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COUNCIL OF GOVERNORS

Meeting to be held on 25th April 2018
6.00pm – 7.30pm, Robens Suite, Guy’s Hospital

AGENDA

1. Welcome, apologies and opening remarks
2. Minutes of meeting held on 24th January 2018 attached (CG/18/08)
3. Matters Arising oral
   • The impact of General Data Protection Regulation (GDPR) on staff members of the Trust
4. Reflection session on Board of Directors meeting oral
5. Update from Nominations Committee attached (CG/18/09)
   Tom Hoffman
6. Block 9 Update presentation
   Alastair Gourlay and Peter Ward
7. Governors’ reports – to note and for information
   1. Lead Governor report oral
      Devon Allison
   2. MeDIC attached (CG/18/10)
      James Palmer
   3. Quality and Engagement attached (CG/18/11)
      Kate Griffiths-Lambeth
   4. Service Strategy attached (CG/18/12)
      Giles Taylor
8. Questions and answers – for information attached (CG/18/13)
9. Any other business
10. Date and time of next meeting:
    The meetings will be held on 25 July 2018, Robens Suite, Guy’s Hospital
    Board of Directors meeting 3.45pm – 5.30pm
    Council of Governors meeting 6.00pm – 7.30pm
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Council of Governors

Minutes of the 59th meeting of the Council of Governors held on
Wednesday 24th January 2018 in the Robens Suite, Guy’s Hospital

Present:

Devon Allison
Jonathan Farley
Noreen Ging
Tom Hoffman
Tony Hulse
Anita Hulse
Darren Oldfield

Approved by Chairman
CG/18/01 Welcome, apologies and opening remarks

The Council noted that Linda Goldsmith had resigned as a governor and that Barry Silverman, a former governor, had died just before Christmas.

Dawn Hill, a former governor, had been awarded a CBE in the New Year’s Honours list.

CG/18/02 Minutes of the meeting held on 25th October 2017

The minutes of the meeting held on 25th October 2017 were approved as a true record.

CG/18/03 Matters arising

There were none.

CG/18/04 Reflections session on Board of Directors meeting

Affordable housing – the data in the paper on nursing was at odds with the general tenor of reporting about why nurses left the profession in London. The Trust was encouraged to maintain discussions with councils and to tackle local political leaders rather than senior managers.

Governors welcomed the improvement in cancer performance and commended the Trust for its efforts.

The staff governors asked for assurance that communications and engagement in structural change would be maintained. The concern related to proposed changes to the structure of PCCP. It was acknowledged that this was unsettling and there had been dialogue with staff and staff side but the Trust accepted that more could have been done and confirmed that the formal consultation would allow staff to comment and contribute to the final decisions.

It was suggested that the learning from near misses was more powerful than the real errors and that improving systems was essential. It was hoped that effort could go into this aspect of incident reporting and learning. The Board had taken the message from the presentation and be would following it up.

CG/18/05 Changes to the Trust Constitution

The Secretary briefed the Council on the proposal to hold by elections to replace governors who stood down for whatever reason during their term of office rather than adopting the next candidate on the list as this did not necessarily reflect the wishes of the electorate and could lead to a governor serving having received very few votes. The Trust would carry a vacancy if an election was due within nine months of the governor ceasing to hold office.

Governors accepted this in principle but suggested that the new arrangement should come into play for the second and subsequent vacancy in any constituency. So that the first vacancy would be filled from the poll that elected the governor standing down and by elections held thereafter. The Secretary was asked to revise the drafting accordingly.
Council of Governors elections 2018

The Governors noted the election timetable and proposals and that a further paper would be presented to the next meeting of the Council. Governors asked that work to encourage membership should continue.

Workforce Strategy

The Director of Workforce reminded the Council that there had been discussions with Governors about the strategy being reviewed.

The majority of the workforce lived in Greater London including 37% from Lambeth and Southwark – the Trust remained Lambeth’s largest local employer. A future focus would be to ensure that a pipeline of local talented young people was developed.

The NHS had published a workforce strategy for consultation which set out a number of challenges and priorities for trusts to take up – including staff retention, recognising the fragmentation in workforce systems, the impact of Brexit on recruitment, the impetus towards greater integration with social care and the need for pay reform in return for productivity gain. No change and patient demand being maintained would lead to a gap of 120k staff by 2027.

The Trust’s workforce strategy was published in 2015 and was based on 4 pillars. It was under review although the main tenets would remain and would have a new focus on leadership and innovation, creating a flexible and responsive workforce, recruitment and retention and education, training and development. The plan was being widely discussed in the Trust and the revised strategy would be presented to the Board in July.

The Head of Equality, Diversity and Inclusion presented comparative data about BME staff amongst other London trusts. All trusts in the comparison showed similar characteristics meaning that white applicants stood a better chance of being appointed than BME staff while BME staff were more likely to find themselves subject to formal disciplinary process. The Trust had 10% improvement targets in place to reduce the disparity of appointments, formal disciplinary process and to improve career progression as well as reducing the incidents of BME staff experiencing discrimination. At its heart of the improvement plan were equipping junior staff with skills to manage and lead, helping the local community to prepare better applications, train all recruiting managers in unconscious bias and refreshing the disciplinary triage process - this last in conjunction with other London trusts.

