Guy's and St Thomas' NHS
NHS Foundation Trust

Council of Governors Meeting

28th January 2015

(CoG/15/07)

Council of Governors
Questions and Answers

Status:	A Paper for Information
History:	Regular Report

Sir Hugh Taylor
Chairman

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

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

Matters of interest/question	date raised	Responses	Progress/further information	Completed date
How advanced is the proposal to implement Schwartz Rounds? I see this as an important training initiative in compassionate care.	2014-04-29	Dr Adrian Hopper, Deputy Medical Director for patient safety, is leading on the implementation of Schwartz Rounds. A pilot of the programme is underway. A team of programme leads and facilitators have been recently trained with the aim of implementing our first round in the autumn. A review of the pilot will take place at the end of March next year to inform any longer term commitment to the programme.	The programme started with a first round held on 21st November. (topic being the "the long road home") Rounds will be held monthly up to July 2015.	
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.		
Concern raised at The CoG meeting on 23 July: The community staff is unable to access	2014-07-23	When community services were merged with GSTT the IT Provision for that service remained with the CSU IT. It is our stated strategy to unpick this and provide the service from GSTT IT. We are in a transition phase with a number of Work-streams underway or complete. Email has been transitioned to GSTT WEB Mail this can be accessed from	The arranged meeting with the Director of IT did not proceed because insufficient staff governors were able in the event	

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printing from the GSTT server		the CSU IT service and printing is enabled. A number of teams have moved to GSTT locations and are provided services from GSTT IT including printing. A large proportion of the community teams still remain on CSU IT Services but they can access their clinical system Rio and all their files and print from that service. A number of locations on the CSU IT service have requested GSTT EPR access, a tactical solution has been designed and deployed in the requested locations and this includes EPR Printing. A number of users use GSTT Field Worker Access when in a CSU IT service location. This gives them access to the GSTT Desktop but is not capable of enabling printing in a CSU location. There are emails workarounds are in place for most circumstances to allow printing. However these are all tactical responses to a complex environment. As part of the IT Strategy the Trust's full End User Technology (PC's, Laptops, Tablets, and back end infrastructure.) will be replaced and this programme with convert all Community Services personnel to a new GSTT windows 7/8.1 environment at any location including printing. Detailed design work has been completed and the final two potential suppliers are in due diligence. A business case has been repaired, and is due for approval at the September IPB. If approved this work will take 12-18 months to complete transforming service for 18000 end points and 16000 users.	to attend	
Trust planned in partnership with KCL to build affordable accommodation. What is the timescale of the project and the cost contribution promised by the Trust?	2014-07-31	We are working on an investment strategy as part of our 5 year plan for presentation to the Board of Directors at the end of September and part of this will focus on the issues facing us with regard to staff residential accommodation. As part of this planning exercise we are working on a joint strategy with KCL who have a far greater demand for residential accommodation than the Trust. This will		

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		endeavour to identify opportunities for providing appropriate off-site accommodation for those who need it, and options that are under consideration include possible joint developments, or working in partnership with housing associations or registered social landlords. No firm decisions will be made until we have explored the options. **(Steve McGuire to John Burns on 05/08/2014)**		
Now that it seems clear that Route 381 is not immediately to return to St Thomas St, it would be helpful for QEWG to review with the Trust the advice given to patients in respect of accessing Guys Hospital. In addition there is the sustained problem of reaching the main hospital entrance by private car or Tax which is poorly signposted and requires a circuitous journey (which might even be included with a diagram in patients' letters). Previously, patients on foot could easily reach the hospital, via Bus 381, to the stop in St Thomas St just north of Great Maze/Shard. The current situation is that passengers served by both routes 381 & RV1 are advised by a message given with the stop information 'Hop Cellars – alight for Guys Hospital. This is a long way from Great Maze via St Thomas St unless one of the narrow lanes from Borough High St leading down to Gallery shop opposite the hospital entrance is used. However, these lack complete pavements and are Victorian cobbled - very dangerous for infirm/disabled	2014-08-03	The Trust has checked with Transport for London and both bus routes 381 and RV1 do stop at London Bridge bus station along Duke Street Hill, which one would agree is a better and safer stop for patients to alight to get to Guy's Hospital. Over the years the Trust has been proactive in influencing both communication and signage within London Bridge station by working closely with Network Rail. The Trust now has better directional signage and floor markings from London Bridge station towards the hospital. In additional the 'Guy's Hospital' sign has been made bigger, better positioned and illuminated to clearly direct patients and visitors to the pedestrian access along Great Maze Pond. The Trust also ensures that the most up-to-date information is provided within Guy's and St Thomas' Hospital's website (www.guysandstthomas.nhs.uk) under the 'getting here' section and encourage anyone travelling to either sites to check before travelling. There is also journey planner for any visitors via Direct Enquiries with photographic journey plans, site maps and access information, e.g. step free access and corridor widths for both hospitals. The Trust have been in touch with Transport for London to ask that the bus stop for the 381 and RV1 are cited closer to Guy's		

