of the well-led inspection had not yet been confirmed, though a minimum notice period was expected.

6.2. The well-led inspection was an assessment of the strength of the Trust's leadership and governance and would focus on areas including risk management, quality improvement and responsiveness to patient and staff feedback. Governors would be invited to participate in a focus group as part of the inspection process. To help prepare governors for this and provide further insight into the inspection approach, a briefing pack had been circulated, and a mock focus group session had been arranged for the following week. Participation in the CQC focus group was encouraged but not mandatory.

7. Council of Governors and the ten-year health plan

7.1. The Council considered anticipated changes arising from the Government's ten-year health plan and associated legislative proposals, including the planned removal of the statutory requirement for NHS foundation trusts to have councils of governors and members. While the detailed legislative position remained uncertain, it was noted that the direction of travel implied greater central oversight and changes to existing accountability arrangements.

7.2. It was emphasised that the Council of Governors' statutory role and responsibilities remained unchanged unless and until legislation received royal assent, and that normal governor business would continue in the meantime. The potential loss of formal structures was acknowledged as a significant change; however, it was also framed as an opportunity for the Trust to develop more effective and inclusive mechanisms for patient, public and stakeholder engagement.

7.3. Governors were invited to work collaboratively with the Trust, including executive and non-executive directors and relevant managers, to help shape alternative arrangements aligned with the principles set out in the ten-year plan, with a focus on meaningful representation, accountability and insight. The importance of learning from developments across London and nationally, including engagement through governor networks and peer trusts, was noted. Further discussion was proposed through existing forums and forthcoming governor development events.

ACTION: Corporate Affairs to add topic to the next triangulation meeting and governor away day agendas.

8. Governors' reports for information

8.1. Governors noted reports provided for information, including updates from the Lead Governor and its working groups. Specific positive achievements highlighted included improvements in service performance measures and continuing engagement activity. The Lead Governor thanked Leah Mansfield for her hard work as chair of both the Quality and Engagement, and Strategy, Transformation and Partnerships working groups over the last few years. Governors were encouraged to note a draft action plan that had been developed following discussions at the previous Membership Development Working Group meeting.

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

9.1. A question-and-answer session was held covering safety, quality, access and patient experience. Governors raised concerns regarding never events and healthcare-associated infections, noting an increase compared with previous years. It was confirmed that each incident had been reviewed in detail, common themes had been identified, and further actions were underway through established governance and quality committees, with a renewed organisational focus on safety culture and learning.

9.2. Issues relating to patient access, including difficulties with telephone contact and communication, were reiterated as ongoing concerns requiring further attention. Governors also raised questions regarding the implementation of advice and guidance within new primary care arrangements, particularly around patient visibility, waiting times and avoidance of patients being left in uncertainty. It was noted that further work was ongoing to design robust processes that supported patient understanding and timely care.

9.3. The Chair and non-executive directors acknowledged the issues raised, reaffirmed the Trust's commitment to transparency, learning and improvement, and thanked governors for their role in representing patient and public perspectives.

10. Any other business

10.1. There was no other business. The next meeting of the Council of Governors would be held on 22 July 2026.

Guy's and St Thomas' NHS Foundation Trust

COUNCIL OF GOVERNORS

WEDNESDAY 22 JULY 2026

Report title:	**Annual Report and Accounts 2025/26**
Executive sponsors:	Amanda Pritchard, Chief Executive and Steven Davies, Chief Financial Officer
Report author:	Edward Bradshaw, Director of Corporate Governance and Trust Secretary
Purpose of report:	For awareness/noting only This is a requirement under the Trust's Constitution
Previously presented at:	Board of Directors, June 2026
Key points of report:	• Per the Trust's Constitution *The Board of Directors shall present to the Council of Governors in a general meeting the Trust's annual accounts, any report of the auditor on them, and the Trust's annual report*. • Receiving these documents is therefore one of the governors' key statutory duties. • The Trust has submitted its Annual Report and Accounts 2025/26 to be laid before Parliament; however, as at the time of writing (15 July), the Trust had not received confirmation that it had been laid. • National guidance is clear that the Annual Report and Accounts cannot be published (including in public-available meeting papers) until it has been laid before Parliament. As such, in order to discharge this duty, the Trust has provided governors with soft copies of the Annual Report and Accounts 2025/26 and the relevant auditor's reports under separate/private cover. • Once the Annual Report and Accounts has been laid before Parliament it will be published on the Trust's website.
Primary BAF risk:	Risk 11: Organisational excellence
Supporting material:	All governors have received the Annual Report and Accounts 2025/26 and the relevant external auditor's reports.
Recommendation(s):	The COUNCIL OF GOVERNORS is asked to: 1. **Receive and note** the Trust's Annual Report and Accounts, and the external auditor's reports.

