Council of Governors, 24th January 2018

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COUNCIL OF GOVERNORS
Meeting to be held on 24th January 2018
6.00pm – 7.30pm, Robens Suite, Guy’s Hospital

A G E N D A

1. Welcome, apologies and opening remarks

2. Minutes of meeting held on 25th October 2017 attached (CG/18/01)

3. Matters Arising

4. Reflection session on Board of Directors meeting oral

5. Changes to the Trust Constitution attached (CG/18/02)
   Peter Allanson

6. Council of Governors elections 2018 attached (CG/18/03)
   Peter Allanson

7. Workforce Strategy presentation
   Julie Screaton

8. Governors’ reports – to note and for information
   1. Lead Governor report oral
      Devon Allison
   2. MeDIC attached (CG/18/04)
      James Palmer
   3. Quality and Engagement attached (CG/18/05)
      Kate Griffiths-Lambeth
   4. Service Strategy attached (CG/18/06)
      Giles Taylor

9. Questions and answers – for information attached (CG/18/07)

10. Any other business

11. Date and time of next meeting:

    The meetings will be held on 25 April 2018, Robens Suite, Guy’s Hospital
    Board of Directors meeting 3.45pm – 5.30pm
    Council of Governors meeting 6.00pm – 7.30pm
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Council of Governors

Minutes of the 58th meeting of the Council of Governors held on
Wednesday 25th October 2017 in the Governors’ Hall, St Thomas’ Hospital

Present:
Devon Allison
John Balazs
Prof Kevin Burnand
Anita Campolini
Dr John Chambers
Yvonne Craig Inskip
Robert Davidson
Noreen Ging
Linda Goldsmith
Tom Hoffman

Anita Macro
Darren Oldfield
James Palmer
Prof John Porter
Vicky Rogers
Giuseppe Sollazzo
Jenny Stiles
Bill Williams
Dr Bryn Williams

Apologies:
Heather Byron
John Duncan
Jonathan Farley
Jane Fryer
Kate Griffiths-Lambeth
Tony Hulse

Matthew Patrick
Prof Lucilla Poston
Mohammed Seedat
Sue Slipman
Giles Taylor
Prof Warren Turner

In Attendance:
Executive Directors:
Dr Ian Abbs
Jon Findlay
Alastair Gourlay
Amanda Pritchard
Julie Screaton
Martin Shaw
Dr Simon Steddon

Robert Drummond
Felicity Harvey
Girda Niles
John Pelly
Reza Razavi
Sheila Shribman
Priya Singh
Sir Hugh Taylor (Chair)
Steve Weiner

Non Executive Directors:

Other Attendees:
Thomas Alexander
Peter Allanson
Adeola Ogunlaja

Chief Executive’s Planning Officer
Trust Secretary and Head of Corporate Affairs
Membership and Governance Co-ordinator
CG/17/33  **Welcome, apologies and opening remarks**

Apologies had been received from Eileen Sills, Hannah Coffey, Steve Townsend, David Perry, Heather Byron, Jonathan Farley, Kate Griffiths-Lambeth, Tony Hulse, Lucilla Poston, Sue Slipman, Giles Taylor and Warren Turner.

The Council congratulated Anita Macro who had been elected by the Community Services staff constituency.

The death of David Maurice, a patient governor was noted with regret and a welcome given to Giuseppe Sollazzo who was replacing him for the remainder of his term.

Governors had recently met informally and given useful feedback to the Chairman on areas where it would be helpful to focus over the coming months. These included deepening governors’ engagement with their constituencies; how the Trust responded to concerns and questions from governors – where refreshing the format of the accountability session could be a useful first step; coverage of the day to day operational IT issues, as well as the strategic agenda where progress had been visible to governors; how the Trust was dealing with its teaching and education responsibilities including dealing with concerns raised by students over which the Trust had oversight; and getting further under the surface of equality and diversity issues.

CG/17/34  **Minutes of the meeting held on 12th July 2017**

The minutes of the meeting held on 12th July 2017 were approved as a true record.

CG/17/35  **Matters arising**

There were none.

CG/17/36  **Reflections session on Board of Directors meeting**

Members of the Council of Governors raised a number of issues that had been discussed by the Directors at their earlier meeting.

Governors congratulated the sexual health team on their work and achievements in introducing new practices and coping with the reductions to the available money for their services which remained in great demand. It was disappointing that what governors and the Trust saw as a premiere service was under such attack and unable to deal with as many patients.

Although the closure of the Vauxhall clinics seemed not to have had the impact anticipated, there were concerns about the treatment of asymptomatic patients especially as there seemed to be incentives to treat more complex patients instead. Whilst the continuing availability of test through SH:24 until the new service came on line was welcome it was unfortunate that some could be turned away until the new provision was in place. The kits were made available on a daily basis so when they ran out that would mean that some patients would have to wait or seek provision from elsewhere. There were concerns about the efficacy of the new service already and it was suggested that the directorate should assess this as a risk. The MSM clinic had been amalgamated with another service currently based on internal referrals although there were plans
to reintroduce the service later. The numbers coming through the service had not reduced.

Following the public health presentations - which were welcomed - the governors asked the Trust how it struck the balance between its role as a treatment centre and the part it could play in prevention.

Board members said that they had spent time on their away day considering population health. The Trust aspired to be a part of a system focussed on population health but that was a remit that had emphatically to be done in collaboration with others. It sat alongside the aim of providing world class services across a wider, sometimes international, geography – for example cardio vascular – where the local population was a beneficiary. Other examples included reablement work and the mind and body agenda working with SLaM and patients with complex conditions. The Trust's role in the community had brought real benefits of being involved in these services. The mismatch between demand and provision where local authority funding cuts led to service reductions could have a long term possibly national impact in the long term.

