Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Council of Governors Meeting
18 July 2024

Agenda and papers

St George's University Hospitals
NHS Foundation Trust

Council of Governors

Agenda

Meeting in Public on
Thursday, 18 July 2024, 14:00 – 16:30
Wandsworth Professional Development Centre, Building 1, Burntwood School, Burntwood Lane, SW17 0AQ and MS Teams

Feedback from Governor visits					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
14:00	-	Feedback from visits to various parts of the site	Governors	-	Verbal

1.0 Introductory items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
14:15	1.1	Welcome and Apologies	Chairman	Note	Verbal
	1.2	Declarations of Interest	All	Note	Verbal
	1.3	Minutes of previous meeting	All	Note	Verbal
	1.4	Action Log and Matters Arising	All	Note	Report

2.0 Strategy					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
14:20	2.1	Group Chief Executive's Report	GCEO	Update	Report
14:40	2.2	Strategy Update	GDCEO	Update	Report

3.0 Quality and Performance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
14:55	3.1	Independent maternity governance review	GCNO/GCMO	Note	Report
15:15	3.2	Emergency Department Pressures	GCNO/GCMO	Discuss	Report
15:30	3.3	SGUH Operational Performance (including Theatre utilisation)	GDCEO	Discuss	Report

4.0 Finance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
15:50	4.1	Finance Update	GCFO	Discuss	Report

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5.0 Governance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
16:00	5.1	Annual Report from External Auditor on Annual Accounts	GCFO	Receive	Report

6.0 Membership Engagement					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
16:10	6.1	Report from the Membership Engagement Committee	Committee Chair	Inform	Report
16:20	6.2	Annual Members' Meeting 2024: Planning	GCCO	Note	Report

7.0 Closing Items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
16:25	7.1	Any Other Business	All	Note	Verbal
	7.2	Council of Governors Forward Plan	All	Note	Report
	7.3	Reflections on Meeting			

St George's University Hospitals
NHS Foundation Trust

Council of Governors Purpose	The general duty of the Council of Governors and of each Governor individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

Membership and Attendees		
Members	**Designation**	**Abbreviation**
Gillian Norton	Trust Chairman	Chairman
Nasir Akhtar	Public Governor, Merton	NA
Afzal Ashraf	Public Governor, Wandsworth	AAs
Padraig Belton	Public Governor, Rest of England	PB1
Alfredo Benedicto	Appointed Governor, Merton Healthwatch	AB1
James Bourlet	Public Governor, Rest of England	JB
Sandhya Drew	Public Governor, Rest of England	SD
James Giles	Public Governor, Rest of England	JG
John Hallmark	Public Governor, Wandsworth	JH1
Chelliah Lohendran	Public Governor, Merton	CH
Atif Mian	Staff Governor, Allied Health Professionals and other Clinical and Technical Staff	AM1
Lucy Mowatt	Public Governor, Wandsworth	LM
Augustine Odiadi	Public Governor, Wandsworth	AO
Jackie Parker	Public Governor, Wandsworth	JP
Abul Siddiky	Staff Governor, Medical and Dental	AS
Khaled Simmons	Public Governor, Merton	KS
Huon Snelgrove	Staff Governor, Non-Clinical	HS
Ataul Qadir Tahir	Public Governor, Wandsworth	AQT
Stephen Worrall	Appointed Governor, Wandsworth Council	SW
In Attendance		
Ann Beasley	Non-Executive Director, Vice Chair	AB
Jenny Higham	Non-Executive Director	JH
Yin Jones	Non-Executive Director	YJ
Peter Kane	Non-Executive Director	PK
Andrew Murray	Non-Executive Director	AM
Sarah Forester	Appointed Governor, Healthwatch Wandsworth	SF
Tim Wright	Non-Executive Director	TW
Tara Argent	Chief Operating Office - SGUH	TA
Andrew Grimshaw	Group Chief Finance Officer	GCFO
Richard Jennings	Group Chief Medical Officer	GCMO
James Marsh	Group Deputy Chief Executive Officer	GDCEO
Victoria Smith	Group Chief People Officer	GCPO
Arlene Wellman	Group Chief Nursing Officer	GCNO
Patricia Morrissey	Head of Governance	HoG
Apologies		
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Patrick Burns	Public Governor, Merton	PB2
Dympna Foran	Staff Governor, Nursing and Midwifery	DF
Julian Ma	St George's University of London	MA
Georgina Simms	Appointed Governor, Kingston University	GS
Kate Slemeck	Managing Director - SGUH	MD-SGUH
Stephen Jones	Group Chief Corporate Affairs Officer	GCCAO

St George's University Hospitals NHS Foundation Trust

Minutes of the Meeting of the Council of Governors (In Public)
Wednesday 22 May 2023, 18:00 – 20:30
Hyde Park Room, Lanesborough Wing, St George's Hospital
and via Microsoft Teams

Membership and Attendees		
Members	**Designation**	**Abbreviation**
Gillian Norton	Trust Chairman	Chairman
Padraig Belton *	Public Governor, Rest of England	PB1
Alfredo Benedicto	Appointed Governor, Merton Healthwatch	AB1
James Bourlet	Public Governor, Rest of England	JB
Patrick Burns *	Public Governor, Merton	PB2
Sarah Forester	Appointed Governor, Healthwatch Wandsworth	SF
Dympna Foran	Staff Governor, Nursing and Midwifery	DF
John Hallmark	Public Governor, Wandsworth	JH1
Chelliah Lohendran	Public Governor, Merton	CH
Augustine Odiadi	Public Governor, Wandsworth	AO
Abul Siddiky	Staff Governor, Medical and Dental	AS
Khaled Simmons	Public Governor, Merton	KS
Georgina Simms	Appointed Governor, Kingston University	GS
Huon Snelgrove	Staff Governor, Non-Clinical	HS
Sandhya Drew	Public Governor, Rest of England	SD
Ataul Qadir Tahir *	Public Governor, Wandsworth	AQT
In Attendance		
Ann Beasley	Non-Executive Director, Vice Chair	AB
Jenny Higham *	Non-Executive Director	JH
Yin Jones *	Non-Executive Director	YJ
Andrew Murray	Non-Executive Director	AM
Tim Wright *	Non-Executive Director	TW
Richard Jennings	Group Chief Medical Officer	GCMO
Stephen Jones	Group Chief Corporate Affairs Officer	GCCAO
James Marsh	Group Deputy Chief Executive Officer	GDCEO
Angela Paradise	Group Chief People Officer	GCPO
Stephanie Sweeney	Site Chief Nurse, St George's Hospital and Group Director of Quality and Safety Governance	GSQSG
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Arlene Wellman	Group Chief Nursing Officer	GCNO
Patricia Morrissey	Interim Deputy Director of Corporate Affairs	IDDCA
Apologies		
Julian Ma	St George's University of London	MA
Afzal Ashraf	Public Governor, Wandsworth	AAs
James Giles	Public Governor, Rest of England	JG
Jackie Parker	Public Governor, Wandsworth	JP
Lucy Mowatt	Public Governor, Wandsworth	LM
Stephen Worrall	Appointed Governor, Wandsworth Council	SW
Peter Kane	Non-Executive Director	PK
Atif Mian	Staff Governor, Allied Health Professionals and other Clinical and Technical Staff	AM1
Nasir Akhtar	Public Governor, Merton	NA

** Joined the meeting via MS Teams*

	Feedback from Governor visits	Action
	Feedback from visits to various parts of the site A number of Governor visits had taken place in April and May with existing and new Governors. John Hallmark (JH) and Chelliah Lohendran (CL) had visited Lanesborough Outpatients; St James' Outpatients; Cardiac Outpatients and Neurology Outpatients on	

	9 May 2024. During the visit to the Lanesborough out-patients the Matrons had noted that the area could become very busy as patients waiting for clinical appointments were waiting in the same area as those accessing phlebotomy services and had asked whether it would be possible to move phlebotomy to another area. The GCNO noted that she and the GCMO had also undertaken a recent visit and had heard the same request and unfortunately due to estate constraints it would not be possible to move phlebotomy. However, the number of patients waiting in the area had reduced as a result of introducing appointments for phlebotomy services. AS noted how impressed he was with the clinical areas visited and in particular the impressive efforts of the maternity team in providing a dedicated environment for those experiencing loss, separate to the waiting area, which they had done of their own accord and of which they were rightly very proud. It was during this visit that he had become aware that there was no dedicated space for gynaecology in-patients and that patients were scattered across different wards. The GCEO reminded Governors that as part of the efforts to address the actions during the period when the Trust was placed in special measures, relocating the renal unit out of the Knightsbridge Wing had impacted on the gynaecology ward. While there weren't enough day patients to warrant a dedicated gynaecology ward, she agreed that there should be a dedicated space available for gynaecology patients and that she would speak to the MD-SGUH about what might be possible. Sarah Forester (SF) provided feedback on her recent experience of Trust services as a carer and reflected that the service provided by the endoscopy team had been fantastic. However, the appointment letter issued by the Trust was too long and not in plain English and could be improved. The GCEO flagged that the Trust was using the NHS App and encouraged its use, while acknowledging that not all patients had access to a smart phone. The Chairman noted that a patient group was scheduled to review Trust letters and that there was an opportunity for Governors to be involved in this work, if available. The option to prioritise this work in a difficult year would be explored outside the meeting. JH1 noted that he had undertaken a night-time visit on 10 April 2024 along with CL, Khaled Simmons (KS) and Dympna Foran (DF). During this visit Governors had spent time with the Critical Care Outreach Team (CCOT) and the Site Management Team as well as visiting the Emergency Department (ED) and the Acute Medical Unit (AMU). Governors had found the hand-over with the Site Management Team to be informative. The visit to ED had been very quiet but it was noticeable that there were a number of patients with mental health issues in the department. DF highlighted that during discussion with CCOT it was noted that there had been no increase in resource capacity to address the introduction of Martha's Rule and she didn't get a strong feel for the Trust's strategy in managing sepsis and escalating concerns quickly. In response, the GCNO noted that the Trust had successfully bid for extra funding related to Martha's Rule and was in the process of working through what the Trust required in order to meet the new requirements, which would also include a detailed communications plan. The GCMO informed Governors that there was a major programme of quality improvement related to sepsis and that there were criteria for assessment and escalation protocols in place, which were underpinned by an education programme. However, he acknowledged that Sepsis was one of the biggest risk areas for the Trust and that the Trust was not complacent and there was always more that could be done. HS informed Governors that there was on-going permanent work with education regarding Sepsis and he was working with the CCOT and Resus teams around Sepsis particularly for newly qualified band 5s coming into the organisation. With regards to Martha's Rule and discussions with the CCOT team, the data shared from the pilot studies indicated only an extra 2-3 calls would be received per week.	**GCEO** **GCEO**

1.0	OPENING ADMINISTRATION	Action
1.1	**Welcome and Apologies** The Chairman welcomed everyone to the meeting, both those attending in person and those joining remotely via videoconference. Georgina Simms was warmly welcomed to her first meeting of Council. The Council of Governors noted the apologies as set out above.	
1.2	**Declarations of Interest** The updated register of interests of the Council of Governors had been circulated with the papers. There were no new declarations of interest.	
1.3	**Minutes of the Public meeting held on 20 March 2024** The minutes of the meeting held on 20 March 2024 were approved as a true and accurate record.	
1.4	**Action Log and Matters Arising** The Council of Governors reviewed the action lo and , agreed to close those actions proposed for closure – COG260723.3; COG221123.2 and COG200324.1.	
2.0	**STRATEGY**	
2.1	**Group Chief Executive Officer's Report** The GCEO presented her new style report, which was taken as read, and highlighted that the national team had challenged Trusts on emergency care performance in March. The top 10 best performers in the country for ED would receive £2m in capital funding and she was pleased to report that SGUH had been allocated £2m in light of its improved performance. SF highlighted that cancer wait times were not being met and asked about those patients waiting 52 weeks or longer. In response, the DGCEO clarified that there were 19 patients waiting longer than 65 weeks with a national ambition to eliminate this number by September 2024, which the Trust was on track to deliver. There were 614 patients waiting over 52 weeks which had increased since March with an ongoing focus on gynaecology and dermatology cases. With regards to treatment, the Trust was not achieving the 62-day cancer standard but it was exceeding the national target of 70% and performing well nationally. The most challenged areas were gynaecology and breast cancer. SF queried whether the challenged areas gave rise to health inequalities impacting female patients. The DCEO noted that gynaecology was a challenged area nationally and that SGUH was working in association with the Royal Marsden on a recovery action plan for both breast services and gynaecology. The Chairman noted that breast screening was a commissioned service and that discussions with partners were required as the Trust could not easily deal with the challenges related to this service on its own. Governors supported the new style report from the GCEO which helpfully reinforced the Trust's strategic aims. The Council noted the GCEO report.	
2.2	**Strategy Update**	

	The GDCEO presented the six monthly update on local improvements, corporate enablers and strategic initiatives as read, and highlighted that the focus was now on delivery of the strategy and the corporate priorities for 2024/25 which had been agreed by the Board. The financial challenges faced by the Trust meant that there was limited resource to invest in strategy deployment. KS noted that the paper helpfully reinforced the strategy a year on since its launch but reflected that it would have been even more helpful if 1 or 2 metrics had been included. In response, the GDCEO agreed and explained that the IPQR would be refreshed to link with the ambitions in the strategy. SF noted that as with any transformation work it would be important to consider the impact of changes on all different groups. The GDCEO noted that the Trust was mindful of ensuring that it did not create any inequalities in its programmes of work, and that in relation to the work on electronic patient records this was for operational use within the Trust, and was not a digital interface with service users. However, SWL was supporting the Trust with having a digital interface for those patients that want to access services via the NHS App. The GCEO noted that the NHS App was getting more coverage and the Trust was sign posting patients to use it but accepted that there would be circa 20% patients who were not technically enabled and that the Trust would support these patients in its use, as required. The GDCEO noted that the use of digital services could actually provide an opportunity to reduce inequalities eg people in low paid employment can access services digitally, reducing the time away from work, which would be less of a barrier. The GCMO also noted the example of ESTH which was delivering virtual out-patient appointments to prisoners who had found it difficult to access services in person given the additional complexities with travelling to site. JH noted that it would be helpful to have an update on estates and facilities and asked if there were still plans to demolish the Lanesborough Wing. The Chairman noted that there was an ambition to bring an updated paper to the meeting but that the shortage of capacity in the estates team meant that this had been added to the schedule of meetings for a future date. She also noted that a visit to the site of the new Intensive Care Unit would be arranged. In response to a query from JH regarding the renal build, the GDCEO noted that the process had been slow, while the outline business case had been approved and the Treasury had approved a quantum of money, the full business case was still in the process of being drafted. The GCEO noted that Mark Bagnall had been appointed as the substantive Group Chief Facilities, Infrastructure and Environment Officer and was due to start work full-time from August. While capacity in the team was a challenge, a light-touch report would be prepared for the Governors July meeting alongside the visit to the IC site. In response to a query from SD regarding how strategic collaboration with City University met the objective of developing our workforce and whether there was a formal partnership document with St George's University, the DGCEO noted that merger of City University London and St George's University of London offered a fantastic opportunity for the co-design of integrated healthcare education programmes for the healthcare workforce across the country. JH echoed the opportunities not only for healthcare professionals but for health sciences and research. The Chairman suggested that a separate session could be scheduled to further explore the benefits of the merger. She also noted that there was no single document that outlined the relationship between the Trust and the University and that there were a number of documents that covered specific aspects. JH noted that the Trust had very formalised relationships around education and research and that there was a specific contract for staff which amounted to millions of pounds which was subject to external review. The Chairman noted that the merger offered an opportunity to formalise the relationship within a single document.	**DCFIEO**

	AB1 welcomed the collaboration with local partners and asked about the scope of the initiative to make the discharge process more efficient. The GDCEO explained that a multi-pronged approach would be taken including, discussions with Merton and Wandsworth Councils to reduce the bureaucracy around care packages for those patients ready for discharge as well as specific measures within the Trust such as speeding up clinical decision-making to make patients medically stable and ready for discharge earlier. The challenge of working with local partners was not underestimated and a piece of work was underway to explore the barriers to optimise the interfaces between health and social care. As there was no additional money to resolve the issue, the only answer was to transform the way that care is delivered. The Chairman noted that it was important to get upstream of health issues and that the ICB had a role in this regard to reduce preventable ill-health and thereby reducing the demand for services within acute hospitals. The Council noted the Group Strategy Update report.	
3.0	**QUALITY AND PERFORMANCE**	
3.1	**Patient Safety Incident Response Framework Update** The GCNO introduced the paper which provided an update on the progress with the transition to the Patient Safety Incident Response Framework which would shortly replace the current Serious Incident Framework (SIF). The GCMO highlighted that the SIF had been very structured and transactional and there was a view that it had done little to improve patient safety and that the case-by-case approach hadn't shaped systems and processes as it should do. PSIF handed back responsibility to the Trusts to decide which cases required in depth investigations and which ones required a thematic rather than individual approach. However, one of the main challenges with the move to PSIF was not to lose oversight of individual cases. AM reminded Governors that the Quality Committee had oversight of SIs and would receive regular PSIF reports. The last report to the Committee had updated on the progress with transition which had been slower than expected, although part of this was deliberate to phase the introduction and learn along the way. The Committee had had a detailed discussion on what it would like to see going forward in order to gain assurance including detailed information on themes, demonstrable action taken and measuring the impact that actions were having to prevent future reoccurrences. At its June meeting the Committee would consider examples of incidents and themes that had been through the PSIF process so that it could take assurance that the actions taken were having the impact to address the issues raised. HS noted that staff were dispirited with the lack of listening to repeated escalations and datix reports and asked what assurances there were that historical issues of escalation fatigue would be addressed in the new system. In response AM stated that the new system wouldn't necessarily fix those issues but that the Quality Committee would be looking for assurance that working in this different way would deliver something different. There would be different ways to triangulate how PSIF was working and the link to outcome measures and actions would also capture 'soft' data around how staff felt they were heard. The Chairman noted that in some cases where concerns were raised by staff, the concerns were heard but the issues were not always easy to fix eg IT issues and budgetary constraints and that communications back to staff had not been clear enough about what action was possible. It was the therefore the lack of communication which may have given rise to the perception of not being heard. The GCMO noted the 'listening' issue was broader than PSIF and that there were times that the Trust had not listened properly to concerns raised and had not protected whistleblowers. HS noted that staff were in a catch 22 position when raising systems issues as there no means to address them. The Chairman agreed and that despite relentless prioritisation there just wasn't the money to fix all the issues. The GDQSG flagged that the new system would not just look at the harm caused to patients but would	

	also consider the impact and moral injury caused to staff and reiterated that staff voices would be heard as part of the weekly PSIF review meetings. KS noted his longstanding concerns about whether there was the management competence in the organisation to deliver the measures of evidence of learning that should have been embedded – this was a concern under the SIF and remained a concern with PSIF, particularly as only 25% of those that most needed the PSIF training, medical and dental staff, had not yet completed their training. AM agreed that the Quality Committee would be looking for the assurance that KS outlined but considered that there was the level of management competence in the organisation, but that in the past there might not have been the focus on demonstrating that actions were having the desired impact. The Quality Committee would have the same level of oversight of PSIF and the opportunity to see the evidence that safety actions were embedded. KS noted that the greater discretion with the new system might lead some to view an opportunity to do less and that it would be helpful to have anticipated this possible issue and address how we will ensure that the risk around this does not materialise. The Chairman noted that the Board was also worried about risk and had spent time considering it. RJ noted that with regards to the recent CQC report into Maternity Services, the report had highlighted that avoidable harm was being reported but events considered by mothers to have caused harm were not reported as such and should have been based on the impact on the mothers. He was confident that this had been addressed and that incidents considered by mothers to have caused harm were now reported as such and that he and the GCNO were seeing these incidents reported in their weekly updates. He noted that the equivalent work may need to be done in other areas and the risk was recognised. With regards to learning from never events, he noted that the actions related to the recent cases of wrong site surgery in dermatology had taken time to embed and that further events had occurred as not all the actions required had been anticipated at the outset and that subsequent new actions were required. However, there were other areas that had major quality issues where sustained improvement was able to be demonstrated and that Cardiac Surgery was a prime example of this with the department now leading nationally in some key areas. The GDQSG also noted that there was the opportunity to share and embed learning across SWL rather than just within the Group. In response to a query from SF regarding patients and carers, the GCNO reiterated that PSIF focussed on harm from the patient and carer perspective and not just the healthcare provider perspective. The Chairman noted that demonstrating learning was a national issue and was likely to be impacted by the pressures of working within the challenged NHS environment. The Council of Governors noted the progress toward implementation of the Patient Safety incident Response Framework by June 2024.	
3.2	**Quality Priorities 2024-25** The GCNO introduced the paper setting out the proposed annual quality priorities for the Trust which would be considered in detail by the Quality Committee at its next meeting. The number of priorities had been deliberately kept small to focus on key areas aligned to the Group Strategy. KS queried whether the measures detailed in relation to PSIF, ED flow and Treatment Escalation Plans were meaningful. With regards to the reduction in the number of cardiac arrest calls, the GCNO agreed that the wording should be revised to make it clearer that it was about early escalation leading to a reduction in cardiac arrest calls. With regards to Treatment Escalation Plans the GDCEO flagged that it would be important to have discussions with patients regarding the ceiling of care and that the	**GCNO**

	measure for reducing the number of cardiac arrests calls would be an appropriate measure as some of these patients would not wish to be resuscitated. JH1 queried whether the priorities were for 23/24 or 24/25 and highlighted a number of typographical errors in the paper relating to the dates. The GCNO confirmed that the priorities were for 24/25 and that there were typos in the report where the year had not been updated. While the Trust was already 2 months into the 24/25 financial year, it was working in line with the submission dates for agreeing the 24/25 annual priorities. With regards to ED flow, the Chairman noted that 2 of the targets were set by Government but that further consideration would be given to the measures set out ahead of the Quality Committee. The Chairman noted that the Executive team had been under intense pressure over the prior 8 weeks focussing on the Trust's financial position and agreeing the budget and plan for 24/25. The GCMO assured Governors that both he and the GCNO were focussed on patient safety and quality and that there was no amount of financial pressure that could make them forget that. The Council of Governors noted the Quality Priorities for 2024-25.	**GCNO**
4.0	**People**	
4.1	**NHS Staff Survey 2023** The GCPO set out the key findings from the St George's results, including key areas of strength and challenges and highlighted that: • 3644 members of staff had taken part in the survey, this was a 38% response rate down from 48% the previous year. • Many staff were working unpaid overtime with only 40% of staff reporting that they don't work any additional unpaid hours per week. • 72% of staff who experience physical violence reported it. • 6 People Promise themes were scored below the National average. • All 4 responses to compassionate leadership questions were below the national average and there would be a key focus to help line managers be good managers. • All 4 responses to diversity and inclusion questions were below the national average and the Board had recently considered the new Equality and Diversity Strategy and was focussed on how the Trust could be a fair and inclusive employer where staff feel that they belong and can speak up. • All teams and divisions were currently considering their in-depth results and would report back to HR in May and June so that an action plan could be drawn up. HS noted that 50% of staff reported that they would not speak up when there was a patient safety concern and that this was astounding when so much work had been done on psychological safety. AB1 added that the Trust had previously recognised issues with raising concerns and had put in more resources to support staff and clearly more needed to be done. KS noted that the metrics were not presented in the most helpful way eg 3/4 of responses were significantly worse than the national average and more than half of staff responded that they did not have adequate materials, supplies and equipment to do their work and yet there was no action attributed to it. The Chairman noted that there was no pleasure to be taken from the Survey results and that it was right for Governors to challenge on the results. She reminded Governors that	

	the Interim GCPO had a difficult task in holding together the HR function which required huge amounts of support and leadership. While the Trust would continue to focus on the 'Big 5' it would be the quality of leadership and management in teams that would ultimately move the dial in terms of more positive results. YJ noted that the People Committee had been disappointed with the low response rate and participation would be encouraged going forward with the aim to improve the rate in 2024. The Committee had also spent a long time discussing the results and had looked at the higher performing teams with the aim to encourage best practice. The People Committee had also asked for quarterly updates on EDI in order to track progress being made and the EDI strategy was a sub-strategy of the People Strategy. YJ also highlighted that she is the named NED for Freedom to Speak Up (FTSU) and met regularly with the responsible officer for FTSU and was kept abreast on progress being made. AP noted the results had helped the Trust to shape both its People strategy and EDI strategy and it was looking at ways to help staff to be able to raise concerns. There was a large cultural aspect to staff feeling safe to speak up and it was an HR priority to assist with improving the culture within the organisation. In response to a comment from DF regarding improving the confidence of staff to speak up, the GCCAO noted that the 'Safe to Speak Up' campaign launched in September 2023 which was separate to the FTSU service came too late to have an impact on the 2023 Staff Survey results and while a big impact wasn't expected in the 2024 results there were efforts taking place to triangulate multiple sources of data to identify those services that may require an intervention. Communicating with staff so that they are able to see where staff have spoken up and changes have occurred was also a key focus but it would take time to convince staff that speaking up wouldn't impact negatively on them. He also updated Governors on the restructure of the Freedom to Speak Up service which was now being managed on a group-wide basis and was already starting to have an impact. AM noted that the Quality Committee also had responsibility for quality concerns raised within its remit. In response to a comment from HS regarding recent Never Events, AM noted that Never Events remained a concern and that the Quality Committee would continue to scrutinise the incidents and would have a discussion on this matter at its next informal meeting.	
5.0	**Questions To NEDs**	
5.1	**Questions to NEDs** Linking to the Staff Survey discussion, KS asked about where feedback related to the lack of adequate materials, supplies and equipment was considered. In response, the Chairman noted that general points were often raised by staff about equipment not being replaced quickly enough and cumbersome processes and it was much less about issues that required Committee oversight. AB noted that there some issues that were considered by the Infrastructure Committee and that the lack of money was having an impact eg the Trust was behind on proactive maintenance and had paused the use of agency staff and while the service was still safe it would at times feel uncomfortable to staff. TW noted that staff expected IT to work as it does in their homes and that it was a more complicated and difficult to deliver within the Trust. He was pleased to report that the recent Internal Audit of IT had congratulated the IT team on its competence and IT skills and its intelligent approach to spending money. AM reassured Governors that where decisions were taken to reduce spending a quality impact assessment was always undertaken. The Chairman noted that staff believed that additional funding would always be found and that this was no longer the case and the Executive had put in considerable effort to explain the financial reality to staff.	
6.0	**Closing Items**	

6.1	**Any Other Business** There was no other business. The Chairman thanked everyone for their contributions.	

Date of next Meeting
Wednesday 18 July 2024, 14:00

Council of Governors - Public - 18 July 2024

NHS
St George's University Hospitals
NHS Foundation Trust

Action Log

Action Ref	Section	Action	Due	Lead	Commentary	Status
COG.220524.1	Feedback from visits	Consider if dedicated space can be made available for gynaecology patients.	18/07/2024	GCEO	The Chief Operating Officer for SGUH will provide a verbal update at the meeting.	PROPOSED FOR CLOSURE
COG.220524.2	Feedback from visits	Explore option to prioritise planned work to review patient appointment letters.	31-Jul-24	GCEO	There is no active review at present as current capacity is focussed on expanding the patient portal.	NOT YET DUE
COG.220524.3	Strategy Update	Bring an Estates and Facilities update paper to the next m eeing on 18 July 2024.	18/07/2024	DCFIEO	Deferred to September 2024 meeting due to limited resource capacity within the Estates team.	NOT YET DUE
COG.220524.4	Quality Priorities 2024-25	Revise wording on measure regarding the reduction in cardiac arrest callsto make it clearer that it was about early escalation leading to a reduction in cardiac arrest calls.	ASAP	GCNO	Feedback from the Quality Committee resulted in a reduction in the number of quality priorities to provide for an increased focus on safety with reference to the Emergency Departments, clinical governance, maternity services and fundamentals of care. The quality priority related to the measure regarding the reduction in cardiac arrest calls is no longer included.	PROPOSED FOR CLOSURE
COG.220524.5	Quality Priorities 2024-25	Further consideration would be given to the measures regarding ED flow ahead of the Quality Committee.	ASAP	GCNO	Consideration was given to the measures regarding flow ahead of the Quality Committee at the meetings listed below and the decision made was for these measures to remain unchanged: •Group Executive Board, 4 June 24 •Audit Committee, 12 June 24 •Gesh Quality group, 13 June 24	PROPOSED FOR CLOSURE

INTRODUCTION

This report summarises key events over the past two months to update the Council of Governors on strategic and operational activity at St George's and across the Group.

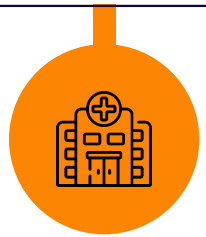
SPECIFICALLY, THIS INCLUDES UPDATES ON:

- The national context and impact at the trust level
- Our work to Date
- Staff News and Engagement
- Next Steps

COLLABORATION & PARTNERSHIP

NATIONAL CONTEXT AND UPDATES

Implementation of the first phase of Martha's Law



St. George's is one of 143 hospital sites that will test and roll out Martha's Rule in its first year, with the aim of ensuring that patients and families have a clear and consistent way to seek urgent review if they or their loved one's condition deteriorates and are concerned it is not being responded to.

The scheme is named after Martha Mills, who died from sepsis in 2021 at age 13 due to the failure to escalate her intensive care despite concerns raised by her family of her worsening condition.

Martha's Rule is made up of three components to ensure concerns about deterioration are responded to swiftly. First, an escalation process will be available 24/7 through various publicly displayed advertisements, enabling patients and families to contact a critical care outreach team to assess and escalate care if necessary. Second, NHS staff will also have access to this same process if they have concerns about a patient's condition. Third, clinicians at participating hospitals will also formally record daily insights and information about a patient's health directly from their families, which will help to identify and address any concerning changes in behaviour or condition noticed by the people who know the patient best.

