


<b>Council of Governors</b>	<b>Guy's and St Thomas'</b>  NHS Foundation Trust
<b>Questions and Answers</b>	<b>27<sup>th</sup> January 2016</b> <b>CG/16/07</b>

This paper is for:		Sponsor:	
Decision		Author:	
Discussion		Reviewed by:	
Noting		CEO*	
<b>Information</b>	<b>X</b>	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.

**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

The following questions have been raised by governors during the last quarter. Answers are included or are ongoing and will be provided to governors once available.

**Note: Governors are asked to send any queries to Andy Simpson or Peter Allanson and not directly to directorates. We will log questions and ensure they are properly handled.**

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
<p>In response to the End of Year Message from Robert Lechler, Executive Director of King's Health Partners, I must say the package leaves me confused about who does what and where the lines of responsibility and authority sit. How do we Governors of GSTT sit within the overall governance of KHP? For instance Robert states that they are developing an electronic patients record to be use across KHP and out into the wider world with its patient care and security implications. How does GSTT fit into the business planning, resourcing and risk assessment of this. There are similar ambiguities in the Outcome Books such as IPR within start up companies and profit share.</p> <p>We have made two attempts to explain the inter-relationships but neither has been entirely successful. Should we make another attempt either as GSTT or in a meeting of joint governors or even joint BOD /COG?</p>	<p><b>15/0021</b></p> <p>2015-12-17 (John Porter)</p>	<p>The fundamental point is that the three FTs retain sovereignty over all acts done in their name so there is no formal governance arrangement because there ought not to be the need for one because decisions are not delegated.</p> <p>Where we've fallen down is in keeping governors abreast of what's going on; we are in the midst of finding a date for a joint meeting in the new year and we could look at this again during part of that event. Carter, which we will also brief you about, will inevitably push us in the direction of sharing lots of things including IT solutions but they will be JVs rather than initiatives.</p> <p>I'm not aware of any KHP IPR successes of any significance - though that's not definitive - and the benefit would accrue to the developers and their sponsors. As a Trust we have a handful of interests via GST Enterprises</p>		

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<p><b>NHS: Call for opt-out organ donation law across UK</b></p> <p>Wales has implemented Britain's first opt-out organ donation system with anyone who has lived in the country for more than a year now considered to be a donor unless they have registered a formal objection, informs The Times (Staff). Just three per cent of adults, or 85,944 people, have decided to opt-out as compared to only a third of the population registering to be a donor. The British Medical Association and the British Heart Foundation has called for the UK to adopt the policy.</p> <p>Does GSST support this campaign - or is that too political?</p>	<p><b>15/0020</b></p> <p>2015-12-01 (Yvonne Craig Inskip)</p>			
<p>The Evelina has been very successful in moving towards becoming the comprehensive childrens' hospital for South London and beyond but the lack of capacity for all clinical activities has now become acute and bed availability problems almost a daily issue. When will the Trust be able to announce a firm timetable for the immediate expansion - Evelina 1+ - and the longer term development, Evelina 2?</p>	<p><b>15/0019</b></p> <p>2015-11-26 (for Accountability by Tony Hulse)</p>	<p>Evelina 1+ is a programme of works to expand capacity in Evelina consisting of a number of projects, some of which are already in progress and already have firm timetables. The current progress is summarised as:</p> <ul style="list-style-type: none"> <li>- NICU - a contract is in progress to create additional neonatal cots in NW due to open in Spring 2016.</li> <li>- PLTV - contractors have started work in South Wing to provide an additional 6 specialist beds (releasing bed capacity in Evelina) due for completion in Spring 2016.</li> <li>- procedures Room - a contract has been awarded to build a minor procedures room in the theatres</li> </ul>		

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		<p>department in Evelina which will create additional surgical capacity from next summer.</p> <p>- Conversion of 6th floor to inpatients use - we anticipate awarding the contract for the detailed design and refurbishment of the 6th floor in December, with a view to the conversion being completed in early 2017 providing an additional 24 beds.</p> <p>The Trust is committed to the longer term expansion of Evelina, known as the Evelina 2. The timetable for progressing the project will be announced once the Trust has concluded discussions with NHS partner organisations and commissioners. The strategic outline case is due in early 2016.</p>		
Funding for Education and Training in the NHS has been reduced significantly in recent years. Could the Board comment on how this has impacted on the Trust? Specifically, is the Board confident that the quality and quantity of postgraduate education for clinical staff is still sufficient to ensure the workforce is adequately trained and skilled to continue to provide high-quality care?	<b>15/0018</b> 2015-11-25 (for Accountability by Sam Newman)	<p>Funding for Education and Training in the NHS is managed by Health Education England who receives a budget from the Department of Health each year. This is devolved to thirteen Local Education and Training Boards (LETB's). Our LETB is Health Education South London (HESL).</p> <p>The total GSTT contract with HESL for 2015/16 is worth £74 million.</p> <p>The national HEE budget has decreased over the last two years and, although the spending review has frozen the budget rather than decrease it, this represents a decrease in real terms. There is added risk to London in that HEE wishes to provide a more</p>		