It was suggested that the Trust should consider where it could make the most helpful interventions in public health and take propositions to the public health teams in Lambeth and Southwark.

**Trust preparations for winter**

The Council of Governors received a presentation from a Board member on the Trust’s preparations for winter. These were crucial, not least because of the national focus on this issue and concern about the system’s ability and preparedness to cope with it.

The Trust’s proposals took full account of national plans and priorities. The flu season in Australia had been difficult and that could be an indicator for the UK. A vaccine had been selected – and that was a major area of focus, particularly for vulnerable groups. The capacity on the 111 phone line had been increased with the aim of preventing hospital admissions and primary care extended access was being discussed so there should be greater pout of hours access to GPs available.

Within the Trust three wards had been designated for flu with appropriate equipment and staff training. The Trust would be vaccinating high risk patients although its main focus was on vaccinating patient facing staff. The Trust’s escalation plans were being updated including its response to coping when the hospital was approaching capacity and dealing with the impact on A&E. Key to this was the work to bring forward discharges – for example by providing day rooms for patients to use whilst they are waiting for take out medication. Individual plans were being laid for each ward.

A live bed state system was being rolled out across the Trust and would be available for the winter. The impact on critical care, ECMO and other respiratory services had been thought through so capacity could be flexed when necessary.

Some extra funds were available from commissioners - with £2mn allocated across a number of services including rapid testing of patients so that those who did not have flu did not have to be isolated. Additional resources for some clinical support units – including pharmacy – had been anticipated.
There were a number of schemes to avoid admission in place. These included extending some services into the weekend and plans for redirecting patients from A&E to other services. It was also planned to change surgical practice in January and February to concentrate on day cases and freeing up beds by reducing the number of elective inpatients. It would be important to ensure that there was extra bed capacity available as it was not possible to cope with emergencies if the Trust was at full capacity. Nevertheless, the Trust aimed to be able to maintain some elective services and still retain some bed flexibility. It was noted that the issue went beyond the number of beds open as all had to be staffed safely.

There was a focus on vulnerable or frail patients regardless of age. This group inevitably made high demands on the hospital and needed support as often admissions of this cohort were often protracted.

The recruitment of A&E consultants had been successful and the department was well staffed. The One team week exercise which had taken place earlier in the year would be rerun in November.

Finally there was a clear aim to exceed last year’s flu vaccination target. The Trust’s responsibility was to report and persuade staff to be vaccinated. The overall responsibility for the community lay with primary care and the community.

The Council noted the presentation and acknowledged the impact that a difficult winter could have on the Trust. Discharge as early in the day was essential and the local authorities had a vital role to play to support this.

**Governors’ Reports**

**Lead Governor report**

There had been a helpful meeting with the Director of Workforce. Governors were interested in the impact on the workforce of the current situation of the NHS.

The lead governors of KHP had met their equivalents from across London. All shared concerns about staffing and the risks associated with transport and housing costs driving staff out of London. The intention was to write to the Mayor about transport.

The posthumous Nightingale awards meant much to those associated and appreciated by the Governors.

**Membership Development, Involvement and Communications Working Group**

MEDIC was working to implement the membership strategy that it had agreed. Attendance at events in the community had been useful and a programme was for external events next year would be devised. Diversity advocates would be trained by the end of the year a part of the initiative to try to access particular parts of the community.

Staff governors were aiming to try to develop the knowledge of staff about being governors and in particular to improve engagement in advance of the elections next year. GIST would in future have a feature on membership and a section of questions
for governors.

**Quality and Engagement Working Group**

The report was noted.

**Service Strategy Working Group**

The Group discussed planning proposals for 2018-19 and the savings target and also took a presentation on the digital strategy. A customer strategy was a topic that needed development. The Group welcomed suggestions for matters to discuss.

**CG/17/39 Questions and answers**

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

**CG/17/40 Any other business**

There was none.

**CG/17/41 Date and time of next meeting**

The meetings will be held on 24th January 2018 in the Robens Suite, Guy's Hospital

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

Signed: ____________________________  Date: ____________________________
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Council of Governors

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<th>24th January 2018</th>
<th>CG/18/02</th>
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<th>Sponsor: Sir Hugh Taylor</th>
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<tbody>
<tr>
<td>Decision X</td>
<td>Author: Peter Allanson</td>
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<tr>
<td>Discussion</td>
<td>Reviewed by:</td>
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<tr>
<td>Noting</td>
<td>CEO* X</td>
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<td>Information</td>
<td>ED* X</td>
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<td>TME*</td>
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<td>Other* X</td>
<td>Board Consulted and in support</td>
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1. Summary

The paper asks for your support for a change to the Trust’s constitution.

This is related to the arrangements we have for filling vacancies on the Council for elected members – that is those from the public, patient and staff constituencies. Nominated governors are replaced by their nominating body.

We are asking for approval to change paragraph 8.14.2 to read:

8.14.2 Where an elected Governor ceases to hold office during his term of office an election will be held in accordance with the Election Scheme save that if an election is due to be called within nine months of the vacancy having arisen the office will stand vacant until the next scheduled election unless by so doing this causes the aggregate number of Governors who are Public Governors and Patient Governors to be less than half the total membership of the Council of Governors. In that event an election will be held in accordance with the Election Scheme as soon as reasonably practicable.

No other amendment is necessary.