The Trust’s total reward initiative, Showing we care about you, covered pay and non pay reward. Wanting to become the employer of choice was important to the Trust. The programme was financially supported by the Charity. Programmes included mental health support for areas of greatest pressure, developing resilience for individuals and teams with solutions coming from work with a theatre group, responding to work life balance, making sure careers appealed to all age groups and recognising that millennials had different priorities. The offer also included a credit union.

A recent campaign has increased the number of staff visiting pages offering services to staff – eg 529% increase in accessing the dieticians’ page after Christmas!
It was suggested that particular attention should be given to IT staff as suitably skilled technology resources were scarce in the Trust and NHS generally. Making working lives easier to improve retention particularly applied to community nursing staff; some issues had been extant for a long time including IT and the difficulties experienced when driving around the boroughs – these were now urgent and should be tackled quickly.

Governors welcomed the refresh of the Trust workforce strategy and were grateful for the update on a subject that the Council felt strongly about given how important staff were.

**Governors’ Reports**

**Lead Governor report**

Governors had met the training team within the Workforce Directorate and offered links into the local community – the openness they had met was welcomed.

The Governors were looking forward to the new style of accountability session and were interested in being part of the mock inspection visits. They were also looking forward to sessions on block 9 and medical education.

The Lead Governor had been a signatory to a letter to the Mayor on transport costs. The response was positive but listed actions for all Londoners rather than key workers. Other trusts shared these concerns and a larger group was likely to write further. Governors from other trusts were also interested in collaborating on public health services and affordable housing.

Given the challenges the Trust was facing the Governors congratulated the Trust on its performance in the face of current challenges.

**Membership Development, Involvement and Communications Working Group**

Increasing the number of members from different communities remained the focus of activity including the training of advocates in the Trust which would take place shortly. The next issue of Gist would have a direct member question that would be answered by a governor.

Recent discussions had shown appetite for dialogue within constituencies particularly the staff governors who were setting up forums and looking at ways of making it easier to vote in governor elections. There were lessons and opportunities for other constituencies. It had been noted that other local trusts were facing similar issues. It was hoped there the work would lead to an improvement in the turn out for the next election.

**Quality and Engagement Working Group**

The group welcomed the opportunities to review public engagement and patient experience. Patient dissatisfaction continued concerning noise at night and food in the hospital. The group had taken a report about complaints and compliments and the changes put in to improve performance on the timeliness of responses. It was important that the Council kept close watch on complaints; the Trust was thorough in its responses but not swift – learning from these was also important.
Service Strategy Working Group

The Lead Governor reported on the work of this group including discussions about the group working, Royal Brompton and the STP which they welcomed but had concerns about the complexity of joint endeavour where the governance levers were potentially weak. They wanted to see benefits for the local population and benefits for staff.

The group would be spending time on finance and planning at its next meeting.

The Trust was under pressure to become system leaders but its natural caution and desire not to be overwhelmed should be reassuring.

CG/18/09 Questions and answers

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

CG/18/10 Any other business

There was none.

CG/18/11 Date and time of next meeting

The meetings will be held on 25th April 2018 in the Robens Suite, Guy’s Hospital

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

Signed: ___________________________ Date: ___________________________
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### Recommendations from Nominations Committee to extend the appointment of 2 Non Executive Directors

**25th April 2018**

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<td>Decision</td>
<td>Author: Peter Allanson</td>
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<td>Discussion</td>
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<td>CEO*</td>
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Board members consulted
1. **Summary**

The Nominations Committee met on 20\textsuperscript{th} March 2018 to consider proposals to offer Steve Weiner a second four year term as a non executive director of the Trust and to extend the Chairman’s term of office for a further two years.

2. **Request to the Council of Governors**

The Nominations Committee unanimously recommends to the Council of Governors that:

1. Steve Weiner is offered a second four year term with effect from 24\textsuperscript{th} July 2018, ending 23\textsuperscript{rd} July 2022 and

2. the Chairman is invited to extend his term of office by up to 2 years with effect from 31\textsuperscript{st} January 2019 up to 30\textsuperscript{th} January 2021 subject to a review in January 2020 to reconfirm that both parties wish the term to continue.
3. Background

The Trust’s constitution allows the Council of Governors to appoint non executive directors for up to two terms of 4 years. In exceptional circumstances these can be extended by a further 2 years but no more

1. Steve Weiner

Steve was appointed to the Board in July 2014. He is a senior executive at Unilever working in their Finance team, latterly as Financial Controller of the Group company, bringing a breadth of business, financial, strategic and operational experience to the Board. He has effectively and rigorously chaired the Audit Committee, been an active member of the Corporate Management Committee and has been a part of an informal group supporting the current refresh of Trust strategy. He has agreed to sit on the newly established Evelina London Board. He has helpfully linked colleagues in Unilever to their equivalents in the Trust which both sides have found beneficial.

Steve will be standing down from Unilever next month which will reduce the pressure on his time and he has confirmed he would be willing to broaden and deepen his contribution here, particularly in terms of visibility within the Trust.

The Nominations Committee accepted the Chairman’s recommendation and commends and supports the proposal to the Council of Governors that they approve the reappointment of Steve Weiner for a second four year term from 24th July 2018.

