

Council of Governors Meeting 25th January 2017

	Document	Page
1	20170125 CoG Agenda	3
2	[2] 20161026 CoG minutes	5
3	[5] Council of Governors election 2017 - Election Timetable and	11
4	[7.1] 20161129 MeDIC meeting report	17
5	[7.2] 20161206 QEWG meeting report	23
6	[7.2a] 20161206 FFF ToC presentation	33
7	[7.2b] 20161206 Going Home presentation	43
8	[7.3] 20161121 SSWG meeting report	53
9	[8] 20170125 Questions and Answers paper	59

This page has been left blank

COUNCIL OF GOVERNORS

Meeting to be held on 25th January 2017
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 26th October 2016** attached (CG/17/01)
3. **Matters Arising**
4. **Reflection session on Board of Directors meeting** oral
5. **Community Services Staff Governor election** attached (CG/17/02)
6. **The Nightingale Project** Presentation
Karen Bonner
7. **Governors' reports – to note and for information**
 1. **MeDIC**
Kate Griffiths-Lambeth attached (CG/17/03)
 2. **Quality and Engagement**
Devon Allison attached (CG/17/04)
 3. **Service Strategy**
Giles Taylor attached (CG/17/05)
8. **Questions and answers – for information** attached (CG/17/06)
9. **Any other business**
10. **Date and time of next meeting:**

The meetings will be held on 26th April 2017, Governors Hall, St Thomas' Hospital

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

This page has been left blank

Guy's and St Thomas'

NHS Foundation Trust

Council of Governors

**Minutes of the 54th meeting of the Council of Governors held on
Wednesday 26th October 2016 in the Robens Suite, Guy's Hospital**

Present:

Devon Allison	Linda Goldsmith
John Balazs	Tom Hoffman
Thelma Bangura	Tony Hulse
Heather Byron	David Maurice
Prof Kevin Burnand	Sam Newman
Anita Campolini	Darren Oldfield
Dr John Chambers	James Palmer
John Duncan	Bryn Williams
Jonathan Farley	Sonia Winifred

Apologies:

Yvonne Craig Inskip	Vicky Rogers
Robert Davidson	Sue Slipman
Jane Fryer	Jenny Stiles
Kate Griffiths-Lambeth	Giles Taylor
Matthew Patrick	Prof Warren Turner
John Porter	Bill Williams
Prof Dianne Rekow	

In Attendance:

Executive Directors:

Ian Abbs
Hannah Coffey
Sir Ron Kerr
Amanda Pritchard
Martin Shaw
Dame Eileen Sills
Simon Steddon

Non Executive Directors:

Robert Drummond
Emma Duncan
Felicity Harvey
Girda Niles
Sheila Shribman
Sir Hugh Taylor (Chair)
Steve Weiner

Other Attendance:

Peter Allanson
Adeola Ogunlaja
Amanda Price

Trust Secretary and Head of Corporate Affairs
Membership and Governance Co-ordinator
Associate Director, Education, Training and
Development

CG/16/33

Welcome, apologies and opening remarks

The Chairman noted that the Nominations Committee needed a governor from the patient constituency to replace Paula Young and proposed to arrange for an election at the meeting in January. In the light of the Lead Governor's

continued serious illness it was also intended to review his position with him towards the end of the year.

CG/16/34 Minutes of the meeting held on 27th July 2016

The minutes of the meeting held on 27th July 2016 were approved as a true record.

CG/16/35 Matters Arising

The appointment of three new non executive directors had been announced by the Trust. Felicity Harvey and Emma Duncan had taken up office and John Pelly would do so in January.

CG/16/36 Reflection session on Board of Directors meeting

Members of the Council of Governors returned to a number of issues raised at the Board meeting, including:

The increase in referrals to the Trust was remarkable and the meeting explored some of the reasons and detail that lay behind them. This was a national, multi-faceted issue. Locally it was known that some locum GPs tended to refer cautiously and the Trust was working with primary care to encourage peer review of referrals within practices. The Trust was receiving referrals that would ordinarily have gone to other Trusts – for example, it was suggested Wandsworth CCG had told their GPs not to refer to St George's for some specialties including dermatology. It was possible that length of other trusts' waiting lists had also deflected referrals. The difficulties of managing demand in these circumstances were acknowledged. The Trust accepted responsibility for providing specialist care and local acute services. It would also work to support improvement in other organisations to reduce referrals. Building on the success of the diabetes initiative a couple of years ago, the Trust would collaborate with others to find different models of care for other chronic, long term conditions.

Governors hoped that the PA review of the Trust's digital readiness would factor in clinician interest. It was emphasised that the review was a diagnostic

of what needed to be done and made considerable play of digital solutions being clinician led. Once the Board had considered the report in more detail it would agree an implementation plan and discuss it with the Council, acknowledging the interest and concern it had expressed about this subject.

It was agreed to give SSWG a confidential briefing on the overall operation of the tariff and its impact on the profitability of particular services. Adjustments to the tariff made it difficult to predict this in confidence, although the Trust continually worked with the regulatory bodies to make the tariff as efficient as possible.

It was agreed that it was important to encourage staff to wear their “#Hello my name is...” badges at all times; they were helpful in developing rapport and could set the tone for any patient clinician interaction.

Finally, the question of developing business cases for the more challenging improvement projects arising from Fit for the Future arose. It was noted that considerable investment in giving staff transformation and empowerment skills to run projects of this nature and the work continued albeit on a more tactical basis. Currently over 150 staff had been trained.

CG/16/37 Improving Care through Learning and Innovation – an Education, Training and Development Strategy

The Head of Education Programmes described the Trust’s current proposals for staff education. The focus, in the context of considerably halved funding from Higher Education England, was to build solutions for the Trust so that staff could develop careers rather than having to move to develop. The Trust would also have to contribute £3mn from the apprenticeship levy to go into a central pool though it would be possible to bid for central resources for apprentices.

The strategy included extending and developing existing roles; the orthopaedic outreach team was an example of this where nurses, occupational therapists and physiotherapists had been trained in each others’ skills and roles so they were interchangeable. The intention was to encourage individuals to identify their learning needs and for there to be local accountability and delivery of

training. This would reflect the changes to the ownership of knowledge and younger people's attitudes to the digital world.

In helping staff to be successful there would be less reliance on classroom teaching and greater access to training and development through the use of technology and learning through collaboration with others and capturing the learning from supporting others – including buddying, the STP and the vanguard. There would be some mitigation through commercialising training – the apprenticeship scheme had been successful and recently nominated for an award. E-learning to develop and reinforce learning was also significant and on line sources would also be used to evaluation of training and education.

It was too soon to tell what impact the removal of NHS bursaries would have on recruitment for nurses and AHPs but an agreement with London Southbank University included the ability to build up credits towards a masters degree and universities generally were becoming more flexible in their attitude to accrediting work based learning.

In addition to the apprenticeship training, which although it was much broader than young people, was being developed through a school careers website which offered work experience in conjunction with a local, science based academy which it was hoped would lead to science based apprenticeships.

CG/16/38 Governors' Reports

Membership Development, Involvement and Communications Working Group

On behalf of the MEDIC Working Group Lead, the Trust Secretary reported that the Group had commissioned a proposal from Green Park, as specialist consultancy, to advise it on strategies for increasing the levels of membership of the Trust in such a way as it made progress towards reflecting the communities served more closely. This would be a long term plan especially as the finance for this would be limited.

Quality and Engagement Working Group

The Group had discussed the need to encourage more end of life conversations, where appropriate, that that people had a better understanding of the options open to them. It had also explored co-design and co-creation as part of the transformation agenda, building on the recent experiences with the project around the Cancer Treatment Centre.

Service Strategy Working Group

SSWG had noted the recent discussions about the future development plans for the Evelina London Childrens' Hospital and the need to align the timetable for its expansion with the development of the education facility at Block 9.

The Group was keen to meet to discuss the next iteration of the Business Plan later in November prior to final sign off by the Trust Board in mid December.

CG/16/39 Questions and answers

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

CG/16/40 Any other Business

There was none.

CG/16/41 Date and time of next meeting


The next meeting of the Board of Directors will be an additional meeting to be held on **Wednesday 14th December 2016** at **1:00-2:00pm** in the Governors' Hall, St Thomas'. The next scheduled meetings will be held on 25th January 2017 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:

DRAFT

Council of Governors	Guy's and St Thomas'  NHS Foundation Trust
Council of Governors Election 2017 – Election Timetable and Communications Plan	25th January 2017 CG/17/02

This paper is for:		Sponsor:		
Decision		Author:	Peter Allanson, Trust Secretary & Head of Corporate Affairs	
Discussion	x	Reviewed by:		
Noting		CEO*		
Information		ED*		
		Board Committee*		
		TME*		
		Other*		

** Specify*

1. Summary

The Trust is holding an election in 2017 for a seat on the Council of Governors. One governor's first term is coming to the end on the 31st August 2017.

2. Recommendation

The Council of Governors is invited to note the timetable on page 3.

3. Details

The governor from the community services staff group reaches the end of her first term on the 31st August 2017. As the term of office begins on 1st September, the election timetable below has been planned so that new governors will take up their post on that date.

Date	Action
January	
Wednesday 25 th January	Council of Governors meeting - election arrangements highlighted
April	
Wednesday 26 th April	Board of Directors meeting and Council of Governors meeting - election update if appropriate
May	
Tuesday 2 nd May	Formal notice of election
Tuesday 30 th May	Nomination deadline
Wednesday 31 st May	Post formal notice of candidates
June	
Friday 2 nd June	Final date for nominated candidates to withdraw
Tuesday 20 th June	Formal 'notice of poll'
Wednesday 21 st June	Election mailing – ballot paper etc sent to Community Services staff members only
July	
Friday 14 th July	Election close
Monday 17 th July	Trust to be notified of results, Trust posts results
Monday 17 th July	Board of Directors advised of results via email
w/c 17 th July	Successful and unsuccessful candidates contacted
August	
Thursday 31 st August	Existing governor steps down
September	
Friday 1 st September	New governor takes up their post

4. Election and Communications plan

The first stage of the election process is to contact the Trust's independent ballot services provider to notify them of the intention to appoint them to facilitate the 2017 election.

A formal notice of election is to be provided to the independent ballot services provider by 18th April 2017, for dispatch on 2nd May 2017. Since the independent ballot services provider do not host staff data, a request will be made to the Human Resources Department to take this extract from the internal database.

Electronic voting will be the primary method available to staff members for the election however they will be given the option to request for ballot papers to be sent. We will continue to monitor whether the electronic method makes much of an impact in terms of receiving votes.