Paper A: Summary of the Council of Governors' current views regarding future arrangements for patient, public and staff voice following the anticipated abolition of the Council of Governors

For: GSTT Council of Governors and members of the Board of Directors

Purpose: To present governors' initial views regarding the preferred direction for future patient, public and staff voice arrangements following the expected abolition of statutory Council of Governors functions from April 2027.

Context

The NHS 10-year plan, published in July 2025 stated:

We will remove the requirement for foundation trusts (FTs) to have governors. While governors have provided helpful advice and oversight for some FTs, we expect the next generation of NHS FTs 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.

The NHS Modernisation Bill – which is currently making its way through Parliament – is expected to enable the removal of statutory Council of Governors functions and the associated Foundation Trust membership model from April 2027. GSTT will therefore need to decide what, if anything, should replace the current arrangements.

At the Council of Governors meeting on 29 April the Trust committed 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." To date, no guidance has been issued by NHS England or the Department for Health and Social Care to help foundation trusts decide or shape any new arrangements.

On 3 July the GSTT Council of Governors held its annual away day, where a primary focus of the discussions was to reach a collective view about what the new arrangements should be, in order to aid the Trust's considerations. During the away day it was agreed that the Trust should not seek to recreate the Council of Governors under another name. However, allowing the current model to fall away without replacement would risk losing important functions: independent patient, public and staff voice; visible escalation; structured engagement; public-facing accountability; and a route for issues that cut across existing Trust structures.

This creates an opportunity for GSTT to develop a simpler, more representative and more purposeful model, using the flexibility expected under the new statutory framework that could also help shape arrangements across the NHS.

Recommended approach

Following the away day, governors recommend that the Trust should develop a **GSTT Patient, Public and Staff Voice Model.**

This would include:

1. **A central Patient, Public and Staff Voice Forum**
   Around 20 to 25 members, including patient, public, carer and staff voices, with representation designed to reflect the communities and services GSTT serves.
2. **A representative pool for Trust committees and engagement routes**

Forum members could contribute to relevant Board-level committees, patient experience work, population health activity, service change programmes and staff experience work including statutory consultations where appropriate.

3. **A focused annual work programme**
   The forum would undertake 3 to 4 focused reviews each year on agreed Trust priorities, and areas raised by patients, public and staff using a call-for-evidence style approach. Reviews would produce short reports, recommendations and formal Trust responses.
4. **An annual public meeting or report**
   GSTT would retain a visible public-facing accountability route, setting out what was heard, what changed, what remains unresolved and the Trust's response to the recommendations and what comes next
5. **A renewed public engagement/membership offer**
   Subject to UK GDPR and relevant data protection requirements, GSTT could invite current members, neighbourhood and community partners, specialist patient groups and wider communities to opt in to a new public engagement network, broadening reach beyond the existing statutory membership model.
6. **A supporting London learning layer**
   GSTT could work with other London trusts to share good practice, public seminars, templates and learning. This would support the Trust model, not replace it, and would position GSTT as a leading organisation shaping credible post-CoG arrangements.

Why this option

This approach gives the Board a practical route between two weaker alternatives: recreating the current Council of Governors model, or doing nothing. The proposed approach would:

- preserve the strongest elements of the current arrangements;
- reduce cost and complexity;
- avoid routine NED accountability sessions becoming burdensome;
- create clearer outputs through focused reviews;
- support Board assurance through existing committees;
- provides proportionate, timely and transparent accountability;
- broaden public engagement after statutory membership ends;
- provide a model that could be shared across London and beyond.

Options considered

Option	Summary	Assessment
A. GSTT Patient, Public and Staff Voice Model	Central forum, representative pool, focused reviews, annual public reporting, renewed engagement offer and London links.	**Recommended.** Best balance of renewed focus, simplification, Board support and public legitimacy.
B. Strengthen existing routes only	Rely on PPE, Patient Experience, PALS, complaints, staff networks, Staff Side, IHOP and improved reporting.	Simpler, but risks losing independent cross-cutting voice.
C. London/system model	Prioritise London-wide or place-	Useful as a supporting layer, but

first	based arrangements.	too diffuse as GSTT's main response.
D. Do nothing	Allow current arrangements to lapse when statutory duties end.	Not recommended. Lowest burden, but highest risk to voice and accountability.

Proposal:

The Council of Governors and members of the Board are asked to:

1. Note governors' initial views regarding 'successor' arrangements for the Council of Governors, should it be abolished.
2. Agree governors should develop a more detailed design paper – and present this at the next Council of Governors meeting in October – that covers composition, selection, reporting routes, costs, transition arrangements, public engagement/membership, and draft terms of reference.
3. Agree to remain receptive to input from other stakeholders and any national guidance that may be issued, as the Trust designs new arrangements for patient, public and staff voice.