2. Sir Hugh Taylor

Sir Hugh is approaching the end of his second 4 year term as Chairman of the Trust. The Nominations Committee met to consider plans for appointing his successor. However, it noted that the Constitution allows the Council of Governors to extend the Chairman’s tenure for up to 2 further years in exceptional circumstances. Having taken advice it was satisfied that such circumstances currently existed through
the weight of the external agenda; it would not be sufficient to point to the current operational and financial challenges facing the NHS generally and which the Trust itself is facing. The particular circumstances relate to the current discussions with the Royal Brompton and Harefield Foundation Trust. These discussions are delicately balanced; both trusts are pursuing them seriously and with intent. Whatever the outcome of the RBH talks, the work to create the cardiovascular institute with KCH and KCL will continue.

This concatenation of events points to the importance of there not being a vacuum at the top of one of the trusts; this is underlined by the good professional relationship between the chairs of the two trusts. It would be difficult to underestimate the time commitment and skill that will be needed to bring along the diverse partners, including lobbying very senior stakeholders where necessary. Hugh’s unique skills set makes him eminently suited to lead this and so the Committee was concerned that a change of leadership would be unhelpful, to say the least. By the beginning of 2021 the way forward should be clearer and a change of Chairman here less likely to have a negative impact on whatever outcome is by then in view. After 10 years he would have to stand down.

Any such extension is only possible if the post holder is performing at the highest levels. The most recent, independent, 360 degree appraisal of Hugh’s performance, undertaken during the second part of 2017, was entirely positive and supportive. The Nominations Committee also noted that this proposal would be supported by other members of the Board.

Hugh himself is conscious of the governance implications of this extension and has suggested that there should be what could be described as a break clause after the first year for the Council and him mutually to reconfirm that the arrangement should continue for a second and final year. Work will also begin early to identify and appoint a successor in order to achieve a smooth handover.

The Nominations Committee supports and commends the recommendation to offer Hugh up to two years more as Chairman of the Trust, ending 30th January 2021.
## Council of Governors

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<th>Membership Development, Involvement &amp; Communications Working Group Report, 20\textsuperscript{th} February 2018</th>
<th>25\textsuperscript{th} April 2018</th>
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This paper is for:

- Decision
- Discussion
- Noting X
- Information

Sponsor: MeDIC Working Group

Author: Adeola Ogunlaja

Reviewed by: James Palmer and Peter Allanson

CEO*

ED*

Board Committee*

TME*

Other*

* Specify
1. Welcome and apologies for absence

The meeting was attended by: Peter Allanson (Trust Secretary and Head of Corporate Affairs); Devon Allison (Lead Governor, Patient); Michael Carden (Head of Media and Corporate Communications); Lisa Doughty (Patient and Public Engagement Specialist); Kate Griffiths-Lambeth (Public Governor); Anita Macro (Staff Governor); Girda Niles (Non-Executive Director); Adeola Ogunlaja (Membership and Governance Co-ordinator); James Palmer (Lead, Public Governor); Vicky Rogers (Staff Governor).

Apologies: Yvonne Craig Inskip (Public Governor); Jonathan Farley (Patient Governor); Noreen Ging (Staff Governor); Tony Hulse (Staff Governor); Jenny Stiles (Public Governor).

Michael Carden, the new Head of Media and Corporate Communications, was welcomed to his first MeDIC meeting since joining the Trust.

2. Notes of the meeting held on 17th October 2017

The minutes of the meeting held on 17th October 2017 were agreed as a true record of the meeting by all attendees.

3. Matters Arising

The Trust Secretary and Head of Corporate Affairs reflected on the February issue of the GiST magazine. The Q&A column did not appear as governors had hoped because the question considered turned out to have too narrow an interest for the Trust as a whole. Further, concerns had been raised about the sustainability of a Q&A format for this type of column.
A conversation was needed with the communications team to understand what would work for the governors section in the GiST magazine going forward. The Membership and Governance Co-ordinator would arrange a meeting once the new Head of Media and Corporate Communications had settled into his new role.

4. Membership strategy progress

A meeting had been held with a few staff members who volunteered to be diversity advocates. The meeting generated other ideas to reach diverse local people including attending events at local colleges to talk to students about the career opportunities available at the Trust and the membership opportunities. Local councils also hold housing events which could be an avenue to encourage local people to become members. The diversity advocates were keen to be involved and would be matched to opportunities.

The Membership and Governance Co-ordinator and the Patient and Public Engagement Specialist would work to update the involvement options concerning Trust services available to members on the website. The online membership form also needed to be updated. Meetings had been held with the Client Experience Manager at the membership database company, Membership Engagement Services, who would look into making changes to the membership form including the possibility of having mandatory fields to improve the member data captured.

5. Membership action plan 2018-19

It was agreed that the working group would continue to deliver the actions from the 2017-18 membership action plan in the next financial year, though additional items could be added. The 2018-19 actions would be discussed and agreed at the next MeDIC meeting.

It was suggested that there should be a focus on the dialogue between members and governors in next year's action plan. The relationship between members and governors needed to be improved.
6. 2018 Council of Governors election plan

Mi-Voice, who had been appointed to facilitate the 2018 elections had made a few suggestions which could encourage more members to take part in the elections. Including election briefing and meet-the-candidates sessions at the health seminars in March and May, videos of candidates so they could be more visible, and mobile polling stations at both hospitals to encourage more members to vote and also encourage those who are not members to complete membership forms.

The working group decided against the candidate videos as this could discourage those who may be uncomfortable with the camera from nominating themselves, and could cause bias during voting.