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		<p>equal funding across England rather than concentrated in London.</p> <p>The bulk of the contract is for postgraduate medical education and includes salaries for doctors in training. It also includes budget for educational and clinical supervisors, library and central costs for running medical education department. This funding has not decreased materially since HESL was founded in 2012.</p> <p>In addition we have had the opportunity to bid for additional funding for simulation, strategic investment, apprenticeships, innovation grants and preceptorship (the latter for newly qualified healthcare professionals). We have taken full advantage of these opportunities over the last three years. However, this is not likely to be available to the same degree next year due to the HEE financial situation and the changes this week to funding for Business and Skills (impact on apprenticeships not yet clear).</p> <p><b>Mitigating against the decrease</b></p> <p><b>What we have done so far</b></p> <p>We spend almost half of our indirect budget on mentorship courses for nurses in order to support student training. This year we have renegotiated prices with our local universities by using a lower credit module or a no credit module.</p> <p>We have started to support directorates to develop internal education programmes and have them</p>		

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		<p>accredited by a partner university at a lower cost than university modules.</p> <p>We are promoting alternative sources of education funding including GSTT charity individual staff awards and have purchased a live database which staff can use to search for bursaries and grants.</p> <p><b>Plans for the future</b></p> <p>We are driving a change in how the organisation views learning with a shift from classroom based learning to more work-based learning backed up with e-learning and a smaller amount of face to face.</p> <p>However, in order for people to still be able to gain post-graduate qualifications, we will accredit this informal learning so staff can 'collect' credits as they work. The launch of nurse revalidation will support this move as 50% of the required continuing professional development can be through reflection on work-based or other informal learning.</p>		

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<p>Christopher Smallwood, Chairman of St. Georges Healthcare NHS Foundation Trust, recently spoke out about the significant financial pressures faced by NHS Trusts (The Guardian, 08/11/15). As we are all aware, Guy's and St. Thomas' is not immune from these pressures, and is itself facing a large deficit for the first time. This is despite the Trust making multi-million pound efficiency savings during the previous few years. We are not facing a deficit because we are wasteful and inefficient; we are facing a deficit because the DH (and the Government) is under investing in the NHS.</p> <p>Does our Chairman, or any other senior member of the Board plan to speak out publicly about the difficult financial situation faced by GSTT and the wider NHS? As such a large, high profile Trust, I can't help but think that some carefully chosen words would carry much weight and add enormously to the conversation and debate on the future of the NHS.</p>	<p><b>15/0017</b></p> <p>2015-11-25 (for Accountability by Sam Newman)</p>	<p>The Trust clearly explains the financial position at the Trust Board and Council of Governors Meetings in the public arena and to staff in town hall meetings. The £22b NHS challenge and £1b challenge for the south east London sector over the next 5 years are also in the public domain. The £8b requested by NHSE is also well publicised. The trust attempts to influence the Treasury, DH, NHSE, and regulators in private. The £3.8b announced in the comprehensive spending review and the phasing of it may have been influenced by public or private approaches. Unless we can prove what level of efficiency is reasonable getting the Treasury to fund more than the £8b and reduce the £22b challenge whether publicly or in private will prove difficult</p>		
<p>With regards to the new cap on agency staff spend, would the Board be able update the Council of Governors on how this has affected the Trust to date? I realise that the cap has only just come into force, and will become more severe over the next few months, so perhaps the Board could provide an ongoing update on its effect? Specifically its effect on</p>	<p><b>15/0016</b></p> <p>2015-11-25 (for Accountability by Sam Newman)</p>	<p>The Trust supports the need to control agency costs and to reduce the pricing of temporary staff but seeks to do so in a way that does not compromise patient safety. GSTT is fortunate in having a large internal staff bank on which we rely to fill the majority of shifts but we do not have sufficient numbers to fill all requests.</p> <p>We are pleased that we're successful in our lobbying</p>		



