## Council of Governors Meeting, 24th October 2018

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COUNCIL OF GOVERNORS

Meeting to be held on 24th October 2018
6.00pm – 7.30pm, Robens Suite, Guy’s Hospital

A G E N D A

1. Welcome, apologies and opening remarks

2. Minutes of meeting held on 25th July 2018 attached (CG/18/20)

3. Matters Arising

4. Reflection session on Board of Directors meeting oral

5. Election to the Nominations Committee attached (CG/18/21)

6. Essentia: who we are and what we do Presentation
   Alastair Gourlay

7. Governors’ reports – to note and for information oral
   1. Lead Governor report oral
      Devon Allison
   2. MeDIC oral
      James Palmer
   3. Quality and Engagement attached (CG/18/22)
      Jenny Stiles
   4. Service Strategy attached (CG/18/23)
      Devon Allison

8. Questions and answers – for information attached (CG/18/24)

9. Any other business

10. Date and time of next meeting: The meetings will be held on 23 January 2019, 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 61st meeting of the Council of Governors held on
Wednesday 25th July 2018 in the Robens Suite, Guy’s Hospital

Present:

Devon Allison  James Palmer
Tahzeeb Bhagat  Samantha Quaye
Heather Byron  Vicky Rogers
John Chambers  Sue Slipman
Marcia Da Costa  Giuseppe Sollazzo
Jonathan Farley  Jenny Stiles
Annabel Fiddian-Green  Yu Tan
Tony Hulse  Bryn Williams
Margaret McEvoy  Peter Yeh

Apologies:

John Balazs  Placida Ojinnaka
Robert Davidson  Matthew Patrick
Jacqui Dyer  John Porter
Jane Fryer  Lucilla Poston
Alice Macdonald  Mary Stirling
Anita Macro  Warren Turner
William Moses

In Attendance:

Executive Directors:  Non Executive Directors:
Dr Ian Abbs  John Pelly
Steven Davies  David Perry
Jon Findlay  Reza Razavi
Alastair Gourlay  Sir Hugh Taylor (Chair)
Amanda Pritchard  Steve Weiner
Julie Screaton
Eileen Sills

Other Attendees:

Peter Allanson  Trust Secretary and Head of Corporate Affairs
Paul Dossett  Partner, Grant Thornton UK LLP
Judith Hall  Head of Community Rehabilitation and Falls
Debbie Miller  Deputy Head of Nursing
Ginny Nash  Assistant Trust Secretary and CEO Support Manager
Diane Spillane  Governance Support Manager

CG/18/22  Welcome, apologies and opening remarks

The Chairman welcomed new members of the Council of Governors and congratulated those re-elected following the recent election. The recent “away day” had been successful and benefited from considerable input from Governors.
CG/18/23  **Minutes of the meeting held on 25th April 2018**  

The minutes of the meeting held on 25th April 2018 were approved as a true record.

CG/18/24  **Matters arising**  

CG/18/16 - The Chairman confirmed that the main criteria in assessing whether his tenure would be extended beyond 2020 included a willingness on his part, to establish a good succession plan and the implementation of the strategy with a particular focus on the partnerships being developed.

CG/18/25  **Reflections session on Board of Directors meeting**  

Governor raised a number of issues based on the discussions at the meeting of the Board of Directors that had preceded the Council:

Lone practitioners – this covered a wide range of staff sometimes the sole expert on a particular specialty. This meant that appraisal was sometimes undertaken by someone not fully familiar with the practice so further thought should be given to extend the appraisal process outside the Trust including perhaps 360 degree methodology to gather feedback.

The question of the deliverability of the CDIO as currently formulated was raised in view of the resignation of the CDIO and the need to cover the role in the short term in an interim appointment. It was acknowledged that the Trust would need to review the wider governance within which the role operated, given the scale of the strategic and operational issues to be addressed. However the current postholder was of the view that the role was deliverable with the right support and should be attractive to other CIOs.

The Digital Board would continue to review and discuss the finances of the EHR programme which would report periodically to the Board and an important intersection would take place in October. The outline business case set out the current financial expectations including the costs of transformation and infrastructure. The OBC was commercially sensitive and so had not been published but there were governors sitting on the Digital Board. It was suggested there should be a briefing meeting for governors on the OBC later in the autumn following the October review.

Staff and patient engagement were important in rolling out major IT programmes. It was confirmed that patient engagement was a significant part of the EHR transformation programme. New governance arrangements would be set up with more clinical leadership to demonstrate that it was much more than an IT programme.

FGM – Governors regretted that the service would not continue at the Trust. In response it was stressed that the Trust would continue to provide a maternity service for FGM. In relation to non maternity services however NHSE had decided to have multi professional groups to support women and their families in 4 places in the UK. The Trust had been operating with a sole practitioner and this model was outmoded.

The discussion about the refreshed strategy was welcomed. Whilst the Board noted Governors concerns about turning this into a deliverable reality given the
current operating challenges, it was confident that there had been considerable directorate engagement in the process of creating it so business as usual would move the strategy into action. The Trust would be building management and governance processes to keep track of the pace of delivery including some changes to governance - establishing a strategy board, an improvement digital board and an operations board to give overall co-ordination.

