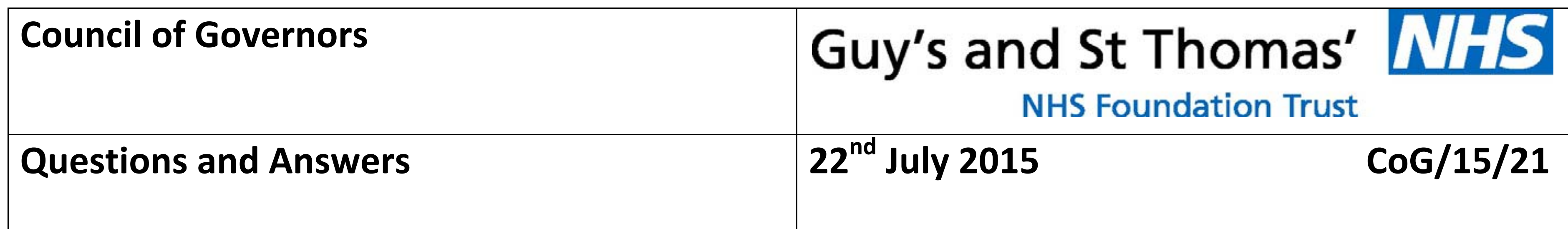

Council of Governors	Guy's and St Thomas' NHS Foundation Trust	
Questions and Answers	**22nd July 2015**	**CoG/15/21**

This paper is for:	
Decision	
Discussion	
Noting	
Information	x

Sponsor:	**Peter Allanson, Trust of Secretary and Head of Corporate Affairs**	
Author:	**Sandrine Michel-Gibson, Governance Administrator**	
Reviewed by:		
CEO*		
ED*		
Board Committee*		
TME*		
Other*	x	**Council of Governors**

* *Specify*

1. Summary

This report provides a list of queries which 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.*

2. Request to the *Council of Governors*

The Council of Governors is invited to note the report.

3. Detail/ Commentary

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

Matters of interest/question	date raised	Responses	Progress/further information	Completed date
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.		
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		

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		on a joint strategy with KCL who have a far greater demand for residential accommodation than the Trust. This will 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)**		

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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	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	**Update on 23.06.2015** - The Trust has met with TFL and Network Rail beginning of May 2015. Some aspects have been actioned whilst others are still outstanding: – bus announcement (TfL confirmed they changed this in November 2014) – improving the signage within London Bridge station to Guy's Hospital (Network Rail to still action) – improving the road signage for	

Matters of interest/question	date raised	Responses	Progress/further information	Completed date
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 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		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 will be in touch with Transport for London to ask that the bus stop for the 381 and RV1 are cited closer to Guy's Hospital and the new Cancer Centre at Guy's when it opens in 2016. In the meantime, the Trust will assess 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. (**Response from Steve McGuire sent to Barry Silverman and QEWG members on 21-08-2014**)	cars/taxis dropping off patients to Guy's - many are going to the dead end at Weston Street instead of turning into Snowsfields/then Great Maze Pond resulting very distressed patients coming to their appointments (partially actioned by a 'no through' road sign installed by Network Rail) – improving the poor traffic management along St Thomas Street (this is an issue for TfL and they can't assign	

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Engagement Unit, as well as from TFL.			personnel to manage this daily – the issue will be raised at the London Bridge stakeholder board in September)	
Fracture Clinic 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	2014-09-17	The Trust is in the midst of a major complex refurbishment of the Emergency Department. Until this has been completed it is not realistic to undertake a major review of the Fracture Clinic – which we intend to put in hand at that point. In the meantime we are keen to work with you to improve the experience of patients in this increasingly busy clinic. The fracture clinic team have already started to act on some of the issues that you have highlighted in your letter. A fracture clinic improvement working group has been set up and has met three times to discuss concerns		

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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 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		and make plans for improvements. This group currently consists of a multidisciplinary team of experts from the nursing team and Orthopaedic services. This group would like to invite a governor to join them. Perhaps we could agree with SSWG who should take this up. Their plans include: • Improving the booking process to ensure that doctors and clinics have a more appropriate allocated time for each patient. This will result in fewer queues for reception and a reduction in waiting times overall. • Improving the waiting area to make it more appealing (e.g. rearranging the seats, placing magazines and TV) Part of the plan includes: • A proposal to consider a "virtual" clinic using telephone review. This system has already been set up in other Trusts and proves to be working well. This would reduce visits to the clinic and improve waiting time. • Whilst work is in progress in the Emergency Department: o Fracture Clinic patients in need of x-ray		