In process terms, to agree the change, the Board has to agree which it did by correspondence in December. The Council of Governors must approve in general meeting and then we have to let NHSI know of the change. As this change is not about the powers of the council of governors, no further consent is needed.
2. Request to the Council of Governors

The Council of Governors is asked to agree to the wording of paragraph 8.14.2 in the Trust Constitution to be amended to read:

8.14.2 Where an elected Governor ceases to hold office during his term of office an election will be held in accordance with the Election Scheme save that if an election is due to be called within nine months of the vacancy having arisen the office will stand vacant until the next scheduled election unless by so doing this causes the aggregate number of Governors who are Public Governors and Patient Governors to be less than half the total membership of the Council of Governors. In that event an election will be held in accordance with the Election Scheme as soon as reasonably practicable.

The Trust Secretary will then inform NHS Improvement of the change.
3. Further Background Information

The position in respect of filling a vacancy left by an elected governor is currently as follows:

- The candidate with the next highest number of votes in the last election for the constituency in which the vacancy has arisen will be offered the governor position. If they decline the person with the next highest number of votes is offered the position.
- This continues until the vacancy is filled or all of the candidates have been offered and declined the position.
- At this point, if there is nine months or less until the next election for a governor from the constituency in which the vacancy has arisen, then the position will be left vacant until that election (unless leaving the position vacant causes the total number of public and patient governors to less than half of the Council of Governors).
- If there is more than nine months left until an election for that position, then an election is held in accordance with the Model Election Rules.

Throughout the life of the Foundation Trust we have had occasionally to replace a governor who has stood down or died. However, we have had to replace three governors in one constituency in the current council which means we are well down the list of candidates with a relatively small vote and so not really representing the preference of those voting. We are therefore proposing to change the constitution so that there would be a by-election to fill any vacancy unless we were within 9 months of calling an election in which case we would add a seat to the number to be elected. As this situation has just arisen, we wish to take action now.

Whilst there are a number of practices amongst other Foundation Trusts, the norm currently is to run a by-election if a vacancy arises.
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<td>Other*</td>
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1. Summary

The Trust is holding elections in 2018 for seats on the Council of Governors. There are fourteen seats in total up for election for the term starting 1st July 2018. Eight governors are coming to the end of their first term and six are coming to the end of their two-term tenure.

2. Recommendation

The Council of Governors is invited to note the arrangements for the elections and the proposed timetable on page 3.

3. Details

The constituency split is as follows:

- **Patient Constituency (five governors in total)**
  - Four governors reach the end of their first term
  - One governor reaches the end of her two-term tenure

- **Public constituency (six governors in total)**
  - Two governors reach the end of their first term
  - Four governors reach the end of their two-term tenure

- **Staff constituency – clinical (three governors in total)**
  - Two governors reach the end of their first term
  - One governor reaches the end of her two-term tenure
## 4. Timetable

The election timetable below has been planned so that the new governors will take up their post on 1\textsuperscript{st} July 2018, when the term of office begins.

<table>
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<tr>
<th>Date</th>
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<tr>
<td><strong>January</strong></td>
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<tr>
<td>Wednesday 24\textsuperscript{th} January</td>
<td>Council of Governors meeting - election arrangements highlighted</td>
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<tr>
<td><strong>March</strong></td>
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<tr>
<td>Tuesday 27\textsuperscript{th} March</td>
<td>Election briefing at members’ health seminar</td>
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<tr>
<td><strong>April</strong></td>
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<tr>
<td>Wednesday 11\textsuperscript{th} April</td>
<td>Website information/social media campaign</td>
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<td>Wednesday 11\textsuperscript{th} April</td>
<td>Formal notice of election</td>
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<tr>
<td>Wednesday 25\textsuperscript{th} April</td>
<td>Council of Governors meeting - election update if appropriate</td>
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<td><strong>May</strong></td>
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<td>Friday 4\textsuperscript{th} May</td>
<td>Nomination deadline</td>
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<tr>
<td>Tuesday 8\textsuperscript{th} May</td>
<td>Post formal notice of candidates</td>
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<tr>
<td>Thursday 10\textsuperscript{th} May</td>
<td>Final date for nominated candidates to withdraw</td>
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<tr>
<td>Tuesday 15\textsuperscript{th} May</td>
<td>Meet the candidates session at members’ health seminar</td>
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<tr>
<td>Tuesday 22\textsuperscript{nd} May</td>
<td>Voting opens - formal notice of poll and issue of ballot papers</td>
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<td><strong>June</strong></td>
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<td>Wednesday 6\textsuperscript{th} June</td>
<td>Mobile polling station, Guy’s</td>
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<td>Thursday 7\textsuperscript{th} June</td>
<td>Mobile polling station, St Thomas’</td>
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<td>Friday 15\textsuperscript{th} June</td>
<td>Election close</td>
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<tr>
<td>Monday 18\textsuperscript{th} June</td>
<td>Declaration of results</td>
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<tr>
<td>w/c 18\textsuperscript{th} June</td>
<td>Successful and unsuccessful candidates contacted</td>
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<tr>
<td>Saturday 30\textsuperscript{th} June</td>
<td>Existing governors step down</td>
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<tr>
<td><strong>July</strong></td>
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<tr>
<td>Sunday 1\textsuperscript{st} July</td>
<td>New governors take up their post</td>
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Council of Governors

Membership Development, Involvement & Communications (MeDIC) Working Group report, 17th October 2017

24th January 2018

CG/18/04

This paper is for:

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<th>Information</th>
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Sponsor: MeDIC Working Group
Author: Adeola Ogunlaja
Reviewed by: James Palmer and Peter Allanson

CEO*
ED*
Board Committee*
TME*
Other*

* Specify
1. Welcome and apologies for absence

The meeting was attended by: Peter Allanson (Trust Secretary and Head of Corporate Affairs); Yvonne Craig-Inskip (Public Governor); Lisa Doughty (Patient and Public Engagement Specialist); Noreen Ging (Staff Governor); Linda Goldsmith (Public Governor); Tony Hulse (Staff Governor); Anita Macro (Staff Governor); Girda Niles (Non-Executive Director); Adeola Ogunlaja (Membership and Governance Co-ordinator); James Palmer (Lead, Public Governor); Vicky Rogers (Staff Governor); Jenny Stiles (Public Governor); Bryn Williams (Staff Governors)

Apologies: Matt Akid (Head of Media and Corporate Communications); Devon Allison (Lead Governor, Patient); Griffiths-Lambeth (Public Governor); John Porter (Public Governor)

2. Notes of the meeting held on 28th June 2017

The minutes of the meeting held on 28th June 2017 were agreed as a true record of the meeting by all attendees.