CG/18/26 Governor/NED Visiting Programme

This was part of the programme to link governors to their constituencies and a governor/NED visiting programme would offer opportunities to see the Trust in action. The CNO office had developed the proposals which would be circulated in due course. This would offer a more systematic method of creating soft intelligence for the Board and Governors.

CG/18/27 External Audit and Annual Reports

The External Auditor presented their findings following the annual audit of the Trust’s report and accounts and confirmed there were no concerns about the financial information or accounts which the Board had approved on time.

The Auditors assessed the Trust’s arrangements for delivering value for money based on financial sustainability and gave a positive report especially in the context of pressures within the NHS.

The Quality report reviewed compliance with content of the report on which no issues arose. The Auditor was also required to test some indicators of which the referral to treatment indicator was difficult to deliver. Large trusts reporting RTT experience difficulties as on a small sample of patient records there were some discrepancies and a qualified opinion given – this repeated the outcome from previous years and other trusts had the same issues. It was noted that work to improve the position continued.

This was the first audit undertaken by Grant Thornton and the Governors were grateful to them for their work.

The Council of Governors received the Trust’s Annual Report and Accounts for 2017-18.

CG/18/28 The benefits of integrating hospital and community services – our seven year journey

Integrating local services remained a strategic ambition for the Trust. The presentation illustrated a number of the positive developments since the Trust became responsible for delivering community services in Lambeth and Southwark in 2011. These included the ‘@Home’ services, the amputee rehabilitation centre in Kennington, the preventative falls pathway and the embedding of consultants both in the hospital and the community. For neuro rehabilitation, a new neighbourhood nursing model was being established to help patients with multiple long term conditions and the integrated reablement provision in both boroughs had led to additional CQC registrations to offer personal care.

The falls programme was designed to prevent falls rather than deal with the consequences. Strength and balance classes through self referral with
advertising done through local pharmacists. There were now 31 classes rising to 37 by next March. There were maintenance issues as the speed of decline after the programme was fast if not followed through. A number of initiatives to follow up classes had been trialled including buddying with volunteers and learning from other local trusts would be helpful. The outcomes were good and there was a demonstrable fall in costs as a result of these classes being in place.

The @Home service looked after acutely unwell patients running 7 days per week from 8.00 – 23.00 using a multi-disciplinary team enabling early discharge from hospital and preventing re-admission. The service differed from others as it looked after unwell people. Referrals could come from any local clinician including the London Ambulance Service. There was a two hour response and equipment could be provided on a similar timescale. The service to care homes was expanding and accepted nurse referrals. The data showed that this service combined with other measures had been effective in reducing emergency admissions and length of stay proportionate to overall growth.

Community capacity had increased and more patients were being treated in locality places. New roles were able to offer specialist care and undertake more prevention work. Relationships with partners across the system had developed well including with local social services departments and the demand for emergency beds for older people had been arrested though whether this would be sustained was yet to be tested.

Roles would continue to develop – neighbourhood nursing, dealing with long term conditions (extensivists) and understanding population health better so care plans based on needs can be developed on a local basis.

Mind and Body was a priority for KHP and developing staff skills in recognising and surfacing mental health issues were still needed. The @Home service also intended to develop these skills.

CG/18/29 Governors’ Reports

Lead Governor report

The RBH work was welcomed especially for children. The collaboration agenda was to be welcomed but robust governance and reporting procedures should also include governors. The issue likely to arise for governors were trust specific so needed particular attention.

The first governors’ newsletter would be issued with the GIST next month and will feature a range of interviews from the patient and staff constituencies. Ideas for future issues were encouraged.

Membership Development, Involvement and Communications Working Group

The Group was focussing on the quality of encounter with members, was continuing to implement the strategy including meeting appropriate patient groups to invite them to meet governors. Making the voice of members heard together with the page in the GIST would continue to raise the profile of members. There were some concerns that staff having to opt in might reduce the numbers.
MEDIC had reviewed the last election and wanted to address the reduction in turn out and ensuring that the arrangements with those running the elections were robust.

There was to be a sub group set up on looking at the engagement plan and help was needed on drafting a membership survey to be issued later in the year.

**Quality and Engagement Working Group**

The Council noted the notes of these meetings.

**Service Strategy Working Group**

The Council noted the notes of this meeting.

**CG/18/30 Questions and answers**

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

**CG/18/31 Any other business**

There was none.

**CG/18/32 Date and time of next meeting**

The meetings will be held on 24th October 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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## Election of Public Governor to the Nominations Committee

**24th October 2018**  
**CG/18/21**

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<th>Hugh Taylor</th>
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1. **Summary**

There is a vacancy for a governor elected by the public constituency to sit on the Nominations Committee. We have asked for self nominations and we have attached those received by the closing date of 12<sup>th</sup> October 2018. As there is more than one applicant we will hold a ballot amongst the governors elected by the public constituency.