Since the election is being held for the Community Services Staff Governor within the staff constituency, only the community staff group in the staff constituency is eligible to vote. They will be contacted directly by the independent ballot services provider at the two key stages of the election process:


- Formal notice of election (when members are invited to nominate themselves to stand for election as governors)
- Formal notice of poll (when ballot papers are sent to members)

Our communication plan to encourage members of the community staff group to stand for election and then to vote in the election is as follows:

- Team Briefing (published once a month – face-to-face briefing by Executive Directors)
- Adult Community and Local Services News (monthly newsletter sent to all community staff)
- Staff Bulletin (email sent 3 times a week to all staff)

- Email notifications (email to the community staff distribution list)
- Intranet (GTi) Homepage 'blue box' message
- Trust website (to publicise the results)

This page has been left blank

Council of Governors	Guy's and St Thomas'  NHS Foundation Trust
Membership Development, Involvement & Communications (MeDIC) Working Group Report – 29th November 2016	25th January 2017 CG/17/03

This paper is for:		Sponsor:	Membership Development, Involvement and Communications Working Group	
Decision		Author:	Adeola Ogunlaja (Membership and Governance Co-ordinator)	
Discussion		Reviewed by:	Peter Allanson (Trust Secretary and Head of Corporate Affairs); Kate Griffiths-Lambeth (Lead, Public Governor)	
Noting	X	CEO*		
Information		ED*		
		Board Committee*		
		TME*		
		Other*		

* Specify

1. Welcome and apologies for absence

The meeting was attended by: Matt Akid (Head of Media and Corporate Communications); Peter Allanson (Trust Secretary and Head of Corporate Affairs); Yvonne Craig-Inskip (Public Governor); Jonathan Farley (Patient Governor); (Kate Griffiths-Lambeth (Lead, Public Governor); David Maurice (Patient Governor); Girda Niles (Non-Executive Director); Adeola Ogunlaja (Membership and Governance Co-ordinator); James Palmer (Public Governor); Vicky Rogers (Staff Governor)

Apologies: Devon Allison (Patient Governor); Heather Byron (Patient Governor); John Porter (Lead Governor, Public)

2. Notes of the meeting held on 27th September 2016

The minutes from the meeting on 27th September 2016 were agreed as a true record of the meeting by all attendees.

3. Matters Arising

- i. Feedback from the Staff Governors' meeting held on 15th November 2016:

The summary notes from the Staff Governors' meeting were reviewed and discussed. Of the twelve ideas put forward by Staff Governors, there was an agreement that item 6 (hosting internal open surgery sessions for staff, tailored around current issues and topics of interest); item 7 (presenting badges to staff at Friday team briefings); and item 10 (creating an internal email distribution list for staff governors to improve engagement and encourage a two way flow of information and communication with other staff members) were possibilities to explore.

Vicky Rogers (Staff Governor) asked if item 3 (creating a comments box on the governors' page on the staff intranet to address queries or concerns from staff members) was achievable. The Head of Media and Corporate Communications agreed to check with the Digital team and feedback at the next meeting.

The Head of Media and Corporate Communications advised that Staff Governors should meet with the two Internal Communication Managers for a better understanding of the communication channels available in order to raise the Staff Governors' profile. The Membership and Governance Co-ordinator agreed to facilitate this meeting.

The Trust Secretary and Head of Corporate Affairs informed the group that he and the Trust Chairman were of the opinion that the community staff group in the Staff Governor constituency should remain as a separate voice. This was agreed by members of the group. To explore how the Community Staff Governors' profile could also be raised through communication links into the community.

4. Draft membership data mop up / involvement activities survey

The Membership and Governance Co-ordinator informed that as an attempt to update the data we hold on members including information about members' interests, a draft involvement survey had been developed. She asked for feedback and informed that the draft survey had also been sent to the Fit for the Future team for comments. She planned to distribute the survey to members with the next GiST mailing.

Yvonne Craig-Inskip (Public Governor) suggested that we change the order of the survey so that the questions on involvement activities come first followed by questions about personal information. It was also agreed that the aims of the survey needed to be clearer and should state that the information provided would encourage greater involvement and

would improve communication with the Trust and members. The survey could also be more attractive by including some benefits of completing the survey.

5. 2017 Members' Health Seminar Topics

The list of 2017 Members' Health Seminar topics agreed with the Trust Chairman, was presented to members of the group for noting.

The Head of Media and Corporate Communications informed that future seminars would be publicised more widely. Posters would be produced and displayed in clinics to increase attendance levels and to encourage patients and family members who are interested in attending but are not Trust members to join the Trust. It was also suggested that posters could be sent to local GP surgeries to promote the events.

Governors were encouraged to attend the health seminars as a way to interact with members.

6. Draft Membership Communications and Engagement Strategy

The Trust Secretary and Head of Corporate Affairs informed that the draft strategy had been refined since the last meeting with input from the Patient and Public Engagement Team. He informed that the draft strategy also linked with the next agenda item which was a proposal from Green Park to develop a membership that is more representative of the local communities which the Trust serves.

The revised draft Membership Communication and Engagement Strategy was reviewed, including the proposed activities for 2017. It was suggested that success measures needed to be set against the proposed activities. The strategy should also include the recruitment target to be achieved and the resources available to achieve the target.

The Trust Secretary and Head of Corporate Affairs informed the group about the opportunity to promote Trust membership through local community roadshows with a production company called DFP TV. They would produce and show a short film in a loop at their roadshows in local boroughs with the aim to recruit more members. The film could also be used for future recruitment activities. The Head of Media and Corporate Communications stated that he had worked with DFP TV in the past and the team would aim to achieve the target given however we would need to be clear about the membership target.

The need to diversify the Council of Governors was discussed. The Trust Secretary and Head of Corporate Affairs informed the group about a similar Trust who engaged with their local Bangladeshi community by having Dieticians go into the local community to talk about healthy eating. This generated more Trust members within that community and a Bangladeshi governor was elected subsequently. This could potentially be explored through Green Park however we would need to increase the diversity of our current membership in order to diversify our Council of Governors.

It was agreed that the final draft strategy would be presented at the Council of Governors meeting to be held on the 26th April 2017 for approval.

7. Green Park Proposal

The project proposal received from Green Park was reviewed. The Trust Secretary and Head of Corporate Affairs informed the group that Green Park had recommended a 10 day project to identify and build relationships with diverse

communities. A report would then be produced identifying opportunities to increase the diversity of members within these communities, which we could use to put together a recruitment campaign.

Once relationships within these communities are built, we could perhaps get some support from the voluntary services team, enlisting volunteers of the Trust to go into the community once a month to recruit members.


Members of the group queried the cost of the project and sought reassurance that the actions produced at the end of the project would be achievable. The Trust Secretary and Head of Corporate Affairs stated that the project would be professionally managed by a recruitment consultancy with speciality on diversity. The project would take us a step further in understanding why we are under-represented with certain ethnic groups and what we could do about it. He informed that a meeting would be arranged with Green Park following the meeting to discuss outputs and deliverables.

8. Any other business

Members of the group agreed that taking part in the local community roadshows with DFP TV could be useful in addressing the gaps with younger membership, whilst the Green Park project focuses on ethnicity. The Head of Media and Corporate Communications stated that the next step would be to arrange a meeting with DFP TV to negotiate costs and set a clear recruitment target.

9. Date of next meeting

The next meeting would take place on 21st February 2017.

Council of Governors	Guy's and St Thomas'  NHS Foundation Trust
Quality and Engagement Working Group meeting report: 6th December 2016	25th January 2017 CG/17/04

This paper is for:		Sponsor:	
Decision		Author:	Lisa Doughty
Discussion		Reviewed by:	Devon Allison
Noting		CEO*	
Information	X	ED*	
		Board Committee*	
		TME*	
		Other*	X Council of Governors

1. INTRODUCTION

This report details the meeting of the Quality and Engagement Working Group, which took place on 6th December 2016 at the Education Centre, York Road.

2. ATTENDANCE

The meeting was attended by: Sarah Allen (Patient Experience Manager), Devon Allison (Lead), Andrea Carney (Patient and Public Engagement Manager), Julie Gifford (Deputy Director Strategy), Elizabeth Palmer (Deputy Director, Assurance and Compliance), Angela Dawe (Director Operations and Strategic Development - Adult Local Services), Sarah Webster (Deputy General Manager Acute Medicine), Aarti Gandesha (Healthwatch Southwark), Kate Damiral (Healthwatch Lambeth), Vicky Rogers, Jenny Styles, James Palmer, Bryn Williams, Dr. Priya Singh, Mark Tsagli (Patient Experience Facilitator), Lisa Doughty (Patient and Public Engagement Specialist).

Apologies were received from: Thelma Bangura, Yvonne Craig-Inskip, Jonathan Farley, Linda Goldsmith, Kate Griffiths-Lambeth, Heather Byron, Darren Oldfield, John Porter.

3. NOTES OF THE LAST MEETING

The notes were approved as an accurate record of the last meeting.

4. IMPROVING TRANSFERS OF CARE

HEALTHWATCH INSIGHTS INTO USER EXPERIENCES OF 'TRANSFERS OF CARE'

Aarti Gandesha from Healthwatch Southwark and Kate Damiral from Healthwatch Lambeth presented a recent project looking at patient experiences of transfer of care from hospital to home or other care locations. This provided in-depth stories of five elderly patients, tracked weekly for a three month period. Two case studies were discussed and a short film of Margaret's story shown. Key conclusions included that care was very good but communication failures, delays, and the need for better partnership between services had negative impact on patients and sometimes their carers. This work was followed by an event in July 2016 which was attended by over 100 people including representatives from Primary Care, Social Care and all three Trusts. The presentation is attached.

Organisations including Guy's and St Thomas' (GSTT) submitted progress reports in response. GSTT reported on:

- A transfer of care workstream within the Fit for the Future project
- Acute Northern Line Project
- Introduction of Transfer of Care Navigators
- Transfer of Care training and education programme
- 'Good to go' simulation training
- Kings Health Partners (KHP) discharge project

Transfer of Care is highlighted within the Trust's Sustainability and Transformation Plan (STP) and further to discussions at the Partnership Board, the Executive Oversight group chaired by Angela Dawe will oversee the action plan. Progress will be reviewed every three months.

UPDATE ON PROJECTS ACROSS ACUTE AND COMMUNITY SERVICES

Angela Dawe (Director of Operations and Strategic Development - Adult Local Services) and Sarah Webster (Deputy General Manager Acute Medicine) presented on the GSTT Transfer of Care workstream. Angela Dawe is the Senior Reporting Officer (SRO) for this work. The presentation is attached. Planned improvements include:

- Sharing best practice – joining up local discharge initiatives and sharing good ideas across the Trust.
- Developing an IT solution to capture data on discharge delays, so that the Trust knows where to target improvements.
- Developing new ways of working; collaborating with Social Care, Acute and Community Services and supporting implementation of new initiatives across the Trust. Examples include:
 - Transfer of Care Navigators who help facilitate smooth transitions between care settings and monitor patients whose needs may change.
 - Trusted Assessor -
 - A joint programme between GSTT/KCH/L&S Social Services, to review current care needs, assessment processes and reduce duplication by 'trusting' NHS staff to complete elements of Social Worker assessments where possible.
 - Discharge to assess, where medically fit patients are discharged to a care facility for social care assessment.
- A Key Performance Indicator (KPI) dashboard is being developed; Healthwatch are involved in this project and patient feedback is included.

Next steps:

1. Live bed state launch - January 2017
2. Trust wide sharing event and launch of communications plan – January 2017

Finally use of language was discussed – the Trust will be moving from the term 'Discharge' to 'Transfer of Care' as this is recognized as more appropriate terminology.