3. Matters Arising

There were none.

4. Membership strategy progress

The Membership and Governance Co-ordinator gave the below update on the progress made on the membership strategy action plan.
4.1. Green Park report action plan

Progress report

Diversity Advocates: A recurring advert was placed in the Staff Bulletin and sent to all volunteers by email, seeking support with the community engagement project. The advert generated 7 interests from staff members willing to take part as diversity advocates. The next step would be to arrange meetings with representatives to understand how we could engage their diverse community groups to promote membership, and to work with the Head of Equality and Diversity to run a training session for the diversity advocates. She hoped the meetings with the community organisations would take place in November and the training session for diversity advocates would be held in December.

The Membership and Governance Co-ordinator reminded the group of the importance of defining the membership value before meeting with the diverse community organisations. The group suggested promoting the positive impact members and governors have had on the Trust, such as the opening of the Outpatient Centre at Gassiot House. It was also suggested that recruitment opportunities could be promoted more widely within the community, following the recent meeting with governors and the Director of Workforce and OD. Members could also be asked to share some positive stories about why they chose to support the Trust by becoming a member.

4.2. Membership recruitment drive

Feedback from London Pride and Lambeth Country Show

The group noted the breakdown of the profiles of the 13 new members recruited at the London Pride and Lambeth Country Show events. It was agreed that the events were worth repeating as free platforms to encourage local people to become members, though it was necessary to be better prepared for events in 2018.
Membership information stand within the Trust

The group suggested displaying a membership stand at a hospital and community site next year. The new membership leaflet should also be displayed at community centres such as Gracefield Gardens, Burrell Street Sexual Health Clinic and the Akerman Centre.

Using external events held in Governors’ Hall and the Robens Suite as avenues to display the membership stand was also suggested. The Membership and Governance Co-ordinator would meet with the Hospitality Managers to discuss the possibility.

4.3. The GiST magazine

Regular membership plug and Ask the governors column

The membership plug being included in the November issue of the GiST magazine was warmly welcomed.

The group had hoped that future ‘Ask the governors’ columns would be more governor driven. The Membership and Governance Co-ordinator would discuss this with the new Senior Communications Projects Officer. The Trust Secretary and Head of Corporate Affairs explained that though five questions had been received, only one was sent early enough to be included in the GiST. It was not a broad enough issue to be included, therefore a question raised by a governor to the Board was selected for the column instead.

Ask the governors: questions from members

The group welcomed the five questions raised by members to the governors. The Membership and Governance Co-ordinator said that responses had been sought and would be provided to members once available.
It was agreed that the MeDIC Working Group and the Lead Governor would be included when deciding the content for future ‘Ask the governors’ columns. Future columns would also be more governor led.

5. Patient and Public Engagement Strategy refresh

The Patient and Public Engagement Specialist gave an update on the refresh of the Patient and Public Engagement (PPE) Strategy. The first draft strategy had been produced following engagement with staff, patient and public stakeholders during the summer period.

She informed that the framework remained the same though the updated strategy would reflect Trust priorities such as the Trust’s Digital Strategy and Digital Patient Journey. The second draft would be presented to the PPE Strategy Steering Group on 21st November ahead of presenting the final draft at the staff development and training event on 6th December (subsequently postponed).

Linda Goldsmith (Public Governor) welcomed the addition of ‘mind and body’ into the PPE strategy. She hoped ‘mind and body’ would be placed higher on the list of the strategy’s aims. The Patient and Public Engagement Specialist would pass on her feedback to the Patient and Public Engagement Manager.

The working group was assured that the strategy refresh would not dampen ambitions to carry out the membership strategy actions.

The Patient and Public Engagement Specialist would circulate the final strategy by email upon request once it had been launched at the staff event in December.
6. Proposals for 2018 governor elections

The Trust Secretary and Head of Corporate Affairs reminded the group that though elections were promoted through the regular communications channels, the Trust struggled to gain good voter turnout at governor elections.

Two proposals had been received for the 2018 governor elections from organisations who had facilitated previous elections for the Trust. Both organisations offered similar services at similar costs, though Mi-Voice could manage a mobile polling station on site to gain better response at the voting stage. The group agreed that this approach was worth exploring.

The group also agreed that the election period was a good opportunity for membership recruitment and engagement. Governors should be visible at events such as the Fit for the Future roadshows, and also hold events such as a ‘Governor Awareness Session’ ahead of the elections in 2018. Candidates standing for election should be encouraged to be more visible and could perhaps record candidate videos.

An election plan would be developed and presented at the next meeting. The Trust’s diversity team would also be invited to comment on the election plan to avoid unconscious bias.