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patients. The Taxi fare from The Hop Cellars bus stop to the main entrance can be in excess of £7. In fact, it is probably nearer and safer for patients to leave Bus 318/RV1 at the London Bridge stop, cross over on the crossing and proceed to Great Maze via the Arcades along the route to the Shard. It would be helpful to collect information on this situation from Southwark/Lambeth Healthwatch and the Trust Patient Engagement Unit, as well as from TFL.		Hospital and the new Cancer Centre at Guy's when it opens in 2016. In the meantime, the Trust is still assessing the route to see if the wayfinding and signage towards Guy's Hospital can be improved from the earlier stop and also ask if TfL can change the announcement to alight at London Bridge station rather than along Southwark Street.		
We expressed our hope that Fracture Clinic patients could have an improved experience if their needs were considered within the A&E improvement plans, noting that the primary issue for fracture patients is long waits (patient feedback was posted on the wall in the clinic, which was excellent to see). A factor in waiting is the journey between the Fracture Clinic and the X-Ray facility in the A&E Department, as all fracture patients requiring X-rays are sent through A&E reception. We walked the current patient pathway and were able to locate a plan of the redesigned and enlarged A&E Department, which confirmed that under new plans this fracture patient pathway will be as long and awkward as it is currently. We were informed by the A&E service manager that it would not be possible, at this late stage, to relocate X-Ray so	2014-09-17	Following a review by the Assistant Director of Clinical Development further information is to be provided. It was agreed that it would be a shared access with the emergency department patients The Trust will review on this once the Emergency Department has been finished and embedded down. In the meantime The Director of Patient Experience is also reviewing matters.		

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Fracture Clinic patients could access it more easily. However the plans show an area adjoining the back wall of the Fracture Clinic, currently used as storage cupboards and one small office, and identified for future IT use, which could potentially be turned into an X-Ray room for the sole use of the Fracture Clinic. This could significantly reduce the waiting time that patients incur in the Fracture Clinic while also taking some pressure off the A&E X-Ray rooms. There could also be benefit in reducing the need for porters to move fracture patients, and in improving the comfort of patients. Devon and I both agree that this option should be explored further and the staff members concurred with this possible improvement of their service delivery to patients				
When can the agreed lower ground floor car drop off point at St Thomas' for people coming by car to outpatients have a sign explaining that it is free parking for drop off for 20minutes and when will the temporary structures that existed in September 2012 be removed to enable it to be easier to see?	2014-10-07	The Security Management Team is currently reviewing content for one of the signs and a quote for the agreed signage schedule is expected shortly. This will go to the security team for funding approval.	**Update on 16.01.2015 – The signs have been ordered and the art work recently signed off; They should be installed shortly**	
Our receptionists are the first point of contact for many patients and families. A less than caring approach by any one of them can be both upsetting and leave a poor reputation. Do our selection, training and supervision processes help ensure that we maintain a high standard?	2014-10-10	We asked Amanda Millard newly appointed Director of Patient and Carer Experience for her views. She too have asked the same question and is as a result doing some work on both recruitment and training of this group of staff through the outpatients work stream in Fit for the Future led by Alice Jarvis.		