Governors welcomed the presentation and thanked the team. They made the following observations:

- It was suggested care provided at home after a hospital stay is a priority. Not knowing what the individual may need whilst still in hospital was discussed as well as the difficulties assessing this in a hospital environment – the individual may overestimate their needs. In response the team advised each transfer is on an individual basis and once discharged the individual should have a more complete assessment. Part of the care navigator role is to ensure any necessary equipment is organised and set up early. Transfer of Care Navigators attend ward rounds and as much as possible is done in advance.
- The role of Simulation and Interactive Learning (SAIL) for support was discussed. SAIL is a voluntary organisation funded by the CCG to provide a navigation and signposting role. The Transfer of Care Navigator programme is being evaluated and will be expanded to other wards if successful. North Southwark have trained community-based SAIL navigators – for example, GP receptionists and pharmacists, this seems to be working well.
- It was discussed how long after leaving hospital an individual would have care navigator support for. The role of the care navigator was described as to ‘enable’ people, therefore it is hoped by the end of 6 weeks most people would be re-enabled. Factors are monitored such as whether people are at home 91 days after an admission and whether they are readmitted within periods such as 30 days & 90 days to evaluate success.

Angela Dawe provided a brief update on the Buurtzorg project. This is looking at whether the Dutch Buurtzorg model of community neighborhood nursing can be adapted to a UK setting. The team started a small pilot with three nurses in November, have taken on a caseload and a further two nurses have just been appointed. Outcomes have been excellent to date; both in terms of feedback and outcomes such as wound management and healing.

Note: ‘Improving Transfers of Care’ and ‘Going Home’ presentations attached to Minutes

5. PATIENT EXPERIENCE AND PATIENT AND PUBLIC ENGAGEMENT UPDATE

Council of Governors meeting 25th January 2017

Quality and Engagement Working Group meeting report: 6th December 2016

The Patient Experience Manager summarised the key points from the annual patient experience report, which included:

- 2016 National Cancer Survey – overall, the Trust have done well. Areas of suggested improvement include improved clarity of communication and pain control – these will be included in the action plan going forward.
- Friends and Family Test (FFT)
 - Inpatient response was higher and scored better than the national average.
 - Outpatient scores were above the national average but the response rate could be better.
 - For A & E the response rate was quite high but performance lower than the national average.
 - Patient transport scored better than the national average, but the response rate is still very low.
 - Local inpatient and outpatient surveys. We are scoring highly on emotional experience – dignity and respect. On the wards, ongoing issues reported are noise at night and assistance at mealtimes.
- Children and Young People - A number of improvements are being undertaken. For those using community services, a continuing area for improvement is contacting teams to make or change appointments.

The Patient and Public Engagement Manager took Governors through the following areas of activity:

- As governors will be aware there has been a pause on the involvement strategy whilst supporting the sexual and reproductive health consultation over recent months. This is now complete and the outcome will be discussed at the Board of Directors meeting on 14th December before the final report is published.
- The Local Care Networks (LCN's) are looking at how patient care can be better managed for patients with multiple conditions living in Lambeth and Southwark. South London Integrated Care (SLIC) provided funding to produce patient stories. An event is planned for January to develop this work.
- We are supporting a number of strategic initiatives including the Dartford and Gravesham Vanguard, three renal projects, Acute Medicine and several orthopaedics projects.
- Call Quality Assessor Programme Findings – we reported on pain management last quarter and will update on this in the next quarter. The current report show dips in performance in stating department/team when taking a

Council of Governors meeting 25th January 2017

Quality and Engagement Working Group meeting report: 6th December 2016

call and also ending the call, in particular summing up discussions. We are meeting with the team to discuss the success of the programme and how to develop it further. The Patient and Public Engagement Manager asked Governors to let us know about any call difficulties they hear about with specific departments; Dental Services and the Urgent Care Centre were mentioned. The Fracture Clinic used to be of concern but this may have improved.

- Hannah Coffey gave a presentation to the group at the September meeting which outlined a proposed workstream to look at standardization and streamlining of frontline administrative processes as part of the Fit for the Future programme. Patients contact with the trust and getting through on the telephone was part of this workstream. Dr. Priya Singh will follow up on this and it was suggested as an agenda item for a future meeting. There is an ongoing need to test whether phones are answered and, when answered, transferred effectively—as well as to continue testing call quality.

Governors commented upon:

- A governor raised a concern about representativeness of attendees at the Public Meeting held as part of the sexual health consultation. The Patient and Public Engagement Manager confirmed this was just one of the methods of engagement used; over 1200 people have been consulted since May in this transient population. Nearly 600 responses were received to the feedback survey. Work has taken place across all six clinics and the demographic profile of responders is broadly representative of the local population. Concerns about the loss of ‘after five’ specialist clinics was raised. This will be shared with the relevant General Manager/Clinical Director.

6. QUALITY AND SAFETY UPDATE: The Deputy Director of Assurance and Compliance informed the group of the following activities:

- Quality and Assurance team changes - Karen Proctor and Marie McDonald have started in the role of Director of Assurance (job share).
- The Quality Strategy is being updated with current priorities and issues from across the Trust. The Deputy Director, Assurance and Compliance asked how Governors would like to be involved. The Governors asked for the draft strategy two weeks ahead of the February meeting to review and comment appropriately.

Council of Governors meeting 25th January 2017

Quality and Engagement Working Group meeting report: 6th December 2016

- Working on the next update for the January Quality Committee – will bring this to the February meeting.
- A recent 'Always Safe' week was held. This included meetings with staff and talking to the Trust about quality and safety. The opportunity was taken to discuss priorities such as reducing noise at night and discharge.

7. REPORTS FROM COMMITTEES

Quality & Performance Committee:

- Not discussed, to be circulated with minutes

Adult Local Services Committee:

- Not discussed, to be circulated with minutes

Children's Services Committee:

- Not discussed, to be circulated with minutes

End of Life Care Committee:

- Not discussed, to be circulated with minutes

8. ANY OTHER BUSINESS

A. The lead referred to a letter noting the Health Select Committee's concerns regarding Health and Social Care funding; she wanted to bring this to the Governors' attention and is happy to share the letter upon request.

B. The current arrangement for meal times means there is no opportunity for families and friends who want to help relatives during meals. This was taken forward to the next meeting - the Patient Experience Manager will raise this with the Nutritional Ward Group for discussion.

C. The Deputy Director of Assurance and Compliance asked the group whether the group would like to see the quarterly complaints report, they confirmed they would.

DATE OF NEXT MEETING

Tuesday 7th February 2017, Globe Theory Room, Education Centre, York Road.

Council of Governors meeting 25th January 2017

Quality and Engagement Working Group meeting report: 6th December 2016

Appendices:

- a) Improving Transfers of Care presentation
- b) Going Home presentation

END

This page has been left blank

Improving Transfers of Care

Fit for the Future Workstream

Council of Governors – 6 December 2016



The case for change

Patient story: Mrs Y

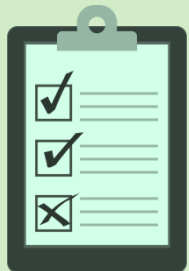


On average, **internal delays contribute 6 excess days** per adult non-elective inpatient stay at GSTT

– May 2016 inpatient audit (Acute)

70% of admitted patients aged 65+ (non elective) to be transferred to **same place** of residence **within 7 days**

- 2017/18 National CQUIN



90% of CHC* **assessments** to be completed **outside of the acute** hospital

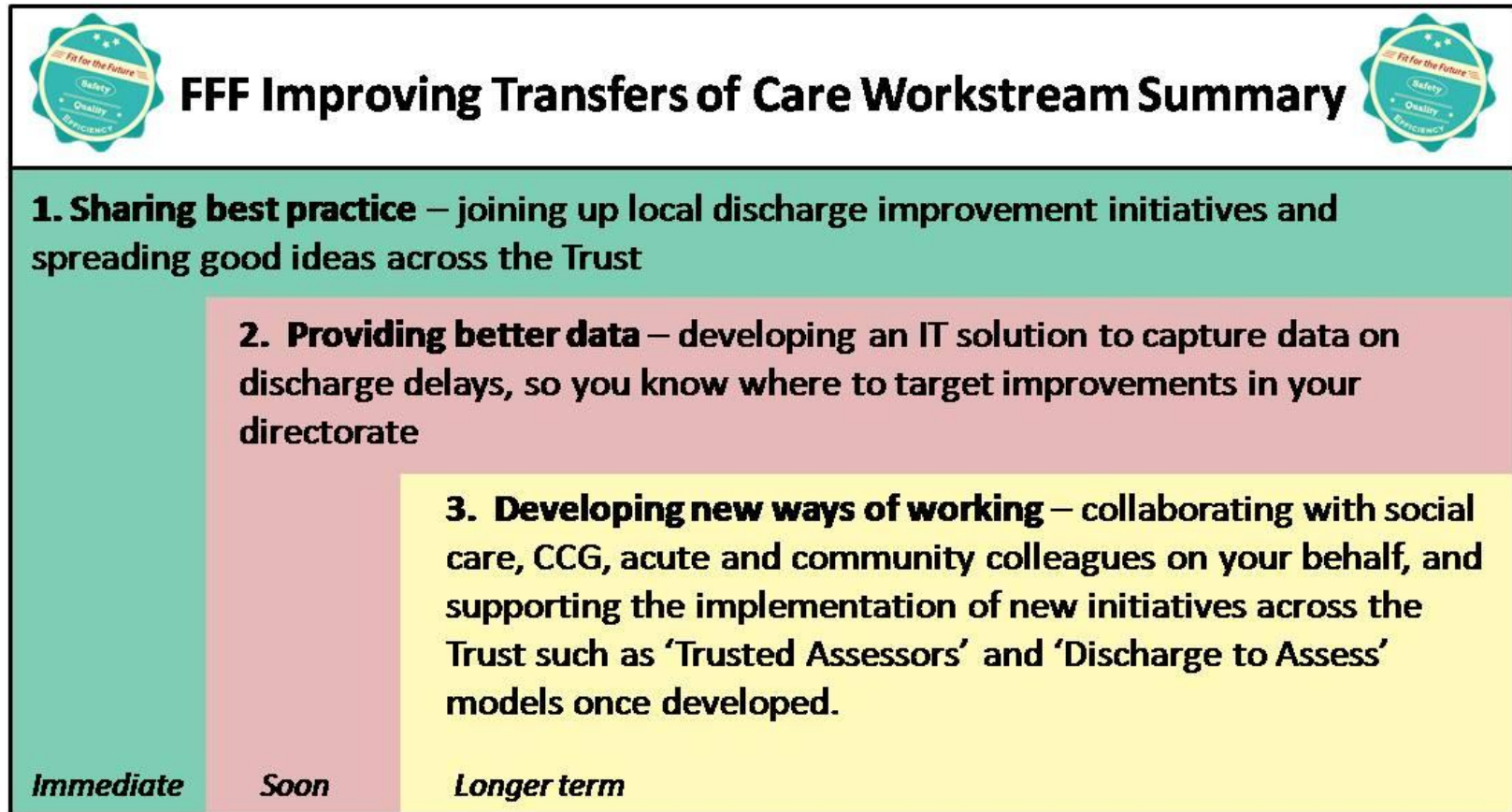
– 2017-19 Planning Guidance

Significant **financial funding reductions** across both health and social services



*Continuing Health Care

The approach to change



Example – Local improvement initiatives

Acute Medicine Board Round Template

Covers existing medical criteria

PLUS

Specific focus on early transfer/discharge planning

Pilot ongoing during December 2016 and output will be shared Trust-wide once assessment is complete

ACUTE MEDICINE DAILY BOARD ROUND GUIDE

At the start of the BR:

- Stand as near to the board as you can: to **minimise** risk of being overheard or not hearing information
- Introductions: to ensure all staff present know who each other are

Each Patient

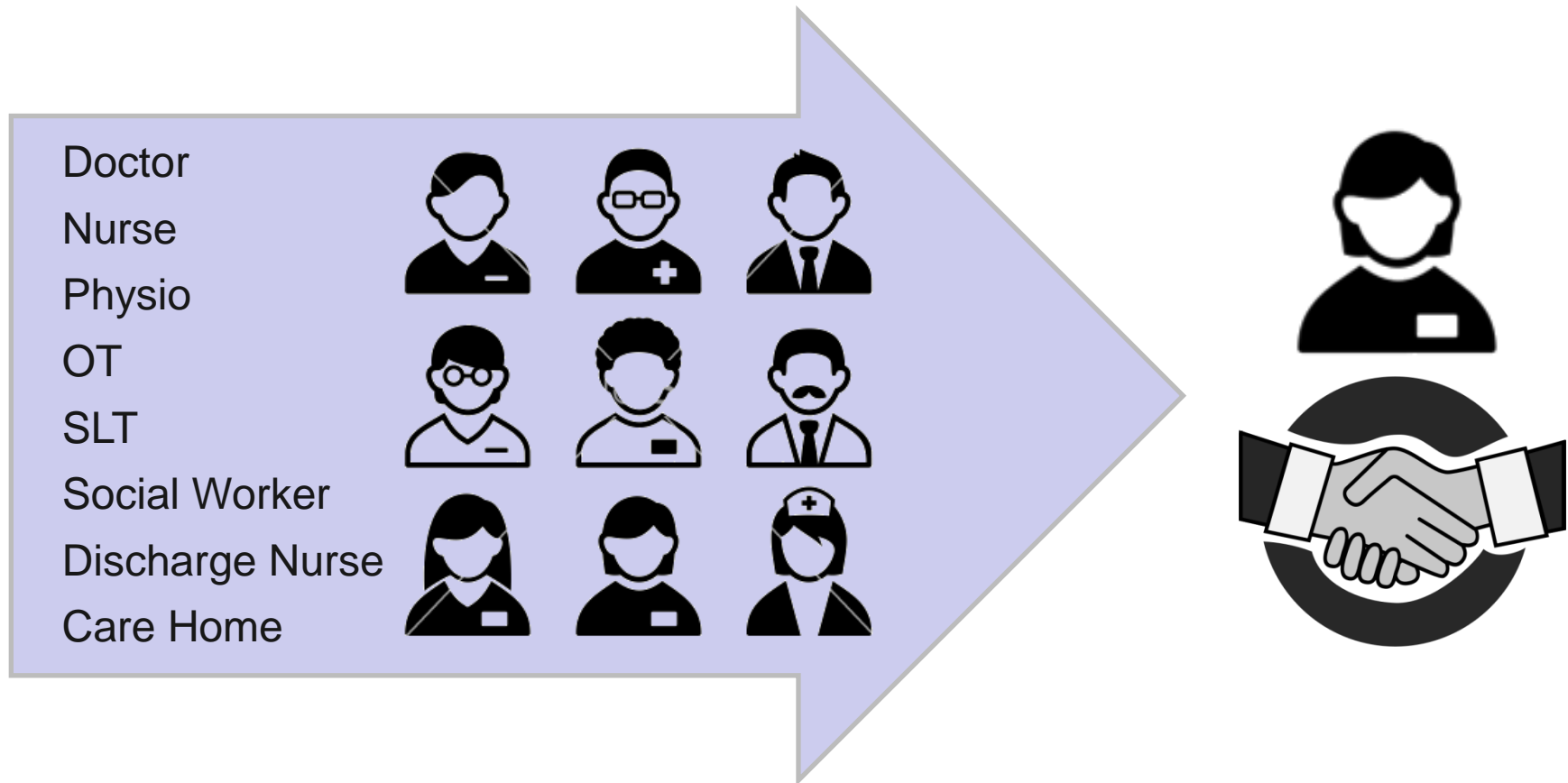
- NICresus & escalation plan, NEWS/CREWS score, any significant changes (i.e. fall, delirium, acute episode, violence & aggression).
- If new patient a brief summary of reason for admission and known plans to inform the MDT regarding priorities and to refer new patients
- State the EDD as recorded on the board & **confirm** accurate & realistic
- Confirm** patient aware of date.
- If date not achievable, **confirm** new date and note reason for change (to be added to enoting post BR) & agree to inform patient &/or significant others and mark on board how many additional days to new EDD (e.g. 30/6 +3. Remember to **chase & challenge**!
- Ask: Does the patient need to be in an acute bed, or could the patient's care needs be met @home or at BBR – **confirm** & agree to who will refer, as appropriate
- If plan includes completion of referrals, LHNA etc: **confirm** progress, if breached standard completion time, **chase & challenge**
- If EDD within 48 hours **confirm**:
 - EDL written
 - TTO dispensed
 - Is there anything pending pre discharge, i.e. blood result, speciality review? Ask: would you be happy for a criteria led discharge? (refer to criteria led SOP)
 - Any social care arranged & confirmed, if not **chase**
 - Any community health services arranged & confirmed, if not **chase**
 - Transport arrangements agreed and confirmed
 - Any equipment needed? Is it essential for dc? If essential, is it confirmed? Anything needed to go with the patient from the ward (i.e. walking frame)

At the end of the BR:

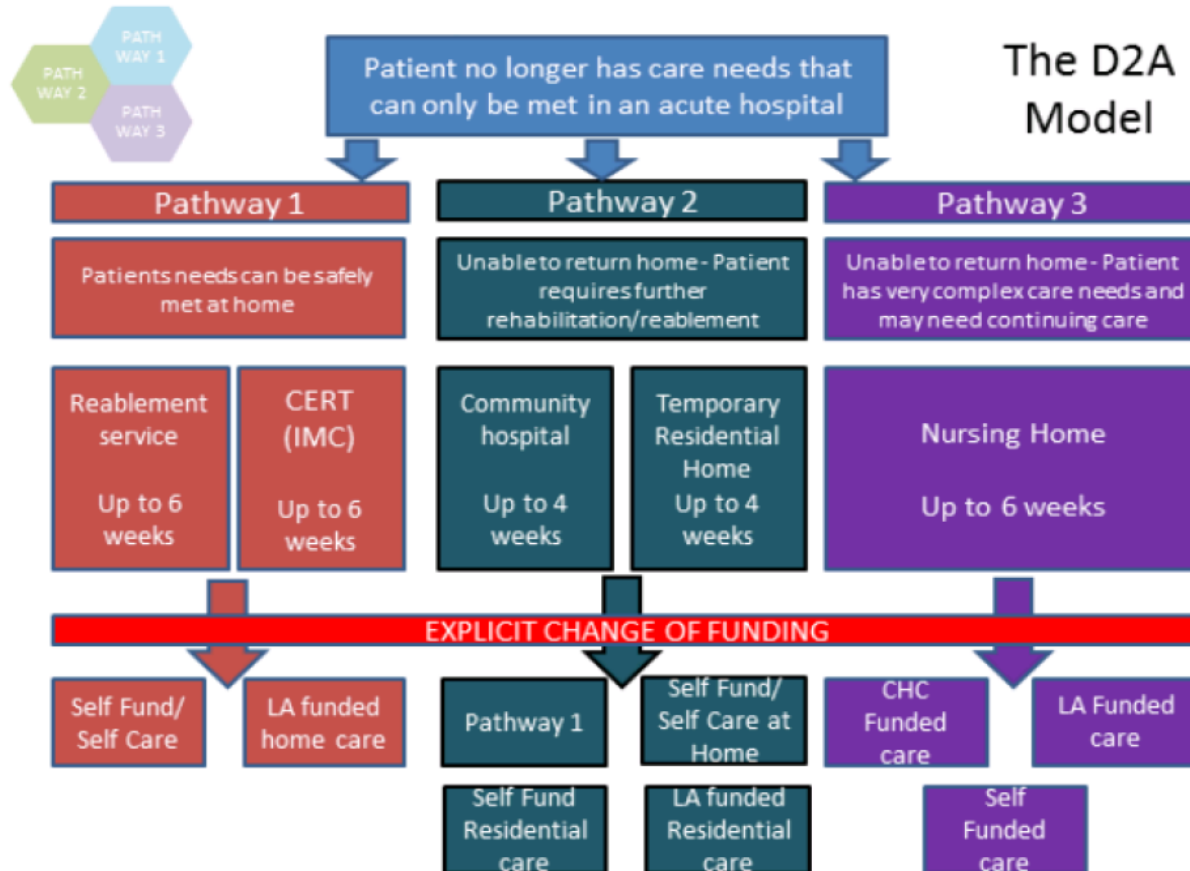
- Prioritise** the work ahead. Medics review as sick, discharge, stable
- Confirm** who is available that day to do those things that will progress the patient towards their EDD
- Escalate any concerns &/or delays to matron



Example – Trusted Assessor



Example – Discharge to Assess



South Warwickshire Model

- Defined pathways
- 'Transfer triage' in hospital
- Assessments occur outside of the hospital
- Pooled funding
- Explicit change of funding post-assessment

.... BUT their local health economy has greater access to care home beds



Benefits

- ✓ **Better patient experience and outcomes**
- ✓ **Better staff experience**
- ✓ **Eliminate process duplication and inefficiencies**
- ✓ **Financial benefits**
 - Cost containment - Absorb additional activity within current bed base
 - Cost reduction - Reduce/reallocate beds if possible
- ✓ **Better flow** – increase % transfers occurring in the morning and at weekends
- ✓ **Improved governance** around transfer of care improvement initiatives
- ✓ **Local Health Economy benefits** – fewer people in long term residential care, and reduction in intensity of packages of care



KPIs

- KPI dashboard under development. Examples given below of some KPIs which will be directly impacted by ToC Actions, and which in turn will have an indirect positive impact on A&E performance

KPI	Target	Trust-wide		Comments / Actions
		Oct 16	YTD	
Discharge pre 12pm midday	> 30%	15.3%	TBC	<ul style="list-style-type: none"> Trust-wide campaign under development Aim for launch by end January 2017.
% non-elective admitted patients aged 65+ discharged within 7 days to the same place of residence	> 70% By end of 2017/18	61.0* ↑	59.6%*	<ul style="list-style-type: none"> Will likely require additional temporary placement capacity in system, which is limited. Working group to be established by CCG in Nov/Dec 16 re: D2A
# MSFT Patients	< 30 (trust wide)	76**	n/a	<ul style="list-style-type: none"> Live Bed state to be launched in Jan 17 to collect more robust MSFT data Re-launch of Patient Choice Protocol in January 17.
% patients with recorded EDD	> 98%	100%■	99%◆	<ul style="list-style-type: none"> Data captured by manual audit Live Bed State will capture EDD electronically and consistently



* Excludes ambulatory activity. Performance improves by 10% on average when included.