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

To note the background information and the class election to the Nominations Committee to be held by ballot.
3. The Nominations Committee

One of the key roles of the Council of Governors, as part of their responsibility to hold the non executive directors to account for the performance of the Board, is to appoint them. This is done by the Council in general meeting guided by recommendations agreed by its Nominations Committee.

The responsibilities of the Nominations Committee are set out in the Constitution. It operates on behalf of the Council to run the process for appointing non executive directors, setting their remuneration and monitoring their performance. Each constituency chooses one of their number to sit on the Committee. The Committee is chaired by the Trust Chairman, unless it is dealing with the appointment or performance of the Chairman in which case the Vice Chairman chairs the Committee. It is supported and serviced by the Trust Secretary and can be advised by the Chief Executive or any other adviser it wishes to appoint.

Members usually serve from election to the end of their term of office. The current vacancy for a member of the public constituency arises because the previous member stood down as a governor at the end of his second term.

We invited governors from the public constituency to put themselves forward for election by their fellow public governors by sending in a short statement, these are attached below. We will invite the public governors to make their choice by secret ballot.
Annex

Candidates standing for election to the Nominations Committee, October 2018.

**Marcia Da Costa**
I make this application believing my organisational, professional and voluntary involvement has equipped me to contribute, as a Public Governor Nominations Committee Member, in decision making to appoint and remunerate GSTT Non-Exec Directors. This is in-line with hospital Directorship recruitment procedures.

I also commit the fulfilling other Nominee Committee shared responsibilities such as: adherence to the 7 Nolan Principles of Public Life, monitor appropriate Director(s) performance, contribute my level of expertise and participation to this committee, able to give excellent written/verbal advice/feedback to my Governor colleagues in-line with my delegated responsibilities and ensure Director(s) appraisals are undertaken.

Previous agencies where my experiences were gained: Local Authority Social Services, Metropolitan Police Gold, Diamond Groups/Boards, Hospital senior management planning groups and committees, Community/voluntary/charity organisations and contributing to a few parliamentary committees.

I shall prepare and represent my Governor colleagues and diverse constituents views well on the Nominations Committee.

**Annabel Fiddian-Green**
I have worked as a Director in several leading healthcare agencies and have recruited, mentored and appraised many other Directors too. As a senior consultant, I interacted at Board level with major pharmaceutical companies, as well as providing commentary and feedback for senior level client appraisals.
I have sat on recruitment panels, written appraisal criteria and have, through this experience, have developed a strong insight and opinion on how people are performing as well as how they can play more to their individual strengths.

The Non-Executive Directors and Chair play such an important role in the overall development and management of GSTT and I would be very interested in applying my business experience to help further in this arena.

**Margaret McEvoy**

I have the necessary skills and experience to represent the Council of Governors on the Nominations Committee and to advise on the appointment and remuneration of Board Members.

As a Senior Civil Servant and Chief Economist I have seven years strategic HR and pay experience whilst supporting eight Pay Bodies in making well evidenced recommendations on public sector remuneration to Governments in England, Northern Ireland, Scotland and Wales. This included reports on senior pay, on performance awards for consultant doctors & dentists and on pay system design for public body Chief Executives.

My experience recruiting candidates for boards will enable me to play an active part in selecting the right people for NED and Chair positions. The aim is to achieve a GSTT Board with the appropriate balance of skills and experience capable of supporting and challenging the executive to deliver top quality healthcare to the diverse communities it serves.
Council of Governors

Quality and Engagement Working Group: Report from the meeting held on 25th September 2018

24th October 2018

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Sponsor:

| Author: | Mark Tsagli |
|Reviewed by: | Jenny Stiles |
|CEO* | |
|ED* | |

Board Committee*

TME*

Other* X Council of Governors

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1. Introduction
This report details the meeting of the Quality and Engagement Working Group which took place on 25th September 2018 at the Education Centre, York Road.

2. Attendance
This meeting was attended by: Sarah Allen (Head of Patient Experience), Devon Allison (Lead Governor), Andrea Carney (Trust Patient and Public Engagement Manager), John Chambers, Marcia Da Costa, Margaret McEvoy, Jonathan Farley, Annabel Fiddian-Green, Dr. Neil Goulbourne (Deputy Director of Improvement), Alison Knox (Deputy Director of Quality and Assurance), Emma McLachlan (Programme Director – Digital Patient Journey), Adeola Ogunlaja (Membership and Governance Coordinator) Placida Ojinnaka, James Palmer, Dr. Priya Singh (Non-Executive Director), Mary Sterling, Jenny Stiles (Interim Lead), Mark Tsagli (Patient Experience Specialist) Fatimah Vali (Patient and Public Engagement Specialist)

Apologies were received from:
Tahzeeb Bhagat, Anita Macro, Tony Hulse, William Moses, Yu Tan, Peter Yeh

3. Notes from the last meeting
The notes were approved as an accurate record of the last meeting.
4. Quality Strategy and Quality Accounts update

The Deputy Director of Quality and Assurance updated governors in attendance on the progress of the development of the Quality Strategy and the Trust’s Quality priorities. The following were noted:

- The Quality Strategy is still in its draft stages. The team are working in conjunction with colleagues in the Improvement and Transformation team to make sure this incorporates all Quality Improvement and Quality priorities for the Trust. This includes clinical audits, service improvement projects and strategic projects such as Electronic Health Records (E-HR) and the Digital Patient Journey (DPJ) projects.
- Quality priorities for next year will be identified towards the end of the year. Governors were encouraged to also start identifying areas they would like to include amongst the priorities, these could be informed by patient feedback to them or any other issues governors would like to include. The team will also be reviewing safety incidents to help inform the priorities to be selected.
- In addition, governors were also reminded that every year, as part of the Quality Accounts governors need to select one indicator for audit as part of Quality Report. The Quality Improvement Team will be working closely with governors to help them select the indicator.

**Action:** The Patient and Public Engagement Manager suggested Quality Accounts should be recirculated to governors including background and performance information to help inform their decision.

Governors wanted to know whether issues regarding patient communication with the hospital have been considered as part of the Quality priorities. Responding, the Head of Patient Experience mentioned that some work had begun to try and improve patient’s telephone contact with the Trust. Furthermore, improving patients contact after they have left hospital is one of the Trust’s priorities and a number of initiatives are being taken to address this. It was also noted that the topic on patient contact could be revisited.
5. Digital transformation: insights into patient-user views

1) Digital Patient Letters: how the views of patients have informed its redevelopment:

The Programme Director of the DPJ shared a presentation on the digital letters project and how patients have been involved in shaping the project strategy prior to relaunch.

Governors were taken through the background of this project:

- The NHS and the Trust is would like to reduce its operational costs and digital letters project will significantly help reduce this.
- The Trust supports the national agenda as recognised by the NHS Five Year Forward View with an ambition to be ‘paperless by 2020’
- GSTT’s strategic priorities include ‘Transforming our relationships with patients’ – including meeting their expectations of 21st

Governors were informed that a digital letter rollout was carried out Trust wide in April. The project lead drew governors’ attention to the fact that the digital service was already being used by maternity patients since 2016 who book services through the Patient Access Team.

- The new service was rolled out across the Trust and work was completed by April 2018. Unfortunately, technical testing was inadequate and issues came to light 4 weeks later which necessitated the service being put on hold.
- The issues encountered gave the team the opportunity to improve this. Patient engagement and involvement was decided to be an integral determinant of moving this project forward.
- The DPJ team working with the Patient Public and Engagement (PPE) team and Patient Experience (PE) team undertook a significant patient engagement project, involving conducting 248 face to face interviews over 3 weeks with a broad range of patients, including minority, seldom heard groups. A number of focus
groups were also undertaken with people with learning difficulties and with the Evelina Young People Forum.

- Findings from the engagement process were presented to the Trust Management Executive (TME) in September 2018
- A number of options were considered based on these findings. It was decided to adopt a ‘digital by desire’ option where if the digital letter has been opened, the assumption can be made that patients do not need a paper survey. If the link is not accessed within 48 hours, paper surveys are sent out by default.
- The PPE Manager drew governors’ attention to the lessons learned from the initial launch of the project and the importance of engaging with patients and ensure that the voice of seldom heard groups to inform the redevelopment and relaunch of digital letters.
  - This meant they were able to change the approached based on evidence. It was important to emphasise that patients’ voice had changed the approach. It was also mentioned that the TME has asked that the PPE is involved in testing and implementation stages.

Governors noted that older people will prefer emails and wondered how this will be catered for. The Lead responded that there is no way of identifying recording electronic contact preferences on the current system at moment.
Governors also drew attention to the fact that there were specific group of patients who need to use paper records for patients with ongoing conditions e.g. dental patients. The DPJ Lead responded that the E-HR project should help address some of these concerns.

2) Patient and public engagement in the procurement of the Electronic Healthcare Record (E-HR)

The Deputy Director of Improvement presented on the Trust’s E-HR project, highlighting the overall purpose of the project to change the way the organisation works using digital tools.

Governor representatives in attendance at the meeting noted:
• The Trust’s vision entails a radical shift in how clinical services are delivered and that shift will require transformation of key aspects of the Trust’s operating model, structures, ways of working and the systems that enable this.
• The Trust is in the early stages of this ambitious programme to specify and select an E-HR system.
• The long term vision of the project is to reduce unwanted variation and achieve standardisation, getting the right data out of systems for administrative processes and clinical staff. The project is expected to take up to 10 years to full implementation.
• Governors were also taken through some of the detailed benefits of the proposed E-HR system, these include keeping all electronic records in one system, ensuring that staff only log in to one system avoiding potential information loss.
• Learning from the DPJ experience, the E-HR team felt it is important to involve patients in the designing of the project. The team have placed significant emphasis on involving patients along the way. This will meet the Trust’s equality duties and to make sure it is a system that many can access and will involve a diverse range of patient and public stakeholders, including the engagement of seldom heard from groups.
• The E-HR lead mentioned the process for procuring the IT system would take about a year and the process is expected to commence from March 2019.
• The team is in the planning stage of how best to involving patients in this project. A pilot study was run inviting Foundation Trust members to complete an online questionnaire to which the initial analysis provided very useful insight, however further analysis of the data is yet to be completed.