London Cyber Attack

A recent cyber-attack disrupted blood tests and transfusions at several hospitals in South East London (King's College Hospital, Guy's and St Thomas' and some primary care services). St George's and Epsom and St Helier were not directly affected by the cyber attack, but have been active in supporting our colleagues in South East London while they respond to the incident. The Group has worked closely with system partners to make sure we continue to provide services to our patients while supporting others. We have, for example, taken on some specialist patient where care was impacted at other hospitals.

OUR GROUP

Group-Wide Electronic Patient Record Implementation:

The new EPR system will provide secure access to health records, enabling better clinical decision-making and empowering patients to have more control over their care. This means that patients won't have to repeatedly provide their medical histories. This represents a significant advancement in digital healthcare.

Patient Safety Incident Response Framework (PSIRF)

Plans are underway to implement the new PSIRF. We expect that PSIRF will be fully implemented across all services by the end of June 2024, but this is taking place in a phased, controlled way that ensures robust ongoing scrutiny of patient safety incidents.

PSIRF will have significant implications for the way in which we treat and investigate incidents, but this new approach will help identify and embed learning from incidents and help promote a culture of patient safety.

AFFORDABLE HEALTHCARE,
FIT FOR THE FUTURE

FINANCES

STRATEGIC EXCELLENCE

Over the last few months, we have continued to work towards achieving our strategic ambitions of providing outstanding care across our hospital Group, as we mark one year since the publication of our Group Strategy.

EXCEEDING STANDARDS

Our Group staff consistently provide high-quality care and timely treatment, achieving financial efficiencies. We exceeded key targets, ensuring less than 5% of patients wait over six weeks for diagnostic tests and meeting national cancer diagnosis standards.

OPERATIONAL CHALLENGES

The key drivers for operational pressures are unplaced patients remaining in the EDs and pressures resulting from high numbers of patients with mental health needs presenting at ED. Wider flow through our hospitals represents an ongoing challenge.

RIGHT CARE, RIGHT PLACE, RIGHT TIME

SGUH – KEY UPDATES

Quality Governance Review

- In March 2023, the Care Quality Commission (CQC) inspected maternity and midwifery services at St George's. During and after its inspection, the CQC identified areas where significant improvements needed to be made to maintain safe services to patients.
- The Group commissioned a review of quality governance arrangements across GESH, with the objective of identifying improvements that can be made to strengthen the governance of maternity services.
- The first phase of this work – which focused on quality governance in maternity services - is now complete and the report of the independent review, together with the management response, is on the Group Board agenda. Work is underway to implement the recommendations and actions arising from Phase 1.
- Phase 2 of the review will have a wider focus on quality governance across both SGUH and ESTH, particularly at divisional level, to ensure that there is effective quality governance from service to division to site and upwards to the Board. This second phase will be implemented in a way that enables the Group to adopt a model of reviewing quality governance maturity in a robust and ongoing basis.

New Renal Unit

- We have continued our plans to improve kidney care in South West London, Surrey and beyond, which will be transformed into a specialist renal unit designed to treat the most seriously ill patients. The proposed facility, to be based at St George's, will be utilised by patients currently receiving care at St George's and St Helier hospitals. It will be one of the largest and most modern renal services in the UK. Our plans aim to improve the quality of kidney care in the region by providing specialised inpatient care in a single location.
- While most outpatient care and dialysis will still be provided close to patients' homes, 95% of patients will continue to receive care and treatment in local hospitals, clinics, and at home.

Visits

- Richard Meddings, Chairman of NHS England, recently visited SGUH to learn about the efforts being made to reduce health inequalities and to observe innovations within the NHS. During his visit, he engaged with the staff and saw a demonstration of how virtual reality is used in physiotherapy for trauma patients. Additionally, he visited the Liver Bus to gain insight into our work in Hepatitis and HIV testing. We are now offering a Hepatitis C test and a non-invasive liver health check to more communities than ever before in SW London. This is a crucial step in addressing health disparities and working towards the goal of eliminating Hepatitis C for all.

OPERATIONAL PERFORMANCE

Our ambition is to be at the top quartile of key performance targets. While we are not where we want to be, GESH, and South West London (SWL) are doing well relative to overall national performance. Last week, of 445 patients surveyed 89% stated that the service they received was 'Very Good' or 'Good'.

WAIT TIMES

The number of patients waiting over 65 weeks is on target to be at zero waits by September 2024

ED VISITS

In June 2024, the 4-hour wait performance at SGUH was 81.8%, exceeding trajectory and national target of 78%. The discharge profile improved which supported flow, reducing waits and improving capacity within the department.

CANCER WAIT

In May 2024, SGUH's 62-day performance was 80%, exceeding the plan of 76%. However, theatre capacity constraints continue to be a challenged in Urology and Thoracic Surgery.

DIAGNOSTICS

Performance remains strong and on target, with only 1.3% of patients waiting over 6 weeks at the end of May meeting the recovery target of <5%

EMPOWERED,
ENGAGED STAFF

STAFF EVENTS

- **GESH Celebrations:** Over the last few weeks, I have spent time with staff celebrating various important events, including Pride Month, Armed Forces Week, Eid Al Adha, National Health Estates and Facilities Day, Windrush Day, and so much more. I am inspired by how our diverse teams come together to celebrate one another and reinforce our CARE values, and by the energy and enthusiasm brought by our staff networks across our Group.
- **Catering services at St George's have been recognised as "exemplary"** by NHS England and have been chosen to join the NHS Exemplar Trusts Programme for Catering. This is in recognition for innovation, high food standards, and consistent service in providing food for patients, staff and visitors. St George's is one of only 20 hospitals across the country to have been awarded this accreditation.

- **St George's Hospital Charity** was awarded 'Highly Commended' in the Best Charity of the Year category at the 2024 Wandsworth Business Awards. This was the charity's first time participating, and it was one of nine local charities shortlisted, ultimately coming in second to Age UK Wandsworth. The annual Wandsworth Business Awards recognize and celebrate both emerging and established businesses in the area for their excellence in various aspects. The charity's award application highlighted St. George's Hospital's integral role in the Wandsworth community, staff and patient initiatives for improving wellbeing and care, as well as the charity's work with the local community and businesses for fundraising and community connection to the hospital.

St George's University Hospitals
NHS Foundation Trust

Council of Governors

Meeting in Public on Thursday, 18 July 2024

Agenda Item	2.2	
Report Title	**Group Strategy Update**	
Executive Lead(s)	James Marsh, Group Deputy Chief Executive Officer	
Report Author(s)	Zahra Abbas, Group Strategy and Planning Manager	
Previously considered by	n/a	n/a
Purpose	**For Noting**	

Executive Summary

On 15 May 2023 we launched our new five-year strategy for St George's, Epsom and St Helier University Hospitals and Health Group. **Our vision for 2028 is – we will offer outstanding care, together.**

Our strategy describes how we will achieve our vision through the delivery of:

1. **Local improvements**: against a framework of annual priorities aligned to our CARE objectives.
2. **Corporate enablers**: corporate departments, working with clinical teams developing and implementing enabling strategies.
3. **Strategic initiatives**: nine large, complex, long-term, Board-led, transformational programmes of work.

This report describes progress in these three areas since the last COG update, including summaries of the latest enabling strategies to be agreed by the Board (People Strategy 2024-26, Quality & Safety Strategy 2024-28, and Green Plan 2024-28).

Action required by Council of Governors

The Council of Governors is asked to note the update.

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Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Group Strategy Update

Implications				
Group Strategic Objectives				
☒ Collaboration & Partnerships			☒ Right care, right place, right time	
☒ Affordable Services, fit for the future			☒ Empowered, engaged staff	
Risks				
Regulated activities				
CQC Theme				
☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led
NHS system oversight framework				
☒ Quality of care, access and outcomes			☒ People	
☒ Preventing ill health and reducing inequalities			☒ Leadership and capability	
☒ Finance and use of resources			☒ Local strategic priorities	
Financial implications				
As per report				
Legal and / or Regulatory implications				
Compliance with the Health and Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations				
Equality, diversity and inclusion implications				
As per report				
Environmental sustainability implications				
As per report				

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Group Strategy update

Council Of Governors

James Marsh
Group Deputy Chief Executive Officer

Report Author:
Zahra Abbas, Strategy and Planning Manager

18 July 2024

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Introduction

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St George's Council of Governors is asked to:

- Note the update

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Delivering our 5-year vision

Local improvement

A range of work is underway to embed the CARE framework across the organisations, and to support staff to pursue improvement against it. In May, the Board agreed 2024/25 'board to ward priorities' to support this, which are set out on slide 4.

Strategic initiatives

Each of our 9 strategic initiatives have been set up as programmes of work, led by an Executive SRO, and are progressing. The Board and then COG receive a full progress report on these initiatives on a 6-monthly cycle, with the next Board review due in July. The Board has agreed objectives for these programmes in 2024/25 which are set out here.

Corporate enablers

The Board has agreed 24/25 objectives for corporate teams, set out below, and has also approved a People Strategy, with a quality and safety strategy and green plan being prepared for board approval in the summer.

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Outstanding care, together: our plan for 24/25

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Board-to-ward priorities

C Work with other teams to reduce delays in patient journeys through our services

A Live within our means: innovating, working more efficiently and cutting costs

R Keep our patients safe – including those waiting for our care

E Make our team a great and inclusive one to work in

Strategic initiatives

Electronic patient record
- Progress shared electronic patient record across gesh, for implementation in 2025

Building your future hospitals
- Submit outline business case
- Submit planning application
- Progress enabling works

Group collaboration
- Integrate most corporate services
- Submit full business case for renal build
- Agree 3 Group-wide clinical strategies, and begin implementation

Collaboration with SWL hospitals
- Strengthen hosted APC partnerships
- Deliver agreed transformation programmes – e.g. joint PACS
- Develop new partnership programmes to support long-term financial sustainability – e.g. hubs

Collaboration with local partners
- Develop gesh-wide approach to frailty
- Work with local partners to reduce length of stay
- Work with partners on redesign of community services in Merton & Wandsworth

Specialised services
- Get gesh ready for devolution of specialised service budgets
- Strengthen the services we want to be renowned for
- Improve oversight of our specialised service portfolio.

Culture
- Implement sexual safety charter
- Develop and implement plan to tackle violence & aggression against staff
- Deliver our diversity & inclusion plan

High-performing teams
- Support our teams to develop shared goals, linked to our strategy
- Support teams to use continuous improvement habits and tools against these goals
- Align our approach to performance

Outpatient transformation
- Redesign pathways with primary care, e.g. more advice & guidance for GPs
- Deliver more virtual and telephone clinics
- Deliver more patient-initiated follow-up

Corporate enablers

People
Bring together one, transformed HR function across the Group, with policies/processes aligned

IT
Improve the performance and resilience of our IT infrastructure.
Deliver a programme of major IT projects, with EPR on track for 2025, a new shared PACS, and iClip for Maternity at St George's

Environmental sustainability
Develop a Group-wide Green Plan, with implementation underway

Quality & safety
Integrate corporate medicine and nursing departments, and strengthen quality governance & oversight – including roll-out of PSIRF

Research & Innovation
Develop our partnership with the newly merged City St George's University, and recruit 10% more patients to trials than in 23/24

Estates & facilities
Deliver a programme of building projects across both Trusts, including new ICU capacity at St George's

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Local improvement update

A range of work is underway to embed the CARE framework across the organisations, and to support staff to pursue improvement against it, for example:

- Individual teams have started articulating their priorities/purpose using the CARE framework, with the offer of facilitation available from corporate teams
- The HR department are reviewing both Trusts' policies for individual objective-setting with a view to aligning it to our CARE objectives
- We are developing plans for our CARE awards in December – where the categories will be linked to the ambitions within our CARE strategy, including improving staff wellbeing, reducing waiting times, delivering outstanding care and value for money.
- Ongoing communication campaign, with CARE branding being disseminated across our physical sites and virtually. Staff comms on our main campaigns and priorities have been explicitly linked to our five-year strategy.

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Corporate enablers update

The Board has previously agreed that 6 corporate enabling strategies should be developed:

Strategy	Update
People strategy	Approved by Board in May 2024. See summary overleaf.
Quality & safety strategy	Approved by Board in July 2024. See summary overleaf.
Green plan	Approved by Board in July 2024. See summary overleaf.
Estates	Work commenced. We are targeting spring 2025 for approval.
Digital	Work commenced. We are targeting summer 2025 for approval.
Research & innovation	We are targeting July 2025 for board approval.

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People Strategy 2024-2026

Our vision is that by 2028 gesh will be among the top five acute trusts in London for staff engagement.

We will achieve this through a focus on the following areas:

- Get the basics right for all our staff
- Improve staff wellbeing
- Ensure our culture is inclusive and driven by our values
- Develop our workforce for the future
- Embrace different ways of working

Our People Strategy sets out the actions we will take over 2024-2026 against these areas:

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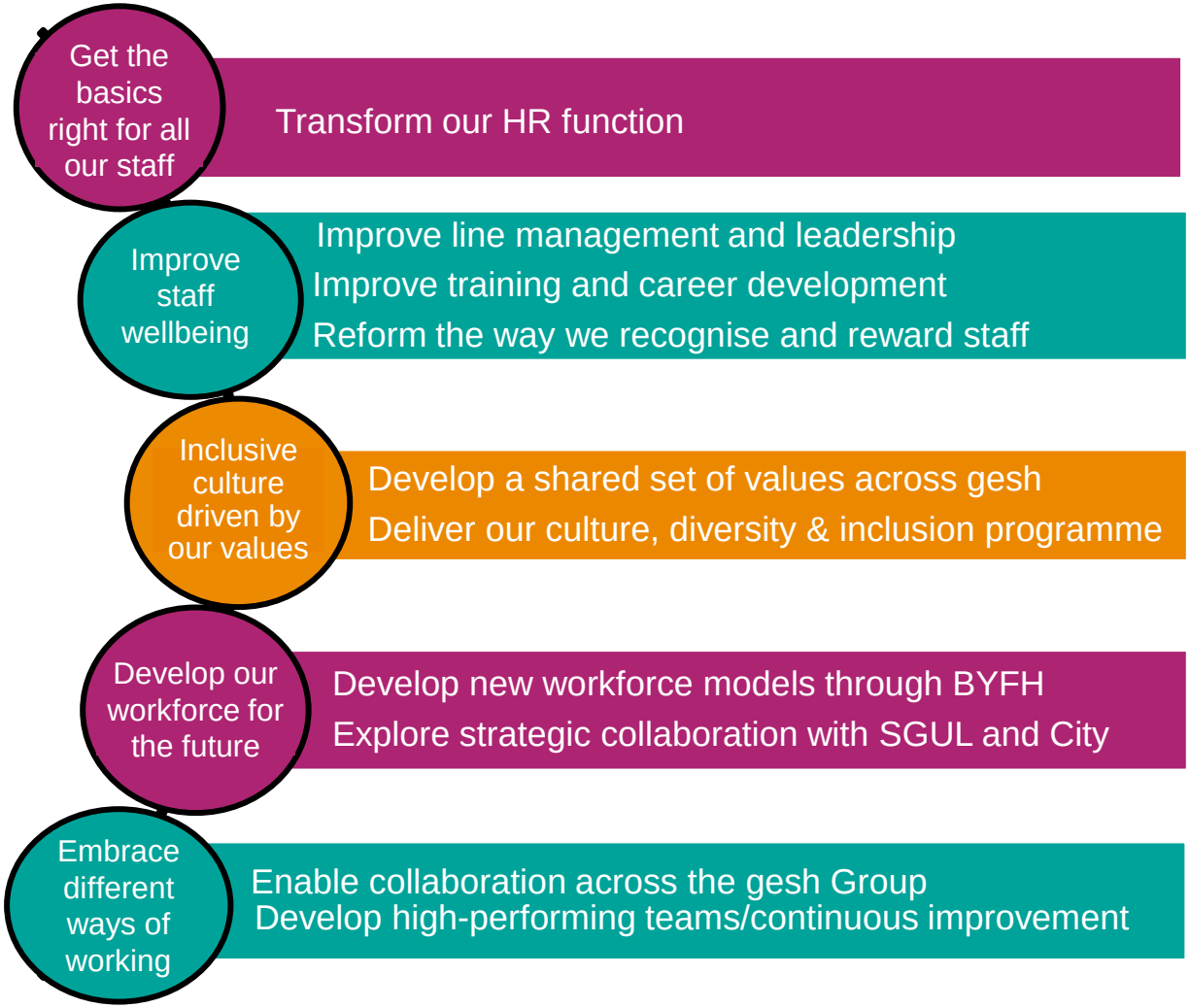

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Our quality & safety strategy

The NHS is operating in a difficult environment. We face major financial and workforce pressures, with growing demand for our services. Waiting times for planned care and patient flow (making sure the patient is in the right place at the right time) for unplanned care are worse than we want them to be. There is significant overcrowding in our three Emergency Departments, impacting on patient experience and outcomes.

But our aspirations remain high. **Our aspiration by 2028 is to deliver outstanding care together:**

- waiting times among the best in the NHS,
- lower than expected mortality rates and a reduction in avoidable harm,
- improved outcomes and patient experience
- a reduction in health inequalities.

The route to delivering those aspirations is not going to be to spend more money on additional staff or capacity – indeed the financial context is going to get harder. Instead our strategic priorities are ...

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STRONG GOVERNANCE
We will strengthen governance & oversight of quality and safety

1. Reform our Group quality governance approach and embed this throughout the Group to ensure collective understanding of quality & safety.
2. Enhance patient safety by systematically learning from incidents through implementation of the Patient Safety Incident Reporting Framework and Learn from Patient Safety Events (LFPSE) service.

BETTER FLOW / SHORTER WAITS
We will improve flow through our services, so that patients get the right care, in the right place, more quickly.

3. Improve waiting list management for planned care, and improve patient flow in hospitals, so that all patients get timely, safe care in the appropriate environment and timely discharge. Mental health patients in Emergency Departments will be a focus, as will be improving the integrated care service for frail elderly patients at St George's. This will involve collaboration with system partners.

A LEARNING ORGANISATION
We will embed a culture of psychological safety, continuous improvement, learning from mistakes and learning from others

4. Develop an outstanding patient safety culture in which all our staff feel psychologically safe to speak up and confident the organisation will act in response.
5. Embed a new Group-wide approach to clinical effectiveness, incorporating better use of data and intelligence, and greater use of peer learning/review across our services.

Enablers

6. Maximising the clinical value of every pound we spend
7. Tackling health inequalities
8. Engaging patients & co-production
9. Embed continuous improvement in everything we do

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Green Plan 2024-2028

Our vision is that by 2028 we will achieve outstanding care, together by integrating sustainability into everything we do.

All our staff will have the opportunity to benefit from sustainability training and education.

We will support the delivery of our vision with internationally recognised management standards

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Estates and Facilities	• We will be well on the way to reducing our direct emissions of carbon by 80% to hit the 2032 target • For indirect emissions, we will have made significant progress towards reaching the 80% reduction target (by 2036 to 2039) • We will produce minimal waste and be meeting national waste targets • Our current and new infrastructure will be sustainable, and resilient to the impacts of a changing climate • Patients, staff and the public will benefit from flourishing grounds and outdoor spaces
Travel and transport	• We will transition to an electric fleet, generating minimal harmful air pollution • We will promote virtual care where possible • We will promote zero emission travel for staff, patients and the public
Clinical pr ovision	• Outstanding care will be provided across the Group in a financially and environmentally sustainable manner • We will have minimised the environmental impact of the medicines and care we provide
Supply chain	• We will reuse and repair everything that can be reused and repaired • Our hospital supplies will be sourced from environmentally friendly suppliers who can demonstrate a commitment to achieving Net Zero Carbon • We will be applying the principles of a circular economy in all our procurement decisions i.e. avoiding single use equipment and buying reusable goods

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Strategic initiatives update

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Initiative / Programme	Update
Building Your Future Hospitals	• An initial funding allocation for continuing the development work in 2024/25 has been secured from NHSE and a Memorandum of Understanding (MoU) agreed, with a plan to target the remaining fees later in the year • Wider clinical and non-clinical engagement began in May '24 and will conclude in July '24; • There will be a review of the national program as the new government settles in.
High Performing Teams & Leaders *(C/I)*	• Explored emerging options for the Quality Management System workstream with the Group Exec and drafted the implementation plan for 2024-25; • Launched Cohort 2 of the St George's Leading Improvement programme with 19 delegates from the MedCard division.
Shared EPR	• Funding re-set in progress following detailed bottom-up resource planning; • Contract update to take us through to go-live with Oracle Cerner currently in discussion; • The Infrastructure Committee of the Board is meeting monthly to ensure assurance regards programme delivery.
Transforming Outpatients	• A governance structure with drafted Terms of Reference is in development to oversee group and site deliverables, with group transformation objectives identified and agreed by GEM; • Ongoing efforts include scoping deliverables for prioritization, stakeholder discussions on using data to address inequalities, reducing outpatient wait times.
SWL Collaboration	• 3 key deliverables for this initiative in 24/25 have been agreed by the Board (see plan on a page on earlier slide); • The four acute trusts are currently exploring further opportunities for collaboration in elective care
Transforming Our Culture (Diversity & Inclusion)	• Capacity constraints have impacted the Culture, Diversity, and Inclusion initiative, but key deliverables are being addressed; • Toolkits on civility and psychological safety will be launched soon; a Civility 1-day course was successfully trialed at ESTH.
Collaboration with Local Partners (Surrey, Sutton, Merton & Wandsworth)	• Approach to site / place-based frailty for ESTH progressing well with the establishment of new single clinical leadership structure; • New programme director recently brought in to support delivery
Collaboration across GESH	• Integration of corporate departments progressing, with nursing and corporate medicine consultations concluding this summer • Collaboration across clinical teams also progressing, including development of Group pharmacy, surgery and children's services strategies
Strengthening our Specialist Services	• Ongoing work to strengthen specialist services, including cardiac surgery (range of initiatives pursued to enable increase in activity), major trauma (including work underway across clinical services to review our model of care) and paediatrics (where discussions with NHSE are ongoing following the decision to move paediatric cancer to the Evelina).

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Summary

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Recommendation:

St George's Council of Governors is asked to:

- Note the update

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St George's University Hospitals
NHS Foundation Trust

Council of Governors

Meeting in Public on Thursday, 18 July 2024

Agenda Item	3.1	
Report Title	**Independent Review of Maternity Governance**	
Executive Lead(s)	Arlene Wellman, Group Chief Nursing Officer Richard Jennings, Group Chief Medical Officer	
Report Author(s)	Dr Sally Herne, NHSE Improvement Director	
Previously considered by	Group Public Board Group Board Development Session Quality Committees-in-Common Group Executive SGUH CWDT Divisional Triumvirate ESTH Women's & Childrens Divisional Tri SGUH & ESTH Maternity Leadership	04 July 2024 06 June 2024 25 April 2024 16 April 2024 March 2024 March 2024 March 2024
Purpose	**For Noting**	

Executive Summary

Following the CQC inspection of Maternity at St George's, GESH tendered for an external consultancy to review quality governance arrangements within the Group. Those terms of reference were approved by the Group Executive.

The Group Chair and Chief Executive also requested verbally that the review addressed two specific questions:

- Why did it take CQC to unearth issues in SGUH maternity when Group believed it understood all the issues?
- Have we made our quality governance systems too complicated in the move to a Group structure?

The triple lock in SW London meant that procuring a consultancy firm was ultimately not a viable option, and an Improvement Director from NHS England was seconded for a year to cover the two pieces of work. Given the reduced capacity available to do the work Phase 1 has taken slightly longer than requested in the terms of reference.

This report is designed to brief the Council of Governors on the findings of Part 1 and to give a view on the two questions. It brings together findings from a number of external reviews in 2022 and 2023 and

my own analysis to describe what is and is not working in maternity quality governance, plotted against a model which considers quality governance in 3 parts – Anatomy (structural building blocks of governance), Physiology (behavioural aspects of governance) and Vital Signs (ability to step back and reflect on whether governance is fulfilling its' core purpose). Whilst the greatest number of issues are within the anatomy category, there are powerful drivers more associated with the physiological aspects. Strengthening quality governance therefore needs a mix of practical and cultural changes.

In terms of the two questions from the Chair and Chief Executive, it is difficult to replicate an external inspection and completely rule out any surprises. That said, there appear to be six issues which could have contributed. These may also have relevance for quality oversight beyond maternity and are therefore important areas for the Board, Sites and Divisions to reflect on.

Reporting

The way reports were sent up through the governance systems made gaining a rounded view of the issues difficult for leaders at different levels. The format of the regular Maternity report has changed several times, but CNST Maternity Incentive Scheme (MIS) compliance was at the fore in the run up to the 2023 CQC inspection. Given the importance of CNST clinically, financially and reputationally, this was an understandable starting point. The MIS technical guidance sets out a list of what should be regularly communicated to Board for Safety Action 9 on ward to Board reporting MIS-Year-6-guidance.pdf (resolution.nhs.uk) (p.50) . Not everyone receiving the report was aware of this guidance. It was unclear if there had been a conversation to discuss whether this was enough on its own to give division, site, Executive and Board assurance.

There is a significant difference between what CNST measures and the CQC assessment framework. For example, MIS has very little on the maternity specific or trust wide audit compliance looked at by CQC or medicines safety and the known health inequalities gap in Maternity. It suggests including a digest of that month's incidents, HSIB referred cases and complaints but not the themes emerging through those processes. A regular report which focuses on the former therefore can create a visibility gap on CQC key lines of enquiry, unless this is bridged through other means.

In the reports coming to Board the degree to which harm is *avoidable* was often more implicit than explicit. The report self-assessed whether each site was achieving the CNST safety standard on the Saving Babies Lives Care Bundle (SBLCBv3). However, committees did not get to see the actual data underpinning this such as the relative success of Carbon Monoxide Monitoring screening, effectiveness of Fetal Growth Restriction, CTG monitoring compliance or compliance with Management of diabetes and hypertension in pregnancy. There are outcome measures suggested in SBLCBv3 which could be included in a future iteration of the report. CQC inspectors saw some data that concerned them that leaders at GESH had not had the benefit of reviewing first - unplanned readmission to hospital or babies born before the women/birthing person reaches hospital.

The way the reports were presented at Board compounded this further. It could be difficult to weigh the information being presented, particularly in the case of the specialist service at St George's. Benchmarking, narrative, granularity, triangulation and external peer review are all essential to know how to interpret sufficiency of staffing, outcomes and harm. The benchmarking and external assessment of perinatal mortality by MBRRACE commissioned by the Board has demonstrated the value of this kind of independent information for assurance.

Finally, the experts were not in the room for the discussions of the Maternity reports. GESH chose to invite Group Executives to present the report on behalf of the teams. Committees were therefore not hearing or benefitting from the expertise of Midwives, Obstetricians or Neonatologists. Equally the Maternity leadership teams were not privy to the discussion with Group leaders which would help them understand what a Non-Executive chaired committee needs. This could have helped both bridge the gap between what was being reported and what was needed for assurance and also provide support

for discussions of specialist and technical issues. The midwives now have a voice through the Chief Midwifery Officer, but the doctor voice is still missing.

Meeting Cycles

There was a focus on frequency of reporting, not least because CNST technical guidance sets an expectation of a monthly Board report. A monthly Quality Committee in Common mitigated against the reports going through the complex network of division, site and exec first to allow those layers of management to offer support, check and challenge or take action prior to a Group level Board. It also compressed the time available for thinking, planning and doing for the Maternity teams themselves. This was compounded by the web of reporting internally and externally we have exposed through the review. Despite all the reporting and concern about issues such as staffing and the physical environment, very little maternity risk made its way onto corporate risk register and therefore the radar of the wider leadership.

Standards of Assurance

The bar for assurance left the leadership vulnerable to surprises. Board received and took assurance from reports which tended to emphasise whether an action had been completed. It is critical that assurance also demonstrates whether the impact of those actions has been felt and whether the team(s) can sustain their progress. It is high risk to accept less, especially in a speciality subject to so much national concern.

Organisational Culture

Culture may have played a part in two different ways. 'A guide to good governance in the NHS' includes an important quote from Bill Moyes *"There is no such thing as a perfect organisation. The best we can ever hope for is that an organisation is self-aware, recognises its issues, and deals with them effectively".* The report stresses that one of the most important enablers for this is 'problem sensing' leaders who assume that there are issues out there to be found, seek out information that might challenge the perception things are okay, don't take undue comfort in getting most things right, who use a range of means, including soft intelligence, to form a view and who embrace people who highlight concerns. The report describes the very real challenges of making problem sensing a reality in the NHS.

- Providers are increasingly complex, as are the systems they operate within.
- The NHS has a poor track record on bullying behaviours and senior leaders are not immune from being on the receiving end of it, challenging their own sense of psychological safety.
- Problem sensing requires high levels of professional curiosity, but deep curiosity is only possible if leaders themselves have the psychological safety to enable them ask questions about issues which may beyond their portfolio and expertise.
- It also requires leaders to have the resilience to hear, accept and respond to difficult news.
- These challenges are likely to exist in every NHS organisation, but teams and organisations which have had challenging times can find it particularly difficult to operate problem sensing. The prospect of more difficult news and acquiring more to do on top of a long current to do list can be draining and demoralising. Maternity has had a difficult history nationally and locally in recent years. St George's as a site has had to content with quality and financial special measures, Covid, Cardiac Surgery external review and now an increasingly difficult financial environment to work in.