** Snapshot data from manual MSFT audit undertaken in November 2016

■ Data from audit completed in September 2016 (Acute Med only)

◆ Combined data from audits in May 2016 and September 2016 (Acute Med only)

Next steps

- **Live Bed State** launch in January 2016
- Trust-wide **Sharing Event** during January 2016 and launch of comms plan
- **'Discharge to Assess Board'** hosted by the CCGs in January 2016

Finally, a note on terminology:

Discharge (verb):

- 1.To relieve of a charge, load, or burden
- 2.To release from an obligation

We are proposing that GSTT adopts the term **Transfer of Care**, rather than Discharge, as a more accurate term to describe what we do. We transfer care; to the community, to social care, to GPs, to patients. Patients are not a burden, looking after them to the very best of our ability is why we are here.



This page has been left blank

Going Home: patient experiences

Aarti Gandesha and Kate Damiral

Going Home: transfer of care after a hospital stay

The project

- Tracking the recovery journey
- Five stories, weekly, over three months
- Older patients from GSTT and KCH

Questions

1. How well do services work together?
2. How can we use the findings?

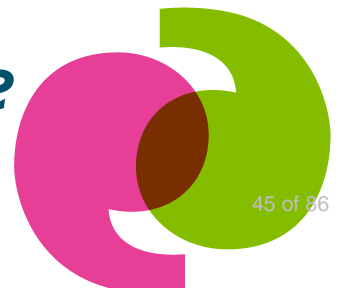




Laurence

- 10 weeks in step-down extra care flat
- Institutionalised (medication, walking)
- No social support
- Lack of information and control

'I felt I had to be winkled out'





Margaret

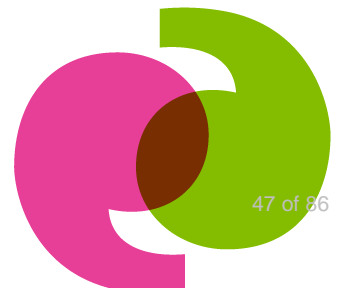
- Discharged home with daughter
- 10 services, 2 emergency admissions
- Lack of information
- Family carer burden - sleep deprivation & anxiety

***‘I was looked after nicely’
‘A nightmare three months’***



Going Home: the film

<https://www.youtube.com/watch?v=wk4hQo7rAEA>



Going Home Quality Summit: July 2016

Why?

- Raise awareness of issues experienced by patients leaving hospital
- Hear about work across Lambeth and Southwark to improve experiences

Who?

Over 130 people attended - representing patients, local authorities, the three main NHS providers, CCGs, VCS.



Going Home Quality Summit: July 2016

What happened?

Local health and social care leaders talked about the work they are doing to improve the experience of people leaving hospital.



Event highlights

- There is drive and commitment to work collectively.
- What we need...
 - ✓ Much better cross-organisation needed
 - ✓ Care navigators with in-depth knowledge of support across sectors e.g. SAIL
 - ✓ To better involve patients and carers
 - ✓ To change the way we think and talk about 'discharge' - it's a 'transfer of care'



What next?

- Progress reports from all organisations who presented.
- GSTT told us...
 - ✓ GSTT ‘Fit for the Future’ - ToC Workstream
 - ✓ Acute Northern Line Project
 - ✓ Introducing ToC Navigators
 - ✓ Develop a ToC Training and Education Programme
 - ✓ “Good to Go” simulation training courses
 - ✓ Medicines Reconciliation Project
 - ✓ KHP Discharge Information Steering Group
 - ✓ Caring for Carers course
 - ✓ “Supporting Patient’s Choices to avoid long hospital” protocol
 - ✓ “Building on the Best” palliative care improvement programme

What next?


South East London's Sustainability and Transformation Plan (STP)...

“All the different parts of local health and care services working together to use available money and resources in the best way possible - helping us avoid a £1bn overspend by 2021”

The Lambeth and Southwark Strategic Partnership Board has been asked to:

- identify where the work best sits
- provide resources and support needed to drive a system-wide project



Council of Governors	Guy's and St Thomas'  NHS Foundation Trust
Extraordinary Service Strategy Working Group report – 21st November 2016	25th January 2017 CG/17/05

This paper is for:		Sponsor:	Giles Taylor, SSWG Chair	
Decision		Author:	Dan Price	
Discussion		Reviewed by:	Giles Taylor, SSWG Chair	
Noting	X	CEO*		
Information		ED*		
		Board Committee*		
		TME*		
		Other*		

* *Specify*

1. Attendees:

Giles Taylor (Chair), Devon Allison, Vicky Rogers, Kevin Burnand, Jenny Stiles, Linda Goldsmith, John Duncan, Kate Griffiths-Lambeth, Darren Oldfield and Bryn Williams.

Martin Shaw (Director of Finance), Simon Steddon (Acting Chief Operating Officer) and Hugh Taylor (Chairman) and Dan Price (Strategy Manager) attended from Guy's and St Thomas'.

Apologies were received from Ian Abbs, Sheila Shribman, Jackie, Parrott, John Balazs, John Porter, Heather Byron and James Palmer.

2. Notes of the previous meeting and matters arising

2.1 This was deferred until the next meeting on the 17th of January.

3. Draft Operational Plan 2017/18 & 18/19

3.1 Martin Shaw started the presentation by refreshing governors on the overall context for the draft plan. At month 7 we are still performing better than forecast for this point in this year's financial plan. The Trust also started its internal business planning this month where a similar context was given to directorates. The Trust can confidently say it is delivering; however there are some difficult decisions ahead for the Trust. Martin then went through the national timeline noting that the Trust hasn't had all the details on the tariff as yet.

3.2 Simon Steddon updated SSWG on what the plan said about the Trust's performance and activity. On the Referral to Treatment standard (RTT) the Trust had been meeting the standard earlier this year but that has been difficult since due to high growth in demand and additional referrals beyond the planned increase in activity. There is an action plan in place but meeting the standard in 17/18 will be a challenge. For the 4 hour accident & emergency standard the Trust was compliant in 16/17 but the increase in demand and the major rebuild has meant we haven't been able to

comply with the standard. We're on phase 2 of the rebuild and are planning a phased return to compliance linked to an action plan. On the 62 cancer standard we have set a tough internal challenge for ourselves to be compliant but the overall compliance is dependent on joint working with other providers. The 17% growth in referrals has impacted our performance against the 2 week wait standard, but this hasn't converted into impacting on the 62 day wait through additional diagnoses of cancer. A recent deep dive on our cancer performance by the regulators said that the Trust was on the right track to improvement and to keep going.

- 3.3 Martin Shaw then provided Governors with an overview of the financial element of the draft plan. High demand is good as long as we get paid for it but the Trust is also sending clinicians to other organisations to keep services safe – there is no financial return on that but it does help manage the demand we could face if those services had additional problems. The initial savings target for the Trust to achieve breakeven in 2017/18 is estimated to be £100m.
- 3.4 For 2017/18 the Trust has been offered £3m more in Sustainability and Transformation Funding (STF), although to secure this funding the Trust would have to increase its financial performance by around £13m. This is all subject to final confirmation and NHS England hasn't confirmed how they made their calculations. This would still leave the Trust needing to save £90m to reach the control total. The Trust thinks that it can save £60m of the £90m required, with a further stretch target which might get the Trust to around £77.7m in savings. That still leaves an additional £13m in savings to be found.
- 3.5 This leaves the Trust with 3 scenarios for financial planning for 2017/18;
 - 3.5.1 – Scenario 1 – If the Trust stretches to close the gap we might be able to deliver the overall control total. The issue is if the Trust tries to do this, doesn't succeed and then is branded a failure. However if the Trust is able to achieve £80m in savings and get £13m in external funding it would be able to meet the control total that has been set.
 - 3.5.2 – Scenario 2 – Is if the Trust takes a more pessimistic view and think that it achieve the stretch targets required and meet the control total then we wouldn't get the STF funding, CQUIN funding and would be fined. This would impact on us substantially and could push the Trust into a £40m deficit even if we achieve the £80m savings target.
 - 3.5.3 – Scenario 3 – Assumes that we get no additional money and we increase the stretch target for savings and attempt to meet the control total without external financial support.

- 3.6 In early conversations with NHS Improvement they have been positive but keen to stretch the Trust's saving target as much as possible. We had also provided the context of the negotiations with NHS England to NHS Improvement and how difficult the challenge will be if we cannot get agreement on payment for the specialised services activity we believe is needed to meet demand. The Trust has been successful in opening a dialogue with NHS Improvement on the control total and this will be discussed further at the next board meeting.
- 3.7 On the basis of meetings with NHS Improvement, and pending the board's view, the Trust would be considering pursuing scenario 1. This is assuming we get some external financial support and that our stretch targets are considered suitable by the regulator. There are loans for capital in the plan, but these have not been signed off yet despite the Trust being considered credit worthy by the ITFF. A lack of capital availability might be an issue the Trust has to face in the future.
- 3.8 Simon Steddon gave an overview of the workforce and quality elements of the plan. The quality priorities and plans would be coming to the Quality and Engagement Working Group on the 6th December. The Trust had started the internal business planning process in November and was focused on ensuring that the directorate's plans aligned with the external plans.
- 3.9 Since the last meeting the Sustainability and Transformation Plan has been published. Amanda is leading the south east London STP and it's clear that we are not ceding any sovereignty and all decisions will have to go back to individual boards. There has been wide clinical engagement in the transformation workstreams. The plans are now being turned into bottom up action plans, especially for the support services workstreams. King's Health Partners are all looking to use the same improvement methodology to drive out variation. The Trust is also looking to work with partners to release development potential and produce a five year estate strategy.

During questions and discussion the following was highlighted:

- That the level of referrals to the Trust was higher than the 8% increase in activity that the Trust had planned for. The Trust is in negotiations with the regulator about this unusual increase which is difficult to deal with. This increase is related to multiple factors such as referrals from other trusts, primary care and changing geographic flows. Work is

being done on referrals, for example 40% of GPs in Lambeth and Southwark are Locums, and they have a tendency to refer to the Trust on a higher than average basis, through peer review by non-locums we can check that against best practice.


- That on cancer the Trust isn't an outlier in performance, but that the Trust is continuing to push to improve performance. Other trusts that provide a similar scale of cancer services are also experiencing similar problems. Clinically driven change is in the early stages of producing benefits in performance across the system. However we have over 20 different district general hospitals that refer to us, all with a variety of different issues.
- That the time and effort with the regulators was time well spent and that it would be unlike the Trust to give up in difficult circumstances. The board will be considering the scenarios very carefully and there is a governance issue here around the board signing up to what it believes the organisation can achieve.
- That there are opportunities within the Sustainability and Transformation Plan to help with the finances. The Trust is looking for a range of benefits through collaboration including by looking at the creation of ventures in human resources, finance and payroll across south east London. The Trust is also considering how to work with primary care pharmacy services as spend between them and acute pharmacy is around £0.5bn. The Trust is also encouraged by the development of the Local Care Networks and the benefits to patient care that will entail. Within all the work across south east London there are lots of moving parts, there are no solutions as yet, but staff are working hard to find them.
- The risk is that the Trust loses control of its destiny and its future becomes externally dictated. This might mean that we then have to reduce the quality and the high standards we adhere to meet other demands. Workforce is a big issue externally as many places are struggling to recruit and the Trust wants to continue to provide safe and high quality staffing.
- That the Trust and other health organisations are still working through and understanding the risks within the tariff. It looks like that in two years there will be a more substantial change to the tariff, and if that happens then the trust will look to engage and influence that process.
- The view within the Trust is that if we can sign up to the control total we should do it. However the board and the executive team are conscious that this is a big challenge, and people are getting worn down by the level of demand

placed upon them, and we risk seeing sickness rates increasing. The whole organisation has driven the success of the last few years; it's thousands of people who have delivered the plan.