The Membership and Governance Co-ordinator would put together a schedule of membership engagement activities in the run up to the elections and governors would be asked to indicate their availability to take part.

7. 2018 membership survey

The working group needed to agree on the aim of the membership survey and the survey questions.

The membership survey would be discussed at the governors meeting with the communications team. Governors were asked to think about the questions they would like to be included in the survey in advance of the meeting.

It was hoped that the survey would be included in the next issue of the GiST magazine.
8. GDPR and staff membership

The Trust Secretary and Head of Corporate Affairs gave an overview of the General Data Protection Regulation which would come into effect on 25 May. He informed that it would have an effect on staff membership because to be compliant, staff would be asked to opt-in to membership when joining the Trust rather than the previous auto-enrolment system. Therefore there could be another change to the Trust constitution.

A further update would be given at the Council of Governors meeting in April.

9. 2018 health seminar topics – confirmed

The Membership and Governance Co-ordinator informed that four topics had been agreed with the Chairman for the health seminars in 2018 including hearing loss, sleep disorders, skin cancer and cardiology.

Sickle cell, a topic suggested by a governor, could be one of the seminars held in the community. Menopause, which another governor suggested, was thought to be a narrow topic. It was suggested that a seminar on women’s health could be considered for 2019, which could cover menopause.

10. Any other business

Devon Allison (Lead Governor) fed back on the discussions at a recent meeting with the Chairman and Trust Secretary and Head of Corporate Affairs, including having pictures of governors and Non-Executive Directors displayed on screens within the hospitals.

She also asked for a list of the patients groups which governors could attend to be made available. The Patient and Public Engagement Specialist informed that an audit would take place in June 2018, the list of patient groups would be available afterwards.
James Palmer (Lead, Public Governor) asked for the use of ‘she’ alongside ‘he’ to be considered when making further changes to the Trust constitution.

11. Date of next meeting

The next meeting would take place on Tuesday 26th June 2018.
1. Introduction
This report details the meeting of the Quality and Engagement Working Group which took place on 27th February 2018 at the Education Centre, York Road.

2. Attendance
This meeting was attended by: Sarah Allen (Head of Patient Experience), Andrea Carney (Trust Patient and Public Engagement Manager), Tom Hoffman, Kate Griffiths-Lambeth (Lead), James Palmer, Vicky Rogers, Jenny Stiles, Mark Tsagli (Patient Experience Facilitator), Bryn Williams

Apologies were received from: Devon Allison, John Chambers, Jonathan Farley, Tony Hulse, Yvonne Craig – Inskip, Anita Macro, Darren Oldfield, Lucilla Poston, Dr. Priya Singh (Non-executive Director), Warren Turner, Fatima Vali (Patient and Public Engagement Specialist), Alison Knox (Deputy Director of Quality and Assurance), Karen Proctor (Director of Assurance)

3. Notes from the last meeting
The notes were approved as an accurate record of the last meeting.
4. External assurance of the Quality Report 2017/18

The chair introduced a summary paper to the group as an additional item to the meeting’s agenda.

Governors noted that:

- That all NHS Foundation Trusts are required to produce reports on the quality of care as part of their annual reports.
- The Trust is also required to obtain external assurance on our Quality Report.
- The Trust subjecting the report to independent scrutiny ensures the quality of the data on which our performance reporting depends is of a high standard.
- Auditors Grant Thornton will audit the following mandated indicators to provide external assurance on the Quality Report:
  - Percentage of patients with a total time in A&E for four hours or less from arrival to admission, transfer or discharge.
  - Percentage of incomplete pathways within 8 weeks for patients on incomplete pathways at the end of the reporting period.
- Governors are required to select an indicator for audit. The lead highlighted the seven audits that governors were asked to choose from.

Governor representatives in attendance discussed all seven audits presented in the paper and two indicators were discussed in detail:

- The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the report period.
- The number and rate of patient safety incidents reported within the Trust during the reporting period and the number and percentage of patient safety incidents that resulted in severe harm or death.
• Governors also expressed a keen interest for a review of patient safety related incidents reported within the Trust, but agreed this will probably require an internal review, not an audit.
• The governors were unable to reach a decision between the indicator relating to venous thromboembolism and the indicator related to the rate of safety incidents reported by the Trust within the reporting period. To help the governors reach a decision the following additional information was requested:
  • To get more clarity and information on what the audit process involved.
  • Governors also enquired whether two indicators could be selected to audit.
  • Identify what current initiatives being carried in the Trust with respect to ‘Never events’.

**Actions:** It was agreed that the Head of Patient Experience would obtain and circulate the additional information requested and the group would be invited via email to nominate which of the two indicators the preferred.

5. QEWG Work planning session:

The Head of Patient Experience and the Patient Public and Engagement Manager facilitated the work planning session for governors to identify topics for the coming year. The ideas and topics were self-generated by governors. Facilitators themed all governors suggestions into five key areas. Themes included, but were not limited to the following suggestions:

• Care Redesign (improvement & transformation) – joined up working/ holistic approach to care, improving the referral process, better information on discharge, consistent post – operative care.
• Digital Strategy and Technology – how the Trust can communicate better with members, taking advantage of shared learning e.g. Babylon, the use of digital messages, use of buzzers during clinic waiting times, and robotic surgery. The use of video consultations and also linking up the Trust’s digital and estate strategies.
• Quality and Patient Safety – a need for greater understanding about patient safety issues, ‘never events’, care for vulnerable people, management of single sex accommodation, the Trust’s adherence to the WHO surgical safety checklist.
• Health and Well - being – understanding what the Trust is doing to improve staff health and wellbeing, how we are helping with affordable accommodation for staff, preventative exercises for patients to improve mobility and health, better food for patients, flexible leave policy for staff, buddies or mentoring scheme to improve staff retention.