Secondly, evidence shows there is no such things as equality of psychological safety in *any* organisation. Difficulty speaking up is particularly an issue for staff who are women, from a BAME background or who are more junior in the hierarchy. Maternity has many staff who meet all three of those criteria. It is not uncommon to have a gap between leaders' perceptions of how easy it is to raise concerns, challenge how things are done or contribute ideas and the reality of staff experience. Saying

my door is always open is not enough. Walkabouts create visibility, but not necessarily approachability. SGUH maternity team felt they escalated concerns vigorously. Leaders outside the service did not feel those messages were clear. Research on just culture and speaking up suggests it is perfectly possible for those two perceptions to co-exist and both positions be honestly held. There is good advice available on the tactics for building psychological safety for the people who really need it in the white paper *"Most of the Advice About Psychological Safety at Work Isn't Helpful".*

Purpose of Governance

The fundamental aim of quality governance can get lost amongst process. Organisations put significant time and effort into risk management, audit, patient experience and safety investigations to learn, embed and improve. Every team and every organisation needs to assess if it is actually achieving that aim, including whether learning is actually effective and to make that part of an iterative, continuous improvement process.

Complexity of Group

The experience of staff involved in Phase 1 suggests navigating Group is highly complex practically and politically. The understanding of the role of Group was low and the relative roles and responsibilities of site leadership versus group in need of greater clarity. This may be inevitable in a large group where the group layer is still relatively new.

Action required by Council of Governors

The Council of Governors is asked to:

a. Note the detailed observations of governance and culture at each Trust and Group level.
b. Note the risks identified for delivery of the improvements and mitigations required.

St George's University Hospitals NHS Foundation Trust

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Executive Response to the Independent Review of Maternity Services
Appendix 2	Priority Actions

Implications

Group Strategic Objectives

☐ Collaboration & Partnerships

☒ Right care, right place, right time

☐ Affordable Services, fit for the future

☒ Empowered, engaged staff

Risks

Risk	Mitigation	Owner	Assurance Mechanism
Culture and volume of meetings compresses the time available for planning, reflection and improvement	Review and recalibrate meetings at unit and site level, using a methodology such as Good Governance Institute initiative at Morecambe Bay or the NHS Institute for Innovation and Improvement Productive Leader Effective Meetings module. Set expectation with Local Maternity and Neonatal System (LMNS) that one report is produced for internal and external audiences	Group Chief Midwifery Officer	Hours released from meetings compared to 2023 baseline Pace of improvement Staff wellbeing & Leadership visibility metrics in staff survey compared to 2023 baseline
The organisation addresses the structural but not the cultural aspects required to support change and build trust	The organisational development approach at GESH embodies 'problem sensing' and just culture behaviours Issues of leadership values not matching local team values are investigated and acted on	Group Chief People Officer	Overall staff survey metrics on reporting culture compared to 2023 baseline Progress against 2023 SCORE metrics in leadership, teamwork and safety climate in Maternity Freedom to Speak up reporting

	Requests for investment are prioritised, supported by benchmarking and have clear cost benefits		Successful clawback of Clinical Negligence Scheme for Trusts (CNST) premiums
Strengthening governance arrangements is constrained by the financial position of the Group and SW London	Time is released in the form of efficiency gains where possible	Group Chief Nursing Officer	Compliance against Ockenden actions
	The organisation uses the review to support requests for investment from commissioners and NHS England (NHSE)		Performance against quality governance outcome measures (see recommendations)

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

☒ Quality of care, access and outcomes	☒ People
☒ Preventing ill health and reducing inequalities	☒ Leadership and capability
☐ Finance and use of resources	☒ Local strategic priorities

Financial implications

Investment may be needed in the governance infrastructure in Maternity, particularly to ensure robust medical input at a time where there are numerous regulatory requirements to fulfil, high national NHS, public and political concern. The extent of the investment needs to be clarified by medical leadership at site and group.

The approach to meetings in the organisation consumes significant amounts of staff time without the benefit of added assurance. There is a potential efficiency opportunity in streamlining the approach to meetings.

Legal and / or Regulatory implications

Recommendations are designed to support effective monitoring of compliance with regard to

- Health and Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations
- Ockenden Immediate and Essential Actions
- CNST Safety standards
- Antenatal and Newborn Screening standards
- NHSE Maternity Three Year Plan, 2023

Equality, diversity and inclusion implications

Poor maternity outcomes are known to disproportionately affect women from excluded communities and specific ethnic backgrounds. Quality governance mechanisms in maternity need to establish ward to board assurance that

the organisation's mechanisms for understanding this and targeting services appropriately is closing the outcomes and experience gap.
Environmental sustainability implications
None identified.

St George's University Hospitals
NHS Foundation Trust

Independent Review of Maternity Governance
Council of Governors 18 July 2024

1.0 Purpose of paper

1.1 The purpose of this paper is fivefold:-

- To share a model for considering three dimensions of quality governance
- To summarise in one place the feedback from CQC, NHS England's Maternity Services Safety Programme (MSSP), Ockenden assurance visit and NHS England Antenatal and Newborn Screening Quality Assurance reports as they relate to quality governance and the 2023 Perinatal Culture and Leadership Programme SCORE (Safety, Culture, Operational Risk, Resilience/Burnout and Engagement) Survey and 2023 National Staff Survey results relating to culture, particularly psychological safety, involvement in decision making and improvement readiness.
- To add observations and evidence from this quality governance review which commenced in November 2023 and outputs of two joint governance workshops between SGUH and ESTH.
- To set out the scope, leadership and governance arrangements for a Group-wide Maternity Quality Governance Improvement Programme for approval
- To flag issues which may have broader relevance for the approach to quality governance at GESH for consideration by the Executive and Board.

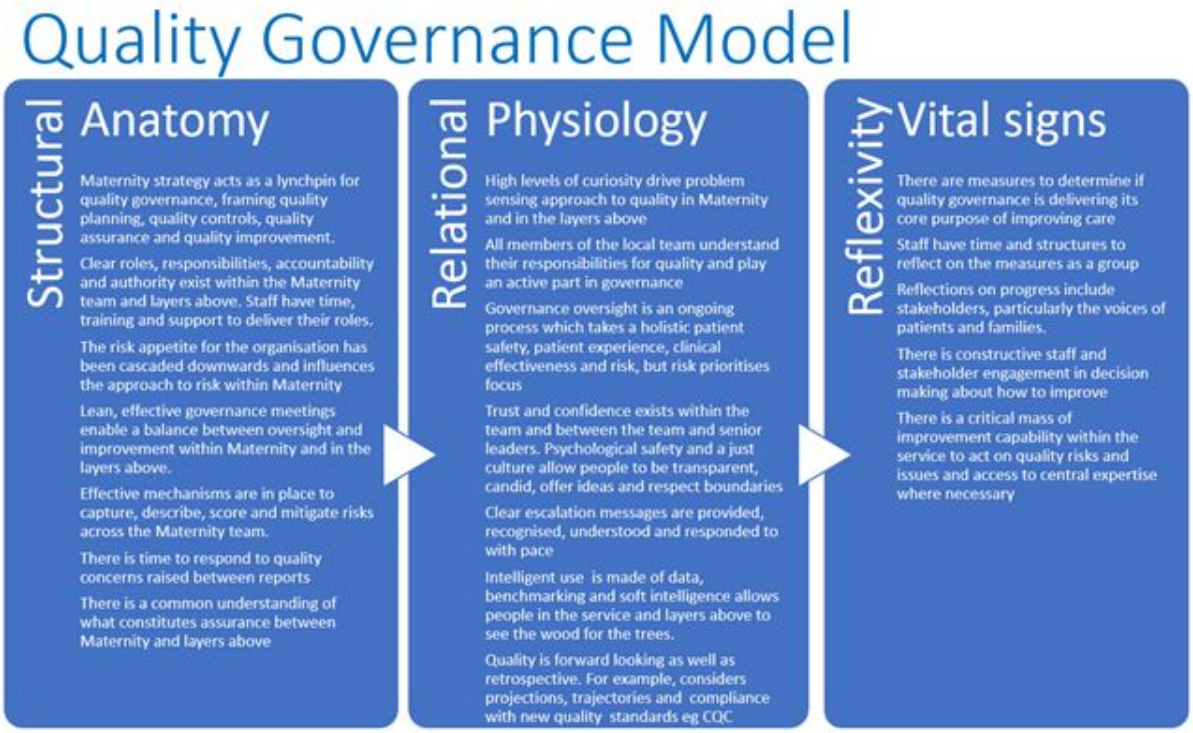
2.0 Background

2.1 Over the course of 2022 and 2023, insights into quality governance arrangements in Maternity services at SGUH and ESTH have been gleaned through a number of assessment processes

Reporting Body	SGUH	ESTH
NHSE Insight Visit Teams	Ockenden Assurance Visit, May 2022	Ockenden Assurance Visit, May 2022
CQC	Maternity specific inspection Safe and Well Led domains March 2023	Maternity specific inspection Safe and Well Led domains August 2023
NHS England (Screening)	Antenatal and Newborn Screening QA programme May 2023	-
NHS England externally commissioned	Perinatal Culture and Leadership Programme SCORE Survey, May 2023	Perinatal Culture and Leadership Programme SCORE Survey, December 2023
NHS England (Nursing and Midwifery)	Maternity Services Safety Partnership (MSSP) November 2023	Due to take place in Q1 2024/5
Picker Institute	National NHS Staff Survey Autumn 2023	National NHS Staff Survey Autumn 2023

The SCORE survey is a nationally recognised tool for measuring culture and engagement. It has been widely promoted for use in Maternity services. It measures 9 dimensions of Culture and 5 dimensions of engagement. Trusts receive their own scores, the percentage change since the last survey (2019 for SGUH and ESTH) and their benchmark percentile ie what proportion of organisations perform worse than them. This means the higher the percentile noted, the better. Most dimensions set a standard of at least 60% positive responses. Below this should be regarded as a cause for concern. Some SCORE survey dimensions are more relevant to good governance than others. For the purposes of this review, results for burnout climate & personal burnout, local leadership, safety climate, team work, improvement readiness and decision making have been incorporated. Multiple measures within the NHS staff survey cover similar themes and have been used for triangulation.

2.2 In addition, between mid-November 2023 and January 2024, discussions were held with the two Maternity teams, divisions, sites, Group and the 2 LMNS, culminating in two workshops on 26th January and 26th February. Observations of several meetings were also undertaken to gain a sense of how things work in practice. More emphasis was placed on the SGUH site given the CQC rating and concerns shared by MSSP. The lines of enquiry aimed to assess current arrangements using the model of quality governance set out on page 8. This considers governance across three dimensions



3.0 Analysis

Reviewing the approach using the model highlights a number of potential contributory factors to the gap between what senior leaders knew and what they needed to know. The greatest volume is in the Anatomy / Structural category. Given these have been designed in, they can equally be designed out. Although less numerous, there are powerful influences which are in the Physiology / Relational aspects where beliefs and behaviours are very much at the heart. These may take longer to change but the benefits are likely to go beyond the Maternity services if successful. The table below highlights the themes and impacts from the analysis.

3.1 Anatomy

Theme	Current concerns and implications	Recommendations
Strategy	Strategy. A clinical strategy normally acts as a golden thread linking the aspirations and direction for the service with routine quality planning, quality control, quality improvement and quality assurance. That does not appear to be the case for either Trust – strategy and quality governance seem to exist in parallel rather than fusing to create a coherent quality system. Assurance reporting does not report on progress on the strategies or risks to achieving them creating a gap in oversight. External reviews. MSSP and CQC have noted annual plans which should be helping to set priorities for teams and individuals are out of date. This suggests the process of operationalising strategy as part of business planning needs to be more robust. Future direction. Staff contributing to the workshops recommended developing a single strategy for maternity services to set a clear direction for people working in both organisations and maximise the benefits of Group.	Co-create a single 3 to 5 year maternity strategy for GESH with staff, stakeholders and service users. Ensure it has SMART (Specific, Measureable, Achievable, Realistic, Timebound) objectives embedded. Build in the recommendation from MSSP to include the **7** features of safety into the new document 1. Commitment to safety and improvement at all levels, with everyone involved 2. Technical competence, supported by formal training and informal learning 3. Teamwork, cooperation, and positive working relationships 4. Constant reinforcing of safe, ethical, and respectful behaviours 5. Multiple problem-sensing systems, used as basis of action 6. Systems and processes designed for safety, and regularly reviewed and optimised 7. Effective coordination and ability to mobilise quickly Ensure that there is total quality management system in place to embed the aims of the strategy. An example from East London Foundation Trust is given here ELFT's Quality Management System - Quality Improvement - East London NHS Foundation Trust

		: Quality Improvement – East London NHS Foundation Trust. Embedding this approach in Maternity may provide a useful model for other services.
Roles and Responsibilities for leadership and governance	Group Complexity. Maternity services now exist in a highly complex multi-site group where the boundaries and responsibilities between local teams, division, site and group are complex and difficult to navigate practically and politically. Staff reported finding it difficult to understand who they should escalate to and in what order. This was exacerbated by their limited understanding of what Group roles do in practice. Introducing a Group Chief Midwifery Officer has added to the confusion. The lengthy job description and lack of an organogram makes it difficult to understand lines of accountability, the level of authority the role carries and how the interface with site leadership should work. This has the potential to create unhelpful tensions for the postholder and staff within the services navigating the new arrangement. Once the issue of future management arrangements for Women and Children's Services has been resolved (see next section), it would be helpful to revisit the Group Chief Midwifery Officer role and describe clearly it's fit with site leadership teams and the reporting line for the two Directors of Midwifery. The experience of the current postholder should be used to shape the end state. In the meantime, the most productive change would be to be clear how this new Group role works constructively with the leadership teams of the two sites so that the division of responsibilities is clear and all involved feel they know what they need to know, when they need to know it. Stability and cohesion. Each trust has had stable medical leadership but periods of churn in the Director of Midwifery (ESTH) and the General Manager (GM) for Women's Health (SGUH). Both teams need a period of stability, time and support to gel as a collective.	Develop a clear Responsible, Accountable, Consulted and Informed analysis and organogram to set out the accountability and authority of the Group Chief Midwifery Officer, the site teams, divisions and Maternity teams, whilst discussions are progressing on future management arrangements for Women and Children's Services. (see next section) Prioritise developing the relationships between the Group Chief Midwifery Officer and the two site Managing Directors, Chief Medical Officers and Chief Nursing Officers. Agree touchpoints between the Group Chief Midwifery Officer and site leadership teams to ensure the approach to Maternity quality is coherent and joined up. Refresh the existing Executive protocol for escalation of issues to Group, test it with Maternity staff and recirculate. Recruit substantive GM for SGUH service and explore team coaching support, particularly for the SGUH team. Pursue the MSSP suggestion to recalibrate maternity roles and responsibilities at SGUH, including ensuring there is clarity on the DoM role within the divisional leadership arrangements.

	Clarity of Responsibilities. The staff survey suggests staff working in maternity in both trusts have a clearer sense of their own responsibilities than those of members of the wider team, but the specialty performed better than both Trust averages. This echoes MSSP concerns at SGUH that roles and responsibilities between bands of midwifery are particularly in need of recalibration to address historic behaviours. Director of Midwifery (DoM) roles in the Structure. Whilst the DoM at ESTH is explicitly included in the divisional Quad for Women's and Children's services, the position remains unclear for the equivalent role at SGUH and therefore her ability to be aware of and influence areas of interdependency may be impeded.	
Capacity for leadership and governance	There appears to be no direct relationship between workload and the capacity allocated to governance work. Detailed data is included in Appendix 2. This issue affects a number of levels. Divisional oversight of Maternity varies significantly between SGUH and ESTH. The CWDT division has oversight of Women's Heath quality, risks and compliance alongside Intensive Care, Paediatrics, Pharmacy, Therapies, Diagnostics and Outpatients. The SGUH Clinical Chair only has 1 Programmed Activity (PA) more than his ESTH equivalent, despite having 5 additional directorates to oversee. Women's Health Leadership. Although the triumvirate structure is the same across the two trusts, there is less allocated PA time for the Clinical Director for Women's Health at SGUH than her ESTH equivalent, despite SGUH being a specialist service handling high risk, complex cases. This role was also noted to be perceived as 'a poison chalice' by MSSP, with limited appetite from clinicians to act into the role.	Develop an options appraisal for future management arrangements for Women and Children's services and implement the agreed preferred option. This might include leveraging the benefits of Group by progressing integration or a stand-alone Women and Children's Division at the St George's site to allow greater leadership and management bandwidth. Once this is completed, revisit how the Group Chief Midwifery Officer role fits with divisional and site leadership and the line management arrangement for the Directors of Midwifery. Review medical leadership and governance roles using the governance workload data collated by the two Clinical Directors included in Appendix 2. Leverage MSSP support to benchmark medical resourcing for a tertiary unit. Ensure that action is being taken to address involvement of Neonatology in joint safety work at the Epsom site.

	Governance leadership. The two midwifery led governance teams are structured and resourced differently. They also have different approaches to their work. The benefits of working more across group have not been fully realised but there is an appetite to address this and move towards a more integrated infrastructure. The two teams have suggested a model which has a shared senior layer responsible for both Trusts Maternity quality governance work, with some site-specific resource eg for safety investigations. The organisation can either elect to do this over time, remodelling specific posts as they become vacant, or move more quickly via a formal consultation. The Group Chief Midwifery Officer has requested the teams start to describe a new end state. Many of the conversations about the Maternity service have focused on midwifery, because of staffing and cultural concerns. The role of medical leadership and expertise in Obstetrics, Anaesthetics and Neonatology has been underplayed. Given the need for quality governance to be multidisciplinary, it is critical that infrastructure is considered in the round and the workload associated with the two Obstetric services is taken into account. A comparator of governance workload based on 2023 data is included in Appendix 2 and tends to show greater safety investigation workload per 1,000 births at St George's. MSSP is likely to be better placed to obtain comparator data for other tertiary units to inform the wider conversation about team job planning and consultant capacity. At present it is unknown whether NHS England will repeat the Maternity staffing Census conducted in 2023. If this is requested, there may be an opportunity to flag the need for additional medical resource. The lead for Obstetrics at ESTH wears numerous other leadership hats and would therefore create a significant gap	Co-design and work towards an integrated multidisciplinary governance infrastructure for Maternity, Gynaecology and Neonatology across the 2 Trusts. On receipt of a proposal, agree the pace at which the organisation wishes to move in that direction. Include more measures of staff wellbeing in the routine Maternity report and share learning across the two teams on work-life balance to continue to monitor health and safety eg staff absence due to stress, health and safety incidents affecting staff such as verbal and physical assaults, experiences of discrimination and burn out risk. Implement the existing recommendation to develop Band 7 & 8 midwives, new and existing consultants and create a talent pipeline.

	if she were to step down. Recruitment of new consultants aims to reduce the focus on a single individual. Engagement in governance from Neonatology at Epsom has also been highlighted as a gap, which requires medical support from the lead and the Divisional Medical Director to address. Resilience. Both services have experienced a deterioration in burn out climate (ie the perception that the service is burning out colleagues) and risk of personal burnout. The risk of personal burnout was felt most acutely by midwifery staff. Burnout may compromise willingness to take on additional responsibilities including governance and leadership roles. Bucking the trend, an improvement in work-life balance was noted in the ESTH SCORE survey. Talent Management and Succession Planning. Both CQC and MSSP highlighted the need for a more structured approach to developing the next cohort of medical and midwifery leaders, particularly Band 7 and 8 midwives, new and existing doctors.	
Robust risk architecture	The Board Risk Appetite Statement should be sending a clear message about what the Board wants escalated upwards. Neither team appeared to be aware of the risk appetite statement, so it is not surprising neither Trust's Maternity Risk and Governance Framework makes no reference to it. This suggests a potential disconnect between the intent of the Board and the practical application of risk appetite in other tiers of the organisation. Both trusts were noted as having a gap between concerns identified as part of external reviews and what is actually recorded on the risk register and therefore formally as part of the risk management process. Observing meetings has shown this continues to be a gap – for example, staff raise concerns in meetings but are not translating those concerns into risks	Establish a group workstream which includes - Co-creating a single group wide risk and governance framework which embeds PSIRF principles and dovetails with the refreshed group risk framework and risk appetite. MSSP will be able to provide good examples. - Sharing best practice in risk management and escalation - Offering training and coaching to staff identifying risks to complete the Trust documentation and ensure the risk register reflects the whole team's concerns. - Ensuring the practical implications of risk appetite are understood and influencing practice

	which need to be documented. The analysis of 2023 risks on the 2 Trusts risk registers shows that ESTH had nearly twice the number of risks scoring 12 or over on their risks register (See Appendix 2). Given the degree of regulatory and operational concerns about Maternity at St George's this disparity is worth looking into. If risks are missed locally, they are likely to be off radar for others in the hierarchy. MSSP also noted limited Maternity risks on the corporate risk register, suggesting the gap is not just at the local level. Identification and mitigation of risks is not yet a team wide activity. Although any member of the Maternity teams can *theoretically* identify a risk and influence the risk register, both Maternity teams identified lack of team confidence using Trust processes to describe, score and capture mitigations for concerns identified. At SGUH, this results in the governance team being asked to complete the risk assessment rather than the staff who have noted the risk and are best placed to determine the potential impact and necessary mitigating steps. MSSP also noted that members of the team such as specialist midwives and those with professional development opportunities did not seem to be shaping the view of risks. At ESTH, staff struggle more with understanding the scoring matrix. This needs coaching and training to address. Different mechanisms are in place in each Trust to oversee risks locally. ESTH has dedicated weekly meetings on a cycle, discussing specific types of risk eg Safeguarding. SGUH relies on a slot at the governance meeting to discuss risk. In practice this means only the very top scoring risks are aired. This focus on a small proportion of risks is then replicated at the Divisional level. There is no dedicated time for the leaders within SGUH maternity service to review the *whole* register.	- Refresh local and corporate risk registers to take on board observations made by CQC and MSSP

	There is an opportunity to level up good practice and ensure systems ensure risk identification, scoring and mitigations match the 'worry list' of staff working in the service and compliance gaps.	
Lean Effective Meetings	Meeting burden. Analysis of information supplied by the two trusts suggests there are 220 hours of meetings where maternity is discussed at SGUH every month and 163 hours at ESTH. This volume of meetings is not providing sufficient assurance but does consume significant time. Both trusts have monthly maternity governance meetings but the scope of what is discussed is different and would benefit from some consistency to ensure there is adequate coverage of all pertinent aspects of quality. Without this, it will be difficult for the team to have a holistic view of quality and relay that view upwards. Proportionality. Meetings tend to be focused on safety, with far less time spent on clinical effectiveness, patient experience and risk. This misses the need to have a broad view of what is and isn't working, before using exception reporting to focus on areas of concern. There is not always a direct relationship between risk and the prioritisation of items for discussion. Opportunities to hone the focus onto areas which are greatest quality risks or barriers to progress may be being missed. Complexity of external reporting. Currently the two trusts have to report to two LMNS, two Maternity Voices Partnerships and multiple local authorities. Staff report having to produce different reports for different audiences or similar information but in different formats. This results in governance staff having to transpose information into different templates.	A leaner approach to meetings is adopted to release time for planning and implementing improvement. The methodology Good Governance Institute used with University Hospitals Morecambe Bay focuses on assessing meeting value Lean governance – focusing on what you want to achieve | Good Governance (good-governance.org.uk). Units should be supported to re-think their local meetings to distill what is needed to support assurance and engagement, frequency, members and quoracy. At unit level, the *NHS Institute Productive Leader series 'Meetings Management'* guide might be a more helpful approach. The Improvement Director has an electronic copy which can be shared. Sites may wish to consider where there may be economies to make in frequency, membership or quoracy or where there are opportunities to have a joint cross-trust meeting. A single report on Maternity which serves the purposes of LMNS and Maternity Voices Partnership (MVP) would also help to reduce the time needed to prepare for external meetings. A common understanding of what ought to form standard items and the forward plan for the main governance meeting would be particularly beneficial. This may be a helpful area for MSSP to support. Agree one report for internal and external audiences to reduce the amount of time spent preparing for senior internal and external meetings. Executive support may

		be required in the discussions with external organisations.
Common understanding of what counts as Assurance	Different thresholds for assurance. The process of gathering evidence of progress against CQC must and should dos has highlighted different staff views of what good assurance looks like. If there is variability, there is room for risk. This variability is particularly problematic in a system where staff have to present assurance evidence to multiple audiences, where the standard for assurance can be different. For example, Surrey Heartlands LMNS were intending to set up a separate meeting to receive evidence of compliance against the latest set of CQC must and should dos. One, joined up process working to one standard would reduce risk and save duplicate meetings. Many assurance reports rest on an action being completed eg SGUH Board report on CQC actions July 2023. The standard for full assurance should include evidence the impact of the change has been felt and the change has a reasonable chance of being sustained. The GESH threshold should include all 3 components. Gaps in assurance have been identified. There is no ward to board assurance on progress towards the maternity strategy and no reports currently provide assurance on compliance against national screening standards, including Antenatal and Newborn Screening. Instances of lack of ongoing assurance were also noted eg the Board has not had assurance on Ockenden compliance since August 2022. Whilst a number of the recommendations have been subsumed into other oversight mechanisms, it is worth ensuring that nothing critical is missing. In addition, although the Board signed off the decision to diverge from the approach to fetal growth monitoring used in most trusts at the SGUH site, it is not clear how the organisation is assured this is as effective/more effective on an ongoing basis.	The Board sets and communicates clear standards for assurance. The Group establishes a Compliance Evidence Assurance Panel, Chaired by the Group Chief Midwifery Officer. This involves site and external stakeholders in a single discussion on whether a regulatory requirement has been met. This would review evidence of action, impact and sustainability and make recommendations for closure to GESH Quality Group. Support will need to be provided by quality governance staff in divisions and corporate teams to aid teams progressing through the process. A detailed paper to describe this is due at Executive on 16th April. Routine Maternity reports need to ensure ongoing reporting of compliance against historic recommendations which remain relevant eg Ockenden requirements which have not been subsumed into other oversight processes and assurance the SGUH fetal growth monitoring protocol is at least as effective as the systems used in most other trusts. This could be included in the clinical effectiveness section of the new report template. The Group CMO has suggested Quality Committee in Common receives an Annual Report covering compliance against **all** Screening Programmes delivered by GESH. Maternity would include an update on Antenatal and Newborn Screening within this report. Produce a map of the assurance evidence held in Maternity against the CQC Single Assessment Framework quality statements, share findings and action plans to close gaps at site level and Executive Quality Group. Cascade the request to other teams likely to

	In 2023, the CQC moved to a new assessment framework with a number of changes to the evidence requirements. To reduce the risk of surprises at future inspections, it would be beneficial to proactively ask teams to identify the evidence they have available to evidence the quality statements in the five domains. A starter for ten has been shared with both Maternity teams. Our new single assessment framework - Care Quality Commission (cqc.org.uk).	be the subject of an inspection in the next 12 months or where line of sight of compliance may be limited eg those with current concern flags or not inspected for over 4 years.