Governors discussed:
• Data security concerns and protection for patients using this system. The E-HR lead responded that the team is aware of the importance of data security and storage and drew governors’ attention to the fact that some other Trusts in London have already embarked on this. The E-HR lead also sought to reassure governors that security concerns will be a criteria when this goes out to tender.
• How this system will work with other electronic initiatives such as the Local Care Records. The program lead mentioned that this will not undermine the current systems but rather enhance this. The E-HR will be
more accessible to and viewable by patients. Some of these need to be tested with the vendors during procurement.

6. Patient Experience (PE) Report Update

The Head of Patient Experience summarised some of the highlights from Quarter 1 (March – May 18) report including:

- National Inpatient Survey 2017 - Performance compared to last year is stable. Our position is less positive when compared with Shelford Peers and we are in the lower half of the group. Some of the areas we have improved on are how to raise a concern. Areas for improvement include aspects of food quality and cleanliness. Some of these areas for improvement are included in the standards of the Fundamentals of Care that the Nightingale project is covering. Essentia have also put together a program for improvement of food on wards which include a range of quality checks and ensuring patients dietary needs are met.

- FFT scores for Inpatients have remained steady - performance has remained stable during the quarter with recommend scores in line with national averages and above regional averages. Response rate are particularly challenging for day case/ surgery procedures, the PE Team has worked with teams to reduce the survey length and also pass on learnings from other Trusts on how they obtain high volumes of feedback from day case and day surgery patients

- FFT Scores for A&E remain strong with response rates above target. Performance for August is very positive with response rates 6-10% above national and regional average. Further detail will be shared at the next meeting.

- Recommend and not recommend scores for outpatients are broadly in line with regional averages and recommend scores are slightly lower that national averages.
• Community services - performance remains very strong. Trust scores are in line with or above both national and regional recommend scores and in line with average not recommend scores.
• Maternity Services - variation in scores between different Trusts and variation from month to month, which makes it difficult to draw clear conclusions regarding trends. Postnatal FFT recommend score is 7-10% below regional average. Some of the comments from patients were about noise, temperature, staff attitude.
• Areas of high and low performance - There have been improvements in scores for noise at night and this is currently above target to be discussed in next report. Some of the initiatives taken are the provision of sleep packs, eye masks, staff reduction in noise levels for patients, visual stickers, and plans to develop an aide memoire for staff.
• Keeping patients informed of delays in clinic - The PE Team is working with clinic teams to improve this. Posters have now been developed to be placed on reception desks in outpatient clinics to notify patients if they have been waiting for more than 30 minutes after scheduled appointment to contact the receptionist. A tool kit has also been developed to help train staff to deal with announcing delays and dealing with challenging behaviour from patients.
• Patient experience priorities - The PE team have now piloted and introduced contact cards that clinical teams can give to patients with information about who to contact after they have left the department. Some other initiatives are improving contact by telephone, including the effective use of call centre technology.
• Evelina: Patients experiences are mainly positive, FFT scores high. The team have now moved to a process of scanning their questionnaires to help alleviate the additional responsibility of staff inputting questionnaires.

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:
The Trust PPE strategy was approved by the Trust Management Executive and Board in June and July respectively. The objectives of the strategy are intended to support the delivery of the Trust’s strategic priorities over the next 3 years.

To inform the redevelopment of the Trusts ‘Digital Letters’ project, the PPE team, Digital Patient Journey and Patient Experience teams completed 248 face to face interviews with patients in over 20 services across the Trust. The findings were reported to the TME on 20 September.

The team are also supporting work to begin to inform the requirements for future E-HR from the patient-user perspective. They conducted a pilot online survey with Foundation Trust members to get a patient-public view of digital technology to help support this project.

The PPE team continues to support individual teams to engage patients in projects to improve services and clinical pathways. The new cohort of services will be joining the programme from September. The team are also supporting Evelina London to develop a work plan for patient and public engagement in the Evelina Strategic Business Unit.

Work is also ongoing with the Surgery directorate, commercial colleagues and Johnson and Johnson’s appointed building contractor to support patient and public engagement in the design of the Orthopaedics Centre of Excellence. Initial outline building designs are to be shared with a third patient workshop on 27th September. Patients with experience of orthopaedic services will be continue to be involved throughout the key stages of the project.

In May, King’s Health Partners and the Royal Brompton and Harefield NHS Foundation Trust approved a Feasibility Study to continue the partnership and further develop the proposals that were described in the study. The Partnership’s proposals encompass cardiovascular and respiratory services for all ages, from foetus through to old age, for both common and rare conditions. The partners are in the process of developing plans for patient and public engagement in this important programme.

The Trust Patient and Public Engagement Manager also summarised the findings of the Call Quality Assessments for Q1 2018/19. A few areas of improvement including advisors genuinely listening to callers and checking they understood the query. Areas of slight deterioration were staff placing callers on hold and advisor offering assistance to caller. The feedback and areas of concerns will be brought to the attention of call centre managers.
8. Reports from committees (those attended by Governors)
   No notes tabled.