• Patient Involvement and feedback – how we can use feedback to identify areas for improvement, greater patients involvement in areas of care, referencing system from PALS/Complaints.

**Action** – Head of Patient Experience and the Trust Patient and Public Involvement Manager to send the detailed ‘wish list’ through to governors to identify their priorities for focus in forthcoming meetings.

### 6. Patient Experience (PE) Report Update

The Head of Patient Experience summarised some of the highlights from Quarter 1 and 2 (March – August 2017/18) report including:

- National Children and Young People’s Survey – The Trust’s national ranking compares less favourably with others.
  - The Trust performed significantly better in ensuring that young patients stay in age appropriate accommodation and providing children and families with an explanation of how their operation had gone.
  - Areas to improve on include parents of children from 0-7 years not liking hospital food.
  - It was noted that the Director of Nursing Children is working with colleagues in the Evelina to develop an action plan to take forward improvements plans.

- National Emergency Department survey - The Trust’s performance ranks amongst the upper quartile of the Shelford Group. Areas of strength include:
  - Not feeling threatened by other patients in the department.
  - Families having sufficient opportunity to talk to doctor.
- Patients receiving their test results before leaving the department.
- Informing patients of danger signals to look out for on their return.
- Telling patients who to contact if they worried once they had left the department.
- There were a number of areas for improvement including overall length of visit to the department, provision of reassurance to some patients, access to pain relief and some aspects of communication.

- National Maternity Survey – Performance has improved since the 2015 survey. Areas of strength across labour and birth and postnatal touchpoints include:
  - Women felt supported, listened to during antenatal appointments.
  - Women felt both they and their partner were involved in decisions, listened to, and not left alone.
  - Able to get support when required and were treated with dignity and respect.
  - Women valued being able to have their partners stay overnight.
- There were a number of areas for improvement which related predominantly to women’s experience of antenatal and postnatal community care. An action plan will be developed once the Directorate has received the results of the national benchmarking for this survey.

- Fundamentals of care – This programme was led by the Director of Nursing for Adults is leading a piece of work to develop and agree standards for 8 fundamental principles of good care for all inpatient areas. The aim of the standards is to ensure that staff in the multidisciplinary team are able to provide a consistent and high standard of care across all inpatient areas. A number of patient and carer and representatives were invited to attend a workshop in September 2017 to comment on the proposed standards and make suggestions for changes. A patient – friendly version of the standards will we developed to share with patients and their families so that they know what to expect.
7. Patient and Public Engagement (PPE) Update

The Patient and Public Engagement Manager took governors through the report and highlighted the following areas of activity:

- **Refresh of PP strategy:** The team is in the final stages of the refresh of the updated PPE strategy. The framework and aims will remain the same. When finalised, this is intended to support the delivery of the Trust’s strategic priorities over the next 3 years.

- **Orthopaedics Centre of Excellence:** The PPE team are working with the Surgery Directorate, colleagues in Commercial Services, and Johnson and Johnson’s appointed building contractor to develop plans for patient and public engagement in the design of the Orthopaedics Centre of Excellence. Governors were encouraged to attend and observe the workshops planned for the 12th March 2018.

- **Call Quality Assessor report:** There are noticeable improvements in advisor handling of calls. The team will continue to monitor this.
  - It was mentioned that there are challenges with assessing the Dental directorate calls due to the type of telephone technology being used. A number of alternative options had been considered including the possibility of relocating staff to the main call centre but this could cause operational problems and potentially could bias results. This area is still under consideration and is one of the areas that will be looked as part of the DPJ programme.

**Action:** Governors interested in attending the Orthopaedic Workshop were asked to contact Trust Patient and Public Engagement manager or the membership and Governance Co-ordinator in the Membership and Governance team.
8. Quality and Safety Update: Quality Priorities
As the Deputy Director of Quality and Assurance was unable to attend meeting due to the poor weather the update was deferred to the next meeting.

9. Reports from committees (those attended by Governors)
The following notes highlight governor’s feedback from the committee that they are members of.

Quality and Performance Committee
In view of time restrictions a report was not tabled, but the group was informed that the recent meeting covered a significant number of issues many that are currently being discussed in the governors priority planning ‘wish list’ for the coming year. The next meeting will be held on the 11th April.

Adult Local Services Committee
No notes tabled

Children’s Services Committee
No notes tabled

End of Life Care Committee
No notes tabled

10. Any other business
None

11. Date of next meeting
Tuesday 8th May 2018, Education Centre, York Road.
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<td>Service Strategy Working Group Report, 16\textsuperscript{th} January 2018</td>
<td>25\textsuperscript{th} April 2018</td>
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Sponsor: SSWG  
Author: Dan Price  
Reviewed by: Giles Taylor, SSWG Lead  
CEO*  
ED*  
Board Committee*  
TME*  
Other*  

* Specify
1. Attendees:
Devon Allison (Acting SSWG Lead), James Palmer, John Porter, Jenny Stiles, Bryn Williams, Kevin Burnand and Vicky Rogers.