3.2 Physiology

Theme	Current concerns and implications	Recommendations
Assurance Reporting	Maternity has a complex set of compliance requirements to monitor, with some nuance in what they measure. Current reporting tends to report 'slices' of how the service is performing eg compliance with CNST standards or CQC must dos. Quality Committee members reported finding it difficult to get a sense of the whole, progress since the last report and impact on risks. Some NEDs were unaware the CNST technical guidance sets out a core information set required for Board in order to meet the governance safety standard. Filtering. MSSP and CQC inspections have raised concerns about the Maternity report not being presented by the Maternity teams themselves. As well as missing the opportunity to offer their expertise, staff reported that their absence from the discussion meant it was hard to get feedback from QCIC and Board. Some of the filtering may also be the result of gaps in psychological safety (see later).	The current is amended to provided a more holistic view and close a number of gaps - Quarterly thematic analysis of complaints, claims and incidents as well as individual cases since last report - Clinical effectiveness compliance (audit, policies, guidelines) - Progress meeting all outstanding regulatory actions not just CQC - More patient experience feedback and quality improvement activity including progress meeting Maternity Voices Partnership requested actions, Baby Friendly accreditation - Progress on the strategy is reported biannually once the current separate strategies have been refreshed. - More consistent and timely staff feedback eg results of the SCORE and NHS staff surveys - Metrics need to include more visibility of avoidable harm eg progress on smoking cessation, fetal

		growth monitoring, and maternal medicine - Glossary of terms A first iteration of this new report has been developed but it is likely to require further iterations to take account of staff suggestions, Board feedback and changing requirements eg latest CNST guidance. Staff involved in producing the report are able to attend QCIC to understand the needs of Non Executive chaired committees and to contribute to the discussion where appropriate.
Use of Data	Making sense of the data can be challenging for non-specialists. The QCIC report is moving to incorporate SPC reporting to allow readers to distinguish normal from special cause variation. ESTH has struggled to provide this due to IT issues involving the version of Excel which can be supported. Triangulation also needs to be developed – particularly analysis of the interplay between staffing levels (midwifery and medical) and safety indicators. The slides developed for SGUH CQC assurance were a helpful step in this direction. Narrative and benchmarking are essential to make sense of the data, particularly to judge the effect of SGUH providing specialist services. MBRRACE external reviews have provided useful benchmarking but this could be extended to a wider data set. Data currently highlights nationally recommended indicators such as stillbirths, incidents of Hypoxic brain injury and postpartum haemorrhage. There is less visibility of indicators which evidence suggests have an impact on avoidable harm eg interventions highlighted in the Saving Babies' Lives care bundle. QCIC currently gets information on individual cases investigated by the Trust	Staff responsible for producing the reports are given time to attend Making Data Count training, particularly the modules on narrative, benchmarking and triangulation. Making this a core competency for leaders would be a positive step. A refresh of the metrics reported routinely is undertaken to ensure senior leaders have visibility of factors key to reducing avoidable harm and health inequalities.

	or HSIB. However, thematic reviews which help to see the bigger picture and inform quality priorities have been missing. There are well known national inequalities issues in Maternity, Both Trusts serve pockets of deprivation and diverse populations. At SGUH SIDM a number of incidents have been discussed where black women who reported concerns felt they were not listened to. It is difficult to glean from current reports whether the organisation is making in-roads to close the outcomes and experience gap, for example, whether services are being effectively targeted.	
Agility	The pattern of having a monthly QCIC meeting has disrupted the normal flow of reporting through Division, Site, Executive to Board as the timeframes for reporting struggle to incorporate the different meeting cycles. This means levels of management were missing the opportunity to scrutinise, challenge or support issues being raised. This has been addressed with the move to bimonthly QCIC from April 2024.	Create a forward plan to indicate when reports are due at Maternity governance, Divisional Governance, Site and Executive Management Team prior to submission to QCIC.
Psychological Safety	Research suggests that, in **all** types of organisation, there is likely to be a gap between perceptions of how easy it is to raise concerns or contribute ideas and the reality. The key findings of the Hult Ashridge report 'Speaking Truth to Power at Work' are included in Appendix 4. Whilst GESH senior leaders may perceive themselves to be open, approachable and keen to hear from staff, it would be wise to assume this will not be everyone's experience. The state of psychological safety will determine what is included in reports, how it is weighed and framed. At St George's, CQC and MSSP both noted 'Management' having a blaming style which suppresses the ability to speak openly. Specific examples were cited around feedback on the CQC report and handling the change in bank pay rates.	The cultural change programme for GESH incorporates learning from the Hult Ashridge report and works toward a problem sensing approach culture-and-problem-sensing.pdf (nhsproviders.org). This would be a helpful area to explore at Board development and with GESH Top 100 leaders. The Board session held to learn lessons from Cardiac Surgery at St George's may also be helpful to revisit. Further work is also required to embed Just Culture. The PSIRF implementation plan is a critical driver for re-setting how learning is extracted and used. The current Patient Safety Incident Response Plans for the two Trusts set out the framework for the new system – investigatory priorities, changes in structures and oversight. There is

	One of the inhibitors of psychological safety is formal meetings, with long agendas and limited time per item as this gives participants limited time to gather their thoughts and determine how to contribute. Given the information provided in Appendix 3, this is likely to be a contributory factor. There are indicators in recent inspections, the 2 NHS staff surveys and SCORE surveys that suggest the pattern in the Hult Ashridge report is an issue at GESH. (See Appendix 5 for full details) Staff at both organisations felt there was encouragement to report errors, near misses and incidents, feedback on changes made in response and confidence raising concerns about unsafe practice. However, there was much less confidence that staff involved in an error were treated fairly and that it was safe to concerns other than about unsafe practice. This suggests there is still a perceived gap between Just Culture and staff reality. The staff survey includes questions about trust and autonomy. Perceptions of the freedom in how the team does their job was an issue for both services. The concerns were more apparent for SGUH. A good relationship between staff and their local managers, healthy team working and constructive resolution of differences all promote psychological safety. Local leadership, team working and safety climate domains had all declined from the 2019 SCORE survey baseline. Only one area of the local leadership domain in was above standard (predictable leadership visibility) in the SCORE surveys for both trusts. Many of the themes, echoed in the NHS staff survey, suggested staff would welcome more individual feedback about their performance. Similarly, scores for constructive resolution of disagreements in the best interests of patients was well below standard. There was also a concerning gap between the value service staff ascribe to and those	mention of learning and sharing but limited detail on the approach to just culture which is crucial to make this work. Mersey Care has a well developed programme described here. Restorative Just and Learning Culture :: Mersey Care NHS Foundation Trust The Human Resources functions at ESTH and SGUH do a deep dive on a subset of staff survey indicators to identify outlier clinical teams across the wider organisation. Questions on reporting culture (Q19 and 20), Q7 (team working) and local leadership (Q9) are particularly key. This may identify other teams where there may be a gap between what is being surfaced, managed and quality risks senior leaders need to be aware of. The local SCORE and staff survey findings for Maternity are explored with the two teams, particularly the issues of providing feedback, conflict resolution, involvement in decision making, perceptions of inequitable treatment and leadership values. The Perinatal Culture and Leadership Programme includes coaching and facilitation which could support this work. The findings should be used as part of a leadership ‘re-set’.

	of 'facility leadership'. There was low confidence suggestions about quality would be acted on was act both trusts. National evidence suggests BAME staff are disadvantaged in being able to speak up either to raise concerns or contribute ideas. Previous staff surveys, Freedom to speak up cases and CQC have highlighted staff experiences of discrimination, bullying and harassment at both Trusts. In the 2023 staff survey at ESTH 83.7% maternity respondents agreed with 'Not experienced discrimination from manager/team leader/other staff' against a Trust average of 88.9%. On the question 'Not experienced harassment, bullying or abuse from other colleagues' the team scored 72%, well below the Trust average of 80.2%. The issue was more significant at SGUH, where the team performs below Trust average for multiple questions - 'Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public', ''Not experienced harassment, bullying or abuse from other colleagues', 'Organisation acts fairly on career progression', 'Not experienced discrimination from patients/service users, their relatives or members of the public', 'Not experienced discrimination from manager/team leader or other colleagues'.	

1.3 Reflexivity

Theme	Current concerns and implications	Recommendations
Assurance quality governance is effective	Quality governance processes are a means to an end not an end in themselves. The core purpose is to promote continuous learning and improvement in order to improve outcomes and experience and reduce avoidable harm. For Boards to get assurance their quality governance is achieving that core aim requires getting to the nub of whether learning ad improvement are effective. In the past, assurance often came in the form of indicators	Use the NHSE guidance and suggested questions to agree what a new assurance framework might look like and how the sources of evidence would be gathered.B1465-4.-Oversight-roles-and-responsibilities-specification-v1-FINAL.pdf (england.nhs.uk).

	such as whether investigations have been completed in a specific time frame. That tells an organisation whether the learning is timely, not whether it is making a difference. The move to PSIRF provides an opportunity to re-examine the way organisations get assurance that governance is meeting its core purpose. NHS England has published guidance on oversight of PSIRF including the role of the Board. This focuses on principles for oversight and encourages leaders to think about themes such as the quality of learning and whether quality improvement skills and capacity are aligned to bridge learning and practice. NHSE Patient Safety team has confirmed that no organisation currently has a well developed approach to PSIRF assurance. However, there are questions the Board can use to shape their response, some of which have come from discussions with the original author of the PSIRF document. - What is the experience of patients and families involved in safety and complaints investigations ? Did the trust behave transparently and honestly? Were the questions they wanted included and answered ? - What is the experience of staff taking part in internal investigations and external processes such as Coronial inquiries? Were they able to be honest and open about the circumstances of the incident or complaint ? Were they supported by their team and the organisation ? Was the key learning reflected in the investigation outcome ? - Does soft intelligence and surveys such as the staff survey suggest GESH is a place people can speak up either to raise concerns, challenge the status quo or share ideas ? - Are we, as leaders, getting a clear picture of the themes in our learning and is this reflected in the quality priorities being set ? - Are there changes in the themes over time and any evidence we are making inroads into known areas of concern eg inequalities in maternity ? - Are we prioritising and building expertise in quality improvement and safety	Report your outcomes in the AGS for 24/25 financial year and keep refining the process. Local teams are encouraged to develop their own equivalent view of the effectiveness of learning and reflect on this at governance half days. The two maternity teams have some of the data needed to inform their own version from the staff survey and SCORE surveys.

	science overall and the places where we have quality concerns ? - Do teams have the time and support to do the quality improvement work needed to respond to learning ? If GESH builds this new approach to ensuring quality governance is working as it should and reports the outcomes in the Annual Governance Statement (AGS) year on year , the organisation will be ahead of the curve.	
Improvement Readiness	The Improvement Readiness dimension of the SCORE survey tests staff perceptions of the team's ability to find and fix quality defects. Both trusts scores have declined since 2019. Findings were below standard on the question of whether systems effectively fix problems and improve quality, whether learning systems enable insights into successes and having protected time for reflection and learning. The NHS staff survey notes that ESTH and SGUH Maternity services were below the Trust average for '*Members of the team often meet to discuss the team's effectiveness*'	The recommendation to adopt a leaner approach to meetings, develop outcome measures for governance and improve the availability and narration of quality information would all support improving these issues.
Learning mechanisms	Gaps in being able to apply learning effectively have been identified in both CQC and MSSP reviews. • Failure to close the loop between identifying poor compliance, acting on the results and embedding learning. The reports noted poor compliance with areas such as antenatal risk assessment, sepsis screening for babies, MEOWS, born before hospital rates, haemoglobinopathy screening, medicines audit, and lack of benchmarking still birth rates against peer at SGUH. The Antenatal and Newborn Screening Quality Assurance report similarly noted weaknesses in processes to notify the NHSE team of relevant incidents on Datix, deaths of babies or to communicate screening results to women who miscarried or chose a termination.	The workstream to integrate governance teams and approaches includes sharing best practice in disseminating learning and developing stronger mechanisms to ensure the loop is closed between concerns about quality, action plans and evidence of embedding. Agree whether Quality Improvement competence is a requirement for clinical and managerial leadership and conduct analysis of how many staff in the Maternity services have had QI training.

	• Both CQC and MSSP noted weak processes for disseminating patient safety outcomes and learning at St George's. Historically the service has tended to rely on email to disseminate learning, but has taken steps to consult staff on how they want to be communicated with if they are unable to attend meetings to hear discussions first hand. Given ESTH have been commended for their systems by CQC this may be an area where leveraging the benefits of being in a Group would be helpful. • Opportunities to broaden engagement of the wider team and stakeholders in improvement efforts to remedy quality problems were picked up both by CQC and MSSP. • SCORE and the national staff survey both explore how far staff feel able to contribute to decision making and improvement – 32% of ESTH and 22% of SGUH participating in the SCORE survey gave a positive response. There is a marked gradient between the degree to which staff felt able to influence at local level versus feeling they had a voice in the wider organisation.	

4.0 Implications

This review was commissioned to gain and full and honest assessment of why the extent of issues at SGUH were not fully understood by the Board. The information

collected suggests there are a multiplicity of factors involved and to address these effectively really requires root and branch improvement. Iterative changes at the

margins may not go far enough to build confidence in Maternity or other areas of quality governance. Not all the contributory factors are equal and therefore there is

scope to prioritise. The top priorities are highlighted in bold below.

Theme	Recommended actions

Strategy	Co-create a single 3 to 5 year maternity strategy for GESH with staff, stakeholders and service users. Ensure it has SMART objectives embedded. Build in the recommendation from MSSP to include the **7** features of safety into the new document. Use the strategy as the basis for a Total Quality Management approach to quality. (p8-9)
Roles and Responsibilities	Produce a Responsible, Accountable, Consulted, Informed analysis to clarify the relative roles of the Group Chief Midwifery Officer, Site Leadership Teams, Divisional Leadership teams and Maternity triumvirates, whilst discussions take place on future management arrangements for Women and Children's Services. (p9) **Clarify the touchpoints between the Group Chief Midwifery Officer and the site leadership teams to ensure all involved are fully informed and involved and the division of labour is clear. (p.10)** Refresh the protocol for escalation of issues to Group and test it with Maternity staff. Reshare with all Divisions. (p10) **Pursue the MSSP suggestion to recalibrate maternity roles and responsibilities at SGUH, including ensuring there is clarity on the DoM role within the divisional leadership arrangements at SGUH (p10)**
Leadership & Governance Capacity & Capability	**Conduct options appraisal for future management arrangements for Women and Children's services and implement preferred option. This might include leveraging the benefits of Group by progressing integration or replicating the ESTH structure of a stand alone Women and Children's Division at the St George's site to allow greater leadership and management bandwidth. Reassess how the Group Chief Midwifery officer role fits into the future arrangement and the implications for line management of the two Directors of Midwifery (p11)** Recruit substantive General Manager for SGUH service and explore team coaching support (p9) **Review medical leadership and governance roles using the data collated by the two Clinical Directors contained in Appendix 2 and workload comparator. Enlist MSSP support to gather benchmarking data from other tertiary centres to support the wider discussion about team job planning in Obstetrics and Gynaecology. Ensure support is in place to improve Neonatology involvement in joint safety work at Epsom. (p.11)** Co-create an integrated multidisciplinary governance infrastructure for Maternity, Gynaecology and Neonatology to support levelling up practice, promote learning across sites and reduce duplication of effort. On receipt of a proposal, agree the pace at which the organisation wishes to move to the new end state(p.12-13) Expand the measures of staff wellbeing in the routine Maternity report and share learning across the two teams on work-life balance. (p12-13)

	Implement the MSSP recommendation to develop Band 7 & 8 midwives, new and existing consultants and create a talent pipeline. (p12-13)
Risk Architecture & Management	Establish a group workstream which includes - Co-creating a single group wide risk and governance framework which embeds PSIRF principles and dovetails with the group risk framework and risk appetite - Sharing best practice in risk management and escalation - Ensuring the practical implications of risk appetite are understood and influencing practice - Refresh local and corporate risk registers to take on board observations made by CQC and MSSP (p14-15))
Lean, Effective Meetings	**Utilise a methodology such as the Good Governance Institute - Morecambe Bay or NHS Institute for Innovation and Improvement Meeting Management approach to identify where meeting structures could be streamlined to reduce duplication and release time (p16, p26)** **Develop a more consistent approach to the information which should flow through a Maternity Governance Meeting to promote a helicopter view of quality and inform exception reporting upwards (p16)**
Strengthening Assurance – Organisational	Agree Board standards for assurance and communicate clearly to teams submitting reports (p 17) Ensure that there is an annual assurance report on compliance with Screening standards, including Antenatal and Newborn Screening. (p17)
Strengthening Assurance – Maternity	**Maintain focus on sustaining delivery against existing regulatory compliance actions and continue the work commenced to map sources of assurance against the CQC Single Assessment Framework. Report gaps and plans to address them to Divisions, site and Group. Utilise the experience in maternity to identify other teams where this type of assessment may reduce the risk of surprises at reinspection. (p17-18)** **Pilot an Evidence Assurance Panel in Maternity to encourage teams to set a robust bar for compliance requirements. If this proves beneficial, expand the approach**. (p17)
Improving Reporting	**Ensure there is 1 holistic maternity report which serves multiple audiences, including the 2 LMNS ESTH reports into. Encourage staff producing the reports to take up Making Data Count introductory, narrative, benchmarking and trajectory setting modules. (p18-19)** **Review the indicators in the Maternity dashboard to ensure senior leaders have greater visibility of *avoidable* harm (eg Saving Babies Lives indicators such as smoking cessation, fetal monitoring, management of diabetes etc) and the impact on health inequalities (p19)**

	Enable maternity staff involved in producing the reports to attend Quality Committee in Common to understand the needs of a NED chaired committee, support iterative improvements to the report and enable them to participate in the discussion as appropriate (p.21) **Produce a forward plan with clear reporting deadlines for division, site, Executive and Group meetings to allow teams to plan their work and share their intelligence with the tiers of management in the right order (p21)**
Organisational Culture	**Commit to embedding Psychological Safety and encouraging 'problem sensing' mindset as a core leadership requirement at organisational level as part of the next phase of organisational development (p21))** **Strengthen the Patient Safety Incident Response Plans to embed good practice in establishing a just culture, using learning from organisations such as Merseycare. (p21)** **Carry out deep dive on the sub-set of national staff survey indicators highlighted in Appendix 4 to identify other teams where there may be gaps between what is being surfaced and the issues in the service to inform Phase 2 of the external review (p.21-22)** **Carry out further analysis and engagement to explore the issues of authority and autonomy raised by the national staff survey 2023, (SGUH being the priority) to inform the approach to organisational development and the accountability framework. (p 22)**
Local Maternity Culture	Continue work to build local Maternity psychological safety particularly through feedback, involvement in decision making, fair and equitable staff management, resolution of differences and improved communications (p20-22) Explore the issues raised in SCORE about facility leaders approach to living the same values through the support provided by the Perinatal Culture and Leadership Programme and use findings to reset behaviours and expectations (p22) Encourage sharing of effective mechanisms for disseminating learning from ESTH to SGUH and evaluate the QI capability within Maternity and Neonatology (p22-23). Agree whether QI capability should be a core management competency. Explore learning from each other on wellbeing (p13)
Effectiveness of Quality Governance	**Use the NHSE guidance and suggested questions to agree what a new assurance framework for quality governance effectiveness might look like and how the sources of evidence would be gathered.B1465-4.-Oversight-roles-and-responsibilities-specification-v1-FINAL.pdf (england.nhs.uk).**

	Report your outcomes in the AGS for 24/25 financial year and keep refining the process. (p.24) Local teams are encouraged to develop their own equivalent view of the effectiveness of learning and reflect on this at governance half days. The two maternity teams have some of the data needed to inform their own version from the staff survey and SCORE surveys (p24)

The scale of what is required may look overwhelming and therefore it is important to acknowledge the assets the Group has in its favour to tackle these issues.

- Period of stability of leadership in each of the Maternity Triumvirates
- Significant experience and expertise within the two teams
- An appetite to work across the two teams to harness the benefits of Group for staff and for patients and reduce duplication of effort
- In-house expertise in Making Data Count, OD and Quality Improvement
- Willingness from external partners including the LMNS and NHSE to provide support for making changes
- Additional investment into staffing on each site
- Additional capacity and professional leadership in the form of the Group Chief Midwifery role
- Maturing Group infrastructure, with corporate teams gradually slotting into place
- Opportunity with implementation of PSIRF to focus on where investigation and learning can add most value

5.0 Recommendations made

5.1 Senior Leadership were asked to:

- Note the detailed observations of governance and culture at each Trust and Group level.
- Consider the Executive response ahead of the report being reviewed at April QCIC and May Board.
- Note the risks identified for delivery of the improvements and mitigations required.
- Consider the relevance of findings for the broader approach to quality governance.
- Identify any areas where the Improvement Director is required to support implementation.
- Note the plan for priorities signed off by GEM to be worked up and submitted for discussion and approval at a future meeting.
- Provide feedback to Divisions and Maternity teams on next steps.

Glossary

AGS – Annual Governance Statement. A core component of the Trust Annual Accounts

CNST – Clinical Negligence Scheme for Trusts, annual risk management self assessment process

GGI – Good Governance Institute

LMNS – Local Maternity and Neonatal System

MSSP – NHS England's Maternity Services Safety Programme, part of the Chief Nurse's directorate

MVP – Local Maternity Voices Partnership

NHS Institute – the NHS Institute for Innovation and Improvement which produced the 'Productives' series of guides to improve team efficiency and effectiveness

QI – Quality Improvement

PSIRF - Patient Safety Incident Response Framework, which has replaced the serious incident framework

PSIRP - Patient Safety Incident Response Plan – the local response to the new national framework

RACI – Responsible, Accountable, Consulted, Informed analysis

SCORE - Safety, Culture, Operational Risk, Resilience/Burnout and Engagement scale used as a core component of the national Perinatal Culture and Leadership Programme

SMART – Specific, Measurable, Achievable, Realistic, Timebound

St George's University Hospitals
NHS Foundation Trust

Council of Governors

Meeting in Public on Thursday, 18 July 2024

Agenda Item	3.1 - Appendix 1	
Report Title	**Executive Response to the Independent Review of Maternity Governance**	
Executive Lead(s)	Arlene Wellman, Group Chief Nursing Officer Richard Jennings, Group Chief Medical Officer Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Arlene Wellman, Group Chief Nursing Officer. Richard Jennings, Group Chief Medical Officer. Stephen Jones, Group Chief Corporate Affairs Officer. Sarah Hodgson, Business Manager, GCNO & DIPC	
Previously considered by	Group Board Quality Committees-in-Common Group Board (development session) Group Executive Meeting	04 July 2024 27 June 2024 6 June 2024 28 May 2024
Purpose	**For Noting**	

Executive Summary

Following the CQC inspection of St George's maternity unit from 22 March 2023 to 23 March 2023 and the receipt of the CQC report on 17 August 2023, Dr Sally Herne, NHSE Improvement Director, was commissioned by the Group CEO and Chairman to undertake an Independent Review of Maternity Governance.

The Independent Review paper was considered and discussed at the Group Executive Team Meeting on 16 April 2024 and discussed at the Quality Committees-in-Common on 25 April 2024.

The Executive Team was in broad agreement with the direction of travel indicated by the many recommendations, and the CEO asked the GCNO, the GCMO and the GCCAO to prepare a formal Management Response to these recommendations.

This Management Response paper summarises the recommendations, grouping them thematically, and describes the agreed actions being undertaken in response to them and specifically identifies the four immediate priority actions:

- **Culture** – evaluate the Work in Confidence tool. *Sarah Hodgson is setting up a demo for the GCNO, GCMO & GCCAO in June 2024.*
- **Governance & Risk –** Co-create a single, group-wide risk and governance framework. *The introduction of a new risk framework is underway, led by the GCCAO.*
- **Strategy –** Co-create a single 3-to-5 year maternity strategy for gesh with staff, stakeholders and service users. *This will be led by the GCMidO with support from the gesh Strategy Team.*

- **Structure –** Conduct an options appraisal for future management arrangements for Women & Children's services and co-create an integrated multidisciplinary governance infrastructure for Maternity, Gynaecology and Neonatology. *This will be site-led but under guidance from the Group.*

Accountability will lie with the identified action owners. The Executive will have clear and regular oversight of progress through the gesh Quality Group which meets monthly and at which, a Maternity Services update will be a standing agenda item.

Action required by Council of Governors

The Council of Governors is asked to:

a) Note the management response to the recommendations made in the report (under 'comments'), in particular those where work is already underway and the allocation of accountable individuals.
b) Note Management's recommendation of prioritising four key actions.

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Appendices	
Appendix No.	**Appendix Name**
Appendix 1	N/a

Implications				
Group Strategic Objectives				
☒ Collaboration & Partnerships		☒ Right care, right place, right time		
☐ Affordable Services, fit for the future		☒ Empowered, engaged staff		
Risks				
As set out in the original report				
CQC Theme				
☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led
NHS system oversight framework				
☒ Quality of care, access and outcomes		☒ People		
☒ Preventing ill health and reducing inequalities		☒ Leadership and capability		
☐ Finance and use of resources		☒ Local strategic priorities		
Financial implications				
As set out in the original report				
Legal and / or Regulatory implications				
As set out in the original report				
Equality, diversity and inclusion implications				
As set out in the original report				
Environmental sustainability implications				
None identified				

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Independent Review of Maternity Governance – Executive Response

Arlene Wellman, CNO
Richard Jennings, CMO
Stephen Jones, GCCAO

June 2024

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Action 1 – Evaluate the Work in Confidence Tool.

THEME	RECOMMENDATIONS	COMMENTS	ACTION OWNER	DEADLINE	STATUS
Culture	Include more measures of staff wellbeing in the routine Maternity report and share learning across the two teams on work/life balance.	An updated template has been drafted and will be adapted as we learn more. The first version has been shared with Quality Committee ("QCiC") and Board.	GCMidO	30-Aug-24	NOT YET DUE
	Commit to embedding psychological safety and encouraging a 'problem sensing' mindset as a core leadership requirement.	Regular contact will be maintained with the Maternity teams through touchpoint meetings. We have already introduced a strengthened process for case management of Freedom To Speak Up concerns and we are exploring other possible platforms offering staff routes of escalation (e.g. Work In Confidence - an external employee engagement tool). A new gesh leadership course is launching in September 2024. A core component of this will be psychological safety.	Group Executive	30-Sep-24	NOT YET DUE - THE COURSE LAUNCHES IN SEPTEMBER 2024

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Action 1 – Evaluate the Work in Confidence Tool (ctnd.)

THEME	RECOMMENDATIONS	COMMENTS	ACTION OWNER	DEADLINE	STATUS
Culture	Strengthen the Patient Safety Incident Response Plans to embed good practice in establishing a 'just culture'.	**Implementation of PSIRF is progressing.**	**GCNO & GCMO**	**Ongoing review**	**THIS IS NOW A STANDING AGENDA ITEM AT THE MONTHLY gesh QUALITY GROUP MEETING**
	HR function should carry out a deep dive on a subset of national staff survey indicators to identify outlier clinical teams and undertake further analysis/engagement to explore the issues of authority and autonomy raised by the national staff survey 2023 (SGUH the priority).	**The HR team has undertaken an analysis of the top 10 and bottom 10 indicators for staff culture.**	**GCPO**	**Ongoing review**	**PRESENTED AT PEOPLE COMMITTEE ON 20.06.24**
	Continue to build local maternity psychological safety through feedback, involvement in decision-making, fair and equitable staff management, resolution of differences and improved communications.	**Implementation of PSIRF and the 'just culture' has been rolled out across the gesh Maternity teams.** **We have already introduced a strengthened process for case management of Freedom To Speak Up concerns and we are exploring other possible platforms offering staff routes of escalation (e.g. Work In Confidence - an external employee engagement tool).**	**GCPO, GCNO & GCCAO**	**19-Jul-24**	**DEMO OF THE 'WORK IN CONFIDENCE' TOOL WAS HELD ON 19.06.24. AWAITING FEEDBACK AND AGREED NEXT STEPS**

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Action 1 – Evaluate the Work in Confidence Tool (ctnd.)

THEME	RECOMMENDATIONS	COMMENTS	ACTION OWNER	DEADLINE	STATUS
Culture	Explore the issues raised in the SCORE survey (a maternity and neonatal-specific survey) about facility leaders' approach to living the same values (low confidence that suggestions about quality would be acted on across both trusts) through accessing the support provided by the Perinatal Culture and Leadership Programme.	**Improvement work will continue through the Maternity Improvement Programme.**	**Site Maternity Teams**	**Ongoing**	**THIS IS ACTIVELY MONITORED AT THE SITE LEADERSHIP TEAM MEETINGS**
	* Encourage sharing of effective mechanisms for disseminating learning, e.g. from patient safety outcomes and sharing best practice between ESTH (commended for their systems by CQC) and SGUH. * Identify how many staff within Maternity and Neonatology have had QI training. Should QI capability be a core management competency?	**A number of projects are now underway between the Quality Improvement and maternity teams.**	**GCMidO**	**30-Aug-24**	**NOT YET DUE**

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Action 2 – Co-create a single, group-wide risk and governance framework.

THEME	RECOMMENDATIONS	COMMENTS	ACTION OWNER	DEADLINE	STATUS
Governance & Risk	Co-create a single, group-wide risk and governance framework, which: - embeds PSIRF principles and dovetails with the group risk framework; - ensures the sharing of best practice in risk management and escalation, and - reduces disparities between concerns raised by external reviews and concerns raised and recorded on local and corporate risk registers by staff, e.g. through offering training and coaching to staff on raising and recording risks.	A new group-wide risk management framework and policy is already in development and will be in place, following Audit Committee review, in Q2 2024/25. Until this group-wide new risk framework is in place, each trust has in place established trust-specific risk management policies, which were reviewed by internal audit in early 2024 with a reasonable assurance rating. The timescales for the development of the new framework were reported to the Audit Committee in May 2024 as part of the internal audit report. A training and development plan to inform staff about the new framework and effective risk management is also being developed as part of the roll out of the new framework.	GCCAO	01-Dec-24	NOT YET DUE

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Action 3 – Co-create a single 3-to-5-year maternity strategy for gesh with staff, stakeholders and service users.

THEME	RECOMMENDATIONS	COMMENTS	ACTION OWNER	DEADLINE	STATUS
Strategy	* Co-create a single 3 to 5 year maternity strategy for GESH with staff, stakeholders and service users. * Ensure it has SMART objectives embedded. Build in the recommendation from MSSP to include the seven features of safety. Use the strategy as a basis for a Total Quality Management approach to quality.	Work is already underway with the Strategy team. A scoping meeting is scheduled for the w/c 10 June 2024, to explore options and develop a proposal for consideration by the Group Executive.	GCMidO with support from the Strategy Team	Meeting rescheduled to 01-Jul-24	NOT YET DUE

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Action 4 – Conduct an options appraisal for future management arrangements for Women & Children's services and co-create an integrated multidisciplinary governance infrastructure for Maternity, Gynaecology and Neonatology.

THEME	RECOMMENDATIONS	COMMENTS	ACTION OWNER	DEADLINE	STATUS
Structure	* Conduct an options appraisal for future management arrangements for Women & Children's services (and where Maternity Services best sits) and implement the preferred option. Reassess how the GCMidO role fits into the future arrangement. * Co-create an integrated multidisciplinary governance infrastructure for Maternity, Gynaecology and Neonatology to support levelling up practice, promote learning across sites and reduce duplication (e.g. a model which has a shared senior layer responsible for both trusts' maternity quality governance work, with some site-specific resource, e.g. for safety investigations).	**An Options Appraisal paper has been drafted. Group and Site Leadership Teams will meet on 14 June 2024 to progress this.**	**Group Exec leads and Site Leadership Team**	**Meeting rescheduled to 01-Jul-24**	**NOT YET DUE**

St George's University Hospitals NHS Foundation Trust

Council of Governors
Emergency Department Pressures

18 July 2024

Richard Jennings & Arlene Wellman
Group Chief Medical Officer & Group Chief Nursing Officer

18 July 2024

Executive Summary

This slide pack describes the growing pressures on the emergency care pathway, and the quality and safety issues arising from the consequent ED overcrowding, and the measures being taken to improve the situation and to mitigate the risks.

The first slides illustrate the fact that this is a national problem and has increased inexorably for over a decade.

The subsequent slides illustrate the local picture at St George's, list some of the key quality and safety risks that arise from this and illustrate the positive impacts of the improvement work and mitigations that have been put in place.

While a number of important performance metrics have significantly improved, as described here, and while St George's ED performance remains relatively good compared to other London Trusts, and while St George's mortality remains relatively good by national benchmarking, this issue remains one of the most important emerging quality and safety risk for the Trust.

This slide pact focuses on ED because ED is where the biggest impact of the issue is manifested, but the problem is that there are multiple barriers to efficient flow throughout the inpatient pathway and beyond, and much of the most important improvement work continues to be focused on areas outside ED.