7. Associate membership scheme

The Trust Secretary and Head of Corporate Affairs gave an overview of the Associate Membership scheme introduced at King’s College Hospital, where voluntary and community organisations were invited to become Associate Members of the Trust. The group agreed to wait to see if King’s College Hospital had made significant progress by the next meeting before deciding if it was worth exploring.
8. 2018 health seminar topics suggestions

The Membership and Governance Co-ordinator would send an email to governors who attended the working group meeting for their suggestions on topics for health seminars in 2018.

9. Any other business

There was none.

10. Date of next meeting

The next meeting would take place on Tuesday 20th February 2018.
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<th>Quality and Engagement Working Group report, 12th December 2017</th>
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<td>24th January 2018</td>
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<td>Decision</td>
<td>Author: Fatimah Vali</td>
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<td>Other* X Council of Governors</td>
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1. Introduction
This report details the meeting of the Quality and Engagement Working Group which took place on 12th December 2017 at the Education Centre, York Road.

2. Attendance
This meeting was attended by: Sarah Allen (Head of Patient Experience), Devon Allison (Lead), Andrea Carney (Trust Patient and Public Engagement Manager), Yvonne Craig – Inskip, Wendy Doyle (Head of Complaints), Ifeolma Egbuniwe (Patient Experience Information Officer), Jonathan Farley, Tom Hoffman, Alison Knox (Deputy Director of Quality and Assurance), Kate Griffiths-Lambeth (Chair), James Palmer, Mark Tsagli (Patient Experience Facilitator) Fatima Vali (Patient and Public Engagement Specialist)

Apologies were received from: John Chambers, Tony Hulse, Anita Marco, Darren Oldfield, Lucilla Poston, Vicky Rogers, Dr. Priya Singh (Non-executive Director), Jenny Stiles, Warren Turner

3. Notes from the last meeting
The notes were approved as an accurate record of the last meeting.
4. Complaints

The Head of Complaints gave a presentation on the updated Trust complaints process. The presentation highlighted the following work achieved and undertaken:

- A new complaints policy which sets out how complaints will be managed has been developed and;
- A review of how the policy could support staff to improve complaints management, which considered;
  - The accessibility standard (Mental Capacity Act, Learning Disabilities) – to ensure the complaints process is accessible to people who are least likely to complain and how to make it more accessible for them
  - Financial redress and when it is appropriate to offer financial compensation
  - A new escalation policy to address overdue responses and reduce the waiting time for a response or outcome
  - The appeals process under the Zero Tolerance Policy
  - The introduction of a vexatious policy for patients who are increasingly difficult in terms of harassing staff
- There are plans to upgrade Datix – the Trust’s complaints database. This will include reviewing its functionality to identify areas that can be improved
- The Head of Complaints is currently meeting with all Directorates to understand what they are finding difficult and how they can support staff better.

Governors commented or asked:
- Where complaints are directed to a service in the first instance, rather than the Complaints Team, how will we be sure that complaints wouldn’t be suppressed?
  - The Head of Complaints reassured that when a complaint comes in, it is triaged. A red flag is added if it is a serious complaint and is sent immediately to the related Directorate. The Complaints Team would review the response, and if it is not satisfactory it would be sent back to the Directorate and escalated.
There are multiple ways for patients to complain, which are publicised on leaflets, digital screens, posters and on the website.

- Governors also commented on the lack of consistency on services having an information board which provides information on how to make a complaint
- The Head of Complaints noted that all Directorates have been asked to review their service areas to see whether posters and information on how to make a complaint are clearly visible and accessible

The Head of Complaints invited Governors to take part in an exercise. Governors were given two versions of a written response to a complaint and they noted the following:

- If there is a failure in care or service delivery it is important to apologise from the outset
- Welcomed the fact that all response to complaints are reviewed and signed by the CEO
- The importance of the tone of the letter, which should be empathetic and personable.

The Head of Complaints noted the Trusts commitment to the Principles for Remedy recommended by the Ombudsmen.

Governors commented upon:

- Whether the Trust monitors if Directorates have made improvements following a complaint
- The need to ensure statutory governance is in place
5. Compliments

The Head of Patient Experience provided a summary on the different ways the Trust receives compliments from patients, carers and relatives. The following was highlighted:

- The Trust receives compliments from a wide range or sources. For example, wards regularly receive thank you cards or positive feedback is left via surveys. Feedback is also received via social media and from mystery shoppers
- Compliments are sent directly to Directorates, who are encouraged to share these with their teams
- Since the introduction of the yellow name badges, there has been an increase in the number of staff being named individually in the compliments received
- A recent positive feedback from a mystery shopper about their interaction with a receptionist has led to the receptionist acting as a role model for others and used as part of training other admin staff

Governors welcomed the different ways compliments are received by the Trust and commented upon:

- The positive practice examples of staff being a role model for training other staff
- The need for better consistency on notice boards showcasing the compliments received
- The need to continue to increase awareness of the different opportunities for patients to provide feedback.
  – Governors commented that although a number of them and their family have been patients of Trust services, in some cases they have not been invited to complete the Trust survey, including the Friends and Family Tests completed.
6. Patient Experience (PE) Report Update

The Head of Patient Experience summarised some of the highlights from Quarter 1 and 2 (March – August 2017/18) including:

- The Trust survey results are largely stable with some improvements
- The Trust has made a number of improvements in the National Cancer Patient Experience Survey since 2015. Patients tell us we are better at communicating the diagnosis in a more sensitive way, feeling treated with dignity and respect and report higher levels of confidence in our nurses
- There are still a number of areas that can be improved including provision of information and communication as well as information on the support groups available
- A Trust wide action plan is being created to address the improvement areas as well as individual action plans for tumour groups
- The Friends and Family Test remains challenging for A&E
- The Friends and Family Test in outpatient care is indicating in line with national performance and slightly better than other London Trusts
- Performance of maternity services in the Friends and Family Test for the antenatal, labour and birth touch points continue to be strong. However responses rates have been below target rate with a 12%-17% response rate, deemed due to the large turnover in maternity support workers
- Patient transport still remains challenge in terms of scores in recommending and feedback received

Governors commented upon whether it was necessary for the Trust to provide transport.