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hard to staff areas which rely heavily on agency and locum staff (A&E, Critical Care)?		<p>to keep local bank rates outside of the monitoring system – it will allow us to focus on those areas of high cost agency spend in the first instance. The agency cap was introduced on Monday 23rd November and will be further reduced in February and April 2016.</p> <p>We have undertaken an impact assessment with each directorate and identified those areas where they breach to new pricing cap. In the majority of cases, alternative agency providers have been secured and they have been willing to drop their rates to comply with the Monitor cap.</p> <p>The areas most affected by the 1st phase change tend to be highly specialised areas where there are known recruitment problems. The Trust will continue to use these workers where otherwise, the loss would impact on patient safety – our Chief Nurse and Medical Director have provided delegated authority to directorate teams to continue such booking but these will be closely monitored by the Board.</p> <p>A weekly exception report will be submitted to Monitor showing all shifts that were booked that were above the agreed national cap.</p> <p>There are also non clinical areas where there is high use of agency staff or contractors whose rates are above the Monitor cap. Where such resources are used, directorates have been asked to make clear why exception should apply. Directorates are being</p>		

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		<p>encouraged to think more innovatively about how they fill posts, including exploring use of different types of workers.</p> <p>The Board will be pleased to provide regular reports on this matter.</p>		
On what basis is the financial planning for 2016/2017 proceeding or are we assuming another deficit?	<b>15/0015</b>  2015-11-24 (for Accountability by John Porter)	<p>The Trust is currently anticipating a savings requirement for 2016/17 of approx £100m and has made directorates aware of this in the planning round launched in October. This is based on the savings requirements identified in the five year plan for 2016/17 plus moving from the £19m deficit plan in 2015/16 to break even and an assessment of measures implemented non-recurrently in 2015/16.</p> <p>The Board anticipates directorates identifying £30m savings in business as usual for 2016/17. A further £30m savings are being worked up as bold transformational changes.</p>		
Could the Board update on CIP Delivery Year-to-Date; and identify the major Themes that are at Risk of delivery	<b>15/0014</b>  2015-11-22 (for Accountability by John Duncan)	<p>The Trust was faced with income reductions in 2015/16 compared to 2014/15 due to the financial position of the NHS as a whole. The Trust had to achieve £93m worth of cost reduction, efficiency savings or surplus on income for performing additional activity in 2015/16 in order to achieve the planned loss of £19.1m.</p> <p>When the plan was submitted the Trust had identified £54m CIP's and income benefits, a further £16m opportunities had been identified in the fit for the future programme and £23m savings still needed to be</p>		

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		<p>identified.</p> <p>By month 7 the Trust had identified £59m CIP's and income benefits in directorates, a further £16m had been identified corporately. Directorates need to improve their position by £19m for the trust to achieve the plan in full.</p>		
Could the Board update on the progress to allocate the unidentified CIPs	<b>15/0013</b> 2015-11-22 (for Accountability by John Duncan)	The Trust set business planning targets for directorates to achieve the full £93m savings required. Unallocated Cips were therefore showing as directorate deficits. At month 6 revised control totals were issued to directorates with action plans being agreed to achieve these best case positions. The balance of savings required was being pursued by corporate initiatives and release of balance sheet provisions.		
If the risk of delivery is growing, would the NED/Board let us know the likely impact regarding Care & Quality and the consequences with Monitor and how is the risk being managed?	<b>15/0012</b> 2015-11-22 (for Accountability by John Duncan)	<p>If Monitor judges the Trust to be in breach of licence requirements it will consider how to intervene. Challenging financial targets mean the Trust is holding monthly review meetings with Monitor but as yet Monitor has not felt the need to intervene. Proposals which directorates develop come forward from their clinical teams. These are reviewed by the Medical Director and Chief Nurse to ensure patient quality and safety are not put at risk.</p> <p>Performance reviews are conducted with directorates on a monthly basis including covering delivery against the financial plan. For the most challenged directorates additional finance performance reviews have taken place for the last three months to agree action plans and monitor progress with their</p>		