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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		will be directed to the A&E x-ray department on arrival and prior to their appointment. o Patients with mobility impairment will also be able to use the A&E entrance to access the clinic. o All other patients from the fracture clinic will use the designated hospital routes to access the fracture clinic. o A&E Volunteers will be briefed about the fracture clinic patient access to ensure a good patient experience is maintained while the A&E works are in progress and thereafter. o An information card with a map and possibly a flow chart for A&E to give to patient explaining the route to fracture clinic is to be created. • After work completion o Fracture clinic patients will be able to access the A&E x-ray department via a buzzer system; this to avoid patient dignity issues. • The team is currently auditing how often		

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		telephone calls are missed and making an action plan with any improvements including training for the team. • The appointment of a new Orthopaedic Outpatient Manager who will be based at St Thomas' (started in March 2015) and will manage the non clinical staff in fracture clinic. This should have a positive effect on the running of the clinic. **(Response from Peter Allanson sent to Devon Allison and Ken Hayes on 20-04-2015)**		
A&E entrance permanently closed for access to other parts of the hospital. I note the impending permanent closure of the access to the St Thomas Hospital site via the A & E entrance and would like to ask whether : • any consultation took place and, if so, with whom and when in respect of the intention • Any specific consideration was	2015-03-14	The Trust has sought the views of patients and user groups at key points of the design process, from options appraisal to the final workshop in July 2013. There was a particular focus on trying to seek the views of those with long-term conditions, older patients and those with mental health conditions, as these groups tend to be recurrent service users. To each workshop we have carefully and as best we can, recruited a sample of patients who are broadly representative of the demographic groups using A&E or recruited to the theme of a workshop e.g. mental health service users.		

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given to the needs of disabled patients arriving and departing from the hospital – particularly those intending to access the East Wing and Evelina- At present, this access connects with Bus Routes 77 and C10. The nearest 77 Bus stop is now at County Hall/Education Centre. These is no C10 stop nearer than under the Railway Bridge - Route 77 allows a connection with Routes 381/RV1, also located at County Hall. These locations offer a substantial distance to the hospital – especially of access is required beyond the North or Lambeth wings. It is understood that A & E needs may stipulate that this access should be removed but a possible remedy is to establish an entrance by the Evelina (needed for patients/visitors accessing the		Governors have been involved in key workshops, where appropriate. It is important to highlight that for the large part we have sought the views of those with recent and personal experience of emergency care pathways. The business case and final designs for the ED refurbishment were presented to the Board on 30th April 2014. ED art strategy - the views of patients and Governors will continue to inform this facet of the programme. To date staff and patients have selected the artist that went forward to the successful charity bid and this will continue at key points of the programme. The PPE Team and Essentia Stakeholder Engagement are working closely with Sara and John Criddle to plan further activities. With regard to the question of whether the Trust sought the views of patients and public on limiting the access to the rest hospital building via A&E entrance - this point was not raised specifically. Access points to A&E were indeed highlighted at the final patient-public workshop		

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Children's hospital anyway with a new bus stop opposite that new entrance (something required in any case for the same reasons).The continuation of pedestrian access to the A & E Dept. does not, of course, change the situation for patients wanting other parts of the St Thomas site – particularly if they are walking disabled or self arriving in motorised wheel chairs (which are themselves not best suited for hospital corridors. Is there any policy or guidance with respect to these as they are becoming larger and larger (and so dangerous to those on foot in confined spaces).		in July 2013 (the event walked participants through the drawings and slide decks from the event highlight this), but at the time, it was not apparent that access to the rest of the hospital would be limited - this was not included in the scope of discussions for that reason. It is unfortunate that the issue was not brought to light until much later in the process when the design and business case were agreed. Given the challenges of accommodating the emergency floor in a limited foot print and the need to maximise the space available, one might ask whether it would have been proportionate / reasonable to consult more widely on the matter of limiting access to the rest of the hospital from this entrance if a) the entrance from Lambeth Palace Road side has always been the A&E front door (not really intended as a main hospital thoroughfare) and b) if this was the only option in order to maximise space for the department. Instead, is it worth considering whether there are still opportunities to have a helpful discussion with patient-public representatives, in particular		

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		Governors, about the solutions in respect to wayfinding / signage? Mystery Shopping findings and patient feedback continue to highlight, from time to time, that wayfinding / signage is not as clear as it could be in places. The Trust has a wayfinding strategy and design standards, but these set a minimum standard and patients comments should continue to be taken into account. (**Response from Peter Allanson sent to Barry Silverman on 21-04-2015**)		
The Workforce Committee refers to Physician Associates (PAs). Could Governors be given some explanation of what PAs are, what their role will be within the Trust, how they will be supervised and how many it is intended to deploy? Further, how will patients recognise a PA and will patients be given any understanding of their role vis a vis fully qualified doctors and nurses	23-04-2015	The terms Physicians Associate and Physicians Assistants are used interchangeably with Physician Associate (PA) becoming the more common term in recent years. A Physician Assistant (PA) is defined as someone who is: a new healthcare professional who, while not a doctor, works to the medical model, with the attitudes, skills and knowledge base to deliver holistic care and treatment within the general medical and/or general practice team under defined levels of supervision. The role is		