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		(**Response from Peter Allanson sent to Yvonne Craig Inskip on 14/11/2014**)		
A cautionary true tale: 150 would-be medical students assembled to hear a speaker who didn't turn up. Possible disaffection of, say, 10% of those present = £9,000 x 3 x 15 = A Lot of Money. I imagine that clinicians concentrate on a) being clinicians b) research and the pressure to publish and 3) private practice. How can the role of being an educator be made more attractive?	2014-10-22	Disaffected students - should improve performance as a result of Stuart Carney's work - keep records of episodes of short or no notice no show of tutors and fed back for action - happened a couple of times. Identifying and celebrating excellence in teaching - log book certificates etc. Medical school relied on good will for a long time and changing to remunerate firm heads and deputy firm heads - curriculum review under weigh and reward a part of it. (**Response from Peter Allanson sent to Yvonne Craig Inskip on 14/11/2014**)		
Does the Trust's educational programme teach process as well as content, especially the skill of adapting to rapid change over the next decade, such as patients' self-management and a greater reliance on improved technology?	2014-10-22	New curriculum launches for 2021 but aspects will be rolled out over the coming years. Will address changes in the way health care is delivered - current curriculum based on practice 12-13 years ago. (**Response from Peter Allanson sent to Yvonne Craig Inskip on 14/11/2014**)		
I've just learned that in their Finals doctors pass or fail. There are no grades. If this is so, how far do candidates' reputations depend on networking and hearsay? On the magistrate's bench we found neither of these reliable predictors of future conduct	2014-10-22	No grades for pass/fail as such though there are also merits or distinction. Networking and hearsay ruled out of recruitment now largely because applications anonymised and submitted electronically. (**Response from Peter Allanson sent to Yvonne Craig Inskip on 14/11/2014**)		

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Given the rise in the national number of FGM cases, can we be satisfied that this is an area which the Trust can reasonably resource?	2014-10-22	FGM is taught in year 4 obstetrics and gynaecology and one of the international experts - Comfort Momoh gives a seminar every rotation. Students also have access to her clinic to attend. (**Response from Peter Allanson sent to Yvonne Craig Inskip on 14/11/2014**)		**14/11/2014**

Cancer 62 day RTT performance
Whenever this issue is reviewed, the information suggests that the problem is **late referral from other hospitals.** As you know I am a Member of the London Primary Care Transformation Board and have had the opportunity of access to the development intentions of the 8 London Regions. So, find myself intrigued by this question: **what lies behind this simple statement about referrals from other hospitals?**
For example :
• what distinguishes these hospitals that contribute to the poor performance from those that do not – are there any recognisable characteristics
• does the problem extend beyond these hospitals....is the real problem :
  • Late diagnosis in Primary Care?
  • late presentation by the patient (for fear of outcome or some other reason)
  • Poor description of the problem, at first presentation (say because patient fears the outcome)?
• are there any characteristics that identifies
		In many cases it is the capacity in referring trusts to get through the diagnostics to refer people to us in time for us to meet the target – anything after day 42 will miss it. Inevitably it is multi factorial but in the current quarter, if all late referrers retained the breach (we currently take half of it) we'd meet the target. Finally, when we spoke to Mike Richards about it, some time ago when he was still cancer tsar, he felt we should be more concerned about patients having to wait more than 62 days for a diagnosis than about our meeting the target qua target – which is sobering
		
		(**Response from Peter Allanson sent to Barry Silverman on 28/10/2014**)		

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these patients along their pathway to a positive diagnosis • what would be needed to change the present situation Has GSST carried out any analysis in this area of activity; if so, can you tell me any findings.				
Chairs on castors purchased by the Trust. It appears a number of accidents have occurred with the chairs moving when people sit on them. Could the Trust find a type of chair that whilst still having castors to enable movement could be switched to one which can be made static as well?		The issue is being considered by the Trust Health and Safety team		
Cancer Centre - Naming Opportunities The KHP Director of Fundraising presented a paper on behalf of KHP Fundraising explaining the process being proposed. Has it been any progress and is there any update?		A report which would help clarify KHP fundraising's approach around the naming opportunities linked to the Cancer Centre has been shared with the Cancer Centre Programme Board in October. The Board agreed with the new process highlighted in the report. **(Response from Kathrin Ostermann, KHP Director of Fundraising sent to Jeff Whitear on 25/11/2014)**		