The Head of Patient Experience responded that many patients are too unwell to travel to hospital via public transport and require support from hospital transport to enable them to attend their appointments and the Trust. Patient’s needs are assessed according to guidelines and criteria set out by the Department of Health.
The Head of Patient Experience also highlighted the agreed patient experience priorities for 2017/18. Working in partnership with colleagues the priorities taken forward are:

- Improving patients and carers contact with the Trust and the response they receive. This will involve continuing to support The Digital Patient Journey Programme presented at September’s meeting with Governors.
- Ensure patients have adequate rest and sleep during their stay at the Trust. This involves continuing to promote the sleep packs as well as rolling out visual patient bedside stickers to help remind staff to keep noise at a minimum.
- Keeping patients informed and updated on waiting times in clinics. To this end, a small number of Directorates are developing toolkits to support staff on how to deal with challenging patients who may get aggressive.
- Providing patients and their families with information to support self-care and who to contact if they have a concern. This includes piloting a contact card which tells you what to do if you want to change your appointment or department.
- Working to also reduce the number of different version of outpatient letters used – they are currently 190 in use. They have now been cut down to 20 core templates to be used.

Governors commented upon:

- Making clinicians responsible for informing patients they are running late.
- Highlighting and congratulating that through a number of mystery shopper visits, it has been noted that a number of departments are doing very well.
- Whether we are doing better this quarter and whether there is a risk of survey fatigue among patients and carers.
7. Patient and Public Engagement (PPE) Update

The Trust Patient and Public Engagement Manager summarised the key points of the update report, noting:

activity:

- The Trust PPE Strategy is in the process of being updated following earlier discussions with staff, governors and a recent PPE Strategy Steering Group – the updated strategy will be published in early Spring 2018.
- The PPE team continue to support patient engagement in the Dartford and Gravesham Vanguard.
- The team is supporting Health Prevention and Early Intervention Services to develop plans to involve patients in the future delivery of smoking cessation services, taking into account reductions to public health funding. PPE Team continues to support the King’s Health Partners Mind and Body Programme in their efforts to recruiting an Expert Advisory Group, to include staff and service users.
- The Call Quality Assessor Report highlights that there has been a slight improvement in the performance of calls assessed, though some aspects of bringing calls to a close continue to be an area that needs improvement.
- In response to earlier Governors requests, the PPE Team continues to work with Dental Services to find a means of assessing the quality of telephone call handling – at present it is not possible to apply the telephone call centre technology to Dental Services telephones.
8. Quality and Safety Update: Quality Priorities

The Deputy Director of Quality and Assurance presented back the 4 overarching strategic quality goals prioritised following consultation with stakeholders. They are:

- Enable staff to deliver outstanding and inclusive patient and carer experience at every contact
  - care for the dying and their families/carers
  - deliver sensitive care to our most vulnerable patients and service users
  - staff feel valued, supported and safe
  - patient co-production and design

- Prevent avoidable harm and premature death and deliver internationally benchmarked best outcomes
  - reducing harms
  - infection prevention and control (including Sepsis)
  - preventing poor health (making every contact count)

- Deliver the best available evidence based care and reduce variation
  - patient access to treatment
  - medicines optimisation
  - age and place appropriate care

- Ensure effective governance supporting continuous improvement
  - learning from outcomes
  - (100%) procedural compliance
  - Mortality and morbidity governance
  - Full CQC and NHSI well-led compliance
9. Reports from committees (those attended by Governors)
The following notes highlight Governor’s feedback from the committee they are members of.

Quality and Performance Committee
No notes tabled

Adult Local Services Committee
No notes tabled

Children’s Services Committee
No notes tabled

End of Life Care Committee
- Yvonne Craig-Inskip reported on an end of life care resource folder produced by the End of Life Committee. It includes several best practice examples from lay people themselves
- The resource pack is split in different themed sections covering:
  - Caring for patients whose recovery is uncertain
  - Meaningful and relaxing experiences at the end of life care
  - Guidelines on assessment of spiritual needs
  - Guidelines on the use of specialist syringe pumps
  - Management of constipation
  - Trust protocol on dying – standardising how this is dealt with

10. Any other business
None

11. Date of next meeting
Tuesday 27th February 2018, Education Centre, York Road.
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<th>24th January 2018</th>
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<td><strong>Service Strategy Working Group report, 10th October 2017</strong></td>
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<td>Dan Price</td>
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1. Attendees:

Devon Allison (Acting Chair), James Palmer, John Porter, John Duncan, Vicky Rogers, Kate Griffiths-Lambeth, Jenny Stiles and Bryn Williams.

Martin Shaw (Director of Finance), John Pelly (Non-executive Director), Steve Townsend (Chief Digital and Information Officer), Darragh Twomey (IT Business Engagement Manager) and Dan Price (Strategy Manager) attended from Guy’s and St Thomas’.

Apologies were received from Giles Taylor, Jackie Parrott, Ian Abbs, John Chambers, Lucilla Poston, Linda Goldsmith, Darren Oldfield and Thelma Bangura.

2. Notes of the previous meeting and matters arising

2.1 The notes of the meeting held on the 4th of July were approved as a true record and it was noted that the Service Strategy Working Group dates for 2018 had been set.