Martin Shaw (Director of Finance), John Pelly (Non-executive Director), Jackie Parrott (Director of Strategy), Sarah Morgan (Director of Organisational Development and Vanguard Programme Director), Maria Higson (Head of Organisational Design Vanguard Programme) and Dan Price (Strategy Manager) attended from Guy’s and St Thomas’.

Apologies were received from Giles Taylor, Ian Abbs, John Chambers, Yvonne Craig Inskip, John Duncan, Kath Griffiths-Lambeth, John Chambers, Tony Hulse, Anita Macro, Lucilla Poston, Giuseppe Sollazzo and Warren Turner.

2. Notes of the previous meeting and matters arising
2.1 The notes of the meeting held on the 10th of October were approved as a true record and one change of the list of attendees was requested.

3. GSTT Alliance & Association of Health and Care Provider Groups
3.1 Sarah Morgan and Maria Higson opened the presentation by setting the context for the development of the Healthcare Alliance. David Dalton led a review in 2014 that suggested that hospital groups would be the direction of travel for provider organisations in the NHS. Group models were considered as routes to reducing variation in care and spreading best practice. Dartford and Gravesham NHS Trust approached the Trust looking to explore this model by using the vanguard programme as a safe way to test the concept.

3.2 The Vanguard programme ends at the end of this financial year and the boards of both organisations have agreed to go to the next stage and form a group. Sarah then set out the spectrum of different governance models that the Trust uses and where the Healthcare Alliance would fit within that. Sarah highlighted to the
working group that under the proposed model both the Trust and Dartford and Gravesham would maintain their sovereignty. The Trust would not be liable for the operations and finances of Dartford and Gravesham but there may be an element of reputational risk.

3.3 Some of the major drivers for the development of the Healthcare Alliance were the need for workforce solutions that cross organisational boundaries, increasing demand both organisations are seeing – including the extra 56,000 people in the Ebbsfleet Garden City development. Dartford have no capacity to build and so many of these new patients would be passed through to us for care. There are also opportunities around backroom efficiencies. The Trust has taken on Dartford’s procurement function which has saved them £800k on a c£300M turnover.

3.4 Much of the work now has been developing the governance approach across the organisations and determining how to move the programmatic work into business as usual. The first year of the Healthcare Alliance will be focused around delivering on the benefits without the centrally funded money from NHS Improvement.

During questions and discussion the following was highlighted:

- The Governors asked whether we are a member of the Group and Sarah indicated that we are the lead member. The first year is being considered a proof of concept with each member contributing £300k to the running of the group. All members will have a set of behaviours and expectations, however the ones for the Trust will be slightly different as leader of the Healthcare Alliance.

- The members of the alliance are working through how non-compliance with group decisions would be handled. A conflict resolution model based on the one used in King’s Health Partners is being developed and there will be limits on what items like branding could be used without compliance to set standards.

- That GSTT Consulting would be the route of engagement for distressed organisations rather than through joining the Healthcare Alliance. The Trust is in a range of complex partnerships with different organisations that the Healthcare Alliance will impact upon, influence and contribute to.
• That the Trust expects the healthcare alliance to benefit both organisations and their patient groups. We expect a two way street of learning. For example, Dartford and Gravesham provide high quality and efficient services which we can learn from. There are also clear benefits for patients not having to come into central London but still getting access to specialised services and the broader benefit that this group might support the stabilisation of the local health system.

• That a large amount of communications work has been done on the healthcare alliance at Dartford and Gravesham. Many clinicians were initially wary but have now been won over to the potential benefits of the alliance. One of the main drivers of this has been the approach taken of clinical co-production between the organisations and the messaging from Dartford and Gravesham that they see this as a key part of their future. Because the model is not a takeover, like the Medway approach to Dartford and Gravesham, and the gradual clinically led approach there has been great deal of buy in from staff involved in both organisations so far.

• Governors asked how they would be involved in the governance process. Sarah and Maria agreed to give this some thought and come back to the Governors on how best to do this and reiterated that they and the Board were keen to approach this in a transparent manner.

4. King's Health Partners Royal Brompton & Harefield Partnership update

4.1 Jackie Parrot presented this item by setting the scene for the presentation. A year ago the Royal Brompton approached the Trust for cautious and informal discussions prompted by commissioner considerations of the paediatric provision in Chelsea. The ultimate vision is that the Royal Brompton hospital on the Sidney Street site would shut down in its entirety (the Harefield site would continue as is) and the services would move to the St Thomas’ site and Evelina site. Discussions are underway on what might happen with respiratory.

4.2 This isn’t a complete KHP initiative as SLAM are not involved in the governance of this programme, but the Trust is thoughtful about the Mind and Body agenda. The ambition is to provide cardiovascular care across the full spectrum of services and care. The potential scale of the offering is so big that it offers opportunities on providing training such that it would be unique in the UK, for example potential exposure to every kind of...
transplant possible. This is also an opportunity for us to contribute to UK plc and offer a world leading service. The KHP vision for cardiovascular is huge, but with the Royal Brompton it would be a world leading service working with a wide range of partners to support a wide geography of patients. This would also require that Evelina 2 proposal needs to consider how it might handle Royal Brompton paediatric activity.