- The board are more aware of the pressure on staff and are actively offering more support, especially to Clinical Directorate leadership teams. There is still opportunity to improve our productivity and efficiency on multiple levels, but we need staff to have the headspace to be able to realise those opportunities. The board are particularly conscious that the senior leadership are stretched and split in multiple different directions – it's very challenging but our responsibility is be positive and enable the staff to succeed.

4. Any other business

4.1 There was no further business and the next meeting was confirmed for 17th January 2017, 5.30pm to 7pm at York Road.

Council of Governors	Guy's and St Thomas'  NHS Foundation Trust
Questions and Answers	25th January 2017 CG/17/06

This paper is for:		Sponsor:	Corporate Affairs	
Decision		Author:		
Discussion		Reviewed by:		
Noting		CEO*		
Information	X	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

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
What are the risks of Hays having an exclusive contract to supply agency staff including as a master vendor sourcing from other suppliers?	17/0012 2017-01-11 (Vicky Rogers)	It is a LLP led contract with high volumes from lots of agencies so reducing cost of recruiting temporary staff across London. There will be a phased introduction for IT agency staff, particularly where it is necessary to retain the organisational memory of long standing agency staff. (11-01-2017)		
The NHS is always in the news but there appears to be lots of arguments about facts e.g. has the budget gone up or not, which is unhelpful for the public. At what point can the Trust, either alone or with others, make their views known. Is this not an important public service?	17/0011 2017-01-11 (Devon Allison)	The current practice is for the Board to do “good by stealth” and there are risks of being penalised for making overtly political statements. It is better to be indirect; speaking out is a weapon to be used sparingly. We have to remember that the Chairman of the CoG and Trust is the same person. Taking on the Prime Minister is a big step and NHS Providers is representing the sector well. (11-01-2017)		
Nutritional strategy launch (I attended yesterday) and the disconnect between it and our concierge offerings for patients and guests on the hospital site (ie AMT and WH Smith un healthy)	17/0010 2017-01-11 (Heather Byron)	The Trust is working with all its retail partners to review and improve the offerings for staff and visitors using the facilities. AMT, WH Smith, Marks & Spencer and the Guys outlets “Sakar” have all made a commitment to work with the Trust and by February 2017 we will see the banning of price promotions on sugary drinks and foods high in fat, sugar and salt (HFSS). The banning of advertisement on NHS premises of sugary drinks and foods high in fat, sugar and salt (HFSS) and the banning of sugary drinks and foods high in fat, sugar and salt (HFSS) from checkouts.		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
		<p>The majority of HFSS fall within the five product categories: pre-sugared breakfast cereals, soft drinks, confectionery, savoury snacks and fast food outlets;</p> <p>AMT in particular have been very receptive to the trusts requests and have made several changes and additions to their offering to improve variety and the health of the food and drink they sell e.g. reduction in high energy ingredients and sat fats, reduction in calories with increased focus on green/amber nutritionals, responsible portions, gluten free, wheat free, dairy free and vegetarian meal options are available, and improvement on pack messaging with clear navigation for the consumer front of pack: calorie/nutritionals, health credentials.</p> <p>Even more work has gone on with the Dietetic department working with the in house retail catering team and recent activity includes: increase in fruit volumes and healthy breakfast options, a protein and carbohydrate option with free vegetables for hot meal deals, healthy salad bar option is available, healthy portion control, no added salt soups are made fresh on site on a daily basis. With regard to drinks, lower sugar varieties have replaced higher sugar flavoured waters and fruit juices, all 500ml sized sugary drinks, including fruit juice, have been removed from the premises, and sugary drinks are supplied in smaller portion sizes (330ml or smaller) in line with Government</p>		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
		<p>Buying Standards; over 50% are sugar free.</p> <p>In principle healthy foods and drinks are given greater prominence by being placed at eye level and where possible, in greater volumes and in premium locations in the retail catering space. There is no signage encouraging unhealthy choices, traffic light colour coding system is used and all healthy options have a healthy eating logo so that they are visible.</p> <p>(11-01-2017)</p>		
Obtaining more transparency on the calculations behind how much of the Evelina 2 capital work will come from Fundraising and the approach to achieving it	17/0009 2017-01-11 (Heather Byron)	<p>The figure included in the Strategic Outline Case was a high level estimate based upon what had been achieved in other high profile children's hospital developments nationally and internationally, and that the work to test this assumption in more detail is now underway. The KHP Fundraising Team have commissioned an expert external study to advise on the feasibility of achieving the level of financial contribution required for Evelina 2, and to advise upon what would need to be put in place to deliver this successfully. We expect an initial report by end of January. As part of this feasibility study, GST Governors (including the one who raised this question) were interviewed by the individual undertaking this work.</p> <p>(11-01-2017)</p>		
What benefits are available to staff as a result of being members of the Trust's and how are these benefits communicated to them?	17/0008 2017-01-11 (Kate Griffiths-Lambeth)	<p>Staff are key stakeholders in the life and well being of the Trust and their almost automatic enrolment as members (there is a rarely used opt out) offers the opportunity to play a different role to that of being an employee. Being a member - or a</p>		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
		governor - allows staff to exert influence and provides a different route for these voices to be heard. And of course any benefits available to public and patient members of the Trust are open to staff - GIST, APM, seminars... However, we haven't been all that successful in persuading staff that there is additional value in being a member of the Trust and there are few who are active most notably the group of staff governors who play a full part in the life of the governors. We are working with the staff governors to see what we can do to promote more active membership but realistically, this will remain an uphill struggle. That said, we are revising the membership pages on the Trust Intranet, making sure there is a staff governor present at team briefing to talk to colleagues about membership and also piggy backing onto other staff events so that there is a presence. (11-01-2017)		
What money does the Trust spend on management consultants each year?	17/0007 2017-01-11 (John Chambers)	Of the £3M recorded during the first eight months: - just over half £1.6M is attributable to what would be viewed as hosted services KHP, HLP and Vanguard - a further £700K have been spent on specific initiatives; PWC turnaround, the recent IT review, 2020 delivery and strategic work within Evelina London - a further £600K is across three corporate areas, Finance, Commercial and Essentia. (11-01-2017)		
Given the predicted rapid rise in inflation for 2017, coupled with the already high cost of living within London and the anticipated impact of Brexit on non-UK nationals' desire	17/0006 2017-01-11 (Kate Griffiths-Lambeth)	The Workforce Directorate is working to build on the strong reputation that the Trust has as an excellent place to work. It has a long history of providing a range of benefits to attract and retain		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
and/or ability to work here, what is the Trust doing to attract, retain and support staff?		<p>staff, further enhanced over the past 18 months through the Trust's Showing we care about you initiative, detailed in the answer below. The Workforce directorate has developed a retention action plan and which includes developing well defined career pathways and opportunities, promotion of flexible working options, developing a flexible workforce through the use of a talent pool, developing flexible careers (to include rotational contracts, secondments, role redesign and skill mix review), engaging with the workforce to create an environment where employees are motivated, valued and empowered to deliver the quality care expected and go that extra mile, ensuring we develop our staff to be the best they can be, giving people the opportunity to experience the work of the Trust through apprenticeships; volunteering; placement students and work experience. Supporting staff to work longer or retire and return to retain the skill and knowledge in the Trust. Working with external bodies to support armed forces personnel to return to civilian life. All of these initiatives seek to ensure that the GSTT workforce is reflective of the diverse community it serves.</p> <p>(11-01-2017)</p>		
What has been the growth in managers over the last 10 years within the Trust?	<p>17/0005 2017-01-11 (John Chambers)</p>	<p>In April 2011 GSTT merged with Community Services in Lambeth and Southwark which saw an increase in Trust staff numbers, with further growth each year as patient numbers have increased and new services introduced. Additionally the expansion of Hosted Services has led to an increase in provision of Trust based</p>		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
		support staff in the intervening period. In November 2007 4.3% of staff were classed as managers (357) and last November this had become 5.7% (770). (11-01-2017)		
What arrangements are being made to deal with the crisis caused by the implosion of vascular surgical services at St George's hospital?	17/0004 2017-01-11 (Kevin Burnand)	<p>Deterioration of relationships between services and individuals. All trainees were withdrawn and the Trust had only a third of the number of consultants it needed.</p> <p>There was an executive turnaround led by GSTT. A further review took place on the on the 10th January 2017 with the Deanery – new consultants have been appointed.</p> <p>The service was maintained thanks to the efforts of a GSTT Consultant and trainees are expected to return after the final visit on 17th January 2017.</p> <p>South London Vascular Network as run by GSTT is now to be used as a template for other network developments.</p> <p>From April the only KCH vascular activity will be in diabetic foot and stroke carotid procedures - everything else will be at St Thomas'.</p> <p>(11-01-2017)</p>		
How will the trust demonstrate that the implementation of an integrated sexual health care model will effectively offset the impact of closing the specialist LGBT/MSM & Men-only clinics in Lloyd & Vauxhall clinics respectively? As implied in the consultation's Equality and	17/0003 2017-01-11 (James Palmer)	The Sexual Health and Reproduction consultation outcomes represented over a year's worth of work talking to patients, examining where costs arose and ensuring that proposals met the needs of patients especially where the profile was changing – for example the most prevalent increase in STIs		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
Equity Impact Assessment, I believe the changes will have a disproportionate effect on these communities (especially MSM) by reducing access, at a time when evidence shows increased access/outreach is needed		<p>was arising amongst men who had sex with men and work would continue with this group to manage infections. The aim was to spread clinics across the geography making sure that public transport and access was as good as possible. At the same time improving on line access and using IT to help with diagnosis would enable clinicians to focus face to face consultations on those who needed them. The Charity had funded a project to design on line services which, when trialled, showed a greater compliance than the norm and work would continue to improve this. Opening hours, including at the weekend, would support improved access. The proposed opening hours for Sundays differed from what patients had suggested but reflected the Trust's experience of usage over four years. The Trust is committed to undertaking a further impact review after 6 months after implementation of the new arrangements. The reduction represents 20% or £1.2 million.</p> <p>(11-01-2017)</p>		
Given the well-publicised shortage of funding for the NHS, what is the Trust doing to mitigate losses (such as seeking repayment from overseas-based patients) or to supplement the Trust's coffers (for example by expanding commercial services or via research-originated intellectual property)?	<p>17/0002 2017-01-11 (Kate Griffiths-Lambeth)</p>	<p>1) to mitigate losses such as seeking repayment from overseas-based patients:</p> <ul style="list-style-type: none"> - the Trust regularly finds itself in a difficult position over this issue; some patients are not entitled to free NHS care but the rules – and common humanity – require us to treat them if they need urgent or critical care – and then to send them the a bill – even if they have no money to pay (e.g. if they are destitute, stateless refugees with no right to earn money in this country) - the Trust makes every effort to collect all the 		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date																					
		<p>money owed to us; we work hard to identify all patients who are not entitled to free NHS care; all clinical staff are briefed about this issue and trained to provide the minimum care consistent with our clinical obligations; we encourage patients to pay in advance or provide a deposit during their stay; we have a dedicated overseas visitors unit who manage the recovery of all monies owed and will visit patients at all stages of the treatment (even at the bedside when necessary); we have accelerated credit control procedures to follow up overseas visitor debts; we employ specialist debt recovery agencies both in this country and abroad when appropriate; we participate in the UK Border agency scheme who will work with us to bar entry to this country to anyone recorded as owing the NHS money if they seek to re-enter the country; and we are participating in the current NHSI initiative to further improve the processes for identifying those not entitled to free care at the earliest point in the treatment cycle.</p> <table><tr><th colspan="3">EU and overseas visitors at Guy's and St Thomas'</th></tr><tr><th>Outpatients</th><th>Attendance Apr15-Mar 16</th><th>Income Apr15-Mar 16</th></tr><tr><td>All patients</td><td>1298713</td><td>£186,437,908</td></tr><tr><td>Overseas</td><td>3358</td><td>£506,982</td></tr><tr><td>Of which EU</td><td>260</td><td>£41,700</td></tr><tr><td>% overseas</td><td>0.52%</td><td>0.55%</td></tr><tr><td>% EU</td><td>0.04%</td><td>0.04%</td></tr></table>	EU and overseas visitors at Guy's and St Thomas'			Outpatients	Attendance Apr15-Mar 16	Income Apr15-Mar 16	All patients	1298713	£186,437,908	Overseas	3358	£506,982	Of which EU	260	£41,700	% overseas	0.52%	0.55%	% EU	0.04%	0.04%		
EU and overseas visitors at Guy's and St Thomas'																									
Outpatients	Attendance Apr15-Mar 16	Income Apr15-Mar 16																							
All patients	1298713	£186,437,908																							
Overseas	3358	£506,982																							
Of which EU	260	£41,700																							
% overseas	0.52%	0.55%																							
% EU	0.04%	0.04%																							