3. Business and Financial planning 2018/19

3.1 Martin Shaw opened the presentation by highlighting that this presentation was based on the one given at the Board away day in the previous few weeks. This financial year the Trust started with a £90M gap, we received some support from regulators but there were other cost pressures which meant the total financial target was £99M. The Trust is behind plan by £19.5M, the Trust knew it would be behind plan but not to this extent. However this figure is stabilising and improving.

3.2 The Trust is monitoring the cost improvement programmes and we have reduced the gap of unidentified cost savings down to £14M. This has been helped by an increase in centralised initiatives, but these are not recurrent savings and the budget will have to be rebased. There are three reasons that the Trust needs to hit
the saving targets; if we don’t we won’t get the Sustainability and Transformation Funding, a deficit would be unhelpful for securing capital projects and once you get into a deficit providers almost never get out of that position.

3.3 The background to this plan was that we signed up to a two year financial plan with NHS Improvement and NHS England, and so in 2017/18 the Trust is aiming for £10M surplus including sustainability and transformation funding, which the Board have confirmed and means that £99M is the required financial target for next year. We are told that there are no further planning guidance for this year so sticking with the assumptions from the previous year on inflation and QIPP. If we are able to identify recurrent savings options this year we won’t be adding to the 2018/19 control total, however if saving actions are non-recurrent this will add to the 2018/19 control total. There are further costs pressures we have to consider too such as commissioner affordability and generic inflation cost in items such as CNST, Brexit and other risks in the system.

3.4 Business planning will be launched across the Trust on the 2nd of November. If we can’t achieve the financial targets for this year that may affect the savings target required for 2018/19 and put us in a more difficult position. The Board agreed to aim at a breakeven position and deal with any additional saving requirements at risk. We are using more data to help us benchmark against other organisations like Carter and model hospital to identify savings opportunities. This is because we are looking to increase our efficiency but also because we expect greater challenge from the regulators on these figures, even if we don’t completely subscribe to them.

3.5 The Trust is considering a few different approaches this year. One is whether we pass income growth through to Directorates which might limit post growth and cost, and then redistribute the income from growth later. We are also considering that we may need to go externally for capacity to meet the demand from patients if there is no capital for facilities.

During questions and discussion the following was highlighted:

- The governors asked whether there were any particular concerns about line items in the cost improvement programmes. Martin indicated that there weren’t any in particular. The Trust has taken action with three
directorates who have problems, each for different reasons, to provide them with more support and bring them back into hitting their targets. The Trust is taking a positive approach and if it achieves the vast majority of the savings target it will have done well. It is then the Board’s responsibility to worry about what to be done with the amount that isn’t achieved.

- The Trust is pursuing multiple angles to secure the savings target, such as chasing all the income from debtors and encouraging all staff to take holiday so it can minimise it’s the Trusts holiday accrual. The Trust is telling the directorates that they have to go for the maximum because the range of central financial solutions is reducing.
- If the budget announces pay increases, the Trust will have to save an extra £9M per annum for every percentage point increase in pay. However this won’t be an issue if these pay increases are funded from government rather than Trusts being expected to find the additional funding required.
- There is interest in government in implementing the Capped Expenditure Process but that would be asking the impossible in south east London given King’s and Lewisham’s position and the regulators do recognise this.
- Martin explained the balance between the purchaser and provider split in dealing with income growth and the recognition that the commissioner has to be able to afford the increase in activity or the Trust does work at risk and needs to rely on its reserves to undertake additional work. This can create disincentives which the Trust wants to avoid and so the Trust is trying to work collaboratively with commissioners and other providers to move money around organisations so activity is done in the right places with the best outcomes for patients and taxpayers.
- Every year the Trust recruits an additional five to six hundred more staff which equates to a £40M-£50M increase in costs, so we closely monitor the number of posts that we have in Trust. However it’s the number of staff that are actually in post which is the key number because factors like vacancy rates and turnover come into the calculation. We maintain safe staffing levels but these factors mean the increase in staffing levels doesn’t have the level of impact that would be expected on a summary overview of the increase in recruitment.
- It is hard to predict the impact of Brexit at this point, there’s nothing concrete to plan on at the present time. We have seen a few price hikes because of the exchange rate changes.
4. Digital Strategy

4.1 Steve Townsend and Darragh Twomey joined the meeting for this item. Steve gave an overview of the Trust’s developing digital strategy. The Trust is thinking about how it can increase its use of data with the organisation and enabling working differently and stop silo working. Issues such as the increasing generation and use of data, as the costs of hosting it are dropping dramatically while new ways to use that data, like machine learning, are becoming more commonplace mean the Trust needs to adjust its approach to the digital agenda. The Trust needs to be in a position to collect and use that data to turn it into useable information to drive decisions.

4.2 The Trust needs a digital step change and this is recognised that we need to make sure that the standards and technology work together to meet the needs of the Trust. The strategy also sets out that we need to consider the opportunities and how we link digital to other developments, for example Julie Screaton is starting to talk about a digital workforce. The digital change won’t take away from the clinicians, it might change how we select which patient undertakes what procedure but it won’t do away with the need for the clinician to apply the right pressure on the scalpel.

4.3 A digitised approach to our services will help us remove silos but we need to ensure that we have the right expectations, skills and expertise to provide better care for patients. The Digital Patient Journey is already starting to do this and help patients take control of their data and determine who should have access to it. Patients don’t get sick in the right place, but our ambition is to get the data to the right place.