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		<p>implementation with directorates to improve their financial position.</p> <p>The trust meets monthly with Monitor to review progress in meeting the financial targets. The trusts projections and risks are shared with Monitor. Monitor in view of the National position wants the trust to achieve the plan in full. The trust will endeavour to do so but the question of what would be deemed good performance against such a significant target is worth asking.</p>		
Why are Board Members unable or unwilling to seek voluntary income from grateful patients?	<b>15/0011</b> 2015-11-20 (for Accountability by John Burns)	This is a difficult area. Whilst many people would be prepared to pay if approached others might possibly feel obliged to make a donation. There would be a range of practical issues in collecting the contributions. We believe it is better to publicise how donations can be made to the Charity if people wish to make gifts and for the Trust to benefit from their grant making abilities.		
<p>I feel the CoG could do with a better understanding of what is going on with the digital infrastructure present and future at Guy's &amp; St Thomas'. I cannot help but think there is a lot more going on than we know about as a collective and it makes it near on impossible to hold the Board accountable to something we don't know about.</p> <p>We also need to explore why decisions have been made, especially since there are many other local hospitals that are doing very</p>	<b>15/0010</b> 2015-11-16 (for Accountability by Gyles Morrison)	<p>There is certainly is a lot going on and I would be happy to have my teams explain in greater detail should any governor wish to spend the time required. Of course much of this is specialist and technical in nature but we would attempt to make things as plain English as possible.</p> <p>The strategy was built with significant input from the trusts internal stakeholders and external views from industry experts such as Gartner taking into account worldwide trends and thinking. In doing this we looked beyond what local hospitals are doing looking at</p>		

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<p>different things to compare with us.</p> <p>There are a number of us who are experienced with more complex digital projects, and it may be of benefit to have a group that explores this issue regularly since it's a very large part of the budget, as well as having significant impact on service deliver, again present and future.</p>		<p>system leaders such as the Mayo Clinic etc.</p> <p>We are not alone in taking the approach, notably Leads and Salford have similar strategies and we liaise with them regularly to share learning. Over the last year three trusts have visited us based on our strategic approach.</p> <p>It should be noted that the strategy also delivers opportunities to leverage the platforms being developed to drive income diversification through ETL.</p>		
Can the Board give us an understanding of the Governance arrangements for the information systems programmes that underpin progress toward the Digital Trust? Do these arrangements include access for Governors?	<p><b>15/0009</b></p> <p>2015-11-16 (for Accountability by John Porter)</p>	<p>Considering setting up a Board committee chaired by a NED with external expertise on systems, IT and digital able to sweep the horizon and have a view on what is being proposed within the wider health system – such as the things Beverly Bryant was talking about in HSJ a week or so ago – and probably beyond. Perhaps someone from PWC or other such advisory group. As far as membership goes, in addition to Scott and Steve, we would expect to see some clinical IT expertise and an operational overview so that the direction and management of process fitted in to delivery.</p> <p>The terms of reference would be rather trickier and probably to be argued later on if we go down this route – ie approval, watching, project monitoring etc are all candidates and the what would depend on whether the Board wished to delegate anything to it.</p>		
I would like an update on the progress of capital projects in the light of the Trusts financial position...particularly the New	<p><b>15/0008</b></p> <p>2015-11-16</p>	Governors have been briefed on the Trusts financial position and the consequent restrictions in available capital which has led to the decision to prioritise		

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Theatres in North Wing, the extension of the Evelina , the cardio thoracic centre and block nine!	(for Accountability by Kevin Burnand)	<p>capital investment towards patient safety projects and the expansion of children's services. In addition to contract commitments already made and in progress in the short to medium term, the capital programme will focus on:</p> <ul style="list-style-type: none"> <li>- £35m investment in Evelina 1+ Capacity expansion</li> <li>- £9.5m investment in improving the safety and infrastructure in North Wing wards</li> <li>- £2m investment in increasing the site electrical supply at Guys to ensure long term sustainability</li> <li>- £2.5m investment in increasing operating theatre capacity at Guys</li> <li>- £2.5m investment in replacing the PACS system</li> <li>- other improvements in patient discharge facilities and the St Thomas mortuary.</li> </ul> <p>The strategic business case for the development of the cardiovascular institute is being progressed in conjunction with colleagues at KCH and it is anticipated that the requirements for this facility will be defined in the first part of 2016.</p> <p>The Trust and KCL are working in partnership to bring Block 9 back in to use as the Education and Training Centre at St Thomas for both organisations and with the potential to attract commercial income. The business case is being developed by a project board with membership from both KCL and GSTT which is working with architects on confirming requirements and an update report is due in the new year.</p>		