COUNCIL OF GOVERNORS
WEDNESDAY 22 JULY 2026

Report title:	**Lead Governor's report**
Report author:	Katherine Etherington
Purpose of report:	For awareness/noting only
	The Lead Governor
Previously presented at:	-
Key points of report:	• 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.
Primary BAF risk:	Risk 11: Organisational excellence
Supporting material:	N/a
Recommendation(s):	The BOARD is asked to: 1. **Note** the report.

1.1. Since April there has been a lot of activity amongst the Council of Governors. I would like to thank all governors who attended the recent Away Day, more details of which are set out below. I also chaired the first London Governor Conference with attendance from various trusts across London which was incredibly insightful and useful, and I would encourage all governors to read the notes of the meeting. The past few months have seen many working groups convene and start to think about what is next for the Council of Governors. We have also welcomed a new member of the Council, David Chatt, staff governor, following the departure of Cordwell Thomas to pastures new. I know you will all join me in welcoming David.

1.2. The London Governor Conference in June was attended by fellow governors from King's, University College London Hospital, and Homerton. During the Conference governors considered the implications of proposed legislative changes to councils of governors and explore how the most valuable elements of governor activity could be retained in future. The discussion highlighted widespread uncertainty across trusts, alongside a shared view that patient, public and staff voices must continue to have meaningful routes into decision-making. Conference attendees identified structured governor visits, observational assurance, community engagement, staff voice, public education events and clear mechanisms for escalating feedback as key strengths worth preserving. While there was limited support for formal lobbying to retain existing statutory structures, there was strong consensus that successor arrangements should focus on representation, accountability, visible responses to feedback, collaboration with patient experience teams and inclusion of diverse communities. Attendees also agreed on the value of establishing a London-wide network to share good practice, support transition planning and help shape future engagement models. A discussion paper will be developed by myself, Tommie Sheridan and Alison Mould to reflect these principles and set out possible options for future arrangements. The group plans to reconvene in the autumn to discuss the paper produced, gather feedback from other trusts, and reflect any emerging national policy developments. It was also agreed that this paper would take into account discussions at the Guy's and St Thomas' Away Day in July. The paper will also be shared with the National Lead Governor's Association which I think will provide some useful feedback and challenge.

1.3. The Annual Away Day, this year held on 3 July 2026, was well attended and focussed on what we would like to achieve ahead of the anticipated abolition of foundation trust councils of governors. Governors considered the implications of the Government's proposals and the future of patient, public, staff and member engagement within GSTT. Governors expressed strong support for retaining a mechanism that preserves independent challenge, community representation and accountability, particularly in relation to holding Non-Executive Directors (NEDs) to account for engagement, listening and escalation of concerns. There was broad consensus that governors provide a valuable independent voice, bringing together the perspectives of patients, staff, members and local communities in a way that complements, rather than duplicates, existing engagement channels.

1.4. Discussion focused on developing a successor model that would retain the most effective aspects of the current arrangements, including representation of local populations, patient and public voice, staff engagement, structured feedback and escalation routes, and oversight of

issues affecting quality of care and patient experience. Ideas included the creation of a representative advisory body of approximately 20–25 individuals drawn from patients, public, staff and carers, potentially operating through focused task-and-finish groups. Governors emphasised the importance of ensuring any future arrangements are representative, straightforward and evidence-based, whilst avoiding duplication of existing structures such as Patient and Public Engagement (PPE), Patient Experience teams, staff engagement mechanisms and the Improving the Health of Our Populations (IHOP) Committee.

1.5. Governors also highlighted concerns regarding how staff concerns and public feedback would be escalated to Board level in the absence of a Council of Governors, noting the need to maintain clear links between staff engagement, staff wellbeing and patient outcomes. Members stressed the importance of understanding current engagement and assurance arrangements before proposing new structures and suggested that governors should play an active role in shaping future options for consideration by the Board. There was support for continuing member health seminars, exploring opportunities for London-wide collaboration and shared learning, and maintaining advocacy for retaining meaningful public accountability and influence within NHS governance arrangements as national policy develops.

1.6. Following the Away Day, we have pulled together a paper of recommendations for what we would think should be the new look and responsibility of a patient, public and staff voice group. This has been circulated to the Council for comment and will be presented to the Board at the Council of Governors meeting.

1.7. I would like to remind you all that being a member of the Council is what you make it. If you would like to attend a training session, visit or sit on a committee or working group, please contact Corporate Affairs. Similarly, if you would like to contribute to the ongoing work being on the future of patient, public and staff voice, please do not hesitate to contact myself or Alison.