Matters of interest/question	Issue number & date raised	Responses			Progress/further information	Completed date
		Admitted Patients	Spells Apr15-Mar 16	Income Apr15-Mar 16		
		All patients	288862	£195,901,049		
		Overseas	2325	£1,791,821		
		EU	376	£540,074		
		% overseas	1.61%	1.83%		
		% EU	0.26%	0.55%		
		- On a separate, but related point, we have worked very hard to identify visitors for the EEA who are covered by reciprocal agreements; in doing so, we enable the British Government to recover more funding from EEA countries, reducing the burden on the British taxpayer; we are amongst the most successful Trusts in the country at doing this (by value of money earned).				
		2) The Trust has a wide range of commercial activities which generate income which is used to pay for patient care and is keen to expand them appropriately: examples include: - Retail facilities on both sites which enhance the experience of our hospitals for both patients and staff as well as provide income - Income generating healthcare operations expanded outside conventional NHS roles (e.g. Occupational Health provided to other public sector bodies and commercial organisations; a contract to manage the provision of healthcare to the British Forces in Germany which has saved the Ministry of Defence money and ensured soldiers and their families receive the best possible care - Clinical services abroad where GSTT's specialist				

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
		<p>skills can be sold at a premium</p> <p>3) Specifically on Intellectual Property (IP)</p> <ul style="list-style-type: none"> - this area is a priority for the Trust – both to safeguard for the NHS the IP the Trust develops and to generate income for patient care - it has a dedicated lead (Head of IP and Commercial Research) - it is particularly focused on R&D - several companies have been spun off with GSTT receiving shares or royalties for its IP. <p>(11-01-2017)</p>		
<p>What the Trust's plans are if we see an ongoing increase in referrals from GPs in areas where local hospitals are not seen to be meeting required CQC standards (e.g. St George's Tooting, Lewisham, Queen Elizabeth's Woolwich, King's College and Imperial College)?</p>	<p>17/0001 2017-01-11 (Kate Griffiths-Lambeth)</p>	<p>The Trust experienced a significant increase in GP referrals (16-17% compared to last year's rates) back in February 2016 and this has continued at a steady rate since. Our waiting list has grown by approx 10,000 patients and it appears that this growth has now stabilised at the end of quarter 3. We have been working with CCGs to understand why this growth occurred but it appears that one of the reasons may be linked to the performance of other Trusts in SEL and other parts of London.</p> <p>We are working hard to deliver additional capacity to ensure that patients who have been referred to us can receive their care at GSTT in accordance with their choice. However, where this may not be sustainable, we are working with our CCG colleagues to agree an approach to demand management, including: redirecting non local referrals to more appropriate Trusts, working closely with GPs to ensure that referrals are appropriate and GPs are supported to manage</p>		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
		<p>patients in primary care; and providing both urgent and routine advice and guidance to referrers. We are also working in partnership with other Trusts to support them to improve services and make best use of local capacity. As such we have a range of partnerships such as our Vanguard work with Dartford and Gravesend, our Vascular network with St George's, the Evelina network across SE London/Kent, Paediatrics and Adult Urology at Lewisham and Greenwich Trust, and a range of King Health Partners projects, where we aim to ensure sustainable services of high quality are available across a wider health economy.</p> <p>In summary:</p> <ol style="list-style-type: none"> 1. Clinical and operational engagement with those Trusts to ensure that services which have existing links with our Trust remain safe and robust to avoid collapse and complete transfer of patients to us. 2. Demand management initiatives to help us provide capacity for local patients and those requiring our specialist care. 3. Increased capacity at GSTT – with increases of 8% in 15/16 and 10% in 16/17 for new outpatient appointments. We are planning a further 5% increase for 17/18. <p>(11-01-2017)</p>		
This is from my own experience and may not apply in all areas of the Trust but I understand that the Trust switched to 'Horizon' [it has a number of names] booking universally, even against protest from specialties such as mine	16/0022 2016-12-20 (Tony Hulse)	Response has been sought.		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
<p>who felt it was inappropriate. What this means is that when you leave your appointment and have a follow-up say in 6 months you are not given a date at the time [as happens when I go to my dentist] but the name is put on a 'waiting list' [though it is not called that] and the appointments are sent out about 6 weeks in advance. It is in fact a form of demand management as often there is not the capacity so then appointments are delayed to say 8 months - for me the record was 1 year of delay for a child under cancer surveillance. There is little or no clinical input into this, or if there is it is impossible to vet about 3-400 appointments every 6 weeks or so on the list. The consequences are many - patients spend time ringing [and usually not getting through] to ask about appointments, people can not plan appointments in advance when they know they will be away etc etc. It was introduced to avoid large numbers of clinics being cancelled because of leave etc. which was happening. However it is a blunt instrument which I think has made the problem worse not better. Horizon booking may work in some areas but not in mine. Before this, we knew when clinics were getting full as they gradually filled and could make an appropriate judgement at the time to delay if not urgent. Booking of follow-ups needs to be much more finessed than at present - probably with a form of prioritisation ie those that can be delayed if there is a</p>				

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
capacity issue and those that cannot. This would not be hard. I would be interested in the Trust response to these comments.				
What is the internal process when patient feedback is received from Healthwatch about our services, what are the actions taken to ensure that they are acted on? And are there any other forums in our local communities that Governors should be aware of in terms of gathering feedback?	16/0021 2016-11-15 (John Chambers)	<p><i>What is the internal process when patient feedback is received from Healthwatch about our services, what are the actions taken to ensure that they are acted on?</i></p> <p>In responding to this query, It's important to understand Healthwatch's role, as there are a number of ways in which Healthwatch receives feedback from its members and how the Trust is expected to respond, in accordance with Healthwatch regulations. Healthwatch has a role in gathering and reflecting the views of it's wider members concerning the development and delivery of services, but also a 'signposting role', in supporting people to access services. It is important to note that Healthwatch does <i>not</i> manage / support patients to make complaints – the NHS Complaints Advocacy Services does this.</p> <p>1. Responding to concerns about the delivery of a service</p> <p>Healthwatch sometimes receive queries from service users who have had difficulty accessing a service (e.g. unable to contact the service) or who have raised a concern about a recent experience of using a service. In such cases, Healthwatch contact the Patient and Public Engagement Team who act as a single point of liaison and co-ordinate the response to that enquiry, ensuring the service concerned has responded in full, in its reply to Healthwatch. Since the time Healthwatch was</p>		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
		<p>founded, the Trust has only received a 4 such enquiries. In all such examples the services concerned have been very responsive in taking action where necessary or simply providing further information to enable Healthwatch to support or signpost the individual.</p> <p>2. Responding to and acting on an ‘enter and view’ reports by Healthwatch</p> <p>Healthwatch has legal powers to ‘enter and view’ health and social care premises to observe the delivery of care and services - they can take the form of announced or unannounced visits. During these visits they also seek views of service users and collect patient feedback. The findings of these visits are reported to commissioners and providers to support the improvement of services. The Trust is obliged to provide a written response to the report in general and in particular, to any recommendations for action. The Trust must consider the recommendations and note any actions it plans to take. The Trust’s response is published along with the report. Healthwatch request an update, as necessary, on the recommendations / actions. All such reports are overseen by an Executive Director and in providing our response, we agree a timeline for updating Healthwatch or for them to contact us for an update on any actions, as they choose.</p> <p>3. Responding to requests for information about a particular area of service</p> <p>Sometimes Healthwatch will make an enquiry into</p>		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
		<p>an area of service, in response to the views of its membership, which seeks to gather evidence about the current provision of a service(s). This might be related to informing future commissioning strategy or to inform other project work that Healthwatch is undertaking in its role as local health and social care watchdog.</p> <p>4. Healthwatch powers to refer a matter to Overview and Scrutiny Committees</p> <p>Healthwatch has powers to escalate a concern about a service to the local Overview and Scrutiny Committees for consideration and the OSC must keep Healthwatch informed of any actions it takes in response and this would include any liaison with commissioners and providers . This situation has not occurred.</p> <p>In the case of points 2 and 3, the regulations outlined by the Freedom of Information Act (FoIA) guide the process for responding. However, to ensure the Trust remains responsive to Healthwatch, such enquiries are directed by Healthwatch to the Trust Patient and Public Engagement Team in the first instance and our aim is to respond as quickly as possible and within the timescales established by the FoIA.</p> <p><i>And are there any other forums in our local communities that Governors should be aware of in terms of gathering feedback?</i></p> <p>There are many forums and community organisations that reflect the views of the diverse</p>		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
		communities we serve and too numerous to list. Healthwatch are a key source of community engagement and user feedback and provides a valuable link between the Trust, local residents and community organisations. (2016-11-29)		
<p>I read the recent email explaining the new mail drop that would be happening for the Evelina and going to 100,000 addresses. I wanted to ask how the areas / streets / properties were identified for the drop (ethnographic assessment to the area residents inc. ability to support, children present making it a topic relevant to them etc). I am curious to this as I have asked 20 friends and colleagues who live in the more affluent areas of Southwark, Lambeth and Wandsworth and none of them received it. Whilst I appreciate that is a tiny sample, I would have expected addresses in their areas to have been 'hit'.</p> <p>Also, in 3 months post the drop, I would like to understand what the return on this was (I assume donations from it are being tracked) vs. the cost to execute it</p>	16/0020 2016-10-20 (Heather Byron)	<p>The door drop activity is very much about growing awareness of the Evelina as a hospital one can support philanthropically as well as recruiting new donors. One of our challenges as a charity is growing our supporter base (beyond staff and patients) and we have a number of activities in place to achieve that, and this is one of them.</p> <p>The postcodes/households were selected based on their proximity to the hospital with profiling carried out by Whistl (a postal delivery service). The postcodes chosen were placed into deciles based on their propensity to give (as important as ability to give). This modelling is based on a number of factors including; existing Evelina donors in postcodes, MOSAIC profiling of area and level of giving to other charities. Profiling does not include any information relating to children within the household.</p> <p>In addition, whilst the Governor's friends and colleagues may not have received this appeal, it's possible some may have received the previous Evelina door drop in May 2016, which included 50,000 households within a 4 mile radius of Evelina.</p>		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
		<p>In terms of results, our target for the current campaign is to recruit 250 new donors, based on average response rates for the fundraising sector of 0.2-0.3% for unaddressed mailings.</p> <p>Since the mailing landed on doorsteps from 17 October, we have so far received 140 gifts. Typically, we would expect gifts to continue to come in for 9-10 weeks after a door drop mailing, and we will continue to monitor results up to 19 December, and will have further analysis on the return on investment (ROI) after this point. However, the long term ROI will be measured against the performance of this new donor audience in subsequent fundraising appeals over the course of the next 12 months.</p> <p>(07-11-2016)</p>		
<p>Pedestrian access to the Guys site is becoming increasingly hazardous, particularly for those of limited mobility. I suggest that a small group is formed to include a governor to beat the bounds and to look at improvements such as marked pathways and better signposting. The group should also look at more revolutionary solution including the positioning of wheelchairs at access points.</p>	<p>16/0019 2016-09-25 (John Porter)</p>	<p>A meeting will be arranged with the Projects and Estates/Essentia team with a few Governors to understand concerns and talk through some of the works around the Guy's site and actions in place, followed by a walk around the site.</p> <p>(19-10-2016)</p>	<p>The Stakeholder Engagement Specialist, Wayfinding and Access Manager, and Security Operations & Training Manager met with two governors on the 21st November 2016. Summary notes as follows:</p> <p>In terms of access to Guy's the concerns raised were mainly about the state of pavements (particularly along Newcomen Street), lighting and improving signage around the surrounding areas to direct patients towards Guy's Hospital via Great Maze</p>	