   **Quality and Performance Committee**
   No notes tabled

   **Adult Local Services Committee**
   Tabled

   **Children’s Services Committee**
   No notes tabled

   **Cancer Services Development Committee**

   **End of Life Care Committee**
   No notes tabled

9. Any other business

   The Head of Patient Experience highlighted the planned Governor and the Non-Executive Directors visit programme. The visiting programme has been set up to enable both Non-Executive Directors and Governors to learn more about clinical and non-clinical services at the Trust. The Patient Experience team will set up a rolling programme for two areas per month for governors to visit. Interested governors will need to be CRB checked as well as complete Occupational Health and DBS checks. Governors interested in being included on this programme should contact the Membership and Governance Coordinator or the Head of Patient Experience.

10. Date of next meeting

   Tuesday, 4 December 2018, Belvedere Suite, Education Centre, York Road.
## Council of Governors

### Service Strategy Working Group Report – 3rd July 2018

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**Sponsor:** John Balazs, SSWG Lead (interim)  
**Author:** Dan Pembroke  
**Reviewed by:** John Balazs, SSWG Lead (interim)  
**CEO***  
**ED***  
**Board Committee***  
**TME***  
**Other***  
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1. Attendees:

John Balazs (SSWG Lead, interim), Devon Allison, James Palmer, John Porter, Jenny Stiles, Bryn Williams, Tahzeeb Bhagat, Margaret McEvoy, Placida Ojinnaka, John Chambers, Marcia Da Costa, Vicky Rogers, Jacqui Dyer, Guiseppe Sollazzo, Anabel Fiddian-Green, Peter Yeh, Mary Stirling

Jackie Parrott (Director of Strategy), Steve Townsend (Chief Digital Information Officer) Sasha Savic (Electronic Health Record Programme Director) and Dan Pembroke (Strategy Manager) attended from Guy’s and St Thomas’.

Apologies were received from John Pelly, Ian Abbs, Martin Shaw, Anna Burrows, Lucilla Poston, Samantha Quaye, Yu Tan, Tony Hulse, Anita Macro

2. Notes of the previous meeting and matters arising

2.1 The notes of the meeting held on the 17th of April were approved as a true record.

3. Electronic Health Record

3.1 Steve Townsend and Sasha Savic joined the meeting for this item. Steve set out that the planning for an electronic health record (EHR) and the strategic outline case was approved in September in 2017 and the outline business case was approved in April 2018. The Trust is now working to go to market for an enterprise wide EHR to construct a contract that the Trust is able to sign up. Simultaneously the Trust is working to develop a transformation plan to make the most of the deployment of the EHR and how it is used.

3.2 Sasha took the governors through the presentation. The strategic imperative for the NHS’s digital agenda is improving interoperability across organisations and services. There is a drive to deploy an EHR within the Trust because we recognise that it will support and improve the quality of our patient care and is an underpinning component to delivering our strategic ambitions. The Trust’s digital strategy focuses on
empowering and enabling staff to make the most of digital technology. The EHR programme’s focuses on changing the model of care we provide in the Trust through technology and putting in place the technology to do that. In many respects the EHR programme isn’t an IT programme, it’s clinically led programme with a distinct tool to enable us to get the benefits of new technology. The EHR is effectively a single patient database across the services of the Trust which will allow greater accessibility to patient data to support the care we provide. To deliver an EHR we need to have clear models of care and the transformational capability to move to a future model of care.

During questions and discussion the following was highlighted:

- The governors asked what the opportunities or benefits are of the EHR. Steve outlined that this was dependent on what system is procured and that is based upon how we detail our requirements and how the competitive dialogue with suppliers goes. The Trust’s intention is to satisfy all of our requirements but there may be constraints which emerge through the competitive dialogue procurement process.
- That while the Trust recognises the EHR means that we'll have a more digital environment but we also have to provide services to patients who don’t have access to computers. The Trust is engaging patients to determine how best to do this – but it is not likely that we will completely paperless. This will provide more choice for patients and means need to cater for the special requirements that some of our patients have.
- That the EHR programme has formed a working group with clinical staff to support the information gathering for the setting of requirements. The programme is now at the point where the engagement needs to go wider and deeper, Simon Steddon, Cormac Breen, Katrina Cooney and Hannah Coffey are looking at how we do that. The Trust is looking to build a clinical forum consisting of 120-150 people, and this includes community clinical staff too because interoperability is key to the whole programme.
- When asked how we ensure we pick the best supplier, not just the cheapest, Steve outlined that the route the Trust has chosen to procure the EHR, competitive dialogue, was chosen because the Trust believes it will get the best result that way. This procurement route is considered more time consuming and expensive but it gives us a process and the opportunity to purchase something that more closely meets our requirements.
- The Trust is looking at procuring an ‘enterprise core’ EHR. This means that the Trust gets the core components from first deployment and will allow the Trust to deliver care and the speed it needs to
currently. If new technology becomes available after that we can look at introducing it to the system if it’s compatible. This isn’t just a one deployment programme, the Trust will be looking at constant improvement. At the moment there is a large amount of work to focus on the dataset just to be able to take us to the next stage.