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<p>In light of the recent survey findings and discussions at MeDIC, I would appreciate a view from the top as to whether there is an appetite to expand the Trust's membership to make it more representative of our local communities and patients and, if so, where there should be a focus and why. Some comments on how, given budgetary constrain, would also be appreciated.</p>	<p><b>15/0007</b>  2015-11-16 (for Accountability by Kate Griffiths-Lambeth)</p>	<p>The Trust has had a static budget for the last few years for investment in membership. It currently pays for a comprehensive data base which, with the arrival of Andy Simpson who used to work for its supplier we intend to exploit more thoroughly, communications with members through e-mail and post, the despatch of the GiST, the election scheme to elect governors two years out of every three and to pay for the annual public meeting.</p> <p>We realise that a number of local groups are under-represented as members of the Trust and have considered what the survey has told us. The challenge it has not solved is how to access those groups effectively given that different groups respond to different approaches – one size won't fit all and we need to use our small resource carefully and thoughtfully.</p> <p>MeDIC would like the Trust to find cash for this but before we go down that road we need to be confident that we have exploited the resources we have in our current governors, members and patient groups to try to get to others. Clearly the current financial climate means that we must be thoughtful about what we spend money on – we can't ask staff to find small savings and the spend cash unless we are confident of a return. Encourage and support MeDIC in developing its ideas and proposals which we will seriously consider – but there's no blank cheque.</p>		
<p>I would like to know of the progress towards a</p>	<p><b>15/0006</b></p>	<p>Good progress has been made but now centres the vast majority of vascular surgical services for the South</p>		

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single cardio vascular unit at St Thomas's.	2015-11-16 (for Accountability by Kevin Burnand)	East Vascular Network at the major arterial hub at St Thomas'. Working with a network of hospitals including King's College Hospital, the hub at St Thomas' is now one of Europe's leading vascular interventional centres with excellent results. As you are aware, early plans are in development for the establishment of a cardiovascular institute which will be a partnership across King's Health Partners that will bring cardiovascular medicine and science together in an institute that will rival the best in the world.		
<p>Would the Board Update on the digital environment (IT/Software/Hardware/Education) on the following:</p> <p>1. The primary objectives achieved so far against its spend (impact of replacing systems, cost savings, quality of care, etc.)</p> <p>2. The Objectives, Budgets and Deliverables for the next 3 years and specifics for the next 3, 6 and 12 months.</p> <p>Also suggest that we have an oversight committee that meets quarterly and that which also includes Governors.</p> <p>I am also finding out from clinicians that our partner Kings already have some good systems that are tried and tested (e.g. one system and gateway for patient records across</p>	<p><b>15/0005</b></p> <p>2015-11-14 (for Accountability by John Duncan)</p>	<p>The IT Strategy was approved by the board in Late December 2011 and painted the vision of creating a digital healthcare system and culture creating a capable technology platform that would remove the barriers to transformation and allow flexibility of design given the challenges to the existing model of care and potential impact of integrated care models.</p> <p>In 2012 the strategy was impacted by the merging of the Community Care business into GSTT and a community view was added to the strategy.</p> <p>The Strategy contained four key pillars:</p> <ul style="list-style-type: none"> <li>• Critical Remediation and Better Basics</li> <li>• Capable infrastructure</li> <li>• The new Desktop and EHR Consolidation</li> <li>• Research and Innovation</li> </ul> <p>1. Critical Remediation and Better Basics</p> <p>This section recognised that the long standing under</p>		



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<p>departments). In this example we may be trying to reinvent the wheel rather than benefit from economies of scale. I don't have enough information to validate that and would like more transparency.</p>		<p>investment in the Trusts IT had left it exposed to high risk of failure and performance impacts in critical areas. These critical areas have been stabilised and made safe, namely.</p> <ul style="list-style-type: none"> <li>• The LIMS System (pathology) re-platformed to supportable hardware and software upgraded.</li> <li>• Windip (Document Management system) re-platformed to supportable hardware and software upgraded with a redesigned front end.</li> <li>• Print servers replaced and reconfigured</li> <li>• WiFi surveyed and failed end points replaced, black spots removed (where possible with current design.</li> <li>• Telephony System stabilised</li> <li>• Storage System stabilised</li> <li>• St Thomas Data Centre rebuild and all capable systems virtualised.</li> <li>• The main HER System iSoft iCM and iPM upgraded to a supported software version.</li> </ul> <p>These deliverables have created a safe operating environment for Trust IT and have been supported by the adoption of ITIL Processes and the professionalization of the Help desk function utilising cloud based Help desk software. The Help desk is the only 3 star accredited function in the NHS. The average time from order to install a PC or Laptop has reduced from 52 days to 95% within 3 days.</p> <p>After this work Serious Incidents dropped by 33% and</p>		