1.8. Finally, on behalf of all the governors, I would like to thank Edward Brashaw for all of his work to support the Council of Governors. Ed has been a constant supporter of the work the Council does, answers some very, at times, tricky questions and generally offers support to all members of the Council. It has been a privilege to work alongside him and he will be sorely missed by many. We all wish him the very best in his next role and hope he stays in touch!

Guy's and St Thomas' NHS Foundation Trust

COUNCIL OF GOVERNORS
MEMBERSHIP DEVELOPMENT WORKING GROUP

Tuesday 12 May 2026
5.30pm – 7.00pm, MS Teams

Governors in attendance:	Charles Mead (Chair)	
	Steve Bean	Margaret McEvoy
	Kathryn Blake	Alison Mould
	Victoria Borwick	Gavin Morrison
	Felicity Conway	Pater Yeh
	Leah Mansfield	Samuel Oloye
Trust staff in attendance:	Edward Bradshaw	Stephanie Calvert
	Elena Spiteri	

1. Welcome and apologies

1.1. The Chair welcomed members to the meeting of the Membership Development Working Group ('the Group' or 'MDWG'). The Chair explained that the main purpose was to review the draft action plan arising from the previous meeting.

1.2. Apologies for absence were received from Stephanie Petit and Jadwiga Wedzicha.

1.3. It was noted that the Group should continue to focus on three areas: member engagement, governor engagement, and patient/public involvement.

2. Declarations of interest

2.1. No relevant interests were declared.

3. Action Plan

3.1. It was agreed that Action 1.1, on expanding the scope of seminars, should be removed, and that seminars should continue to be delivered based on member feedback and staff suggestions.

3.2. Action 1.2: Members' seminars: The Group supported the scheduling of up to two member seminars each year on Trust performance topics, including the NHS Oversight Framework and the Annual Report and Accounts. A seminar on the strategic plan was not prioritised at this stage, noting that members and governors already receive substantial information on this through existing presentations, members' health seminars and other working groups.

3.3. Governors emphasised the need to understand members' interests and priorities. The Membership Office confirmed that registration data and post-event feedback are collected and could be shared with governors. It was also noted that future governor newsletters could highlight feedback received and identify seminars delivered in response to member suggestions.

3.4. The Group considered that the current APM (Annual Public Meeting) format is not provide sufficient opportunity for members to engage in detail with the Annual Report and Trust performance from the previous financial year. It was noted that this issue had already been raised with Communications colleagues and should be pursued further.

ACTION: Tell presenters to simplify their presentations at health seminars (even if slides are complicated) - talk to them as patients not fellow clinicians.

3.5. Action 1.3: Governor-to-member town hall: The Group supported a governor town hall-style event in principle. The Deputy Lead Governor agreed to work with the Trust Secretary and Membership Office to develop outline proposals and an agenda for consideration at the Governors' Away Day. An indicative timeframe of October to November was noted.

3.6. The Group also discussed the possibility of open public question-and-answer sessions on services. While examples of good practice were noted, concerns were raised about scope, personal case discussions and legal risk. No action was agreed at this stage.

3.7. In relation to governor engagement, several items were paused or deprioritised in light of the uncertain future of the governor role.

3.8. Actions 2.2 and 2.3: Greater guidance about expectations of governors and limits of the governor role & Assess and advertise required time commitment of governors: It was agreed that no further action would be taken at this stage given the uncertain future of the governor role.

3.9. Action 2.4: Governor engagement – governor-only quarterly meetings chaired by the Lead Governor: A proposal to hold governor-only meetings was supported, with the next meeting confirmed for 3 June at 4.00pm at St Thomas' Hospital, to be held in person. It was noted that the invitation still needed to be circulated to all governors.

3.10. Action 2.5: Governor engagement – more opportunity for governors to apply individual skills: The Group considered whether further work should be taken forward on creating more opportunities for governors to apply their individual skills and expertise. Given the current uncertainty about the future of the governor role, it was agreed that this action should be placed on hold until further notice.

3.11. Action 2.6: Governor engagement – more deep dives by governors: The Group discussed the proposal to use 'deep dives' to help governors build a stronger evidence base on issues of public, patient or strategic importance, in order to inform discussion at Triangulation and Council of Governors meetings. It was agreed that deep dives should be focused, time-bound pieces of work, with topics identified in advance and allocated to the most appropriate forum or working group.

3.12. Action 2.7: Governor engagement – attendance at Integrated Delivery Boards as observers: The Trust Secretary agreed to explore whether governors could attend the Integrated Delivery Boards for Southwark and Lambeth in an observer capacity.

3.13. Action 2.8: Governor engagement – staff governor involvement: The Group discussed lower attendance by staff governors and reaffirmed the value of their contribution.