Despite the evidence of some positive change, the experience of staff is that things are not getting better, and at St George's (and throughout the Group) staff are increasingly raising concerns about this issue.

Significant challenges to staff wellbeing and patient safety remain, underlining the importance of Trust based and wider system improvement work.

The National Picture: Overview

Emergency Department (ED) waiting times have worsened over the last ten years in the UK due to multiple, interconnected factors. Whilst St George's is consistently in the top ten performers across London overall, there is a downward trajectory in ED performances across the country.

There are a number of key reasons for this wide-reaching decline. There has been a significant rise in the number of patients attending EDs. Factors contributing to **increased demand** include an aging population and an increase in chronic illnesses. Patients can also face challenges in accessing primary care services, leading to ED as the 'front-door' to care. In addition, staff shortages exacerbate these pressures. Recruitment and retention challenges, including post-Covid burnout, have intensified **staff shortages**, leading to a challenging operating environment in our EDs.

Figure 1: ED Waiting time performance has been declining over the past decade

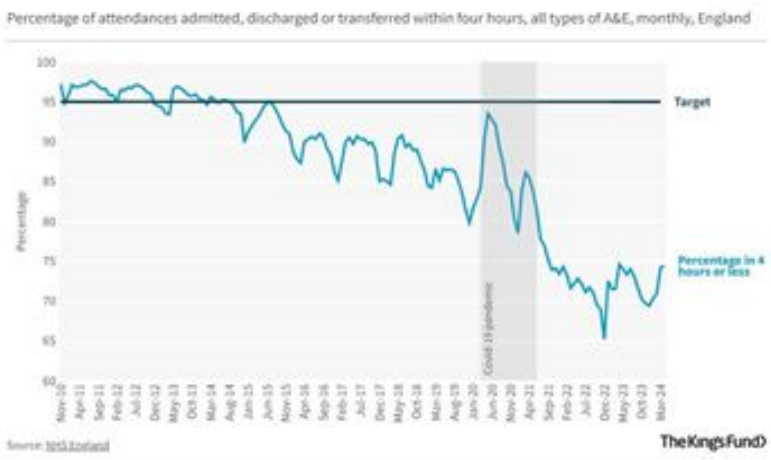
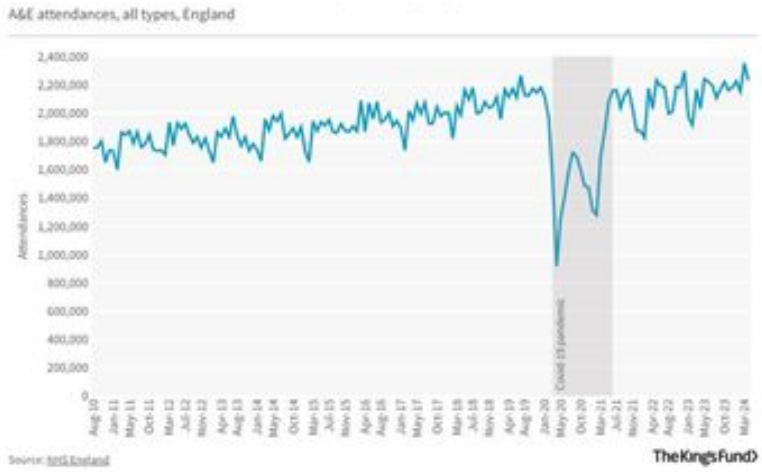
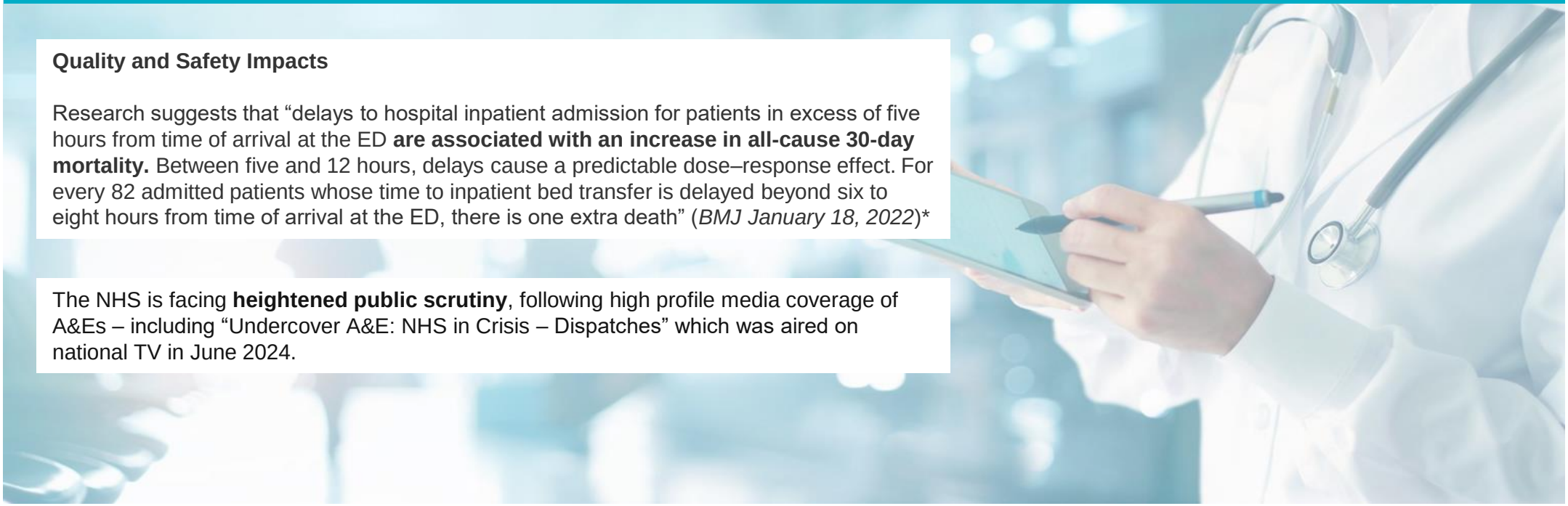


Figure 2: ED Attendances have surpassed pre-pandemic levels



The National Picture: Quality and Safety Impacts



Quality and Safety Impacts

Research suggests that “delays to hospital inpatient admission for patients in excess of five hours from time of arrival at the ED **are associated with an increase in all-cause 30-day mortality.** Between five and 12 hours, delays cause a predictable dose–response effect. For every 82 admitted patients whose time to inpatient bed transfer is delayed beyond six to eight hours from time of arrival at the ED, there is one extra death” (*BMJ January 18, 2022*)*

The NHS is facing **heightened public scrutiny**, following high profile media coverage of A&Es – including “Undercover A&E: NHS in Crisis – Dispatches” which was aired on national TV in June 2024.

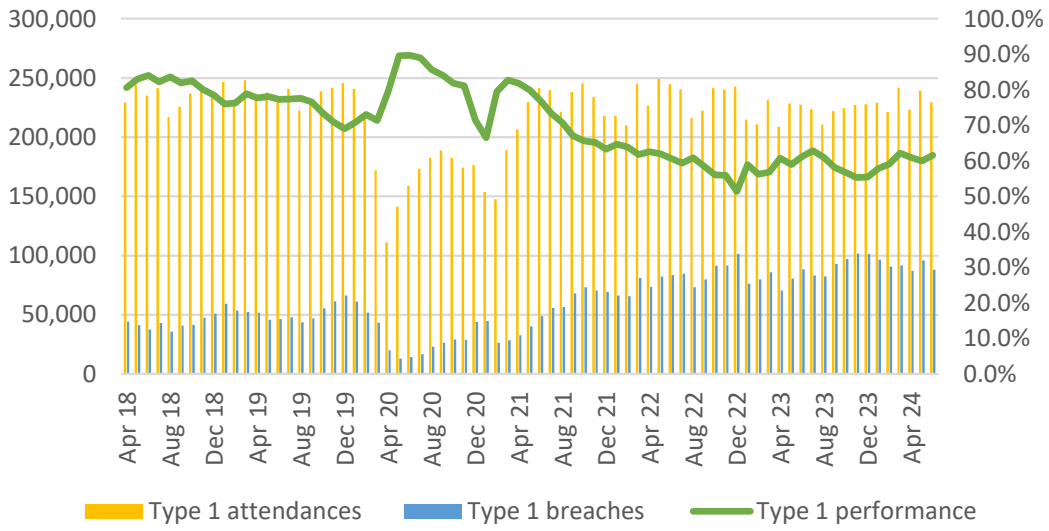
* Ref: *Association between delays to patient admission from the emergency department and all-cause 30-day mortality | Emergency Medicine Journal (bmj.com)*

St George's: Emergency Department Performance

Our Emergency Department is operating in a challenged health and social care landscape, including a cost-of-living crisis which has a detrimental impact on public health. This is overall impacting our ED performance in the following ways:

•**Increased Complexity of Cases**: Patients attending EDs can have more complex medical conditions, requiring longer and more intensive triage and treatment. This increases the time taken to manage each patient, contributing to longer waits.
•**Community Partner Challenges**: Strains on social care partners have made it more difficult to discharge patients from hospitals in a timely manner to the right place of care. This increases the number of beds occupied by patients who no longer need acute care, reducing the capacity for new admissions.
•**Delayed Discharges**: Patients who are medically fit for discharge often remain in hospital due to lack of appropriate community or home care arrangements. This further limits bed availability, and impacts ED.

Figure 3: Emergency Department Type 1** Performance



*Source: Model Hospital NHS
**Type 1 = Attendance to consultant-led 24-hour service

St George's: There is an increase in acute and complex mental health patients presenting to ED

Figure 4: Mental Health Patient Attendances and Length of Stay (LoS) in Emergency Department

Mental Health Patients in ED

An increase in acute and complex mental health patients in ED is due to a number of factors, including a shortage of appropriate places of care outside of an acute hospital and an increase in society of mental illness.

The shortage of appropriate mental health care capacity is having an impact on our ability to ensure these patients receive the right care in the right place. This also has an impact on EDs due to additional pressures on resources and space as patients often remain in our ED for a long period of time before an appropriate place of care is sourced.

St George's: There are quality and safety impacts stemming from these factors

Quality and Safety Impacts

As noted above, published research using large national datasets suggests that ED overcrowding is associated with excess deaths.

Please see related article here: Association between delays to patient admission from the emergency department and all-cause 30-day mortality | Emergency Medicine Journal (bmj.com)

Although SGUH mortality (as measured by Summary Hospital-level Mortality (SHMI) or by the Hospital Standardised Mortality Ratio (HSMR)) remains either "lower than expected" or "as expected", it is quite possible that our inpatient mortality would be still lower (i.e. better) if ED overcrowding did not occur.

Quality & safety challenges arising from ED overcrowding include:

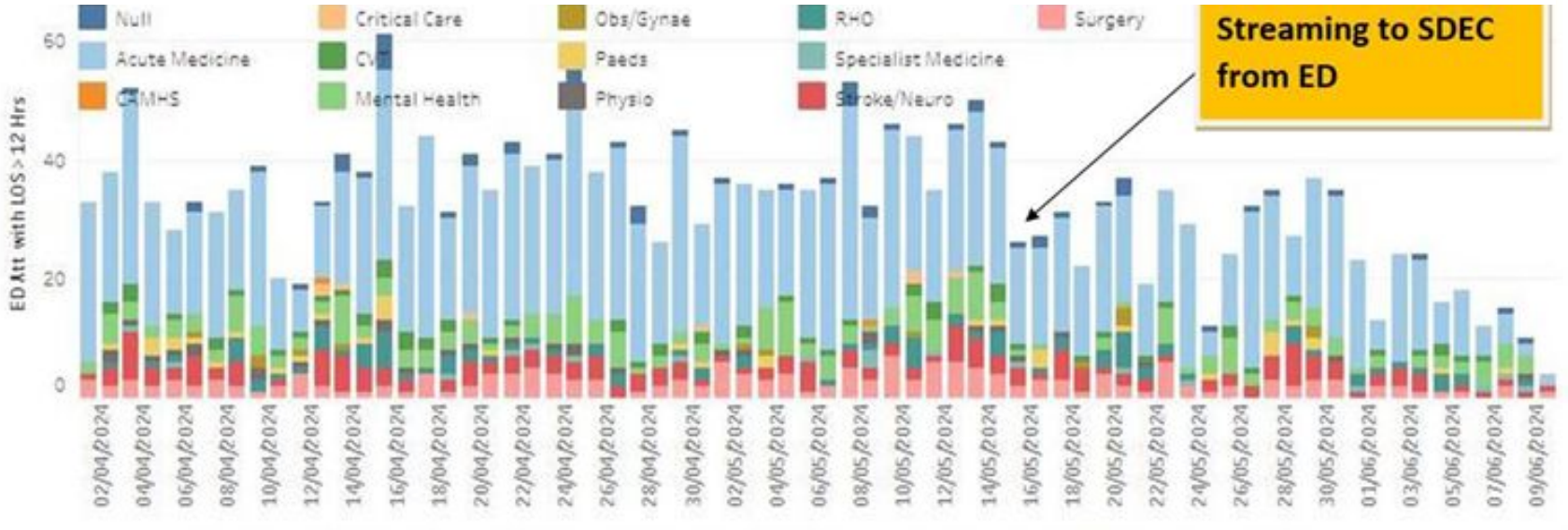
- Risk of delayed ambulance handover
- Patients having to be looked after in corridors
- Delays in investigation & treatment
- More risk in waiting rooms
- Corridor care leading to compromise of privacy, dignity, nutrition, hydration and skin care
- Poorer staff wellbeing

St George's: So what are we doing differently to tackle these challenges? (Slide 1)

The Positive Impact of Direct Streaming to Same Day Emergency Care (SDEC)

The below graph indicates a positive reduction in number of patients waiting over 12hrs in the Emergency Department since the increased focus on Same Day Emergency Care (SDEC) activity has occurred, alongside direct access for LAS to medical SDEC and the launch of a surgical SDEC.

Figure 6: Daily ED attendances (including 111) that were in the department for longer than 12 hours (split by first specialty opinion requested)



St George's - Corridor care: Trend and impact of improvement work

So-called "corridor care" has increased nationally and locally in the face of increasing attendances in ED and a lack of available beds, with significant implications for patient safety and quality of care.

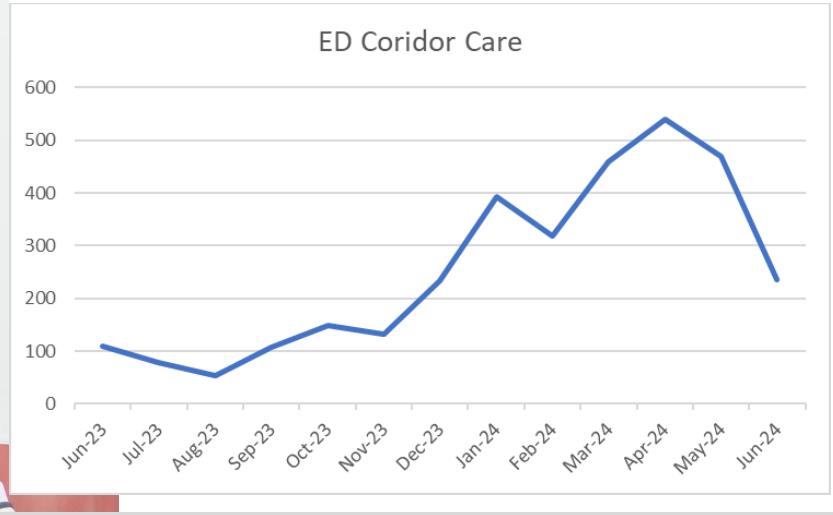
At St George's, in December 2023 there was a notable increase in episodes of corridor care. This was driven by two key factors:

- Firstly the Trust introduced a live bed state system and developed a tool to accurately capture patients receiving corridor care (previous methods underestimated numbers)
- Secondly, the Trust introduced measures to support the system by reducing delays to ambulance handovers, but this in part shifted the waits from ambulances to corridors.

The Direct Streaming to Same Day Emergency Care, however, has improved this situation.

St George's - Corridor care: Trend and impact of improvement work (Slide 2)

Figure 5: "Corridor Care" numbers in our Emergency Department are in Decline



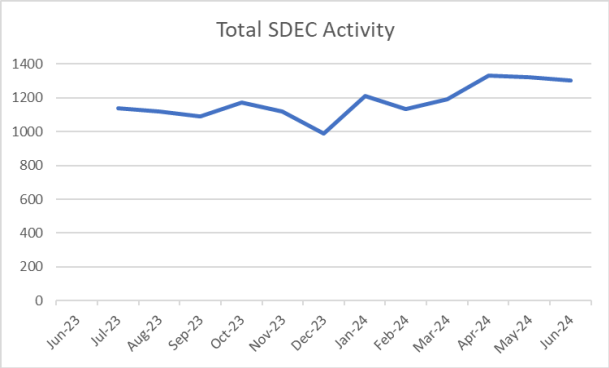
Since April '24 there has been a decrease in "corridor care". This has been achieved at the same time as handover delays from ambulances have been reduced and the number of Decisions-to-Admit (DTA's) in our Emergency Department have also reduced.

St George's: Impacts of Improvement Works (Slide 1)

In addition to SDEC, we have introduced a broad set of measures to improve our performance and strengthen flow throughout the hospital to support efficient patient pathways and tackle overcrowding in our Emergency Department.

1. Strengthening our board and ward rounds, in particular increasing pre-11am discharges.
2. Improving the efficiency of discharge lounge by reviewing data, times of operation, criteria and if a different operation model entirely needs to be considered.
3. Reviewing staffing in place to support flow: This includes increasing the provision of fragility services at the front door and launching a digital discharge tracking system.
4. Strengthen weekend working: For this we are defining how we identify weekend discharges and the role of nurse-led discharge to support efficiency.
5. Interprofessional standards are being re-worked and re-launched to support efficiency.
6. Strengthen our discharge process through a broad variety of means.
7. Strengthen therapy provision which is exploring how we extend front door cover to avoid readmissions to later in the day.
8. Reviewing redirection from ED by working with community partners and frailty services to build more admission avoidance pathways.
9. Strengthen our Urgent Treatment Centre and Same Day Emergency Care (SDEC) by relocating non-SDEC work elsewhere and improving direct access.
10. Reviewing ED workforce to ensure capacity meets needs, and vacancy and sickness is reduced.
11. Improving the use of volunteers is scoping how the voluntary sector can support patient transport, support taking patients home and settling in, as well as supporting patients whilst in our care.

Figure 7: Total SDEC activity in St George's



Same Day Emergency Care has increased since we introduced direct streaming from ED (May '24), with positive impacts on overcrowding, and patient experience.

St George's: Impacts of Improvement Works (Slide 2)

Early Improvements

There has been a positive uplift in the number of patients seen through SDEC environments as a result of a focused project to re-new our commitment to delivering SDEC pathways, this includes providing direct access to LAS where we have gone from the lowest number of direct access referrals to one of the highest in South West London (SWL) (last week being the highest in SWL).

A positive impact of this work is visible in the increase of discharges within two days and a decrease in NEL Length of Stay (LoS).

Figure 8: NEL Length of Stay (past six weeks)

Figure 9: Patients discharged within two days (past six weeks)

A Selection of Success Stories So Far:

- Number of super stranded patients has reduced.
- "St George's Live" and new operations centre has launched, which is supported by a live bed state to enhance real-time patient tracking.
- Rate of patients being repatriated back to their local provider has increased and the delays in achieving repatriation has halved.
- Social care are now back on site and working closely with our transfer of care hub.
- No Criteria to Reside (NCTR) delays have reduced across all pathways.
- Rapid Assessment and Treatment introduced to our Emergency Department, seven days per week.
- SDEC activity increased with London Ambulance Service direct access.
- Pharmacy support service launched enabling five additional discharges per day without having to wait for medications to be delivered.
- Transfer of care hub now covering seven days a week, and on every board round to promote discharge.
- Ambulance handover improving and corridor care decreasing.
- Transfer of care hub now Critical care step down delays decreased.

St George's University Hospitals
NHS Foundation Trust

Council of Governors

Meeting in Public on Thursday, 18 July 2024

Agenda Item	3.3	
Report Title	**SGUH Operational Performance**	
Executive Lead(s)	Group Deputy CEO	
Report Author(s)	Group Director of Performance & PMO	
Previously considered by	N/A	
Purpose	**For Noting**	

Executive Summary

This report provides an overview of the key operational performance information, and improvement actions across St George's Hospitals (SGUH) based on the latest available data.

SGUH reported a number of operational performance improvements and **successes** in May 2024. The key highlights are as follows.

- RTT waits over 52 weeks reduced in April 2024 and exceeded trajectory.
- SGUH performed better than trajectory for Cancer 62-Day Referral to First Treatment waiting times, achieving 78%.
- A new Patient-Initiative Follow-Up (PIFU) process was launched in April 2024. This will increase the number of patients transferred onto the pathway.
- Improvements in capped theatre utilisation were reported at SGUH. The Trust achieved top quartile performance nationally, with 81.4% against the national target of 85%.

A summary of the **key challenges** and **mitigating actions** are as follows.

- The proportion of missed outpatient appointments (Did Not Attend rates) are higher than expected although steadily declining. A number of actions are in place as part of the Outpatient Transformation programme including 2-way messaging functionality, reviewing letter templates and specialty audits that will seek to reduce rates further.

- Urgent and emergency care services continue to experience significant pressures. 4-hour wait performance at SGUH in May 2024 was 76.8%, against a trajectory of 78.6%. The key drivers for operational pressures at both sites are unplaced patients remaining in the Emergency Department including mental health patients impacting on ambulance delays and capacity within the department to see and treat patients. Although overall LAS performance at SGUH remains comparable to previous months, patients are waiting longer to be offloaded, seeing an increase in patients breaching between 30-60 minutes.

Action required by Council of Governors

The Council of Governors is asked to note the report.

St George's University Hospitals
NHS Foundation Trust

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	N/A

Implications				
Group Strategic Objectives				
☒ Collaboration & Partnerships			☒ Right care, right place, right time	
☒ Affordable Services, fit for the future			☒ Empowered, engaged staff	
Risks				
Regulated activities				
CQC Theme				
☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led
NHS system oversight framework				
☒ Quality of care, access and outcomes			☒ People	
☒ Preventing ill health and reducing inequalities			☒ Leadership and capability	
☒ Finance and use of resources			☒ Local strategic priorities	
Financial implications				
Legal and / or Regulatory implications				
Compliance with the Health and Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations				
Equality, diversity and inclusion implications				
Environmental sustainability implications				

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NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

SGUH Operational Performance Report

May 2024

Lead Executive:
Dr. James Marsh, Group Deputy Chief Executive Officer

Outstanding Care, Together: Our strategy 2023 to 2028

Publication Date: 21 June 2024

Executive Summary
Operational Performance

St George's Hospital

Successes

- The Elective Recovery Fund (ERF) activity shows good progress against our plan of delivering 110% of value weighted activity. The 2024/25 internal production plan has now been updated to show numerical and value weighted trajectories for divisions to monitor performance against both values.
- Advice and Guidance utilisation rates at SGUH have improved significantly after agreement with South West London (SWL) to include Referral Assessment Services (RAS) appointments and is now meeting target of 16 per 100 outpatient appointments.
- The new PIFU process was launched on April 24th this will considerably improve our performance and improve our Outpatient value weighted activity as a result over the coming months.
- Number of 52-week waiters on a referral to treatment pathway is ahead of trajectory with the total waiting list size seeing a reduction through April 2024. However, capacity will continue to be impacted by industrial action.
- Cancer 62 Day combined performance achieved 78% ahead of planned trajectory of 75%.
- Theatre capped utilisation rates further improved to 81.4% with continued focus on scheduling, particularly 6-4-2 escalation processes, to ensure fully booked theatre lists.
- Number of patients with a length of stay greater than 21 days has reduced through May 2024 and ahead of planned trajectory.

Challenges

- Faster Diagnosis performance of 71.8% against plan of 74.9% for April 2024. Challenges within Gynae; Reduced access to scans and delay to starting one stop clinics, Lower GI: CTC capacity and endoscopy process delays are contributing factors.
- Whilst theatre utilisation improved, performance was limited due to increased estates issues in May 2024 which caused some delays to the start of lists which lead to over runs, negatively affecting capped theatre utilisation. Clinical and operational teams continue to focus on early discharges and further embedding of the day-of-surgery admission pathways.
- High proportion of beds continue to be occupied by patients not meeting the criteria to reside, and Pathway 2A (Merton + Wandsworth) and Pathway 3 awaiting discharge, adversely impacting on flow from the emergency department to wards and Decisions To Admit (DTAs) in the emergency department.
- 4 Hour Performance did not meet plan in May 2024 driven by high numbers of complex mental health patients in the department, ambulance conveyances waited longer to off load and limited in-and-out spaces to see and treat patients impacted by DTA's.

Operational Performance

Overview Dashboard | Elective Care

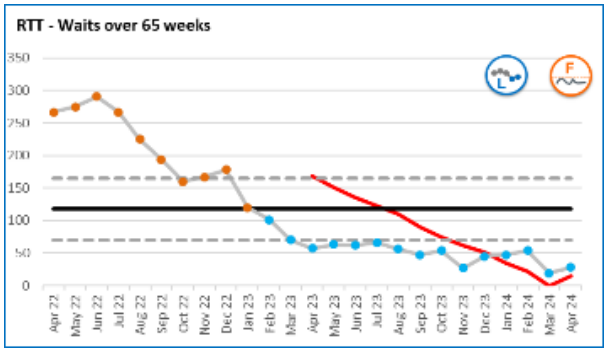
St George's

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Elective Ordinary Activity	May 24	1012	1128	1167			
Elective Daycase Activity	May 24	4743	4580	4517			
Outpatient first attendances without a procedure - ERF scope	May 24	30477	32289	21399			
Outpatient procedures - ERF scope	May 24	24952	22116	15993			
Diagnostic Activity	May 24	19108	21113	19903			
Day Case Rates (BADS Procedures)	Feb 24	70.7%	70.2%	85.0%			Lowest Quartile
Theatre Utilisation (Capped)	May 24	78.2%	81.4%	85.0%			Top Quartile
Outpatients Patient Initiatied Follow Up Rate (PIFU)	Apr 24	0.5%	0.7%	5.0%			Lowest Quartile
First and Procedure Attendances as a proportion of Total Outpatients	May 24	58.9%	58.0%	49.0%			
Outpatients Missed Appointments (DNA Rate)	May 24	10.0%	9.4%	8.0%			Lowest Quartile
Outpatient Advice & Guidance Rate per 100 First OPA	Apr 24	21.2%	17.8%	16.0%			3rd Quartile
RTT - Waits over 65 weeks	Apr 24	19	28	15			Top Quartile
RTT - Waits over 52 weeks	Apr 24	613	499	546			2nd Quartile
RTT - Total Size Incomplete Waiting List	Apr 24	62847	63170	63265			
RTT - Percentage within 18 weeks	Apr 24	65.3%	66.8%	92.0%			2nd Quartile
RTT - Median Waiting Time	Apr 24	11.6	11.7	-			Top Quartile
Cancer - 28 Day Faster Diagnosis Standard	Apr 24	77.6%	71.8%	77.0%			3rd Quartile
Cancer 31 Day Decision To Treat to Treatmnent Standard	Apr 24	96.0%	92.7%	96.0%			2nd Quartile
Cancer 62 Day Referral to Treatment Standard	Apr 24	80.8%	78.0%	70.0%			2nd Quartile
Diagnostics - 6 Week Waits	May 24	1.2%	1.3%	5.0%			Top Quartile
On the Day Cancellations not re-booked within 28 days	May 24	1	1	0			

Targets based on internal plan for DC/EL activity and OP ERF Scope

Operational Performance

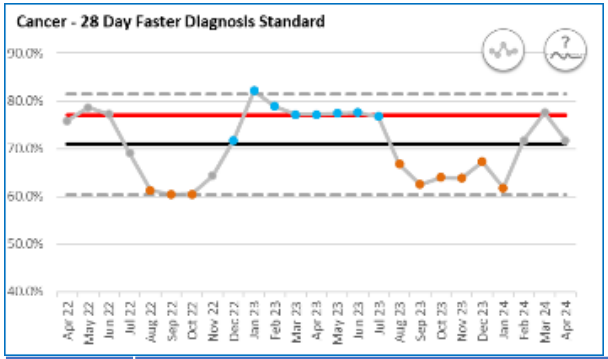
Exception Report | SGUH Referral to Treatment (RTT) 65+ Weeks



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH 65 week waits behind plan of 15 patients	• Reporting 28 pathways against plan of 15. Although it should be noted that the Trust are performing in the top quartile nationally with one of the lowest 65 week wait cases nationally at the end of 2023/24 • We have seen waiting list growth in Gynae, Dermatology, General Surgery and Neurosciences. • Workforce challenges are being addressed • The impact of lost capacity due to industrial action has limited our ability to drive down wait times. Prioritising cancer, urgent and long waits meant the wait list profile changed.	**Production Plan:** The 2024/25 internal production plan has now been updated to show numerical and value weighted trajectories. Providing a one truth forum for divisions to monitor performance and identify areas of challenge requiring solution. **GIRFT Programmes:** The Trust is looking to work with GIRFT on the 'Faster Further' and 'Theatre Productivity' programmes to support an increase in productivity **Waiting List Validation:** We are moving our 'technical' wait list validation process over to the patient portal. This will allow us to run technical validations more frequently with less administrative burden. **Improvement and action plan:** Elective Access meeting has agreed a set of action plans with divisions. Setting measurable benefits, timeframes and action owners.	September 2024	sufficient for assurance