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		<p>outage lengths dropped by 50%</p> <p>2. Capable infrastructure.</p> <p>The focus of this work today has been to redesign and implement a compute and storage infrastructure that is capable of handling digital transactions safely and to have this component of our infrastructure managed professionally by a third party. New integrated compute and storage is in place for all systems that can operate on a modern platform. The newest systems are deployed to be fully resilient. This is demonstrated by the eNoting platform that has had 40 minutes of down time over the last 18 months and has had patches and fixes deployed with no known down time to the users.</p> <p>The design and procurement is complete to make our environment fully cross site resilient making full use of our existing datacentre capability.</p> <p>During this time we have also designed and procured the new desktop environment and are in the build phase of the programme. This will deliver a 60 second logon, full remote and offline access, the latest productivity tools, self-service, and bring your own device capability. It is also the platform that will allow us to deliver Unified communications and collaboration including person to person video calling, document sharing, and integrated video conferencing.</p> <p>Current designs are underway for a network and telephony upgrades to ensure the bandwidth is</p>		

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		<p>available and secure for digital operations.</p> <p>3 The New desktop and EHR consolidation</p> <p>This is perhaps the least understood element of the strategy and there may be some misconceptions as to what we are doing.</p> <p>Starting with EHR consolidation, we have attempted to collaborate with our partners in KCH and SLAM over the last few years without success and 12 months ago the board instructed me to start the work to develop and outline business case for the replacement of our ISOFT system considering which other systems within our portfolio could be consolidated into this. A team of Clinicians with IT support have been assessing the market and reviewing the products available, analysis is underway to develop the options for consideration and this will be reviewed widely with Trust stake holders initial indications suggest circa £85m to implement over a two year period.</p> <p>A number of Electronic systems have been delivered as Key components to going digital some being driven by the closing down of National programmes.</p> <ul style="list-style-type: none"> <li>• New Maternity System (Badgernet)</li> <li>• New Community System (Care Notes)</li> </ul> <p>Some driving digital efficiency and the reduction of paper processed.</p> <ul style="list-style-type: none"> <li>• Job planning (eRoster)</li> </ul>		

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		<ul style="list-style-type: none"> <li>• HR self Service (eHR)</li> <li>• Prescribing (ePMA)</li> <li>• Cancer Network Prescribing (CIS) across GSTT, KCH, Lewisham</li> </ul> <p>The strategy promotes a hybrid approach to going digital and in the Strategy Paper this is describe as the desktop. This is a platform that allows the trust to be innovative in how it delivers digitally and provides the opportunity to provide digital services across integrated care. Key elements delivered from this part of the strategy are:</p> <ul style="list-style-type: none"> <li>• Self check in and call forward (reused in 4 speciality areas)</li> <li>• KHP – On Line viewing clinical systems across GSTT, KCH, and SLAM</li> <li>• eNoting – Core notes delivered into all in patients across Guy’s, St Thomas, and Evalina – so far avoiding the production of £3m pieces of paper and alerting on live acuity across the Trust, and digitising nursing observations, and ward rounds.</li> </ul> <p>The platform is built on two Key products (Microsoft Share point &amp; K2 Forms and Workflow). This is not a build your own strategy as these products provide the functionality and then displayed via customised SharePoint views. The whole point is to buy the generic functionality and configure it to meet the need.</p>		

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		<p>In the next three months the following will be the key deliverables:</p> <ul style="list-style-type: none"> <li>• eNoting roll out to outpatients across the Trust</li> <li>• GP information Displayed within KHP on line</li> <li>• Initial Roll out of the Windows 10 devices to 500 users</li> <li>• Roll out of Skype for Business on Windows 10 devices above</li> <li>• St Thomas Data Centre resilience completed</li> </ul> <p>In the next six months:</p> <ul style="list-style-type: none"> <li>• Completion of the HER OBC work and financial model</li> <li>• Delivery of Windows 10 to a further 2000 desktops including Skype for Business</li> <li>• Roll out of SharePoint Collaboration to Windows 10 Devices</li> <li>• Completed design for network replacement and start of procurement</li> <li>• Migration to St Thomas Datacentre completed</li> </ul> <p>In twelve Months:</p> <ul style="list-style-type: none"> <li>• Roll out of Windows 10 and collaboration tools 80 % complete</li> <li>• Active Active (always on Data Centres) Migrations 75% complete</li> <li>• CSU IT transfer of community service to GSTT complete</li> <li>• Video Conferencing integration with Skype for Business complete</li> </ul>		