- The Trust is currently thinking through what to do about patient and family access to patient data. We want to ensure that appropriate information is used properly but also recognise there is some considerations about data that isn’t appropriate to share. The vision is to build a patient team who work through this as part of the competitive dialogue procurement process, which as a process will enable us to get the supplier to directly show us the options.

- The Trust has sought advice from other trusts who have deployed EHRs to learn from their experience. The single biggest thing that was learnt was that we need to keep operational and financial data safe as we transfer to the new system. If the Trust is able to transfer that information with minimal disruption then it is likely that it will result in a safe deployment which enables transition to a clinical deployment. We knew from the beginning of the programme that the transformation element of this key and from talking to others that when they have had difficulties because they hadn’t adequately thought that through.

- A complete enterprise system must come with a backup facility, and we will have a tertiary back up too. We can’t afford the system to go down for maintenance so the solution should allow continual data access for services. Most data will need to be kept for eight years, but can be asked to be forgotten. This data will also enable us to support population health and public health by having it all in one system to draw upon.

- The Trust has known from early on that any system we deploy need to be intuitive and user experience is a key element of our digital strategy. We are investigating with suppliers the ability to collect data automatically, without typing, by connecting directly to equipment. Throughout this process the programme is looking for patients and staff to keep it honest by asking how easy it is to use the system.

- That this is a programme that no one disagrees on the aims of but the detail of it is something that SSWG are going to want to review fairly regularly. Dan and Jackie would explore how best to do this. Steve proposed that end of 2018, early 2019 would be the next best time to review progress.
4. **Trust strategy refresh**

4.1 Jackie Parrot took governors through the presentation and a two page summary of the strategy that was circulated in the meeting. Jackie set out the external context which has driven the need for the refresh of the strategy including the rise of sustainability and transformation partnerships, a constrained financial environment and increasing demand on a services with increasingly complex patients.

4.2 The Trust is very conscious that we need to find an effective way of describing what we want to do. The two page summary version and a one page framework is what will be circulated to staff over the summer. Then the Trust will do a full, phased, launch in September. The Trust decided to update its vision to something shorter and punchier and three main strategic priorities with seven objectives underneath those.

4.3 Jackie took governors through the strategic framework and sought governors views on the framework, the proposed vision and strapline for the Trust. Jackie then asked for feedback and thoughts from the governors.

During questions and discussion the following was highlighted:

- That a branding specialist was used for 2-3 days to do a low key piece of work looking at the hierarchy of what we were proposing. One of the main outcomes from this was the decision to focus on a vision rather than a mission.
- Dan updated the governors on the engagement work with staff and the patients and how that will input into the final wording for the strategy.
- On the proposed vision views were expressed that there was a preference for the, ‘advancing care’ vision statement, but that perhaps the wording of ‘for all’ sounded arrogant and everyone might be better. Also it was suggested the international and national leader elements may not be of interest to everyone. It was also proposed that the Trust’s role in system leadership should be mentioned in the vision. Jackie noted all the feedback and confirmed that it would all be considered but that there is always a problem with a vision in that everyone wants their bit reflected in it which doesn’t always work.
- Governors were looking for more to be said on prevention given the pressure on health services and the risk that the ‘crisis’ model of healthcare wasn’t sustainable. Linking this to tackling health inequalities would be important as this was a major priority for the NHS at the moment.
- On the strapline there was a suggestion that the Trust could be framed as a listening organisation as people wanted to be listened to. Also it was suggested that we care didn’t necessarily include research and the leadership aspects that are part of what the Trust does.
- Governors liked what was presented as the Trust’s refreshed strategy, finding it simple and effective.

5. Any other business

5.1 Governors were asked to support this year’s pride by tweeting their support and then the meeting closed. The next meeting was confirmed for 9th of October 2018, 5.30pm to 7pm in the Belvedere suite at York Road.
<table>
<thead>
<tr>
<th>Council of Governors</th>
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<tr>
<td>Questions and Answers</td>
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<td>24th October 2018</td>
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<td>CG/18/24</td>
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<th>This paper is for:</th>
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<td>Decision</td>
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<td>Corporate Affairs</td>
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<td>Other*</td>
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1. Summary

This report includes the list of questions raised by governors at the recent Accountability meeting with the Board in September. The questions raised have been allocated to Board Committees. The next stage will be to arrange the questions into themes for consideration by the Committees.

Also included in this report is a list of other 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.