4.3 Similar to the CVIN programme the organisations have concluded that they need an internal Strategic Outline Case to convince ourselves that there is something tangible to this proposition. A ‘SOC-lite’ is being developed for May and early discussions are happening about financing, staging, considering property and operating companies, different versions of joint ventures to support the ambition of the proposal.

4.4 It was a big moment last year when Royal Brompton, the Trust and jointly both organisations responded to a Congenital Heart Disease consultation. The significance of demonstrating that all partners were committed to this vision was very important in setting the tone for this endeavour. The commissioners made a decision on the 30th of November and set timelines for the outcome – this has some anomalies with the practicalities of the vision proposed and will need to be worked through with NHS England to make this do-able.

4.5 Before the joint submission to the consultation went in the Trust gave a public statement announcing the intentions of both organisations. Another public statement will shortly be published announcing that Peter Homa has been appointed the independent chair for the partnership board, which is the apex of the governance that has been set up for this programme. The programme’s main focus at the moment is building on the existing collaboration to develop a light touch Strategic Outline Case. An example of this collaboration would be the Royal Brompton having just joined the South London Genomic Centre.

During questions and discussion the following was highlighted:

- The organisations are currently working through the thorny issues. One of these is how the paediatrics element of the proposal is dealt with – all are agreed on finding a third way but requires a different vision
for many partners and needs working through. At the point we don’t know what model the end result will be, the acceptance that this is the future is the main work at the moment. Then there is still lots of work to be done to create the various options for people to choose from.

- Currently the partnership is working through the variety of different roles that organisations can take in relationship to the property development and the operational running of the new facility. Another service that we need to think about how we operate would be thoracic surgery.

- That the Trust is considering very carefully the implications of the potential building work of this proposal alongside the Trust’s other plans; potentially there could be £1bn of building works going on at each site in a similar timeframe. It’s imperative that we get people and proposals aligned to help with the funding and to deal with the approvals we’ll need from central government for building on this scale. We do know that with the Brompton in the mix the proposals do become more viable.

- One of the other issues to be considered is how you might build the Cardiovascular Institute, the Evelina 2 proposal with both their required additional builders, infrastructure and building works while running the operational site at the same time. The Trust is currently reviewing the infrastructure implications for the two sites to make sure we would have capacity and these issues were factored into the development of the proposals.

- A lot of the Royal Brompton work is national and it is anticipated any move would have minimal impact on North West London. The Harefield site would continue to support and meet North West London demand.

- A range of stakeholder engagement work is underway to ensure that the partnership is talking to the right people about the proposals.

5. Any other business

5.1 There was no further business and the next meeting was confirmed for 17th of April 2018, 5.30pm to 7pm in the Belvedere suite at York Road.
| Council of Governors Questions and Answers | 25th April 2018 | CG/18/13 |

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<tr>
<th>This paper is for:</th>
<th>Sponsor:</th>
<th>Corporate Affairs</th>
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| Author:             |          |                   |
| Reviewed by:        |          |                   |
| CEO*                |          |                   |
| ED*                 |          |                   |
| Board Committee*    |          |                   |
| TME*                |          |                   |
| Other*              |          |                   |

* Specify
1. Summary

This report provides a list of queries which have been raised by governors. Answers are included or are ongoing and will be provided to governors once available. We would like to encourage governors to continue to raise questions.