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		<ul style="list-style-type: none"> <li>Fit for the Future Space and End User technology Transformation projects</li> <li>Utilising full infrastructure capabilities</li> </ul> <p>In response to the comment re: Kings systems, there systems are old and suffer from the same issues as our old systems, the single gateway may refer to KHP on line a system that we built in collaboration based on GSTT's eNoting platform.</p>		
<p>As a Governor Member of the Trust's 'Smoke free Working Group' I asked whether GSST might be able to apply its accumulated work on the Smoke free objective towards a wider purpose with other Commercial Organisations. The reply was that, in relation to its peers, GSST was more at the end of the line than a vanguard for a Smoke free policy.</p> <p>This being so, I would like to enquire whether the Trust is already taking such action as may be available to it of implementing the <b>Public Health England</b> advice to Government on reducing sugar consumption.</p> <p>Therefore :</p> <ul style="list-style-type: none"> <li><b>If so</b>, could Governors be told about the plans and have the opportunity of contributing to them by participating in any established Working Group (such as was the case for developing the 'Smoke free' policy)</li> </ul>	<p><b>15/0004</b></p> <p>2015-10-26 (Barry Silverman)</p>	<p>We'll have to do this in chunks, I suspect. We have just refreshed the nutrition policy – attached – which is an important first step. We need to row in behind those whose national responsibilities include this – primarily PHE – and we are in touch with them on their actions.</p> <p>I will ask Eileen and team whether there are initiatives we think we can espouse in the Trust as well. The KHP diabetes initiative is certainly one way into this but there is a capacity issue at the top at the moment, as I am sure you understand, so we may only be able to hasten slowly whilst recognising its importance.</p>		

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<ul style="list-style-type: none"> <li><b>If not</b>, will the Trust begin a proactive response to the Public Health (E) proposal in those areas not requiring Government action but which are available to the Trust now within its present powers :</li> </ul> <ol style="list-style-type: none"> <li><b>sugar reduction in everyday food and drink</b></li> <li><b>ensure the sale of healthier food in hospitals and also public bodies</b></li> </ol> <p>It would be helpful if Governors could be informed of the scope of any intended response and how it might be applied to :</p> <ul style="list-style-type: none"> <li>hospital catering in the form of measurable targets, including alternative sugar options for patients</li> <li>commercial operations and franchise anywhere on hospital premises and any timescale or targets that might be necessary in relation to present contractual obligations</li> <li>the reputational powers of the Trust in encouraging other organisations in South East London and Westminster too follow its lead</li> <li>protecting staff health in relation to sugar consumption – particularly Agency night staff more removed</li> </ul>				

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<p>from the day to day hospital environment</p> <p>Noting that PHE states that, “if the UK were to meet the SACN target of 5% of energy being sugar within the next 10 years , it would save £484 million per year by avoiding deaths and preventing 204,000 dental caries,” does the Trust have any knowledge of its ‘present sugar consumption’ and is there a way of setting a reducing target in relation to it, by establishing measurable criteria and actions that would advance the PHE objective.</p>				
<p>Local dentists are frustrated that communication for referrals to the dental department has to be on paper and not email or, for urgent cases, by FAX. Further, whilst the treatment received by their patients is seen as excellent, the follow-up reports are very slow in arriving which makes for difficulties.</p>	<p><b>15/0003</b> 2015-06-25</p>	<p>The dental department confirmed that they take referrals by email and the details are on the Trust website. The referrer is required to fill in a form and email it to the department. If a referrer has to send in x rays they are often sent by post. The process for 2 week waits is by the central team and not Dental. They requested faxing in referrals. The department have a new Secretarial Manager in place who is ensuring that the letters are turned around more quickly, and is putting in long term process changes.</p>		
<p>I have written previously about the requirement for Patients wishing to attend <b>Urgent Care</b> (surely to be encouraged rather than to A &amp; E) to register first at A &amp; E. However, notwithstanding my</p>	<p><b>15/0002</b> 2015-06-22</p>	<p>Following Barry Silverman comments, the Emergency Care programme team are reviewing the process for the urgent care centre registration and as an interim measure a sign will be added at the main A&amp;E entrance advising patients to register with A&amp;E</p>		