3.14. Action 2.9: Governor engagement – future of the governor role from 2027/28: The Group discussed the possible implications of expected national changes and agreed that the Trust should remain prepared to respond once the national position becomes clearer. The possibility of a further joint working group, involving governors and Trust representatives, was noted for later consideration once more detail is available.

3.15. The Group noted that any future model would likely require a process of co-design involving governors, Trust representatives and others, once greater clarity is available nationally.

3.16. Action 3.10: Patient engagement – governor participation in clinical group patient panels: The Group noted ongoing work to explore governor involvement in clinical group patient panels. Focus groups remained a possible future action but were placed on hold for the time being.

4. Healthwatch and Patient insight

4.1. The Group discussed the value of stronger links with Healthwatch and with existing patient experience reporting as a way of strengthening governors' understanding of patient and public views. It was

suggested that engagement with local Healthwatch organisations should be explored, including whether Healthwatch representatives could share relevant insight with governors.

ACTION: Membership Office to discuss prospect of Healthwatch CEOs attending a governor meeting with Gavin Morrison.

4.2. The Group noted that patient experience and PALS reports available through the Quality and Engagement Working Group should continue to be used as a source of insight.

5. Any other business

5.1. It was agreed that the minutes of this meeting, the updated action plan, the minutes of the previous MDWG meeting, and the slides from the last away day should be circulated in advance of the next away day.

Guy's and St Thomas' NHS Foundation Trust

COUNCIL OF GOVERNORS
STRATEGY, TRANSFORMATION & PARTNERSHIPS WORKING GROUP

19th May 2026
5.30pm – 7.00pm, MS Teams

Governors in attendance:	Tommie Sheridan, Chair Kathryn Blake Nigel Beckett Felicity Conway Victoria Borwick	Yvonne McPherson Margaret McEvoy Gavin Morrison Leah Mansfield
Trust staff in attendance:	Jackie Parrott Robin Firth (Joined for item 5 only) Anna Grinbergs-Saull (Joined for item 5 only)	Simon Bampfylde (Joined for item 6 only) Nina van Zyl Sally Halford (Joined for item 5 only)

1. Welcome

1.1. The Chair introduced himself as the new chair and welcomed everybody to the Strategy, Transformation and Partnership Working Group. Apologies were noted.

2. Minutes of previous meeting

2.1. The minutes of the meeting held on 17th February 2026 were approved.

3. Declaration of interest

3.1. There were no declarations of interest.

4. Previous meeting report and matters arising

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

5. Satellite and home haemodialysis services

5.1. Robin Firth (General Manager for Transplant, Renal and Urology), and Sally Halford (Matron for Transplant, Renal & Urology) presented on the planned re-procurement of satellite and home haemodialysis services. A briefing letter and Frequently Asked Questions document were shared in advance of the meeting. The presenters noted the following points during the meeting.

5.2. Current dialysis service: The existing dialysis service was described as an integrated model, including six satellite dialysis units distributed across South East London (three staffed by the Trust, three staffed by an independent provider (Diaverum), who also provide facilities management at all six units).
It was explained that the partnership model has evolved over a 15-year contract and has been broadly positive, with high-quality outcomes and strong working relationships between the Trust and the independent provider. The Trust also provides a home dialysis offer, with specialist Trust teams responsible for patient training, clinical care, and ongoing support.

5.3. Rationale for re-procurement: The re-procurement is required under procurement law, as the current contract is due to expire in 2027. It was emphasised that this process represents a significant opportunity for the Trust to:

- Review the service model comprehensively
- Improve patient experience
- Introduce innovation where appropriate
- Future-proof services against demand and workforce pressures

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The presenters provided an overview of the re-procurement timeline. The evaluation framework will be weighted towards quality and patient care (60%), with cost (40%) also considered, reflecting the scale of investment and importance of value for money.
A strong emphasis was placed on patient and public involvement. Plans are in place to ensure ongoing engagement with patients and carers throughout procurement evaluation, implementation planning and service mobilisation.

5.4. Key discussion points

- The group emphasised the importance of ensuring that engagement approaches capture the full diversity of patient voices, particularly those who are frail, vulnerable or digitally excluded.
- Members acknowledged the significant impact of dialysis on patients' daily lives.
- The expansion of home dialysis was strongly supported, with presenters assuring the group that decisions are clinically led and patient-centred, rather than cost-driven.
- There was discussion around challenges to future planning as historical projections have indicated significant growth while recent trends have been more uncertain, requiring careful planning assumptions.
- Governors expressed interest in the role of innovation, particularly health technology. It was confirmed that the procurement process is designed to encourage providers to propose innovative solutions and allows flexibility to incorporate new technologies
- Environmental sustainability was highlighted as an emerging priority, including opportunities through Green Nephrology initiatives to reduce environmental impact of dialysis delivery.