Operational Performance

Exception Report | SGUH Cancer Faster Diagnosis Waiting Times

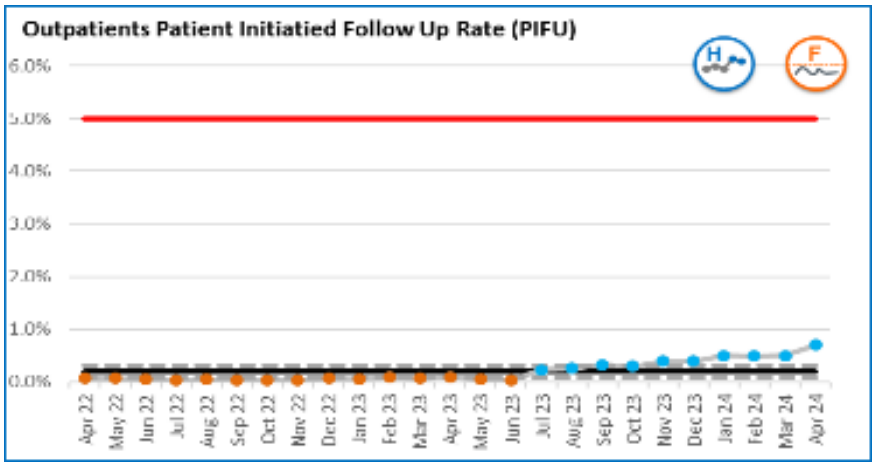


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH FDS – Plan of 74.98% not met	**Faster Diagnosis performance of 71.8% against plan of 74.9% for April 2024.** • Gynaecology reduced access to scans and delay to starting one stop clinics has resulted in a decline in FDS performance. • Lower GI: CTC capacity and endoscopy process delays are contributing factors. • Radiology diagnostic modalities are not consistently achieving the NHSE recommended turnaround time of 7 days for reporting of OP FDS diagnostics. • Pathology: At any given point in the month, 35% of cancer specimens are waiting over 10 days to be reported. • Breast performance has dropped due to access to one stop. • Skin saw a return to baseline performance at 92.7% **62-day Performance was at 78% against a plan of 75% for April 24.** • Theatre capacity constraints continue in Urology and Thoracic Surgery.	• **Summer Resilience funding (70K**) has been awarded for Q1 to support performance delivery. Tumour sites awarded include Haem, H&N, LGI, Derm, Breast and Urology. • **Skin:** The Trust is working on implementation of Teledermatology. • **Gynaecology** plan to run an all-day one-stop clinic at QMH from June 2024. RMP funding has been agreed and will support this service to improve the position. • **Lower GI.** Discharge at scope being worked up and expected to be operational in next three months. Stratified Follow-up will release up to 60 Follow up slots. • **Pathology:** Informatics project to identify all cancer specimens as they enter the lab, to support fast streaming. Currently this is a manual process, which cross references specimens to the cancer PTL after the event. This is not contemporaneous leading to delays in streaming. • **Radiology:** Dashboard under development to support real time tracking of radiology scans and reports against national KPIs. • **Lung thoracic:** The delays are to increased referrals relating to Targeted Lung Health Checks programme. Business case has been developed for additional resources to improve RTT times.	Recovery time scales are dependent on resources	sufficient for assurance

Operational Performance

Exception Report | SGUH Patient-Initiative Follow Up (PIFU)

St George's



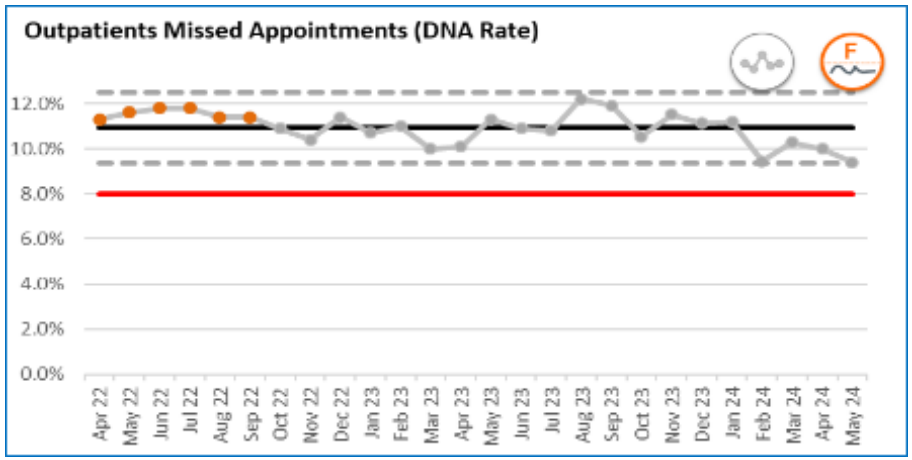
Rate reported one month in arrears in line with Model Hospital reporting

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH PIFU Rate: Consistently not meeting target	In month performance for May was 1.23%(data not yet uploaded to Model Hospital). Activity continues to increase with the technical solution to PIFU now designed and rolled out in 6 services (T&O, Urology, Plastics, Gynae, Dermatology and Therapies). We have now gone live with PIFU functionality in the patient portal as of 14th May 2024 and being used well in a live services.	• Second version of PIFU launched in six services, data showing minimum levels of 1.23% as of May 2024, increase of 0.6% within in March *(completed)* • Third version, due to be ready in September (IT Transformation led project) following consultation with clinical teams. • Remaining GIRFT specialities(Gastro and ENT) are in the process of going live. • Transformation Programme work to identify other recommend pathways *(ongoing)* • Tableau report has now been developed but in draft phase *(new)*	2% planned for July 2024	sufficient for assurance

Operational Performance

Exception Report | SGUH Missed Appointments (DNA Rate)

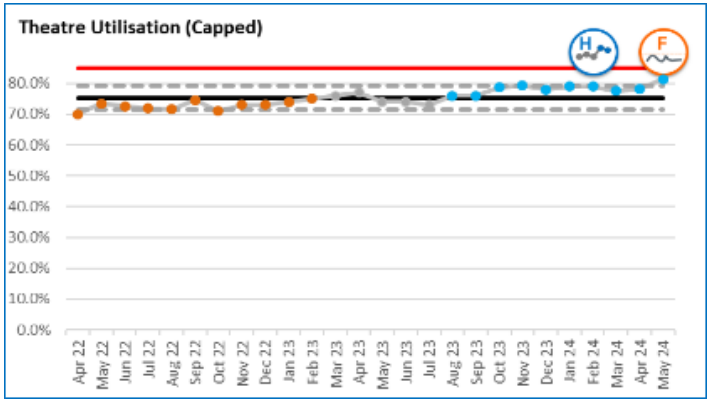
St George's



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH Special cause variation of an improving nature however has consistently failed target	Continued improvement of position and has decreased from 12% to 9%. Submitted data via SUS/SLAM incorrectly included clinic slots "no longer in use / closed", this has artificially inflated our DNA position. This is being reviewed by the BI team to rectify the denominator.	• All services review their appointments that have one way reminder texts monthly for Day 7 and Day 2 before every appointment (one way message to patient but they cannot text back). • Cardiology have had a significant improvement over past three months, reducing their rates from 10.3% in January 2024 to 7.9% in April 2024. In order to further improve they have turned on their 2-way messaging functionality (patient can respond) since 6th May as they have staffing levels currently to support managing their responses • Diagnostics have focus on reviewing letter and text reminders – taking their DNA rates from 6.3% in January 2024 to 1.4% in April 2024 • Being supported by BI to resolve external reporting issues – Recovery data not yet known	TBC	Work in progress to resolve und er-reporting

Operational Performance

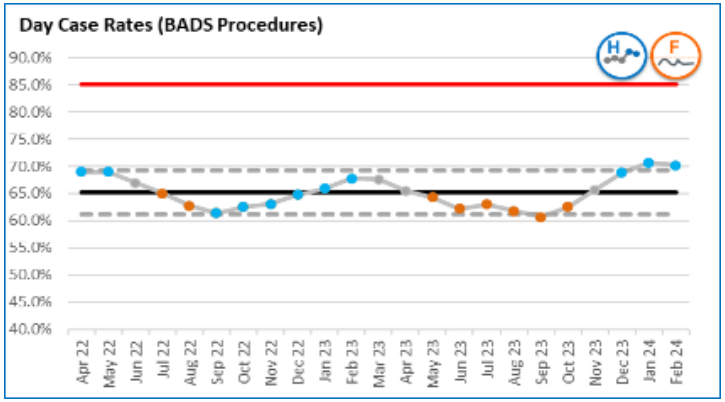
Exception Report | SGUH Theatre Utilisation (Capped)



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH Theatre Utilisation (capped): Consistently not meeting target (85%) and special cause improving trend.	Adherence to 6-4-2 booking principles. Increased estates issues in May 2024 caused some delays to the start of lists which led to over runs, negatively affecting capped theatre utilisation. Theatre utilisation has improved by 3% from April to May to above 80%.	Continued focus on scheduling, particularly 6-4-2 escalation processes, to ensure fully booked theatre lists. New 6-4-2 meeting structure being rolled out w/c 1st July with oversight by the Chief Operating Officer. Theatre performance meeting has been established to ensure lists are fully optimised and booking rules are adhered to. 6-4-2 and scheduling guidelines are being formalised in a document for specialities to work towards. Lists not booked to >75% utilisation with 2 weeks' notice are being reviewed and stood down. Unless there is a clinical exception to this standard. Further work is being planned to understand the scope for improvement of average cases per session across different specialities. Theatre Transformation support started in May 2024, theatre user group meetings are now taking place regularly with each speciality to critically analyse theatre performance, in addition to demand and capacity. The output from these meetings has been positive and has clinical involvement. The groups will also review equipment requirements, ensuring teams have the right kit at the right time, in the right place.	TBC	sufficient for assurance

Operational Performance

Exception Report | SGUH Daycase Rate (BADS Procedures)



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH Day Case Rates (BADS Procedures) not meeting 85% target with improving trend	Data quality issues such as where patients on day case wards (particularly DSU wait) had LoS of 1 or more days. Effects of data correction and improved recording is showing an improving trend.	BADS compliance is being discussed with all surgical specialities within theatre transformation deep dives to explore opportunity. Further work is required to ensure cases are being coded appropriately from DTT. We are also undertaking a significant piece of work on QMH which includes expanding the inclusion criteria at QMH which will increase throughput.	TBC	sufficient for assurance

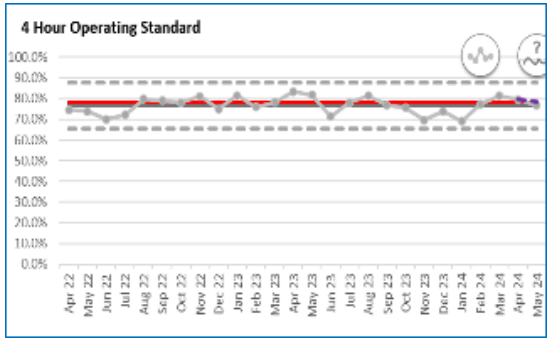
Operational Performance

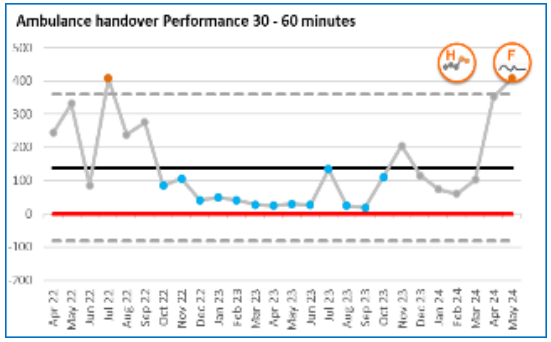
Overview Dashboard | Urgent and Emergency Care

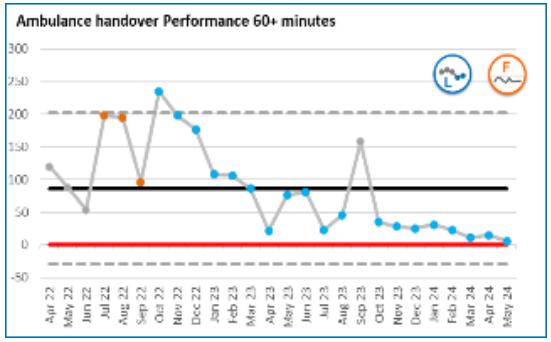
	St George's						
KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
4 Hour Operating Standard	May 24	79.7%	76.8%	78.0%			2nd Quartile
Emergency Department LOS >12 Hours (% of attendance)	May 24	8.8%	7.7%	-			
Ambulance handover Performance 30 - 60 minutes	May 24	352	409	0			
Ambulance handover Performance 60+ minutes	May 24	15	6	0			
Mental health delays 4 Hour Breaches	May 24	123	130	-			
Readmission Rate - Non Elective	Apr 24	13%	11%	-			
Length of stay > 21 days (super stranded)	May 24	180	161	163			
Overnight G&A beds occupancy - Adults	May 24	95.4%	94.6%	96.9%			
Number of patients not meeting criteria to reside	May 24	155	140	91			

Operational Performance

Exception Report | SGUH A&E Waits and Ambulance Handovers



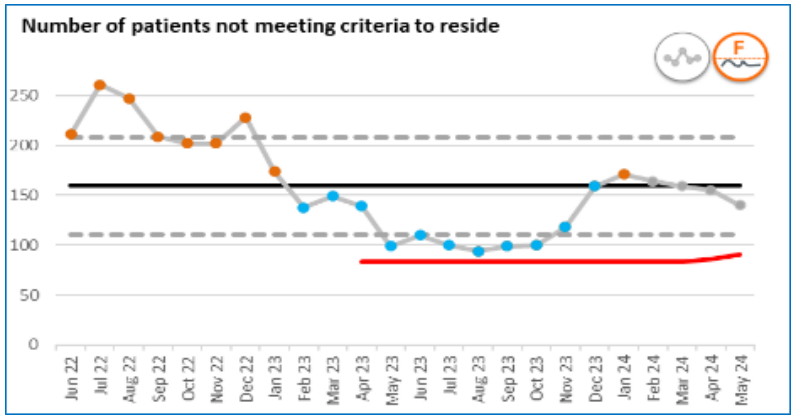




Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH 4 Hour Operating Standard not meeting plan of 78.6% LAS Target consistently not met	Performance in May was 76.8% not meeting plan of 78.6%. The key drivers of operational pressures are: DTA's in department High number of complex mental health patients spending >24hrs in department Limited in-and-out spaces to see and treat patients 78% of 2,696 LAS arrivals were off-loaded <15 minutes. due to an increase in DTA's and pressures within the department, ambulance conveyances waited longer to offload seeing an increase in 30-60 minute breaches. 6 days of >95% non-admitted pathway performance.	Maintaining Extended Emergency Care Unit (EECU) to facilitate waiting of results Maintaining in and out spaces to improve performance and capacity within the department ED to ensure front door RATTING and use of hot clinics is robustly managed Continue to work with 111 to optimise UTC utilisation Community in reach to aid admission avoidance to be pushed for Development of SDEC – medical pathways live 15th May Develop UTC 24/7 Proposal in line with ask from NHSE. Additional EP to front of house for UTC to improve wait times for investigations Navigator at front of house to redirect patients to more suitable healthcare settings in place Monday to Wednesday. Enhanced boarding and cohorting continue to be business as usual across site. Weekly meetings with LAS are underway to resolve issues both Trust and LAS have faced Majors B workstream to streamline clinical effectiveness and treatment areas for patients. SDEC workstream to build SDEC services portfolio LOS workstream to identify where LOS reductions can be made Trusted Assessor Pathway for LAS straight to SDEC	June 2024	ED Performance: sufficient for assurance LAS: Under review

Operational Performance

Exception Report | SGUH No Criteria to Reside (NCTR)



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH NCTR: Consistently not meeting target	High number of patients not meeting the criteria to reside not meeting plan however showing an improving trend. • Largest cohort of patients awaiting; Speciality/ Medical/ Psychology Review or Plan, Care Package (Social) and Residential home - Including interim (Social) • Attributable to on large Wandsworth and Merton Authorities • Specialties with high volumes are Elderly Medicine Service and Trauma and Orthopaedics • There has been significant improvement in the number of NCTR forms completed prior to 9.30am daily, which in turn is now reflecting a more accurate number of patients NCTR	• The Emergency floor and the Integrated Care Transfer Hub have seen benefits in Social Workers & CLCH partners being on site, particularly when working closely with Therapies • Since April there has been united efforts to prevent bedding in SDEC / AAA overnight as ways to reduce admissions and increase flow earlier in the day • Good improvement in earlier discharges however it would be helpful to see this split by ward • Divisional Bronze and consultant of the day review of P0 lists • MADE “style” Events has resumed given increased operational pressure • Transfer of Care team provided vital in-person support on the wards to facilitate discharge • The Trust has replaced Red2Green with the National Criteria to Reside tool for daily electronic tracking patients' readiness for safe and timely discharge to improve patient flow and reduce length of stay. • Focussed sessions with ward teams to improve NCTR data capture and accuracy, supported by Transfer Of Care Team.		sufficient for assurance

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Appendices

Statistical Process Control (SPC)

Interpreting Charts and Icons

	Variation/Performance Icons		
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of a CONCERNING nature.	**Something's going on!** Something a one-off, or a continued trend or shift of numbers in the wrong direction	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an IMPROVING nature.	**Something good is happening!** Something a one-off, or a continued trend or shift of numbers in the right direction. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?

	Assurance Icons		
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Appendix 2

Metric Technical Definitions and Data Sources

Metric	Definition	Strategy Drivers	Data Source
Cancer 28 Day Faster Diagnosis Standard	The proportion of patients that received a diagnosis (or confirmation of no cancer) within 28 days of referral received date.	NHS Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
Cancer 31 Day Decision to Treat Standard	The proportion of patients beginning their treatment within 31 days of deciding to treat their cancer. Applies to anyone who has been diagnosed with cancer, including people who have cancer which has returned.	NHS Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
Cancer 62 Day Standard	The proportion of patients beginning cancer treatment that do so within 62 days of referral received date. This applies to by a GP for suspected cancer, following an abnormal cancer screening result, or by a consultant who suspects cancer following other investigations (also known as 'upgrades')	NHS Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
Referral to Treatment Waiting Times	Monitors the waiting time between when the hospital or service receives your referral letter, or when you book your first appointment through the NHS e-Referral Service for a routine or non-urgent consultant led referral to treatment date.	NHS Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
Diagnostic Waits > 6 Weeks	Percentage of patients waiting for more than 6 weeks (42 days) for one of the 15 diagnostic tests from referral / request date.	NHS Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
Venous thromboembolism VTE Risk Assessment	Percentage of patients aged 16 and over admitted in the month who have been risk assessed for VTE on admission to hospital using the criteria in a National VTE Risk Assessment Tool.	NHS Standard Contract & Constitutional Standard	Local Data
Capped Theatre Utilisation Rate	The capped utilisation of an individual theatre list is calculated by taking the total needle to skin time of all patients within the planned session time and dividing it by the session planned time	NHS Priorities & Operational Planning Guidance	Model Hospital
PIFU Rate	Numerator: The number of episodes moved or discharged to a Patient Initiated Follow Up (PIFU) pathway. Denominator: Total outpatient activity	NHS Priorities & Operational Planning Guidance	Model Hospital
DNA Rates	Numerator: Outpatient missed outpatient appointments (DNAs) Denominator: Total outpatient appointments	Group and System Priority	Model Hospital
Advice and Guidance Rates	Utilisation of Specialised Advice. It is calculated based on the number of 'Processed Specialist Advice Requests' and is presented as a rate per Outpatient First Attendances.	Group, System and National Priority	NHS England Model Hospital
Never Events	Never Events are serious incidents that are entirely preventable	National Framework for Reporting and Learning from Serious Incidents	Local Data
Serious Incidents	An incident that occurred in relation to NHS-funded services and care resulting in one of the following: Acts or omissions in care that result in; unexpected or avoidable death. injury required treatment to prevent death or serious harm, abuse.	National Framework for Reporting and Learning from Serious Incidents	Local Data
Patient Safety Incidents Investigated	Any unintended or unexpected incident which could have, or did, lead to harm for one or more patient's receiving healthcare	National Framework for Reporting and Learning from Serious Incidents	Local Data
Falls	Number of unexpected events in which a person comes to the ground or other lower level with or without loss of consciousness	Gesh Priority - Fundamentals of Care	Local Data
Pressure Ulcers	Number of patients with pressure ulcer (Category/Stage 3 & 4) in the Trust over a specific period of time.	Gesh Priority - Fundamentals of Care/ National Patient Safety Incidents	Local Data
Mental Capacity Act and Deprivation of Liberty (MCADoL)	The Deprivation of Liberty Safeguards are a part of the Mental Capacity Act and are used to protect patients over the age of 18 who lack capacity to consent to their care arrangements if these arrangements deprive them of their liberty or freedom. Percentage of staff receiving MCA Dols Level 2 Training	Gesh Priority	Local Data
SHMI	Rolling 12 months ratio between the actual number of patients who die following hospitalisation at a trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.	NHS Oversight Framework	NHS Digital
FFT scores	Proportion of patients surveyed that state that the service they received was 'Very Good' or 'Good'.	NHS – National Priority	NHS Digital

Glossary of Terms

Terms	Description
A&G	Advice & Guidance
ACS	Additional Clinical Services
AfPP	Association for Perioperative Practice
AGU	Acute Gynaecology Unit
AIP	Abnormally Invasive Placenta
ASI	Appointment Slot Issues
CAD	computer-assisted dispatch
CAPMAN	Capacity Management
CAS	Clinical Assessment Service
CATS	Clinical Assessment and Triage Service
CDC	Community Diagnostics Centre
CNS	Clinical Nurse Specialist
CNST	Clinical Negligence Scheme for Trusts
CQC	Care Quality Commission
CT	Computerised tomography
CUPG	Cancer of Unknown Primary Group
CWDT	Children's, Women's, Diagnostics & Therapies
CWT	Cancer Waiting Times
D2A	Discharge to Assess
DDO	Divisional Director of Operations
DM01	Diagnostic wating times
DNA	Did Not Attend
DTA	Decision to Admit
DTT	Decision to Treat
DQ	Data quality

Terms	Description
EBUS	Endobronchial Ultrasound
eCDOF	electronic Clinic Decision Outcome Forms
E. Coli	Escherichia coli
ED	Emergency Department
eHNA	Electronic Health Needs Assessment
EP	Emergency Practitioner
EPR	Electronic Patient Records
ESR	Electronic Staff Records
ESTH	Epsom and St Helier Hospital Trust
EUS	Endoscopic Ultrasound Scan
FDS	Faster Diagnosis Standard
FOC	Fundamentals of Care
GA	General Anaesthetic
H&N	Head and Neck
HAPU	Hospital acquired pressure ulcers
HIE	Hypoxic-ischaemic encephalopathy
HTG	Hospital Thrombosis Group
HSMR	Hospital Standardised Mortality Ratios
ICS	Integrated Care System
ILR	Implantable Loop Recorder
IPC	Infection Prevention and Control
IPS	Internal Professional Standards
IR	Interventional Radiology
KPI	Key Performance Indicator
LA	Local anaesthetics

Terms	Description
LAS	London Ambulance Service
LBS	London Borough of Sutton
LGI	Lower Gastrointestinal
LMNS	Local Maternity & Neonatal Systems
LOS	Length of Stay
N&M	Nursing and Midwifery
MADE	Multi Agency Discharge Event
MAST	Mandatory and Statutory Training
MCA	Mental Capacity Act
MDRPU	Medical Device Related Pressure Ulcers
MDT	Multidisciplinary Team
MHRA	Medicines and Healthcare products Regulatory Agency
MMG	Mortality Monitoring Group
MRSA	Methicillin-resistant Staphylococcus aureus
MSSA	Methicillin-resistant Staphylococcus aureus
MSK	Musculoskeletal
NCTR	Not meeting the Criteria To Reside
NEECH	New Epsom and Ewell Community Hospital
NHSE	NHS England
NMC	Nursing and Midwifery Council
NNU	Neonatal Unit
NOUS	Non-Obstetric Ultrasound
O2S	Orders to Schedule
OBD	Occupied Bed Days
OPEL	Operational Pressures Escalation Levels

Terms	Description
OT	Occupational Therapy
PIFU	Patient Initiated Follow Up
PPE	Personal Protective Equipment
PPH	postpartum haemorrhage
PSIRF	Patient Safety Incident Response Framework
PSFU	Personalised Stratified Follow-Up
PTL	Patient Tracking List
QI	Quality Improvement
QMH	Queen Mary Hospital
QMH STC	QMH- Surgical Treatment Centre
QPOPE	Quick, Procedures, Orders, Problems, Events
RAS	Referral Assessment Service
RADAH	Reducing Avoidable Death and Harm
RCA	Root Cause Analyses
RMH	Royal Marsden Hospital
RMP	Royal Marsden Partners Cancer Alliance
RTT	Referral to Treatment
SACU	Surgical Ambulatory Care Unit
SALT	Speech and Language Therapy
SDEC	Same Day Emergency Care
SDHC	Surrey Downs Health and Care
SGH	St Georges Hospital Trust
SHC	Sutton Health and Care
SHMI	Summary Hospital-level Mortality Indicator
SJR	Structured Judgement Review

Terms	Description
SLT	Senior Leadership Team
STH	St Helier Hospital site
STG	St Georges Hospital site
SNTC	Surgery Neurosciences, Theatres and Cancer
SOP	Standard Operating Procedure
TAC	Telephone Assessment Clinics
TAT	Turnaround Times
TCI	To Come In
ToC	Transfer of Care
TPPB	Transperineal Ultrasound Guided Prostate Biopsy
TVN	Tissue Viability Nurses
TWW	Two-Week Wait
UCR	Urgent Community Response
VTE	Venous Thromboembolism
VW	Virtual Wards
WTE	Whole Time Equivalent

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Council of Governors

Meeting on Thursday, 18 July 2024

Agenda Item	4.1	
Report Title	**Finance report Month 02 (May)**	
Executive Lead(s)	Andrew Grimshaw, Group Chief Finance Officer	
Report Author(s)	CGFO plus site CFOs	
Previously considered by	Finance Committees-in-Common	28 June 2024
Purpose	**For Noting**	

Executive Summary

The trust is on plan at month 02. The plan position at this point in the year is a deficit.

There are pressures on the plan that are being managed with non-recurrent resources and delivery of the plan by year end is at risk. The key message from the Trust Board to SWL and NHSE is:

- We accept the challenge as set out in the plan.
- We are working hard to identify actions to deliver this plan and manage the pressures we are experiencing.
- At this point in time we have not identified all the actions necessary to deliver the plan.

The paper outlines key actions being taken to help support delivery of the plan by year end. The Group Executive Team are focused on seeking to deliver this and provide regular reports to the Finance Committee and Trust Board.

Action required by the Council of Governors

The Council is asked to note this paper

Committee Assurance

Committee	Finance Committees-in-Common
Level of Assurance	Limited Assurance: The report and discussions did not provide sufficient assurance that the system of internal control is adequate and operating effectively and significant improvements are required and identified and understood the gaps in assurance

Appendices

Appendix No.	Appendix Name
	None

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Implications

Group Strategic Objectives

☒ Collaboration & Partnerships	☒ Right care, right place, right time
☒ Affordable Services, fit for the future	☒ Empowered, engaged staff

Risks

BAF SR4.

CQC Theme

☒ Safe	☒ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

☐ Quality of care, access and outcomes	☒ People
☐ Preventing ill health and reducing inequalities	☒ Leadership and capability
☒ Finance and use of resources	☐ Local strategic priorities

Financial implications

IN support of delivering the Group financial plans.

Legal and / or Regulatory implications

Equality, diversity and inclusion implications

Environmental sustainability implications

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Council of Governors 18th July 2024
2024/25 Month 2 (May) Financial Performance

Group Chief Finance Officer

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Summary Month 2 position

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The summary slides used for the system recovery Board compare actuals to the 12th June plan. All other tables in the report compare actuals against the 2 May plan submission. Given timing of the final plan position during M2 reporting, general ledgers had not been updated for the revised plan position to facilitate full reporting against the 12 June submission.

	Issue	Action
Summary I&E	• Trust on plan after bringing forward NR benefits from later in the year, SGH £2.0m. • Maintaining safe operations across the trust, notably in relation to pressures in the emergency Department are creating costs above the agreed plan. • Delivery of the plan in full by year end should be seen as being at material risk.	• Continued focus on cost control and the development and delivery of CIPs through site management meetings. • Work with system partners to identify actions to address operational pressures.
Expenditure and WTEs	• Pay expenditure is overspent against budget. • WTEs are largely in line with plan	• Increased focus on control actions in key areas notably agency controls all staff groups, medical temporary staff costs, nursing rota management and continued challenge through vacancy control. • Opportunities for system wide work on medical staffing and agency costs. • Management of activity pressures, especially in the UEC pathway in support of both CIP plans and mitigating current pressures above plan.
CIP delivery	• On plan (although the latter includes b/f £1.2m benefit) with £24.0m in opportunity and zero in unidentified.	• Continued focus on CIPs identification and delivery within the Trust. • Work actively with SWL groups to identify other opportunities and system wide actions, including estates, medical staffing and agency.
Capital	• No reported position at M2. • Minor delays in ITU could attract NHSE attention.	• Careful monitoring and forecasting of capital will be required across the year. • Continue focus on key projects.
Cash	• Material pressure on cash could be experienced given potential risk against CIPs and other expenditure pressures.	• Finance Committee updated on current and expected drawdown position. • Maintain focus on cashflow forecasting and management ensuring effective processes in place for working capital management.