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<p>representations, this remains a requirement which is brought into sharp relief with the opening of the new corridor in Lambeth Wing that bypasses A &amp; E. The effect is that Patients requiring the Urgent Care Department, arriving at the Main Entrance (or Lambeth Wing entrance that is very close to it) can easily arrive at the Urgent Care. But, having done so, patients are then directed, <b>by a large notice</b>, to register with A &amp; E before entering. As a result they must retrace their footsteps to the Lambeth Wing Entrance and proceed to A &amp; E via the <b>outside pathway</b> to register and then retrace their footsteps back to Urgent Care. May I suggest that this is an unreasonable imposition – particularly in inclement weather/winter conditions and seems to place the priorities of Departmental administration above Patient welfare. If so, it is hardly a demonstration of ‘showing we care’</p>		<p>reception before attending UCC. These issues are not anticipated to be long term as the Urgent Care Centre will be relocated next to the Emergency Department reception in April 2016.</p>		
<p><b>A&amp;E entrance permanently closed for access to other parts of the hospital.</b></p> <p>I note the impending permanent closure of the access to the St Thomas Hospital site via the A &amp; E entrance and would like to ask whether :</p> <ul style="list-style-type: none"> <li>• any consultation took place and, if so, with whom and when in respect of the intention</li> <li>• Any specific consideration was given to the needs of disabled patients arriving and departing from the hospital –</li> </ul>	<p><b>15/0001</b></p> <p>2015-03-14</p>	<p>The Trust has sought the views of patients and user groups at key points of the design process, from options appraisal to the final workshop in July 2013. There was a particular focus on trying to seek the views of those with long-term conditions, older patients and those with mental health conditions, as these groups tend to be recurrent service users. To each workshop we have carefully and as best we can, recruited a sample of patients who are broadly representative of the demographic groups using A&amp;E or recruited to the theme of a workshop e.g. mental</p>	<p>Discussions continuing with TFL on the re-siting of bus stops on Lambeth Palace Road.</p>	

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<p>particularly those intending to access the East Wing and Evelina- At present, this access connects with Bus Routes 77 and C10. The nearest 77 Bus stop is now at County Hall/Education Centre. There is no C10 stop nearer than under the Railway Bridge - Route 77 allows a connection with Routes 381/RV1, also located at County Hall. These locations offer a substantial distance to the hospital – especially of access is required beyond the North or Lambeth wings. It is understood that A &amp; E needs may stipulate that this access should be removed but a possible remedy is to establish an entrance by the Evelina (needed for patients/visitors accessing the Children's hospital anyway with a new bus stop opposite that new entrance (something required in any case for the same reasons).The continuation of pedestrian access to the A &amp; E Dept. does not, of course, change the situation for patients wanting other parts of the St Thomas site – particularly if they are walking disabled or self arriving in motorised wheel chairs (which are themselves not best suited for hospital corridors. Is there any policy or guidance with respect to these as they are becoming larger and larger (and so dangerous to those on foot in confined spaces).</p>		<p>health service users.</p> <p>Governors have been involved in key workshops, where appropriate. It is important to highlight that for the large part we have sought the views of those with recent and personal experience of emergency care pathways.</p> <p>The business case and final designs for the ED refurbishment were presented to the Board on 30<sup>th</sup> April 2014.</p> <p>ED art strategy - the views of patients and Governors will continue to inform this facet of the programme. To date staff and patients have selected the artist that went forward to the successful charity bid and this will continue at key points of the programme. The PPE Team and Essentia Stakeholder Engagement are working closely with Sara and John Criddle to plan further activities.</p> <p>With regard to the question of whether the Trust sought the views of patients and public on limiting the access to the rest hospital building via A&amp;E entrance - this point was not raised specifically. Access points to A&amp;E were indeed highlighted at the final patient-public workshop in July 2013 (the event walked participants through the drawings and slide decks from the event highlight this), but at the time, it was not apparent that access to the rest of the hospital would be limited - this was not included in the scope of discussions for that reason.</p> <p>It is unfortunate that the issue was not brought to light until much later in the process when the design and business case were agreed. Given the challenges of accommodating the emergency floor in a limited foot</p>		

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		print and the need to maximise the space available, one might ask whether it would have been proportionate / reasonable to consult more widely on the matter of limiting access to the rest of the hospital from this entrance if a) the entrance from Lambeth Palace Road side has always been the A&E front door (not really intended as a main hospital thoroughfare) and b) if this was the only option in order to maximise space for the department. Instead, is it worth considering whether there are still opportunities to have a helpful discussion with patient-public representatives, in particular Governors, about the solutions in respect to wayfinding / signage? Mystery Shopping findings and patient feedback continue to highlight, from time to time, that wayfinding / signage is not as clear as it could be in places. The Trust has a wayfinding strategy and design standards, but these set a minimum standard and patients comments should continue to be taken into account.		
The CEO says that there is a programme of work underway by the Medical Director to address "hospital at night concerns". 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	2014-04-29	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.		