6. Integrated Neighbourhood Teams

6.1. Simon Bampfylde (Director of Strategy for Integrated Specialist Medicine) introduced the Integrated Neighbourhood Teams programme as a central element of the Trust's strategy for delivering more effective, integrated care. The programme responds to a well-recognised system challenge, a small proportion of the population accounts for a disproportionately high level of healthcare utilisation and patients with complex needs often experience fragmented, difficult to navigate services. INTs aim to address this by providing coordinated, person-centred care at neighbourhood level. They recognise that many drivers of poor health are non-medical, including housing, social isolation and access to support services.

6.2. Implementation: The programme formally launched on 1 April 2026 and is currently in a test-and-learn phase. Progress to date includes:

- Establishment of neighbourhood structures across Lambeth and Southwark
- Recruitment of new roles, inc. clinical leads and care coordinators
- Initial alignment of community services
- <100 patients seen to date, with expectations to rapidly scale

The programme aims to scale to a level comparable with a large urban population, demonstrating integrated care at meaningful system scale for the first time. There is a strong emphasis on system-wide transformation, including integration with social care and wider public services.

6.3. Key discussion points

- The group discussed the age thresholds currently in place to identify cohorts
- The group highlighted structural challenges within the workforce including increased specialisation of clinicians and a need for more generalist, holistic care models
- Social prescribing and broader community-based interventions were confirmed as integral to the model, with emerging roles focused on connecting patients to services.
- The importance of robust evaluation was strongly emphasised.
- Members noted that benefits from preventative interventions will accrue over time, however INTs require upfront investment and strong alignment between primary, community and secondary care.

7. Report updates for committees attended by Governors

7.1. No report updates from Governors

8. AOB

8.1. There were no items of AOB.

The next meeting would be held on ***22 September at 5.30pm – 7pm. Meeting to be held on Microsoft Teams.***

COUNCIL OF GOVERNORS
QUALITY AND ENGAGMENT WORKING GROUP

Tuesday 23 June 2026
5.30pm – 7.00pm, MS Teams

Governors in attendance:	Margaret McEvoy, Chair	Gavin Morrison
	Steve Bean	Mary O'Donovan
	Emma Blackman	Yvonne McPherson
	Kathryn Blake	Kendra Schneller
	Victoria Borwick	Alison Mould
	Felicity Conway	
	Leah Mansfield	
Trust staff in attendance:	Sarah Allen	Elena Spiteri
	Oliver Cook	Mark Tsagli
	Anna Grinbergs-Saull	Holly Wharton
	Oliver Cook	Maggie Boreham
	Ciara Mackay	

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 24 March were approved as an accurate account of the meeting.

2.2. Governors noted the responses provided by the Head of Patient Experience to the actions arising from the previous meeting. It was noted that the written responses to the actions would be circulated with the minutes of the 23rd of June meeting. See Annex 1.

3. Supporting the needs of vulnerable patients

3.1 The Director of Nursing for Safeguarding and Vulnerable Adults and the Trust's Planning and Performance Manager delivered a presentation on the Trust's arrangements and governance structures in place for supporting and protecting vulnerable patients.

- Supporting vulnerable patients is a key priority for the Trust**.** A dedicated portfolio oversees initiatives aimed at improving the experience and outcomes of vulnerable people using our services. This includes:
    - Individuals with safeguarding needs, including both children and adults at risk, as well as those experiencing abuse, neglect, or exploitation.
    - Patients requiring additional support, including people with learning disabilities, autism, neurodivergent conditions, mental health needs, dementia, delirium, and those receiving end-of-life care.
- A number of operational committees oversee and support the Trust's work to improve outcomes for vulnerable patients. Governors are represented on some of these groups, including the Trust End of Life Care Committee, Safeguarding Operational Groups (Children