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		therefore designed to supplement the medical workforce, thereby improving patient access. Most commonly found in hospital settings, a small number of general practices in England have employed PAs. Physician associates are trained to perform a number of duties, including taking medical histories, performing examinations, diagnosing illnesses, analysing test results, and developing management plans. The role was developed in the USA in the mid-1960s and was introduced into the UK in early 2003 in a GP practice in the West Midlands. Currently around 200 physician associates are working across the United Kingdom. Most of these are based in Bristol, Edinburgh, Glasgow, Weston-Super-Mare, the East and West Midlands, and parts of London. Many physician associates come from a background where they were already trained health professionals, such as nurses, paramedics, and physiotherapists. Physician associate training lasts two years, and		

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		although it involves many aspects of an undergraduate or post-graduate medical degree, it focuses principally on general adult medicine in hospital and general practice, rather than specialty care. However, at two years, the training is much shorter than a qualified doctor who would typically take around 10 years to train as a GP (including medical school) and 14 years to train as a surgeon. Recent studies have reported high levels of patient satisfaction with PAs, and other clinicians in studies based in primary and mental health settings have been positive, concluding that PAs are competent and safe, as well as being productive in terms of handling appointments and cost. The Royal College of Physicians (RCP) says that the number of physician associates in the UK has so far been limited owing to lack of regulation for those taking on these roles. The college has been pushing for regulation of physician associates		

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		since 2005. The Royal College and the UK Association PA **The Trust's policy for recruiting PA**: The Physician Associates we are recruiting must be members of the UK Physician Associate Managed Voluntary Register (http://pamvr.org.uk/guidelines/index.html) which means they are agreeing to follow the guidelines, fitness to practice rules, code of conduct and scope of practice. The Royal College of Physicians is setting up a Faculty of Physician Associates which will be a membership organisation replacing the UK Association of Physician Associates. Both the RCP and RC Surgeons are lobbying for full registration for the profession. **(Response from Amanda Price to John Porter on 22-06-2015)**		
I was in the fracture clinic at St Thomas' for a couple of hours waiting for my appointment and it was very hot and airless. The consultant I saw said the air	2015-06-18	The Orthopaedic Outpatient Manager apologised profusely and had two units brought in while the air conditioning system was being		

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conditioning has not been working properly for around 7 years and there is no natural air current circulating in the department and the fan was not on. They often see between 40 to 100 patients a day and the conditions are really not comfortable		reviewed by maintenance.		
I have written previously about the requirement for Patients wishing to attend **Urgent Care** (surely to be encouraged rather than to A & E) to register first at A & E. However, notwithstanding my representations, this remains a requirement which is brought into sharp relief with the opening of the new corridor in Lambeth Wing that bypasses A & E. The effect is that Patients requiring the Urgent Care Department, arriving at the Main Entrance (or Lambeth Wing entrance that is very close to it) can easily arrive at the Urgent Care.	2015-06-22	Following Barry Silverman comments, the Emergency Care programme team are reviewing the process for the urgent care centre registration and as an interim measure a sign will be added at the main A&E entrance advising patients to register with A&E reception before attending UCC. These issues are not anticipated to be long term as the Urgent Care Centre will be relocated next to the Emergency Department reception in April 2016.	**In progress**	

Matters of interest/question	date raised	Responses	Progress/further information	Completed date
But, having done so, patients are then directed, **by a large notice,** to register with A & E before entering. As a result they must retrace their footsteps to the Lambeth Wing Entrance and proceed to A & E via the **outside pathway** to register and then retrace their footsteps back to Urgent Care. May I suggest that this is an unreasonable imposition – particularly in inclement weather/winter conditions and seems to place the priorities of Departmental administration above Patient welfare. If so, it is hardly a demonstration of 'showing we care'				

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Local dentists are frustrated that communication for referrals to the dental department has to be on paper and not email or, for urgent cases, by FAX. Further, whilst the treatment received by their patients is seen as excellent, the follow-up reports are very slow in arriving which makes for difficulties.	2015-06-25	The dental department confirmed that they take referrals by email and the details are on the Trust website. The referrer is required to fill in a form and email it to the department. If a referrer has to send in x rays they are often sent by post. The process for 2 week waits is by the central team and not Dental. They requested faxing in referrals. The department have a new Secretarial Manager in place who is ensuring that the letters are turned around more quickly, and is putting in long term process changes.		