2. Request to the Council of Governors

The Council of Governors is invited to note the report.
### 3. Questions raised at the Board and Council of Governors Accountability Meeting, 12 September 2018:

<table>
<thead>
<tr>
<th>Board Committees</th>
<th>Matters of interest/question</th>
<th>Responses</th>
<th>Completed date</th>
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<tbody>
<tr>
<td><strong>Adult Local Services</strong></td>
<td>Is the trust working to implement more consistent clinical supervision including peer reviews? (Notably for community services and particularly niche specialisms respectively)</td>
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<td>Are we doing enough to retain our staff - what more can we do particularly in community services?</td>
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<td><strong>Corporate Management Committee</strong></td>
<td>How does the interaction between KHP partners work?</td>
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<td>How does our partnership strategies involving STP, KHP, GSTT Alliance work together?</td>
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<td>Will the RBH proposals go ahead in the light of the politics?</td>
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<td>How can we make sure the patient benefits of the RBH partnership are front and centre?</td>
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<td>What do we do about the RBH brand?</td>
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<td>How can we rebuild trust and confidence in the patients, parents and public that this is the right plan?</td>
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<td>It is imperative that we align the Charity strategy with the Trust's strategy - it isn't happening at the moment!</td>
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<td>Who owns the relationship into the charity from within the trust and what can we do to better</td>
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<td>ensure the charity's fundraising strategy is aligned to the trusts growth strategy? They don't seemed entirely aligned at the moment.</td>
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<td>How do we ensure that we maintain a focus on, and the innovative and positive attitude to, partnership working?</td>
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<td>How do we ensure good practice is shared between teams?</td>
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<td>How do we facilitate clinically informed change programmes?</td>
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<td>Is there a risk that with the STP, Vanguard, Brompton, cardiovascular institute and all other exciting opportunities and changes, that we lose sight of our core patient needs and risk diluting the quality of service and experience our patients receive from us? What are we doing to mitigate it and keep our eyes on the main objectives?</td>
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<td>What are we doing to address the withdrawal of bursary for student nurses?</td>
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<td>How can the governing body be better briefed and informed about all the excellent work, focus, strengths etc of KCL and how that is feeding into clinical practice?</td>
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<td>What value is KHP providing as an entity (vs SE STP, etc) today?</td>
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<td>How does the Board communicate problems to DoH? e.g. Difficulty recruiting because of Tier 2 visa caps</td>
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<td><strong>Digital</strong></td>
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<td>What kind of culture change would we need to have clinically led transformation?</td>
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<td>Quality &amp; Performance</td>
<td>Who has the overview of both practise and clinical change programmes? With the overview of the whole organisation?</td>
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<td>How are we going to ensure there is enough space to accommodate all the teams and services/ research that we want / need on our sites for both operational reasons and longer term strategic reasons?</td>
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<td>What is the trust doing to address or investigate concerns that Essentia recharges are excessive or seemingly expensive for clinical directorates?</td>
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<td>How can we ensure that staff working across different teams and disciplines work together effectively and efficiently?</td>
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<td>What are the implications of the 3 year pay deal, agreed for Agenda for Change staff, on delivery of patient care?</td>
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<td>How do we ensure that we work more closely with GPs and work more effectively together on population health management?</td>
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<td>Are we paying sufficient attention to staff accommodation?</td>
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<td>For the trust, what work force flexibility is good and achievable? (e.g. online training, flexible working), and what is not (e.g. 24/7 work)</td>
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<td>How do you institutionalise support for prevention? What is the role of GSTT?</td>
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4. Other questions raised:

**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.

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<thead>
<tr>
<th>Matters of interest/question</th>
<th>Issue number &amp; date raised</th>
<th>Responses</th>
<th>Progress/further information</th>
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<tr>
<td>Please can DPJ share the list of as well as demographics within, of the groups / audiences that it has consulted to understand what patients want from their ‘digital’ journeys at GSTT in the future? A recent paper presented to the digital committee made a number of patient statements and it would be useful to understand how representative of our overall patient group those views are, or if they are specific to certain groups.</td>
<td>18/20024 2018-07-25 Heather Byron</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><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</td>
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<td>hasn't yet a systemic problem, talking to the lab and the dietitians, there have been a number of incidents which clearly causes concern both from the perspective of delay to patients on results but also any potential risk / harm resulting from tests which do not arrive or cant be read in the lab.</td>
<td></td>
<td>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)</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 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.

**Whats next:** 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.

- develop a simple, consistent escalation process to Royal Mail (admin driven not lab driven) so that we are consistent in our escalations and have a clearer audit behind us of the issues encountered (this could be a simple form on the portal for example)
- as part of the wider Royal Mail relationship drive some escalation discussions (the sense is that in isolation this isn't 'important enough' to deal with by the RM.
- review whether Royal Mail is the right partner to be responsible for the delivery of such important blood samples or whether a commercial agreement should be made with another party
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<td>(whilst on the surface the 'cost' of the RM business reply service may seem competitive, I wonder when you look at the total cost including the courier costs to bring post from RM to GSST, it may not be... not to mention the slightly unreliable nature of the service. 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>
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<td>Governors understand, from documentation released at Board Committee meetings, that Consultants are helping to identify cost improvement opportunities for FY 2016/17 and that Lord Carter has similarly identified savings opportunities. Could the Board outline the nature of these opportunities and give some understanding of the impact they would have on the operation of the FT.</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 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</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</td>
<td>A further response/update has been sought.</td>
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<td>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>
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<td>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>
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