and Adults), Mental Health Board, and Learning Disability Committee. The Vulnerable Persons Assurance Committee provides the highest level of safeguarding assurance within the Trust and chaired by the Chief Nurse and the Planning and Performance Manager.
    - The Trust's Risk and Assurance Committee provides oversight of patient safety and quality, with Patient Safety Partners playing an active role in providing independent feedback and assurance.
- Providing personalised care for vulnerable patients is important. The introduction of a Reasonable Adjustment Digital Flag enables staff to identify patients with additional needs and deliver appropriate, person-centred care.
- Equally important is ensuring the voices of vulnerable patients are heard. Patient engagement, co-production, feedback surveys and involvement activities are used to shape and improve services.
- The Trust is committed to ensuring staff across all services have the knowledge, skills and support required to provide the care needed for vulnerable patients.
    - The Oliver McGowan Mandatory Training session helps to improve staff understanding of learning disability and autism.
    - Specialist teams provide expert advice and support to frontline staff, including the Corporate Safeguarding Team, a dedicated Mental Health Lead in the Emergency Department, and liaison staff working in partnership with South London and Maudsley NHS Foundation Trust (SLAM).
- The Mental Health strategy, developed with patients and staff, focuses significantly on education and engagement with partners and patients.
    - The Trust recently received a fixed budget from SE London to invest in the development of mental health roles.
- Dedicated community learning disability services support adults across Lambeth, Southwark and Lewisham, and a similar specialist service exists within the acute services.
- There are also a dedicated specialist palliative care services across all our four hospital sites as well as a palliative care at home service.
- The Trust supports the national STOMP programme (Stopping over medication of people with a learning disability and autistic people).
- The Trust's Neurodiversity strategy was developed through extensive engagement with more than 500 patients, carers and family members, ensuring their lived experience informs service development.
- The End-of-Life Care strategy has also been co-produced with patients and carers, helping to ensure services reflect the needs, wishes and experiences of those receiving end-of-life care.

The Trusts Performance and Planning Manager provided additional detail on the Reasonable Adjustment Digital Flag plans and a background on the legal duty to ensure services are accessible to people with disabilities. Governors noted:

- The Trust already records some reasonable adjustment information locally, but recent work has focused on making this information clearer, more visible and more consistent across Epic.
- The programme has two phases: first phase - local identification, recording, flagging, meeting and reviewing of reasonable adjustments; second phase - digital sharing of the information across systems.
- Pilot work has involved GSTT Adult Learning Disability Services, Special Care Dentistry, Evelina Children’s Neuroscience Centre, children with vulnerabilities teams, patient engagement teams and patient experience colleagues across King’s and GSTT.

3.2 Governor questions related to the following:

- Inequalities in accessing healthcare by adults with learning disabilities and shortening waiting times to access services.
- Out of hours support for staff relating to safeguarding issues.
- Advocacy for palliative care patients who don't have family members/carers with them.

4. Quality Assurance. Trust quality priorities: update:

4.1. The Trust Quality and Assurance Manager, Senior Quality and Assurance Manager provided an update on the Trust's quality priorities for 2026-27.

- It was noted that the quality priorities presented to Governors at the last meeting for 2026 have been approved.
- The team plan to continue to focus on delivering 3 quality priorities from 2025/26 (including three new ones set out below) which will enable further improvement on the experience of patients through better communications, improving patient safety by progressing the work on violence and abuse, and progressing the implementation of Martha's Rule.
- Patient Safety:
    - Reduce instances of verbal or physical violence and abuse by patients. Ensuring that patients get the help they need and that staff are supported in recognising, dealing with and recovering from these incidents.
    - A revised WHO Surgical Safety Checklist will be rolled out to key areas within the Trust. Feedback from the pilot will inform any changes before wider implementation across the Trust.
- Clinical effectiveness:
    - Martha's Rule: For 2026/27, the focus will be on designing a digital solution for Component 1of Martha's Rule. This will be implemented across all inpatient areas, enabling patients to share daily information with the staff caring for them. Martha's Rule is also being piloted in the Community wards.
    - Ambulatory care: this major project will review outpatient activity using a data-led approach to prioritise waiting lists according to patient risk, ensuring that those with the greatest clinical need are seen first.
    - Epic functionality: staff knowledge, training and digital capability will be strengthened to maximise use of the electronic health record system.
- Patient Experience:
    - Digital contact routes: The Trust is exploring digital solutions to make it easier for patients to contact the organisation, reducing reliance on telephone calls that may not always be answered promptly.
    - Clinic waiting times: patients' experience of attending clinics will be improved through clearer information and regular updates about expected waiting times.

4.1 Governors thanked the team for the presentation, recognising that this is a critical area of the Trust's work. They welcomed the progress being made in addressing the Trust's key priorities.

5. Patient and public engagement and patient experience updates

5.1. The Patient Experience (PE) Annual Report and Patient and Public Engagement (PPE) quarter 1 report were circulated in advance of the meeting. The Head of Patient Experience gave key highlights of the report circulated. The Senior PPE Manager took questions and comments.

5.2. The following Patient Experience key items in the report were highlighted:

- Strong performance in the 2024 Adult Inpatient and 2024 Children and Young People' s National Surveys.

- Re-establishment of SMS messaging service for local patient surveys in the Heart Lung and Critical Care (HLCC) clinical group.
- Continued positive impact of mealtime volunteers.
- More than 38,000 patients supported by MyChart patient helpdesk.
- Over 17,800 hours contributed by Volunteers at the Trust.
- Improvement in Friends and Family Test (FFT) responses for Maternity Services.
- Short notice changes to appointments and getting appointments are some of the challenges.