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
			<p>Pond.</p> <p>We agreed to look at any studies the Trust may have commissioned prior to building Guy's Cancer Centre that looked at the footfall and direction of pedestrian flowing into and out of Guy's site – this will have changed as a result of the new exit/entrance to London Bridge station but will help to ensure we have covered all known surrounding areas with signs to Guy's Hospital.</p> <p>We are chasing actions agreed with TfL and Network Rail on a regular basis which picks up many of the signage around the surrounding areas. In addition we had asked if TfL would be willing to install benches along Borough High Street (which they have declined due to the volume of pedestrians using this road) however Network Rail have agreed to install additional seating within the new station area which will help patients visiting Guy's. We explained that the state of Newcomen Street is likely to be improved</p>	

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
			<p>for pedestrians from January 2017 onwards as a result of the TfL's highways work for a cycling pathway proposed for this road.</p> <p>We had agreed to pick up the issue about the lighting needed to be adjusted along Great Maze Pond (as it was fairly dark at 4pm when we were walking around) and the tidying up the area for the replacing the damaged bollards at the top of Great Maze Pond.</p> <p>Future thoughts were to look at working with Network Rail with funding from GSTT Charity for a buggy system to bring and drop off patients to Guy's Cancer Centre/London Bridge station if this was deemed to be an issue. At the same time we gave an update on GSTT Charity and other businesses looking to improve the paving within the Inns and Yards that lead towards Guy's.</p> <p>We have agreed to review the actions and meet up with the two Governors in a couple of months if they find this helpful.</p>	

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
<p>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?</p> <p>Problem Statement: The lab is facing some lapse in service from the Royal Mail around a business delivery service that is in place for the prompt delivery of newborn screening / monitoring blood spot tests. Whilst this hasn't yet a systemic problem, talking to the lab and the dietitians, there have been a number of incidents which clearly causes concern both from the perspective of delay to patients on results but also any potential risk / harm resulting from tests which do not arrive or cant be read in the lab.</p> <p>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,</p>	<p>16/0016 2016-07-28 (Heather Byron)</p>	<p>The Head of Nursing for Children's Medicine & Neonatology responded as follows:</p> <p>I have some insight into this, as this must originate from the paediatric metabolic service - she worked in this team for many years, & is well used to the challenges of bloodspot screening, ongoing monitoring & Royal Mail.</p> <p>Just in terms of assurance with regards to delays in NBBS after birth, the national "fail safe" system does provide some reassurance and ensure if a sample is mislaid or significantly delayed a baby would have a repeat sample taken in a timely way. I will look into the other issues raised with the teams involved and will feedback progress around these points.</p> <p>Thank you again for sharing this with us. (26-08-2016)</p>	<p>Further update has been sought.</p>	

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
<p>more often than not, it would be missed for some time, which could have medical and/or quality of life implications.</p> <p>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.</p> <ul style="list-style-type: none"> • 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 (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 				

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
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?				
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.	16/0011 2016-06-22 (John Porter)	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.		
I would welcome a summary of how GSTT's efforts to the keep entrance to the hospital safe are progressing. I want to know what we are doing about TFL's plans for all pedestrians into St Thomas' having to cross cycle tracks - many of them from floating bus islands	16/0009 2016-06-22 (Jenny Stiles)	<p>This is about TfL's proposal to put a cycle lane on the west side of Westminster bridge and a by-pass bus stop outside the hospital entrance so anyone getting off the bus has to cross the cycle lane to get into the hospital.</p> <p>Responded to the consultation</p> <ul style="list-style-type: none"> Put in formal complaint that our concerns had not been given sufficient weight – the only change made as a result is to lengthen the crossing point over the cycle lane from the bus stop Set up petition – closed with over 2,000 signatures – and been to observe the floating bus stop outside the Royal London 		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
		<ul style="list-style-type: none"> Garnered support from Lambeth, SBEG and witness statements from a number of groups and individuals in support of a legal claim to take TfL to Judicial Review on the basis that the proposal makes insufficient reasonable adjustment for people with a permanent disability. The case makes suggestions for a number of alternative ways of dealing with the cycle super highway here. Have been meeting TfL to discuss sensible alternatives and thus avoid litigation <p>We have tried to be clear that we are neither anti cycling nor anti cycle lanes nor, in the right place, floating bus stops and are sorry our actions have been seen as such and as negative by some groups and individuals – however no-one we've talked to thinks the proposal is a good one and it seems unwise to replace a hazard with another one.</p> <p>(22-06-2016)</p>		
<p>NHS England and NHS Improvement are publishing a stream of directives for the sector ranging from income controls, capital expenditure controls through to the required publication of the footprint based Sustainability and Transformation (STPs) plans.</p> <p>Does the Board see any significant diminution of its freedom of action within its Foundation Trust Constitution in this new environment? If it does, how will it protect</p>	<p>16/0006 2016-06-22 (John Porter)</p>	<p>The provision of significant amounts of Sustainability and Transformation Plan funding by NHSI and CQUIN funding by NHSE gives these bodies a degree of control over the finances of Foundation Trusts. NHSI, together with the Council of Governors, holds Trust Boards to account for their governance and licence obligations to ensure service provision.</p> <p>As yet it is unclear how the numerous control totals and guidance, on for example on the usage of agency staff, will impact on the degree of</p>		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
<p>itself and the Council Of Governors from being forced to take actions over which it has no or inadequate control?</p>		<p>freedom Trusts have to manage their own affairs. The Board will ensure Governors are kept up to date on the implications and seek Governors support to push back on NHSI and NHSE where appropriate.</p> <p>Clearly the financial position of the NHS as a whole has led to more central controls and the imposition of targets. The Trust is supportive of these initiatives where they are helping improve the position overall. Indeed many Trust officers are leading STP groups working in collaboration with other local providers.</p> <p>(22-06-2016)</p>		
<p>The policy papers coming out of NHS Improvement make much of place-based service provision. I have seen no discussion of how our 'place' is to be defined but the definition is obviously of considerable interest to governors.</p> <p>We are aware of SLIC placing us firmly in Lambeth and Southwark. We see work on SE London which seems to move our sights Eastward. There is also talk of the southern London dimension. Our membership of course takes us across the river and also into Wandsworth. Then there is the dimension of tertiary care and in particular childrens' services.</p> <p>I hope we are not putting ourselves in a position of a fait accompli on our 'place' which</p>	<p>16/0004 2016-02-18 (John Porter)</p>	<p>The place-based system of care is an initiative developing a whole systems approach to improve the overall response to growing financial and service pressures whilst avoiding further structural changes to the NHS. The idea is for the various organisations within particular geographical boundaries to work together to ensure efficient delivery of services, rather than there being a provider <i>or</i> a commissioner response.</p> <p>Implementation of place-based systems will see the formation of Sustainability and Transformation Plans (STP) for each region. It has been agreed by commissioners that our local STP is South East London (SEL) as part of the Our Healthier South East London (OSHEL) programme embracing the South London Integrated Care (SLIC) project. The SEL STP covers the boroughs of Lambeth, Southwark, Lewisham, Bromley, Bexley and</p>		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
does not reflect the reality of our services.		<p>Greenwich. Our own CEO is the lead from the SEL STP to which we have been allocated.</p> <p>For a trust like GSTT which provides specialist services nationally and which also has secondary flows from South West London as well as Kent, Surrey and Sussex, the geography of our STP is not entirely appropriate and this has been acknowledged.</p> <p>Whilst we agree it makes sense to build upon the work undertaken as part of OHSEL we contend that the sustainability of some specialised commissioned services cannot be addressed through one geographically confined STP.</p> <p>There needs to be, amongst other things:</p> <ul style="list-style-type: none"> • a national and regional discussion and strategy for children's services ; • a south London, Kent, Surrey and Sussex conversation on cardiovascular services; and • a south east London and Kent conversation on cancer services <p>Also, service changes in other London footprints could shift activity flows and volumes that would have an impact on us. We have asked the Programme Director for OHSEL to link with his counterparts in South West London and other London 'footprints', though how London will link with surrounding STP footprints is currently unclear.</p>		

Matters of interest/question	Issue number & date raised	Responses	Progress/further information	Completed date
		We will keep governors abreast of developments. (31-03-2016)		
On KHP, could provide an explanation of the governance. How money flows in, how it is spent and under whose authority. Why no accounts are produced. How NEDs are appointed. How fund-raising across KHP partners is organised. Why no minutes of BOD meetings are produced. How CAGs are controlled and financed. What KHP role is in integrated care across the community and what this community is and will be.	16/0003 2016-02-05 (John Porter)	<p>The running costs of Kings Health Partners (KHP) are shared equally between the four organisations: Guy's and St Thomas' (GSTT); King's College Hospital; South London and Maudsley; and Kings College London.</p> <p>The foundation trusts (FT) have not delegated authority to KHP, so any initiatives it's proposing that will require funds or delegated powers require the approval of all three FT Boards of Directors. Where service reconfiguration is concerned, there should be consultation of the governors of all three FTs and further afield.</p> <p>Our Chairman is minded to release KHP Board minutes to the GSTT Board, which would in turn make them available to governors.</p> <p>We shall respond further with more information generally and with regards to fund-raising. (01-04-2016)</p>		
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.	A further response/update has been sought.	