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SGH - Summary Reported Position

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Table 1 - Trust Total

		Full Year Budget (£m)	M2 Budget (£m)	M2 Actual (£m)	M2 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Income	Patient Care Income	975.6	83.2	83.8	0.6	165.7	166.8	1.0
	Other Operating Income	152.8	12.8	12.6	(0.2)	25.5	26.9	1.4
Income Total		**1,128.4**	**96.0**	**96.4**	**0.4**	**191.2**	**193.7**	**2.5**
Expenditure	Pay	(719.8)	(61.7)	(61.8)	(0.1)	(123.4)	(123.9)	(0.5)
	Non Pay	(443.4)	(39.0)	(39.3)	(0.3)	(79.7)	(81.6)	(1.9)
Expenditure Total		**(1,163.2)**	**(100.7)**	**(101.1)**	**(0.4)**	**(203.1)**	**(205.6)**	**(2.5)**
Post Ebitda		(25.1)	(3.2)	(3.2)	0.0	(4.0)	(4.0)	0.0
Grand Total		**(59.9)**	**(7.9)**	**(7.9)**	**0.0**	**(15.9)**	**(15.9)**	**0.0**

The Trust is reporting a £15.9m deficit YTD in M2, which is on plan.

Income

- Income is £2.5m above plan, with ERF overperformance of £0.7m and additional income across SWLP and R&D offset by additional costs. The Consultant Pay Award is adjusted. in the planned income and expenditure

Pay

- Pay is £0.5m overspent mainly due to premium temporary nursing costs (agency and bank) across wards driven by high operational demand impacting on ED and wards, mainly Acute Medicine. Pressure in M2 has reduced versus exit run rate from Q4 reducing the pressure on the baseline budgets. The Consultant Pay Award is adjusted in the planned income and expenditure.

Non-Pay

- Non-Pay is £1.9m overspent, due to CIP under-delivery of £0.7m (offset by ERF Income) and additional costs across managed services being offset by additional income. £0.8m of non-recurrent benefits are included in the position.

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SGH revenue metrics Scorecard – compared to 12 June submission

Finance

SGH		YTD Plan	YTD Actual	YTD Variance	RAG	% Variance
OPEX	Substantive	109.3	111.0	-1.6	A	-1.5%
	Bank	10.6	10.3	0.3	G	2.6%
	Agency	3.0	2.7	0.3	G	11.1%
	Total Pay	**122.9**	**123.9**	**-1.0**	**A**	**-0.8%**
	Non-pay	75.9	81.6	-5.7	R	-7.6%
	Total OPEX	**198.8**	**205.6**	**-6.8**	**A**	**-3.4%**
I&E	**Reported I&E**	**-15.9**	**-15.9**	**0.0**	G	0.0%
	Underlying I&E	**-18.9**	**-20.9**	**-2.0**	**R**	-10.7%
Cash	**Cash & cash equivalents**	**49.2**	**52.2**	**3.1**	**G**	6.2%

Total pay costs at SGH are rated amber, with only a slight overspend of 0.8% with challenges in ED and acute wards. Non-pay continues to be high with an adverse variance of £5.7m (7.6%) and this is driving the variance in total OPEX. This variance is part laity drive by a mismatch in income and non pay which is in review. The underlying position is £2m adverse and the Trust has brought forward non recurrent to mitigate. This is driven by challenges in recurrent CIP and operational pressure.

Workforce

SGH		YTD Plan	YTD Actual	YTD Variance	RAG	% Variance
WTEs	Substantive	9,546	9,598	-52	A	-0.5%
	Bank	709	796	-86	R	-12.1%
	Agency	292	140	152	G	52.1%
	Total WTEs	10,548	10,534	14	G	0.1%
Cost per WTE	Substantive	5.7	5.8	-0.1	A	-1.8%
	Bank	7.4	6.2	1.3	G	17.1%
	Agency	5.1	8.5	-3.4	R	-65.9%
	Total WTEs	5.8	5.9	-0.1	A	-1.1%

SGH have hit plan in M2 with reductions in agency nursing reducing month on month.
SGH have significantly lower agency WTEs than plan which is driving a favourable variance against total WTE plan. Agency costs per head, however, were higher than plan so the underspend in cost for agency is not of the same scale and the reduction in WTEs.

Efficiency

SGH		YTD Plan	YTD Actual	YTD Variance	RAG	% Variance
Efficiency	Recurrent efficiency	3.1	2.6	-0.5	R	-16.5%
	NR efficiency	1.8	2.3	0.5	G	28.0%
	Total efficiency	**4.9**	**4.9**	**0.0**	**G**	0.0%

SGH have made up for under delivery in recurrent efficiency by over delivery in non-recurrent efficiency. We will need to ensure that more recurrent efficiency is delivered in year so as not to increase the financial challenge in 2025/26. ERF is on target albeit challenges related to industrial action and cyber attack will impact on delivery.

Performance

Performance data is reported one month behind financial data and as is standard it is not reported at month 1. At month 3 this area will be populated so that we can ensure we are balancing and meeting both performance targets and financial targets

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SGH M2 Headlines and Risks

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The Trust reported position is on plan in M2

- The Trust is reporting a £15.9m YTD deficit in M2, which is on plan.

Underlying position £2.0m adverse to plan YTD at M02

- The underlying position of the Trust YTD is a £2.0m overspend.
- The Trust has had to bring forward £2.0m of non-recurrent benefits to mitigate the YTD position.
    - £1.2m planned non recurrent CIP although the level of brought forward has reduced month on month (M1 was £0.9m rephased versus in M2 £0.3m)
    - £0.8m planned non recurrent baseline which has also reduced in month on month (M1 was £0.7m rephased versus in M2 £0.1m)
- Bringing forward £2.0m of non-recurrent items creates additional pressure in future months that will require mitigating.
- The assumption is these will need to be mitigated in future months to ensure the full year plan is delivered. These additional mitigations will increase the total CIP value needed across the year with monthly CIP delivery in future months needing to be above planned levels. To date actions to address this increase have not been identified.

Drivers of the £2.0m underlying adverse position

- Maintaining safe operations across the trust, notably in relation to pressures in the emergency Department are creating costs above the agreed plan. This includes mental health patients in ED, the need to open beds in corridors in support of ambulance handover times and wider pressures from flow through the hospital.
- £1.2m adverse variance on M2 YTD CIP: this is driven by cost, CIP performance with Elective Recovery Fund (ERF) income being on plan at SGH. Significant work is ongoing with the SGH team to identify and drive further CIP development.
- £0.6m Ward nursing pressures, additional operational pressure has led to overspends versus budget, these costs are reduced versus April but further mitigation is required to bring spend back in line with plan.
- £1.5m adverse underlying non pay pressure driven by pressure within theatres and some non-pay contracts above funded levels of inflation.
- £1.3m favourable variance on other income partially offsetting pressures in pay and non-pay.

St George's University Hospitals
NHS Foundation Trust

Council of Governors

Meeting in Public on Thursday, 18 July 2024

Agenda Item	5.1	
Report Title	Annual Report from External Auditor on Annual Accounts	
Executive Lead(s)	Andrew Grimshaw, Group CFO	
Report Author(s)	Andrew Grimshaw, Group CFO	
Previously considered by	Trust Board	
Purpose	**For Noting**	

Executive Summary

The Trusts External Auditors, Grant Thornton completed their audit of the 2023/24 final accounts in June and submitted their Audit Finding report to the Audit Committee for review. The key findings of the Audit findings report were:

- The Trusts financial statements give a true and Fair view of the financial position.
- The Auditors made five recommendations (medium impact on the control system), pages 34-36 of the report. Management has accepted the recommendations.
- There were a small number of misclassification and disclosure changes agreed as part of the audit process (pages 22-23)
- There were a small number of unadjusted misstatements. These were agreed as immaterial with the auditors (pages 24 and 29).

The Value for Money Audit was also completed this identified one significant weakness in arrangements relating to financial sustainability and the deliverability of CIP targets in 24/25. The trust agreed with this assessment given the scale and challenge associated with delivering the agreed financial plan. The report included four recommendations (pages 20-23), all of which were accepted by the Trust.

The Trust Board reviewed and approved the accounts at an extraordinary meeting on 25th June to allow submission to NHSE by 28th June as required.

Action required by Council of Governors

The Council of Governors is asked to note the report.

St George's University Hospitals
NHS Foundation Trust

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	External Audit Findings Report
Appendix 2	Value for Money Report

Implications

Group Strategic Objectives

☒ Collaboration & Partnerships
☒ Right care, right place, right time
☒ Affordable Services, fit for the future
☒ Empowered, engaged staff

Risks

Regulated activities

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

☒ Quality of care, access and outcomes
☒ People
☒ Preventing ill health and reducing inequalities
☒ Leadership and capability
☒ Finance and use of resources
☒ Local strategic priorities

Financial implications

Legal and / or Regulatory implications

Compliance with the Health and Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations

Equality, diversity and inclusion implications

Environmental sustainability implications

Grant Thornton

External audit findings report

St George's University Hospital NHS Foundation Trust

12 June 2024 reported to the Audit Committee

Updated to 20 June 2024

Grant Thornton

Private and Confidential

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Audit findings for St George's University Hospital NHS Foundation Trust for the year ended 31 March 2024

This audit findings report presents the observations arising from the audit that are significant to the responsibility of those charged with governance to oversee the financial reporting process and confirmation of auditor independence, as required by International Standard on Auditing (UK) 260. Its contents have been discussed with management.

As auditor we are responsible for performing the audit, in accordance with International Standards on Auditing (UK), which is directed towards forming and expressing an opinion on the financial statements that have been prepared by management with the oversight of those charged with governance. The audit of the financial statements does not relieve management or those charged with governance of their responsibilities for the preparation of the financial statements.

The contents of this report relate only to those matters which came to our attention during the conduct of our normal audit procedures which are designed for the purpose of expressing our opinion on the financial statements. Our audit is not designed to test all internal controls or identify all areas of control weakness. However, where, as part of our testing, we identify control weaknesses, we will report these to you. In consequence, our work cannot be relied upon to disclose all defalcations or other irregularities, or to include all possible improvements in internal control that a more extensive special examination might identify. This report has been prepared solely for your benefit and should not be quoted in whole or in part without our prior written consent. We do not accept any responsibility for any loss occasioned to any third party acting or refraining from acting on the basis of the content of this report, as this report was not prepared for, nor intended for, any other purpose.

We encourage you to read our transparency report which sets out how the firm complies with the requirements of the Audit Firm Governance Code and the steps we have taken to drive audit quality by reference to the Audit Quality Framework. The report includes information on the firm's processes and practices for quality control, for ensuring independence and objectivity, for partner remuneration, our governance, our international network arrangements and our core values, amongst other things. This report is available at thttps://www.grantthornton.co.uk/globalassets/1.-member-firms/united-kingdom/pdf/annual-reports/transparency-report-2023.pdf.

We would like to take this opportunity to record our appreciation for the kind assistance provided by the finance team and other staff during our audit.

Paul Cuttle

Director
For Grant Thornton UK LLP

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Headlines

This table summarises the key findings and other matters arising from the statutory audit of St George's University Hospital NHS Foundation Trust ('the Trust') and the preparation of the Trust's financial statements for the year ended 31 March 2024 for those charged with governance.

Financial Statements

Under International Standards of Audit (UK) (ISAs) and the National Audit Office (NAO) Code of Audit Practice ('the Code'), we are required to report whether, in our opinion:

- The Trust's financial statements give a true and fair view of the financial position of the Trust and of its income and expenditure for the period; and
- The Trust's financial statements, and the parts of the Remuneration and Staff Report to be audited, have been properly prepared in accordance with the Department of Health and Social Care (DHSC) group accounting manual 2023/24 (GAM).

We are also required to report whether other information published together with the audited financial statements in the Annual Report, is materially consistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

Our audit work was completed through a combination of remote and on site work during May to June 2024. We have not identified any adjustments to the financial statements which impacts your reported Comprehensive Expenditure figure. We have identified several disclosure amendments where updates were required to disclosures in the accounts to ensure that they complied with the requirements of the GAM. These amendments are detailed on pages 22-27. We have also raised 5 recommendations for management as a result of our audit work. These are set out in Appendix B. Our follow up of recommendations from the prior year's audit are detailed in Appendix C.

There are no matters of which we are currently aware of that would require modification of our audit opinion or material changes to the financial statements, subject to the following matters at the date of writing this report;

- receipt of a response to our legal inquiries;
- receipt of management representation letter and
- review of the final set of financial statements.

We have concluded that the other information to be published with the financial statements, is consistent with our knowledge of your organisation and the financial statements we have audited.

Headlines

Value for Money (VFM) arrangements

Under the National Audit Office (NAO) Code of Audit Practice ('the Code'), we are required to consider whether the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. Auditors are required to report in detail on the Trust's overall arrangements, and set out our key recommendations on any significant weaknesses in arrangements identified during the audit.

Auditors are required to report their commentary on the Trust's arrangements under the following specified criteria:

- Improving economy, efficiency and effectiveness;
- Financial sustainability; and
- Governance

As part of our work, we considered whether there were any risks of significant weakness in the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have identified a risk of significant weakness in the Trust's arrangements around financial sustainability. We summarise our findings to date on page 18.

We have completed our work on Value for Money arrangements and our findings are set out in our Auditor's Annual Report which was provided to those charged with governance alongside this report.

As in the prior year we have identified a significant weakness in the Trust's arrangements in relation to financial sustainability.

Statutory duties

The National Health Service Act ('the Act') and the National Audit Office Code of Audit Practice also require us to:

- report to you if we have applied any of the additional powers and duties ascribed to us under the Act; and
- to certify the closure of the audit.

We have not exercised any of our additional statutory powers or duties.

We expect to certify the completion of the audit in June 2024.

Significant Matters

We note there have been a improvement in management responses to audit queries and the quality of working papers provided compared the prior year. However we have still encountered some delays in the responses to the return of full return of sample documentation and to audit queries during the audit that has delayed our progress.

Specific areas which have presented a delay are the resolution of sample and audit queries around: variable income samples, starter/leaver/change of circumstances in employees sampling and capital additions/payables/reclassifications.

We planned our resourcing on the audit to complete the audit by the 14 June 2024 ; a target communicated to the Trust finance team. The teams worked collaboratively to try to meet this target, but some of the delays in receiving samples and query responses have meant some takes were being completed beyond this target date.

Our approach to materiality

As communicated in our Audit Plan dated January 2024, we determined materiality at the planning stage as £17m based on 1.5% of prior year gross operating costs. Following receipt of the draft financial statements, we have reconsidered planning materiality based on the final financial statements. We have retained our determined materiality for the fieldwork stage at £17m. Although the gross expenditure for the Trust has increased, in order to mitigate audit risk we have kept materiality at the same level as the planning materiality previously reported in the Audit Plan

Our approach to determining materiality is set out below.

Basis for our determination of materiality

- We have used 1.5% of prior year gross operating costs as the basis for determining materiality.
- The basis for determining materiality is consistent with the prior year as the trust's activities are driven by patient activity, therefore this is the most accurate determinant of the scale of the organisation.

Reporting threshold

- We will report to you all misstatements identified in excess of £300k, in addition to any matters considered to be qualitatively material.

Our approach to materiality

Materiality area	Single Entity Amount (£)	Qualitative factors considered
Materiality for the financial statements	17,000,000	This is equivalent to approximately 1.5% of the Trust's operating expenses for the period ended 31 March 2024. As communicated in our audit plan, we determined materiality at the planning stage as £17m based on prior year operating expenses. We have determined that gross expenditure in year is the appropriate benchmark as the Trust's activities are driven by patient activity, therefore this is the most accurate determinant of the scale of the organisation.
Performance Materiality for the financial statements	11,900,000	The performance materiality has been set at 70% of financial statement materiality. This reflects our risk assessed knowledge of potential for errors occurring. Performance materiality is used for the purposes of assessing the risks of material misstatement and determining the nature, timing, and extent of further audit procedures. This is the amount we set at less than materiality for the financial statements as a whole to reduce to an appropriately low level the probability that the aggregate of uncorrected and undetected misstatements exceeds materiality for the financial statements as a whole.
Trivial matters	300,000	We will report to you all misstatements identified in excess of £300k as this is the reporting threshold for any errors identified as part of our work on the National Audit Office's Whole of Government Accounts (WGA) exercise.
Senior officer remuneration disclosures.	50,000	Due to the public interest in senior officer remuneration disclosures, and based on the code, we apply specific audit procedures to this work and set a lower materiality level for this area. We design our procedures to detect errors in specific accounts at a lower level of precision which we have determined to be applicable for senior officer remuneration disclosures. We evaluate errors in the remuneration report for both quantitative and qualitative factors against this lower level of materiality. We will apply heightened auditor focus in the completeness and clarity of disclosures in this area and will request amendments to be made if any errors exceed the threshold we have set or would alter the bandings reported for any individual.

Overview of significant audit risks identified

The below table summarises the significant risks discussed in more detail on the subsequent pages.

Significant risks are defined by ISAs (UK) as an identified risk of material misstatement for which the assessment of inherent risk is close to the upper end of the spectrum due to the degree to which risk factors affect the combination of the likelihood of a misstatement occurring and the magnitude of the potential misstatement if that misstatement occurs. A significant risk can be a significant risk due to error or due to fraud. For the purposes of the ISAs (UK), the auditor is concerned with fraud or suspected fraud that causes a material misstatement in the financial statements. Two types of intentional misstatements are relevant to the auditor – misstatements resulting from fraudulent financial reporting and misstatements resulting from misappropriation of assets. As part of our consideration of risks relating to fraudulent financial reporting we consider the potential for override of controls or other inappropriate influence over the financial reporting process, such as efforts by management to manage income, expenditure or accruals in order to influence the Trust's year end performance.

Other risks are, in the auditor's judgment, those where the risk of material misstatement is lower than that for a significant risk, but they are nonetheless an area of focus for our audit.

Risk title	Risk level	Change in risk since Audit Plan	Fraud risk	Level of judgement or estimation uncertainty	Findings
1 Management override of controls	Significant	↔	✓	Low	●
2 Revenue Recognition	Significant	↔	✓	Medium	●
3 Fraud in expenditure recognition	Significant	↔	✓	Medium	●
4 Valuation of land and buildings (Including Right of Use Asset)	Significant	↔	✗	High	●

Key

↑ Assessed risk has increased since audit plan
↔ Assessed risk is consistent with audit plan
↓ Assessed risk has decreased since audit plan

● No adjustment or change in disclosure required
● Non-material adjustment or change to disclosures within the financial statements
● Material adjustment or change to disclosures within the financial statements

Significant risks

Risk	Commentary	Conclusions
Management over-ride of controls Under ISA (UK) 240 there is a non-rebuttable presumed risk that the risk of management override of controls is present in all entities. The Foundation Trust faces external pressures to meet the agreed targets and could potentially place management under undue pressures in terms of how they report performance. We have therefore identified management override of controls, in particular journals, management estimates and transactions outside the course of business as a significant risk of material misstatement.	We have: • Evaluated the design effectiveness of management controls over journals; • Analysed the journals listing and determine the criteria for selecting high risk and unusual journals; • Challenged management's key judgements and estimates and considered whether these judgements and estimates are individually or cumulatively indicative of management bias; • Tested unusual journals made during the year and after the draft accounts stage for appropriateness and for corroboration; • Gained an understanding of the accounting estimates and critical judgements applied by management and consider their reasonableness; and • Evaluated the rationale for any changes in accounting policies, estimates or significant unusual transactions.	During our review of the controls around Journals, we identified users within the financial accounts team who had privileged Journal user rights. Normally, we would anticipate this right to be reserved for those working in the finance systems team rather than the accountants preparing the financial statements. See Appendix B Action Plan for further details.

Significant risks

Risk	Commentary	Conclusions
Revenue Recognition Under ISA (UK) 240, there is a rebuttable presumed risk that revenue may be misstated due to the improper recognition of revenue. Trusts face significant external pressure to restrain budget overspends and meet externally set financial targets, coupled with increasing patient demand and cost pressures. In this environment, we have considered the rebuttable presumed risk under ISA (UK) 240. The majority of the Trust's revenue is received from Integrated Care Boards (ICBs) and NHS England for the provision of patient care services, including performance based payments related to targets in elective recover rates. There is estimation based on contract performance of the year-end revenue and receivables position with commissioning bodies which make this a significant risk area for our audit due to the level of estimation uncertainty applied to this area of the financial statements. We have not deemed it appropriate to rebut the presumed significant risk for material streams of patient care income and other operating revenue, due to the scale of financial pressures experienced by the trust, which increase the risk of material misstatement from improper revenue recognition. We have therefore identified the occurrence and accuracy of the Trust's income streams and the existence of associated receivable balances as a significant risk.	We have: Accounting Policies and Systems • Evaluated the Trust's accounting policies for the recognition of income from patient care activities and other operating revenue for appropriateness and compliance with the GAM for 2023-24. • Updated our understanding of the Trust's system for accounting for income from Patient Care an Other Operating Revenues, and evaluate the design of these associated controls. Patient Care Income • Using the DHSC Mismatch report, we investigated unmatched revenue and receivables balances over the NAO £0.3m threshold, corroborating unmatched balances used by the Trust to supporting evidence. • Agreed significant contract income to signed agreements with ICBs and NHS England. • We agreed, on a sample basis, income from central allocations, non-block contract payments, and other variable income, and year end receivables to signed contract variations, invoices or other supporting evidence such as centrally agreed system allocations. • We evaluated the estimates and judgements made by management with regards to corroborating evidence in order to arrive at the total income from contract variations recorded in the financial statements. Other Operating Revenue: • We have agreed, on a sample basis, income and year end receivables from other operating revenue to invoices and cash payment or other supporting evidence. This will include - but not be limited to – education income, non patient services income, staff recharges and other income.	We have identified some variances/accounts errors impacting revenues in the accounts which are set out in the Audit Adjustments pages 22 to 29. We are satisfied that the unadjusted misstatements are well below our audit materiality, and our work has not identified any material issues in relation to this risk.

Significant risks

Risk	Commentary	Conclusions
Fraud in expenditure recognition As most public bodies are net spending bodies, then the risk of material misstatement due to fraud related to expenditure recognition may be greater than the risk of fraud related to revenue recognition. There is a risk the Foundation Trust may manipulate expenditure to meet externally set targets and we have regard to this when planning and performing our audit procedures. Management could defer recognition of expenditure by under-accruing for expenses that have been incurred during the period but which were not paid until after the year-end or not record expenses accurately in order to improve the financial results. Conversely, in prior years auditors have encountered examples of NHS bodies over-accruing to reach a predetermined outturn position due to changes in funding arrangements and to arrangements made across system partnership regions. Management could also reduce expenditure by inappropriately capitalising expenditure in order to recognise a specific outturn position.	Work completed: • Evaluated your accounting policy for recognition of expenditure for appropriateness and compliance with the DHSC Group Accounting Manual 2022/23; • Understood the Trust's control environment around manual expenditure accruals at the year end; • Tested a sample of expenditure invoices and payments made in the period after 31 March 2024 to determine whether the expenditure has been recognised in the correct accounting period and whether accruals are complete; • Focussed our above journals testing on those manual journals which impact the control total through decreasing or increasing the level of expenditure and assessed whether there was an appropriate basis for posting these journals and the amount was supported by appropriate evidence; • Selected a sample of year end accruals and inspected supporting evidence or payment amounts for the accrual post year-end to assess whether the accruals had been correctly recorded; • We also critically analysed the accruals listing with prior year to ensure completeness of accruals has been achieved; • Inspected transactions incurred around the end of the financial year to assess whether they had been included in the correct accounting period.	We have identified some variances/accounts errors impacting expenditure in the accounts which are set out in the Audit Adjustments pages 22 to 29. We are satisfied that the unadjusted misstatements are well below our audit materiality, and our work has not identified any material issues in relation to this risk.

Significant risks

Risk	Commentary	Conclusions
Valuation of land and buildings (Including Right of Use Asset) The Trust revalue its land and buildings on an annual basis to ensure that the carrying value is not materially different from the current value at the financial statements date. This valuation represents a significant estimate by management in the financial statements. Management have engaged the services of a valuer to estimate the current value as at 31 March 2024. The valuation of land and buildings is a key accounting estimate which is sensitive to changes in assumptions and market conditions. We therefore identified valuation of land and buildings, particularly revaluations and impairments, as a significant risk, which was one of the most significant assessed risks of material misstatement, and a key audit matter.	We have: • evaluated management's processes and controls for the calculation of the estimate, the instructions issued to the valuation expert and the scope of their work; • evaluated the competence, capabilities and objectivity of the valuation expert; • written to the valuer to confirm the basis on which the valuations were carried out; • challenged the information and assumptions used by the valuer to assess completeness and consistency with our understanding; • evaluated the valuer's report to identify assets that have large and unusual changes and/or approaches to the valuation – these assets have been substantively tested to ensure the valuations are reasonable; • tested a selection of other asset revaluations made during the year to ensure they have been input accurately into the Trust's asset register, revaluation reserve, and Statement of Comprehensive Income; • evaluated the assumptions made by management for any assets not revalued during the year and how management has satisfied themselves that these are not materially different to current value; • engaged our own valuer to assess the instructions to the Trust's valuer, the valuer's report and the assumptions that underpin the valuation; • for all assets not formally revalued or revalued on a desktop/indexation basis only, evaluated the judgement made by management or others in determination of current value of these assets.	Our work has not identified any material issues in relation to this risk.

Significant matters

Significant matter	Commentary
Significant events or transactions that occurred during the period	A £107m impairment was made in the valuation of Queen Marys University Hospital, which is the major part of Right of Use Assets portfolio revalued during the year. This was as a result of a change in accounting estimate. In the prior year on implementation of IFRS16, the asset had been valued at cost under the GAM. This valuation estimate on the cost basis is calculated via a method prescribed in the GAM with the key input to the valuation being the lease rental. From discussions with the management we understand that this rental figure was significantly in excess of the market rate due to the nature of the property being held under a PFI contract by the lessor. In the current financial year, the Trust has made a change in accounting estimate to value the land and building Right of Use Assets using the DRC modern equivalent asset method in line with the other DRC specialised assets in the portfolio leading to a significant reduction in the valuation. This is a permitted valuation method under the GAM. As part of our detailed work on valuation of land and buildings (including Right of Use Asset), we have obtained sufficient assurance around the fact that the closing value of this asset is not materially misstated and that the change in accounting estimate applied is reasonable. To do so we reviewed the completeness and accuracy of the underlying information used to determine the valuation. This included testing accuracy of floor areas plans provided to the valuer and challenging the management expert around the method and assumptions they have applied in valuing these assets. Moreover, we also engaged our own auditor's valuation expert to review and challenge the approach to the revaluation in the current financial year. We have concluded that the revaluation of Right of Use Assets was reasonable and materially accurate.
Business conditions affecting the Trust, and business plans and strategies that may affect the risks of material misstatement	From our work during the audit of the financial statements and from discussions with management and those charged with governance, we are not aware of any business conditions that would significantly affect the Trust.
Concerns about management's consultations with other accountants on accounting or auditing matters	From our work during the audit of the financial statements and from discussions with management and those charged with governance, we are not aware that the Trust has consulted with any other accountants.
Significant matters on which there was disagreement with management, except for initial differences of opinion because of incomplete facts or preliminary information that are later resolved by the auditor obtaining additional relevant facts or information	We have not identified any such disagreements.
Other matters that are significant to the oversight of the financial reporting process	We have not identified any other such matters.
Adjustments identified as having been made to meet the system position	We have not identified any material adjustments that have been made to the Trust's position to enable achievement of a specific financial position.

Other risks identified

Risk	Commentary	Conclusions
Assets under Construction	As in previous years, the Trust holds a substantial Asset Under Construction balance, £59.9m in Property, plant, and equipment. It is worth noting that this presents a potential risk of impairment. The reason for this concern is that the Trust is involved in several projects and any significant changes in scope or discontinuation of these projects could potentially trigger an impairment event in accordance with IAS 36. There have been notable instances in the public sector where prolonged construction projects have resulted in significant impairments upon completion. However, it's important to note that the standards necessitate management to assess assets under construction for impairment throughout the project, rather than solely upon completion. We also note there are potential risks around assets under construction and ensuring they are reclassified on a timely basis. The risk here is that they would not be brought into use at the correct date which could lead to the Trust understating its depreciation charge.	Work performed: • We reviewed the Trust's Asset Under construction balance undertaking detailed testing of a sample of key projects. • We reviewed each item to test if we could evidence the project was still ongoing and was not complete. • We also reviewed each project for impairment events as highlighted in IAS 36 just to ensure that there is no such instance present at the trust which could lead to the respective projects being impaired. From our work we tested £48.72m of the overall Asset Under construction balance. The largest 2 balance amounting to £25.4m relate to the ITU Surge Capacity Cavell and Keates project and ITU Expansion Trust Enabling Works, both of which are scheduled for completion in 2025/26 and 2024-25, respectively as per confirmation from the project head. We note that on completion the Trust will likely be required to revalue the asset per the GAM requirements. Management are of the view no impairment events have taken place on these assets or other assets under construction. We identified 2 assets amounting to £4.5m for which we could not receive a confirmation with respect to their expected completion date as these are under review. One of these projects is development of design for children's ward 5th floor, that has an amount accounted for under Asset Under Construction of £2.19m which has remained constant from prior year closing balance. Given the uncertainty around the project as it has no further development since last year, we are of view that this does create some risk around this project's carrying value, however it would not be material to the accounts. To date we have not identified any indications of impairment but note the Trust should look to monitor if any impairment events are identified over the life of the project to ensure they comply with IAS 36. We test additions at cost into the assets under construction asset classification, providing assurance over the existence and occurrence of these transactions and assets. Given our materiality of £17m, our view is that the risk of a material impairment of an asset under construction is low risk, given the largest asset is £25.4m. However, we have added a representation to the management letter of representation around the absence of indicators of impairment in assets under construction.