5.3. Governors sought clarification on the following:
- Changes that have been made in maternity services.
- Waiting times for treatment.

5.4. Governors noted that the Patient and Public Engagement paper provides an overview of key engagement activity. Governors expressed an interest in receiving a further summary of all engagement projects supported by the Patient and Public Engagement (PPE) team across the Trust. It was noted that these details are provided in the Trust PPE Annual Report, which can be shared with Governors once the report is publicly available.

Action: Trust staff to share the PPE Annual Report once it has been published.

6. Reports/updates from committees recently attended by Governors

6.1. None discussed.

7. Any other business

7.1. Nursing and Midwifery Research Committee**:** the Governor representative informed the group that they were standing down from the committee. They commended the excellent work undertaken by staff involved in the committee, including Allied Health Professionals.

7.2. Another Governor representative advised that they would be stepping down from a number of committees for personal reasons. It was noted that this would create further opportunities for other Governors to join those committees.

The next meeting will be held on 10th November 2026

8. Annex 1

COUNCIL OF GOVERNORS
Quality and Engagement Working Group meeting

Update on actions/matters arising at meeting on 24th March 2026.

Action 1: **Advice and guidance implementation and monitoring to be added to a future meeting agenda.**

QEWG chair noted and to add to list of topics for presentation at future meetings.

Action 2: Update on Contacting Us Programme and impact

The following update has been provided by the programme team:

The Contacting GSTT Programme has been running since May 2025 to support the alleviation of identified issues with call answer rates and patient satisfaction through digital means. As part of this work:

- An intensive study was conducted to see why patients call us, finding that 70% of calls are about appointments, and demonstrating that self-scheduling is inseparable from reducing call volumes.

- Self-scheduling rollout has been progressed, with over 30,000 appointments being self-scheduled in the last year. There is more work for the Trust to do to get close to the UK average and to the UK's top-performer by expanding to different service types and increasing patient utilisation of the tools.

- We developed a method to advertise self-scheduling tools to patients, called Channel Shifting. This was tested with patients and evaluated by the Health Innovation Network to ensure optimisation. Guidance has been produced to support services to adopt this once they have tools enabled.

- A tool that allows patients to opt to receive a call back from services instead of waiting on hold, aptly called 'Callback', was piloted in a service. It increased answered calls by nearly 15% in one month, and more than halved patient waiting time, with glowing patient feedback. Guidance has also been produced to help services launch this software, supported by colleagues in the Telecommunications Team.

- The remit for Patient-Initiated Messaging in the Trust was explored and fully outlined, and a proposal has been created for the Trust.

From 1st June the charity grant for this project will continue for the patient scheduling aspects of the programme only.

Action 3: Trust staff to provide an update on the Maternity Good to Outstanding Programme.

The following update has been provided by the Chief Midwife regarding work to improve women and birthing people's experience:

The Patient Experience and Engagement workstream within the Maternity Good to Outstanding Programme has developed a keen focus on listening to women, birthing people and families,

translating feedback into practical co-produced service changes, and strengthening trust between staff and service users. Listening events, thematic feedback analysis and walkabouts involving maternity teams, communications colleagues and the MNVP (Maternity and Neonatal Voices Partnership) have identified priority areas including the postnatal ward, Hospital Birth Centre, optimising electronic patient record communication of information via MY Chart and effectiveness of antenatal call-handling services. This has already led to tangible improvements, including enhanced antenatal contact systems, environmental improvements on the postnatal ward, orientation filming projects, increased support for fathers and community-based engagement initiatives designed to better reach and listen to women and families to reduce inequalities in maternal and newborn health outcomes. The MNVP Chairs with our maternity and neonatal leadership teams also provide their valuable voice in ensuring our quality and safety governance processes always have a patient centred approach to reflect women, babies and family's needs at all times. Additionally, within the programme the Postnatal Flow Workstream has been developing more targeted patient-experience interventions aimed at improving safety, infant feeding support, discharge preparedness and emotional support on the postnatal ward. A significant area of co-production has involved extensive involvement of women and families in the re-design and improvement of our soon to be refurbished Maternity Assessment Unit.

Action 4: Head of Patient Experience to provide a demographic breakdown of volunteers at the Trust

During 2025-26 we had 606 volunteers generously providing 17,898 hours of their time to the Trust

Age
Our volunteers are aged between 16 years and over 90 years
78% of our volunteers are of working age (16-65 years) and of these 32% are aged between 16-30 years.

Ethnicity
54% of volunteers are from a White background, 12% identify as from an Asian background, 11% from a Black background, 3% from a Chinese background, 3% from a mixed background, 3% from other backgrounds and 14% did not state which background they were from.

Disability
79% of volunteers identified as not having a disability, 9% of volunteers said they had a disability and 11% did not answer the question.