4.4 To get to the digital outcome we want it requires a three stage process: establish, implement and embed. The Board signed off the Electronic Health Record Strategic Outline Care on the 27th of September. The next step is to determine what options we want first and then consider the transformation we want, not just the automation opportunities. The Trust is also reviewing the governance as we don’t think it’s quite fit for purpose yet.
During questions and discussion the following was highlighted:

- That the approach to digital within the Trust will need to produce an outcome that is both accurate and fast, but we have to match that with what is available and useable by the Trust. There are understandable concerns about data quality but there are lots of tools to find faults and improve that situation. The data will also need anonymising and the creation of patient tokens to decrypt that data for use.
- The Trust hasn’t yet decided on what its patient digital contact strategy is and this will be developed over the coming months. This will take time in the future to build up the relationships with patients on how their data is used and we can’t just start at blanket permissions. We should be influencing the development of the national health record and the how data is used. This could lead to using healthcare data to change how we deliver care and might allow us to look at options like preventative healthcare in the future.
- There is significant amount of digital talent within the organisation and the Trust needs to provide guiderails for the staff so that we channel the digital conversations along the digital journey – from reporting to analysing. One of the other risks we want to avoid is silos in digital development. The Trust is planning to put together a clinical reference group which would be a community of 100 associates from across the Trust to ensure that changes work across the organisation. The Trust is also working out how best to connect and involve patients as part of this process too.
- One of the major challenges for the Trust is effectively using the data we already have. If we were able to utilise the data we’ve got then the Trust will be in a strong position to take full advantage of the digital agenda.

5. Any other business

5.1 There was no further business and the next meeting was confirmed for 16\textsuperscript{th} of January 2018, 5.30pm to 7pm at York Road.
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This paper is for:  
- Decision  
- Discussion  
- Noting  
- Information  

Sponsor: Corporate Affairs  
- Author:  
- Reviewed by:  
- CEO*  
- 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. We would like to encourage governors to continue to raise questions.

**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

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<td>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 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</td>
<td>16/0022 2016-12-20 (Tony Hulse)</td>
<td>The Trust recognises that there is a problem with delayed appointments, in particular with follow up appointments. This was recently reported to the Trust Management Executive (TME) and in doing so it has subsequently been added to the Trust’s Risk Register as a “High” risk. In response to this, in September the Trust commissioned a full review to be undertaken in order to ascertain all of the contributing factors behind the Delayed Appointments. This analysis has now been completed and the findings were presented in a paper to the Commissioners via the Clinical Quality Review Group Contract Board meeting in October. The Trust will address all the concerns identified in the paper as a formal programme of work and so a Programme Manager has now been appointed to lead on this going forward. The key areas that will be addressed under this Delayed Appointments programme of work will be: - People/Training - Processes - Systems</td>
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| 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 capacity issue and those that cannot. This would not be hard. I would be interested in the Trust response to these comments. | - Management Information  
- Backlog Validation and Clearance  
A working group has been established to scope the detailed work that needs to be completed for each of these work streams and this scoping exercise is expected to be completed by the end of December. The issues identified in your question will be addressed under the Processes work stream and work will commence in each these work streams early in Q4. A formal paper documenting the analysis and work completed to date, recommending the proposed way forward to address the key issues will be presented to TME in December.  
(23-11-2017) | | |
| 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?  
**Problem Statement:** The lab is facing some lapse in service from the Royal | 16/0016  
2016-07-28  
(Heather Byron) | The Head of Nursing for Children's Medicine & Neonatology responded as follows:  
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 | Further update has been sought. | |
### Matters of interest/question

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<td><strong>Mail around a business delivery service that is in place for the prompt delivery of newborn screening / monitoring blood spot tests.</strong> 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 can't be read in the lab.</td>
<td><strong>Context / Risk:</strong> 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 hadnt been returned and</td>
<td>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.</td>
<td>Thank you again for sharing this with us. <em>(26-08-2016)</em></td>
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therefore a further test taken. I fear, more often than not, it would be missed for some time, which could have medical and/or quality of life implications.

**Whats next:** There are a number of things which could happen to support the labs in dealing with the problem so that the service becomes reliable and they are spending valuable time chasing RM.

- develop a simple, consistent escalation process to Royal Mail (admin driven not lab driven) so that we are consistent in our escalations and have a clearer audit behind us of the issues encountered (this could be a simple form on the portal for example)
- as part of the wider Royal Mail relationship drive some escalation discussions (the sense is that in isolation this isn't 'important enough' to deal with by the RM.
- review whether Royal Mail is the right partner to be responsible for the delivery of such important blood samples

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_Council of Governors meeting, 24th January 2018_  
_Questions and answers_
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<td>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 not be... not to mention the slightly unreliable nature of the service. I am very happy to support any next steps, but wanted to share with you for your guidance as to whether this is something we are at liberty to raise awareness to and have the possibility to help resolve?</td>
<td>16/0011 2016-06-22 (John Porter)</td>
<td>The Trust commissioned PWC, following a tender process, to perform a six week diagnostic study to identify and quantify in year savings opportunities for the Trust in 2016/17. The report shows a number of cost saving opportunities over and above existing savings schemes. PWC and the Carter team have provided benchmark data demonstrating potential efficiency savings for the Trust when compared to other similar service providers. This output forms part of the continuing cost improvement plan.</td>
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<td>The CEO says that there is a programme of work underway by the Medical Director to address &quot;hospital at night concerns&quot;. What progress I wonder? I realise how difficult it is to control events at night in a busy hospital, but I have had recent experience of unnecessary noise at night in the wards</td>
<td>2014-04-29</td>
<td>Hospital at Night is about the clinical operating model for looking after patients out of hours. We are currently looking at the future clinical model that will be required at GSTT and the implications this will have for our workforce, given activity changes and the anticipated shift towards a 24/7 care model at a national level.</td>
<td>A further response/update has been sought.</td>
<td></td>
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