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

2. Request to the Council of Governors

The Council of Governors is invited to note the report.
### 3. Detail/Commentary

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<thead>
<tr>
<th>Matters of interest/question</th>
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<th>Responses</th>
<th>Progress/further information</th>
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<tr>
<td>The organisation seems to work in a hierarchical way, will this be unhelpful when thinking about the future and changes/ transformation?</td>
<td>18/0021 2018-02-21</td>
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<td>What impact will the technology of tomorrow (AI/robotics) have on the staff of today?</td>
<td>18/0020 2018-02-21</td>
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<td>Does the digital committee focus enough on current IT issues?</td>
<td>18/0019 2018-02-21</td>
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<td>How can we get our IT people out into clinical services so the requirements of EHR are better understood?</td>
<td>18/0018 2018-02-21</td>
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<td>How are we going to manage the transformation associated with EHR/IT implementation?</td>
<td>18/0017 2018-02-21</td>
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<td>How aware do you think the Trust is to the level of change that is required to achieve the current agenda and the level of effort it will take?</td>
<td>18/0016 2018-02-21</td>
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<td>How equipped are we to manage the cultural change needed to effectively implement EHR?</td>
<td>18/0015 2018-02-21</td>
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<td>Are the clinical outcomes we achieve visible enough and do we have the focus we should?</td>
<td>18/0014 2018-02-21</td>
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<td>How do we balance the pressure to focus less on long term follow up of our</td>
<td>18/0013 2018-02-21</td>
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<td>patients with the push to see new cases - doesn't this reduce access to meaningful outcome data of what matters to patients?</td>
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<td>How well are the governors able to hold the NEDs to account - does the Council of Governors do its job effectively?</td>
<td>18/0012 2018-02-21</td>
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<td>Would informal meetings with Governors and the NEDs be useful?</td>
<td>18/0011 2018-02-21</td>
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<td>How effectively do you think NEDs influence the executive members of the Trust - is the Board is driven by a few personalities?</td>
<td>18/0010 2018-02-21</td>
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<td>What is the overall strategy of the Trust and do the NEDs have an impact on the strategy? Is there a forum where NEDs get briefed on the strategies of the Trust?</td>
<td>18/0009 2018-02-21</td>
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<td>Do you think, as a Board, that the Trust is doing enough long term planning (10/20 year plans)?</td>
<td>18/0008 2018-02-21</td>
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<td>Why don't we focus more on research and education and not just clinical services when looking at strategy and performance - how do we measure research performance?</td>
<td>18/0007 2018-02-21</td>
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<td>Essentia doesn't seem to be talked about a lot at Board level, would like the NEDs to ask more about this area -</td>
<td>18/0006 2018-02-21</td>
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<td>understanding the roles and the differences between Essentia core services and Essentia TL would be helpful</td>
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<td>We appear to be very acute focused - why don't we discuss community services more?</td>
<td>18/0005 2018-02-21</td>
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<td>Are we doing enough about succession planning for EDs and senior managers?</td>
<td>18/0004 2018-02-21</td>
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<td>How do we prepare for the workforce of tomorrow?</td>
<td>18/0003 2018-02-21</td>
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<td>How do we obtain staff views - how is the resilience of all staff groups (but particularly those in less visible areas) assessed and supported at a time of unrelenting pressure?</td>
<td>18/0002 2018-02-21</td>
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<td>What options are there to address the affordable housing issue for our staff - many of whom travel long distances to work here - what collective response could be offered in partnership with others?</td>
<td>18/0001 2018-02-21</td>
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<td>I wonder whether the below is something we can support either as a CoG or raise up to the Children's Services committee given it has impacted the clinical process and patients?</td>
<td>16/0016 2016-07-28 (Heather Byron)</td>
<td>The Head of Nursing for Children's Medicine &amp; Neonatology responded as follows:</td>
<td>Further update has been sought.</td>
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<td>I have some insight into this, as this must originate from the paediatric metabolic service - she worked in this team for many</td>
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<td><strong>Problem Statement:</strong> The lab is facing some lapse in service from the Royal Mail around a business delivery service that is in place for the prompt delivery of newborn screening / monitoring blood spot tests. Whilst this hasn't yet a systemic problem, talking to the lab and the dietitians, there have been a number of incidents which clearly causes concern both from the perspective of delay to patients on results but also any potential risk / harm resulting from tests which do not arrive or can't be read in the lab.</td>
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**Context / Risk:** It is hard to quantify the scale of late delivery of the risk to newborns / patients as the lab never knows exactly how many newborn screening / monitoring blood tests are being sent in. However, we know the implications of a late results, especially in the newborn screening where in many of the conditions being screened for require immediate intervention / treatment. Its concerning that we may not receive a sample and isn't clear whether there are robust processes in place across the community network to years, & is well used to the challenges of bloodspot screening, ongoing monitoring & Royal Mail. Just in terms of assurance with regards to delays in NBBS after birth, the national “fail safe” system does provide some reassurance and ensure if a sample is mislaid or significantly delayed a baby would have a repeat sample taken in a timely way. I will look into the other issues raised with the teams involved and will feedback progress around these points. Thank you again for sharing this with us. (26-08-2016) | | | | |
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<tr>
<td>identify promptly if a newborn test results hadn't been returned and therefore a further test taken. I fear, more often than not, it would be missed for some time, which could have medical and/or quality of life implications.</td>
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<td><strong>Whats next:</strong> There are a number of things which could happen to support the labs in dealing with the problem so that the service becomes reliable and they are spending valuable time chasing RM.</td>
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<td>• develop a simple, consistent escalation process to Royal Mail (admin driven not lab driven) so that we are consistent in our escalations and have a clearer audit behind us of the issues encountered (this could be a simple form on the portal for example)</td>
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<td>• as part of the wider Royal Mail relationship drive some escalation discussions (the sense is that in isolation this isn't 'important enough' to deal with by the RM.</td>
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<td>• review whether Royal Mail is the right partner to</td>
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<td>I want to speak about the delivery of samples. Should I be responsible for the delivery of such important blood samples or whether a commercial agreement should be made with another party (Whilst on the surface the 'cost' of the RM business reply service may seen competitive, I wonder when you look at the total cost including the courier costs to bring post from RM to GSST, it may not be... not to mention the slightly unreliable nature of the service. I am very happy to support any next steps, but wanted to share with you for your guidance as to whether this is something we are at liberty to raise awareness to and have the possibility to help resolve?</td>
<td>16/0011 2016-06-22 (John Porter)</td>
<td>The Trust commissioned PWC, following a tender process, to perform a six week diagnostic study to identify and quantify in year savings opportunities for the Trust in 2016/17. The report shows a number of cost saving opportunities over and above existing savings schemes. PWC and the Carter team have provided benchmark data demonstrating potential efficiency savings for the Trust when compared to other similar service providers. This</td>
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<td>they would have on the operation of the FT.</td>
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<td>output forms part of the continuing cost improvement plan.</td>
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<td>The CEO says that there is a programme of work underway by the Medical Director to address &quot;hospital at night concerns&quot;. What progress I wonder? I realise how difficult it is to control events at night in a busy hospital, but I have had recent experience of unnecessary noise at night in the wards</td>
<td>2014-04-29</td>
<td>Hospital at Night is about the clinical operating model for looking after patients out of hours. We are currently looking at the future clinical model that will be required at GSTT and the implications this will have for our workforce, given activity changes and the anticipated shift towards a 24/7 care model at a national level.</td>
<td>A further response/update has been sought.</td>
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