"In respect of some risks, the auditor may judge that it is not possible or practicable to obtain sufficient appropriate audit evidence only from substantive procedures. Such risks may relate to the inaccurate or incomplete recording of routine and significant classes of transactions or account balances, the characteristics of which often permit highly automated processing with little or no manual intervention. In such cases, the entity's controls over such risks are relevant to the audit and the auditor shall obtain an understanding of them." (ISA (UK) 315)

Key judgements and estimates

Judgement or estimate	Summary of management's approach	Audit Comments	Assessment
Land and Building valuation - £334.5m **Right of Use Asset valuation– £31.5M**	Land and buildings comprises £303.5m of specialised assets such as the St George's hospital site, which are valued at depreciated replacement cost (DRC) at year end, on a modern equivalent asset basis. Management determined the amount of space and location required for ongoing service delivery in the light of their current and projected service needs and have instructed the valuer accordingly. The remainder of land and buildings are not specialised in nature and are valued in existing use (EUV) at year end. The Trust engaged with its external valuer, Gerald Eve, to complete the valuation of properties as at 31 March 2024. Approximately 99% of total land and buildings were revalued at 31 March 2024, as part of the desktop valuation exercise on a five yearly cyclical basis. The total year end valuation of land and buildings was £334.5m, a net decrease of £6.9m from 2022/23 (£341m). For the Right of Use Asset amounting to £46.1m, assets amounting to £31.5m have been revalued representing a significant portion of the portfolio which has been revalued during the year. The Trust has included in its accounting policies that the valuation of the estate contains estimation uncertainty to highlight this to the reader.	We have: • deepened our risk assessment procedures performed including understanding processes and controls around the identification and determination of estimates. This included understanding methods, assumptions and data used; • considered the competence, capabilities and objectivity of the valuation expert used by the Trust. We have not identified any concerns; • considered the data and assumptions used by management to derive the estimate. • assessed the consistency of estimate against market data available. • considered the appropriateness of the MEA assumptions used, in particular we have confirmed that none have changed since the prior year; • We have employed an auditor's expert in order to assess the reasonableness of the data used by the valuer; • confirmed that there have been no changes to the valuation method this year; • reviewed the valuation impairments made to Right of Use Assets. In the first year of implementation of IFRS16 the Trust opted to revalue Right of Use Assets on the cost basis. In this subsequent year the Trust have opted to have their professional valuer revalue the assets on the DRC Modern Equivalent Asset method in line with the main hospital site. This method is acceptable under the NHS GAM and IFRS, and we are satisfied that the valuation assumptions and method applied are reasonable. We tested the inputs to the valuation for reasonableness and we used our own auditor's valuation expert to review the revaluation of Right of Use Assets. We were satisfied that the Right of Use Assets valuations were reasonable and materially accurate ; and • assessed the reasonableness of the disclosures related to accounting estimates. **Conclusion** We are satisfied the estimate of your land and buildings valuation is not materially misstated.	

Assessment

- [Purple] We disagree with the estimation process or judgements that underpin the estimate and consider the estimate to be potentially materially misstated
- [Blue] We consider the estimate is unlikely to be materially misstated however management's estimation process contains assumptions we consider optimistic
- [Grey] We consider the estimate is unlikely to be materially misstated however management's estimation process contains assumptions we consider cautious
- [Light Purple] We consider management's process is appropriate and key assumptions are neither optimistic or cautious

Other findings

Issue	Commentary	Auditor view
ISAE 3402 Service Auditor Reports The ISAE 3402 Service Audit Type II reports have been received which assess the state of the control environment for the period 1 April 2023 to 31 March 2024 for the following services used by the ICB: • NHS Shared Business Service Limited: Finance and Accounting Services • The Electronic Staff Record Programme	**We have considered the service auditor reports to identify any potential control deficiencies impacting on St George's University Hospital NHS Foundation Trust** NHS Shared Business Services Limited: Finance and Accounting Services The ISAE 3402 Service Auditor Type II report for NHS Shared Business Services Limited: Finance and Accounting Services given a clean opinion on the controls reviewed. No issues were identified within this report. The Electronic Staff Record Programme ESR (ISAE 3000 Type II) - clean audit opinion. No impact on our audit.	The audit opinions for both the service organisations provide reasonable assurance that the control objectives were suitably designed and operated effectively during the period 1 April 2023 to 31 March 2024. Considering the above we are satisfied that the control environment for both the service organisations are designed and operating effectively.

Other findings – Information Technology

This section provides an overview of results from our assessment of Information Technology (IT) environment and controls which included identifying risks from the use of IT related to business process controls relevant to the financial audit. This includes an overall IT General Control (ITGC) rating per IT system and details of the ratings assigned to individual control areas.

			ITGC control area rating			
IT application	Level of assessment performed	Overall ITGC rating	Security management	Technology acquisition, development and maintenance	Technology infrastructure	Related significant risks/other risks
Oracle SBS	ITGC assessment (design and implementation effectiveness only)					See above significant risks
Electronic staff record	ITGC assessment (design and implementation effectiveness only)					See above significant risks

For the detail risk identified in relation to Oracle, please refer to slide 30

Assessment

- Significant deficiencies identified in IT controls relevant to the audit of financial statements
- Non-significant deficiencies identified in IT controls relevant to the audit of financial statements/significant deficiencies identified but with sufficient mitigation of relevant risk
- IT controls relevant to the audit of financial statements judged to be effective at the level of testing in scope
- Not in scope for testing

Communication requirements

Issue	Commentary
Matters in relation to fraud	• We have previously discussed the risk of fraud with the Audit Committee and have performed inquiries of the trusts counter fraud team and been made aware of fraud of trivial financial quantum We have not been made aware of any other incidents in the period and no other issues have been identified during the course of our audit procedure
Matters in relation to related parties	• We are not aware of any related parties or related party transactions which have not been disclosed
Matters in relation to laws and regulations	• You have not made us aware of any significant incidences of non-compliance with relevant laws and regulations and we have not identified any incidences from our audit work.
Written representations	• A letter of representation has been requested from the Trust.
Accounting practices	• We are currently evaluating the appropriateness of the Trust's accounting policies, accounting estimates and financial statement disclosures. If any discrepancies are identified then those will be reported to the committee.
Confirmation requests from third parties	• We requested from management permission to send confirmation requests to banking institutions. This permission was granted and the requests were sent and have been received as part of our final accounts work. • We requested management to send letters to those solicitors who worked with the Trust during the period. All responses were received, and no issues were noted.
Disclosures	• Our review found no material omissions in the financial statements
Audit evidence and explanations	• All information and explanations requested from management was provided. Queries are still ongoing though.
Significant difficulties	• See our comments on page 5 under Significant Matters. We experienced some difficulty and delays in obtaining sufficiently clear evidence/responses on some of our samples testing.

Other responsibilities

Issue	Commentary
Going concern	In performing our work on going concern, we have had reference to Statement of Recommended Practice – Practice Note 10: Audit of financial statements of public sector bodies in the United Kingdom (Revised 2020). The Financial Reporting Council recognises that for particular sectors, it may be necessary to clarify how auditing standards are applied to an entity in a manner that is relevant and provides useful information to the users of financial statements in that sector. Practice Note 10 provides that clarification for audits of public sector bodies. Practice Note 10 sets out the following key principles for the consideration of going concern for public sector entities: • the use of the going concern basis of accounting is not a matter of significant focus of the auditor's time and resources because the applicable financial reporting frameworks envisage that the going concern basis for accounting will apply where the entity's services will continue to be delivered by the public sector. In such cases, a material uncertainty related to going concern is unlikely to exist, and so a straightforward and standardised approach for the consideration of going concern will often be appropriate for public sector entities • for many public sector entities, the financial sustainability of the reporting entity and the services it provides is more likely to be of significant public interest than the application of the going concern basis of accounting. Our consideration of the Trust's financial sustainability is addressed by our value for money work, which is covered elsewhere in this report. Practice Note 10 states that if the financial reporting framework provides for the adoption of the going concern basis of accounting on the basis of the anticipated continuation of the provision of a service in the future, the auditor applies the continued provision of service approach set out in Practice Note 10. The financial reporting framework adopted by the Trust meets this criteria, and so we have applied the continued provision of service approach. In doing so, we have considered and evaluated: • the nature of the Trust and the environment in which it operates • the Trust's financial reporting framework • the Trust's system of internal control for identifying events or conditions relevant to going concern • management's going concern assessment. On the basis of this work, we have obtained sufficient appropriate audit evidence to enable us to conclude that: • a material uncertainty related to going concern has not been identified • management's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Other responsibilities under the code

Issue	Commentary
Other information	We are required to give an opinion on whether the other information published together with the audited financial statements (including the Annual Report), is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. No inconsistencies have been identified. We plan to issue an unmodified opinion.
Auditable elements of Remuneration Report and Staff Report	We are required to give an opinion on whether the parts of the Remuneration Report and Staff Report subject to audit have been prepared properly in accordance with the requirements of the Act, directed by the Secretary of State with the consent of the Treasury. We have audited the elements of the Remuneration Report and Staff Report, including the Fair Pay Multiple Disclosures, as required by the Code, and have identified a number of small amendments which have been correctly processed by the Trust in the updated Report. We plan to issue an unmodified opinion.
Licence conditions	We are not aware of any FT licence conditions breaches.
Referral to the regulator	Under Schedule 10 paragraph 6 of the National Health Service Act 2006, auditors can report to the relevant regulatory body if they have reason to believe that the audited body is: - About to make, or has made, a decision which would involve unlawful expenditure - About to take, or has taken, a course of action which, if pursued to its conclusion, would be unlawful and likely to cause a loss or deficiency. We did not make any referral to the regulator

Other responsibilities under the code

Issue	Commentary
Matters on which we report by exception	We are required to report on a number of matters by exception in a number of areas: • the Annual Governance Statement does not comply with guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit, • the information in the annual report is materially inconsistent with the information in the audited financial statements or is apparently materially incorrect based on, or is materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit, or otherwise misleading. • if we have applied any of our statutory powers or duties. • where we are not satisfied in respect of arrangements to secure value for money and have reported significant weaknesses. We have nothing to report on these matters.
Review of accounts consolidation schedules and specified procedures on behalf of the group auditor	We are required to give a separate audit opinion on the Trust accounts consolidation schedules and to carry out specified procedures (on behalf of the NAO) on these schedules under group audit instructions. In the group audit instructions the Trust was selected as a sampled component, meaning additional work is required. Our work in this area is not yet completed. To date, we have nothing to report on these matters.
Certification of the closure of the audit	We intend to certify the closure of the year end 31 March 2024 audit of the Trust in June 2024.

Audit Adjustments

We are required to report all non-trivial misstatements to those charged with governance, whether or not the accounts have been adjusted by management.

Impact of adjusted misstatements

All adjusted misstatements are set out in detail below, along with the impact on the key statements.

Detail	Statement of Comprehensive Income £'000	Statement of Financial Position £'000	Impact on adjusted net surplus £'000	Reason for not adjusting
Bad Debt Expense Trust has recorded write off for NHS debtors outstanding for more than one year amounting to £3.6m, within Note 3.1 Patient Care - Other clinical income. As the write off is an expense therefore this should be recorded as such as well. Therefore, we have proposed an audit adjustment to move the debtor write off expense from income to expenditure in note 7.1. Dr – Other Expenditure Cr - Other clinical income	Dr - Other Expenditure £3.6m Cr- Other clinical income (£3.6m) Overall Impact is Nil	Nil	Nil	N/A
Classification error A classification of an accrued receivable tested amounting to £5,696.485 should have been classified as a Payable, but was classified as a credit transaction within receivables. The Trust agreed with this view and the amount was reclassified in the statements.	Dr. Expenditure £5,696 Cr. Income (£5,696)	Dr. Accrued Receivables £5,696 Cr. Payables (£5,696)	Nil	N/A

Audit Adjustments

Misclassification and disclosure changes

The table below provides details of misclassification and disclosure changes identified during the audit which have been made in the final set of financial statements.

Disclosure omission	Auditor recommendations	Adjusted?
Remuneration Report	• Some minor changes/amendments were made to the tables in the remuneration report as a result of our testing carried out. We are satisfied with the accuracy/consistency of these tables after these amendments were made.	• ✓
Note 1.28 Sources of estimation uncertainty	• IAS1 says that where items are disclosed here, the standard requires a sensitivity analysis to quantitative estimate as to the impact of the uncertainty. I.e. How much does the Trust think the PPE estimate could vary based on the uncertain assumptions.	• ✓
Note 14.1 Property, plant and equipment	• Trust has reflected all the additions amounting to £34m under Assets under Construction. However, from our testing we understand that some of the additions during the year are relating to additions for another PPE asset category which include Buildings amounting to £9m, Plant and Machinery for £921k, Transport equipment for £1.7m and Information technology for £680k with the remaining amount to £21.5m being only for assets under construction. Therefore, the current presentation on PPE disclosure note does not reflect the actual movement for these other PPE asset category, which therefore has to be updated.	• ✓
Note 17.1 Right of use Assets	• Trust has reflected the entire amount of revaluation loss as impairment under Accumulated depreciation part of the note. This presentation is incorrect as under accumulated depreciation only the reversal of earlier charged depreciation on the assets being revalued should be reflected as impairment whereas the rest of the revaluation change should be reflected under the Gross cost part of the note. Trust has agreed to make this change.	• ✓
Note 3.1 Income from patient care activities (by nature)	• Trust has currently classified API variable income amounting to £13m under other clinical income. As per standards practise trusts should have a separate Variable element and other NHS clinical income. • Moreover, Trust has also currently classified under API Fixed an amount of £4m, which essentially relates to API variable and therefore this has to also be reclassified accordingly.	• The note to be reviewed and corrected to be compliant with regulations.
Various minor casting/disclosure amendments	• We identified a number of casting and disclosure issues. The Foundation Trust is working through these. As part of our final checks, we will verify all expected changes have been made.	• The note to be reviewed and corrected to be compliant with regulations.

Audit Adjustments

Impact of unadjusted misstatements

The table below provides details of adjustments identified during the audit which have not been made within the final set of financial statements. The Audit Committee is required to approve management's proposed treatment of all items recorded within the table below.

Detail	Statement of Comprehensive Income £'000	Statement of Financial Position £'000	Impact on adjusted net surplus £'000	Reason for not adjusting
Bad Debt Provision In our testing we identified that the trust has not accounted for a bad debt provision for debtors which relate to St George's University of London as they do not deem there to be a risk of the debtor not paying. Our assessment of the credit loss allowance for these receivables would be £215,654, had they been provided for in line with their general debtor's provision policy. Moreover, Trust has provided the bad debt provision for Injury Cost Recovery debtor balance at 17% however as per the requirements of the GAM this should have been 23.07%. Our assessment of the credit loss allowance for these receivables would be £932,255, had they been provided for in line with the requirements of the GAM.	Dr Expenditure £ 1,148	Cr Receivables (£ 1,148)	£ 1,148	The amount was immaterial
Impairment on Intangible Asset We tested the existence and impairment of intangible assets. During this testing it became clear that there were some long aged assets for internally generated Information Technology from before 2017 and software licence before 2021. This included Cerner, iclip and E-Prescribing assets which on review are not being used by the trust anymore and therefore should no longer be included as intangible assets and should be impaired.	Dr Impairment Expenditure £ 2,080	Cr Intangible Assets (£ 2,080)	£ 2,080	The amount was immaterial

Audit Adjustments

Impact of unadjusted misstatements

The table below provides details of adjustments identified during the audit which have not been made within the final set of financial statements. The Audit Committee is required to approve management's proposed treatment of all items recorded within the table below.

Detail	Statement of Comprehensive Income £'000	Statement of Financial Position £'000	Impact on adjusted net surplus £'000	Reason for not adjusting
Understatement of Prepayments In our testing of prepayments, we identified error in relation to deferred income which had been incorrectly credited to prepayments. Our assessment of the extent of the error on extrapolation is that it would be a maximum of £464k which is below our Performance Materiality, and therefore this is being reported as an unadjusted misstatement.	Nil	Dr Prepayments £464 Cr Deferred Income (£464)	Nil	The amount was immaterial
Overstatement of Accrued Receivable We identified Pharmacy related accrued income (receivables) recorded in the year-end balance which related to January 2023 accruals which should have been reversed out as the accrual had crystallised as paid income in the year. This would result in overstatement of income and receivables.	Dr. Income £2,527	Cr. Accrued Receivable (£2,527)	£2,527	The amount was immaterial

Audit Adjustments

Impact of unadjusted misstatements

The table below provides details of adjustments identified during the audit which have not been made within the final set of financial statements. The Audit Committee is required to approve management's proposed treatment of all items recorded within the table below.

Detail	Statement of Comprehensive Income £'000	Statement of Financial Position £'000	Statement of Changes in Equity £'000	Impact on adjusted net surplus £'000	Reason for not adjusting
Understatement of Expenditures We identified a factual error on a sample item of expenditure amounting to £693k understatement of expenditure for energy expenses. We tested the amount recognised in the accounts against the latest billing/credit note information available at the time the Trust finalised the accounts. Although the Trust were of the view that billing from this supplier has been inaccurate through the year and the meter readings could present more accurate information, we understand that the latest billing information is the only data practically available for making this accrual and this is what we carry out our audit testing against.	Dr. Expenditure £693	Cr Accruals (£693)	Nil	£693	The amount was immaterial
Overstatement of Expenditures In our testing we identified an invoice which related to the previous financial year, however it was received in the current financial year. This expenditure had not been accrued into the prior period as would be expected. The item of expenditure in error was £154k. As it was impractical to fully isolate and identify the extent of other similar amounts, we extrapolated this error in our sample to reach a view as to the maximum extent of the error and gain assurance that this would not be material. The extrapolation came to £4.4m, well below our materiality of £17m hence giving assurance that the error within our representative sample would not be material. We would not request the Trust adjust the accounts based on an extrapolation.	Cr. Expenditure (£4,411)	Nil	Dr. Income and Expenditure reserve £4,411	(£4,411)	The amount was immaterial

Audit Adjustments

Impact of unadjusted misstatements (Continued)

The table below provides details of adjustments identified during the audit which have not been made within the final set of financial statements. The Audit Committee is required to approve management's proposed treatment of all items recorded within the table below.

Detail	Statement of Comprehensive Income £'000	Statement of Financial Position £'000	Statement of Changes in Equity £'000	Impact on adjusted net surplus £'000	Reason for not adjusting
Understatement of Expenditures During our sample testing a variance was noted between the Apprenticeship Levy recognised in the accounts against the NHS SBS Report due to incorrect posting of journals. This had led to an understatement of the expense being reported in the financial statements.	Dr. Employee benefits £496	Cr Other taxes Payables (£496)	Nil	£496	The amount was immaterial
Total unadjusted misstatements	£2,533	(£2,533)	Nil	£2,533	Total immaterial

Audit Adjustments

Impact of prior year unadjusted misstatements

Detail	Statement of Comprehensive Income £'000	Statement of Financial Position £'000	Impact on adjusted net surplus £'000	Reason for not adjusting
PPE valuation understatement due to valuation clerical error An error was noted during our testing of the inputs to the valuation estimate for the new MRI Centre whereby the valuer had made a small clerical error and had input the wrong gross internal area (GIA). This error resulted the valuation of this asset being understated by £422k	Nil	Debit Property, Plant and Equipment £422k Credit Revaluation Reserve (£422k)	Nil	Subject to the satisfactory resolution of outstanding matters set out on page 4, our work has not, to date, identified any material issues similar to this error, which when added to this prior year error would create a material misstatement.
PPE depreciation understatement In our depreciation audit work we carried out a recalculation of depreciation over IT assets and Plant & Machinery. This highlighted that the depreciation expense on these assets had been understated by £368k.	Debit Depreciation £368k	Credit Property, Plant and Equipment £368k	£368k	Subject to the satisfactory resolution of outstanding matters set out on page 4, our work has not, to date, identified any material issues similar to this error, which when added to this prior year error would create a material misstatement.
Capital Payables/Asset Additions (Assets Under Construction and PPE additions) overstatement In our sample testing of Capital Payables we found that the Trust had capitalised/recognised capital payables for items which had not been received by the Trust prior to the year end. This meant that the risk and rewards of the assets had not transferred to the Trust and it was incorrect to recognise these amounts.	Nil	Debit Capital Payables £6,125k Credit Property, Plant and Equipment £6,125k	Nil	Subject to the satisfactory resolution of outstanding matters set out on page 4, our work has not, to date, identified any material issues similar to this error, which when added to this prior year error would create a material misstatement.

Audit Adjustments

Impact of prior year unadjusted misstatements

Detail	Statement of Comprehensive Income £'000	Statement of Financial Position £'000	Impact on adjusted net surplus £'000	Reason for not adjusting
Right of Use Assets and Liabilities Understatement In our testing of the transition to IFRS16 Right of Use Assets and Liabilities it was highlighted that the Trust has miscalculated these amounts in transition by the use ofan incorrect length of lease term, resulting in an advance lease rental payment being excluded from the calculation of the asset and liability.	Nil	Debit Right of Use Assets £2,736k Credit Right of Use Liabilities £2,736k	Nil	Subject to the satisfactory resolution of outstanding matters set out on page 4, our work has not, to date, identified any material issues similar to this error, which when added to this prior year error would create a material misstatement.

Value for money arrangements

Approach to Value for Money work for the year ended 31 March 2024

The National Audit Office issued its latest Value for Money guidance to auditors in December 2021. The Code requires auditors to consider whether a body has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. In undertaking our work, we are required to have regard to three specified reporting criteria. These are as set out below.

Improving economy, efficiency and effectiveness

How the body uses information about its costs and performance to improve the way it manages and delivers its services.

Financial Sustainability

How the body plans and manages its resources to ensure it can continue to deliver its services.

Governance

How the body ensures that it makes informed decisions and properly manages its risks.

In the prior year we raised a significant weakness around the Trust's financial sustainability. This is in part due to the large deficit within the Trust's financial position. We therefore also identified in our audit plan this area as a risk of significant weakness. In relation to this risk we identified the following in our Annual Auditor Report:

- The 2023/24 financial plan agreed in May 2023 was a £15.7m deficit. Following receipt of £24.7m of non-recurrent funding the plan and forecast outturn was updated to a £9m surplus, and the Trust has reported a £3.6m deficit for 2023/24 which is £12.6m adverse to the updated plan. The latest 2024/25 financial plan is a £60.4m deficit, which is part of a Southwest London ICS £138m deficit plan.
- The 2024/25 plan includes a £65m CIP. In May 2024, a significant element of the CIP programme is rated high risk (£27.2m) and/or is unidentified (£6.6m). The Trust medium term financial plan requires further development with support of system partners to identify a path to financial sustainability which needs to be driven by both organisational and collaborative system actions.

We have therefore again identified a significant weakness in the Trust's value for money arrangements in relation to financial sustainability due to the significance of the short and medium-term financial challenges. And we have raised one key recommendation against this significant weakness. For our detailed Value for money findings please refer to our Annual Auditors report on this committee agenda pack.

Independence and ethics

As part of our assessment of our independence we note the following matters:

Matter	Conclusion
Relationships with Grant Thornton	We are not aware of any relationships between Grant Thornton and the Trust that may reasonably be thought to bear on our integrity, independence and objectivity.
Employment of Grant Thornton staff	We are not aware of any former Grant Thornton partners or staff being employed, or holding discussions in respect of employment, by the Trust as a director or in a senior management role covering financial, accounting or control related areas.
Business relationships	We have not identified any business relationships between Grant Thornton and the Trust.
Contingent fees in relation to non-audit services	No contingent fee arrangements are in place for non-audit services provided.
Gifts and hospitality	We have not identified any gifts or hospitality provided to, or received from, a member of the Group's board, senior management or staff.

We confirm that there are no significant facts or matters that impact on our independence as auditors that we are required or wish to draw to your attention and consider that an objective reasonable and informed third party would take the same view. The firm and each covered person [and network firms] have complied with the Financial Reporting Council's Ethical Standard and confirm that we are independent and are able to express an objective opinion on the financial statements

Following this consideration we can confirm that we are independent and are able to express an objective opinion on the financial statements. In making the above judgement, we have made enquiries of all Grant Thornton UK LLP teams providing services to the Trust. No non-audit services were identified which were charged from the beginning of the financial period to the current date. Details of fees charged are set out in Appendix XX

We confirm that we have implemented policies and procedures to meet the requirement of the Financial Reporting Council's Ethical Standard.

Further, we have complied with the requirements of the National Audit Office's Auditor Guidance Note 01 issued in December 2019 which sets out supplementary guidance on ethical requirements for auditors of local public bodies.

Appendices

A. Communication of audit matters to those charged with governance

B. Action plan

C. Follow up of prior year recommendations

D. Fees and non-audit services

A. Communication of audit matters with those charged with governance

Our communication plan	Audit Plan	Audit Findings
Respective responsibilities of auditor and management/those charged with governance	•	
Overview of the planned scope and timing of the audit, form, timing and expected general content of communications including significant risks and Key Audit Matters	•	
Confirmation of independence and objectivity of the firm, the engagement team members	•	•
A statement that we have complied with relevant ethical requirements regarding independence. Relationships and other matters which might be thought to bear on independence. Details of non-audit work performed by Grant Thornton UK LLP and network firms, together with fees charged. Details of safeguards applied to threats to independence	•	•
Significant matters in relation to going concern	•	•
Views about the qualitative aspects of the Trust's accounting and financial reporting practices including accounting policies, accounting estimates and financial statement disclosures		•
Significant findings from the audit		•
Significant matters and issue arising during the audit and written representations that have been sought		•
Significant difficulties encountered during the audit		•
Significant deficiencies in internal control identified during the audit		•
Significant matters arising in connection with related parties		•
Identification or suspicion of fraud involving management and/or which results in material misstatement of the financial statements		•
Non-compliance with laws and regulations		•
Unadjusted misstatements and material disclosure omissions		•
Expected modifications to the auditor's report, or emphasis of matter		•

ISA (UK) 260, as well as other ISAs (UK), prescribe matters which we are required to communicate with those charged with governance, and which we set out in the table here.

This document, the Audit Findings, outlines those key issues, findings and other matters arising from the audit, which we consider should be communicated in writing rather than orally, together with an explanation as to how these have been resolved.

Respective responsibilities

As auditor we are responsible for performing the audit in accordance with ISAs (UK), which is directed towards forming and expressing an opinion on the financial statements that have been prepared by management with the oversight of those charged with governance.

The audit of the financial statements does not relieve management or those charged with governance of their responsibilities.

Distribution of this Audit Findings report

Whilst we seek to **ensure** our audit findings are distributed to those individuals charged with governance, as a minimum a requirement exists for our findings to be distributed to all the company directors and those members of senior management with significant operational and strategic responsibilities. We are grateful for your specific consideration and onward distribution of our report, to those charged with governance.

B. Action Plan

We set out here our recommendations for the Trust which we have identified as a result of issues identified during our audit. The matters reported here are limited to those deficiencies that we have identified during the course of our audit and that we have concluded are of sufficient importance to merit being reported to you in accordance with auditing standards.

Assessment	Issue and risk	Recommendations
● Medium	**Segregation of duty conflicts within Oracle SBS** We have identified a deficiency in the IT General Controls for finance systems relating to the assignment of administrative rights to individuals within the finance team. Administrative access to Oracle SBS has been granted to a combination of users who have non-IT responsibilities and are part of the finance function. The combination of non-IT responsibilities with the ability to set up new users is considered a segregation of duties conflict. We noted that five finance teams users had these permissions in the system. **Risk** The risk associated with the identified deficiency in the controls is that the users with administrative rights are able to post as other or non-existent users and self-approve their journals. This increases the risk of unauthorised access leading to potential misuse or manipulation of financial data as well as unauthorised transactions not detected in a timely manner. Allowing individuals within the finance team to have administrative rights without adequate segregation of duties presents a risk of conflicts of interest and potential abuse of privileges. We have not identified any instances of this user right being inappropriately used in this financial year. However, we typically would not expect those involved in producing the financial statements to have these user rights.	We recommend that the Trust implements a robust user management process within the finance system, ensuring that user additions and administrative rights assignments are regularly reviewed and approved through the appropriate channels. This may include implementing a formalised access request and approval workflow within the system, as well as periodic validation of user lists to remove non-existent or unauthorised users. Additionally, segregation of duties should be enforced to prevent individuals from the finance team having administrative access to systems they are actively using. Management should adopt a risk-based approach to reassess the segregation of duty matrices on a periodic basis. This should consider whether the matrices continue to be appropriate or required updating to reflect changes within the business. If incompatible business functions are granted to users due to organisational size constraints, management should ensure that there are review procedures in place to monitor activities. **Management response** A few individuals in the finance team have administrative rights as well as finance team rights. Management note this recommendation but like many NHS Trusts will continue with current arrangements as it is not realistic in a small team that finance team staff would only have administrative rights. Mitigating controls are in place including requirement for separate review and approval of all journal entries. As per recommendation we have already removed the role from three Finance Managers (allocated during implementation). We expect that two non-IT staff is adequate back up cover if required for the systems manager in a section of one. We are happy this does not pose any risks and have shared a matrix with the Auditors that shows all access and what can and cannot be carried out at different levels and groups. Access is based on job responsibilities roles and privileges and is managed by the systems Manager. We are comfortable with the scheme of delegation in place and this is monitored regularly.

Key

- ● High – Significant effect on control system
- ● Medium – Effect on control system
- ● Low – Good practice

B. Action Plan

Assessment	Issue and risk	Recommendations
Medium	**Deferred income monitoring** To maintain a deferred income schedule to keep track of the individual items awarded to the Foundation Trust and movements over the years. **Risk** 1) There might be deferred income, conditions attached to which have been met and therefore need to be recognised as income 2) There might be long standing deferred income, conditions attached to which have not been met and therefore need to be recognised as a payable as those need to be returned.	We recommend that the Trust maintain a register for deferred income, whereby the income being recognised against those, either on milestone basis or in entirety, as and when the associated conditions are being met can easily be tracked. This will also help identify any long-standing deferred incomes, which either need to the returned or recognised as income, whereby the appropriate accounting treatment can be adapted. **Management response** Management have accepted the recommendation. The Trust will maintain a tracker of deferred income to allow this to be more easily tracked This action will be updated by September 2024.
Medium	**Retention of audit trail documentation for employee changes** In our audit testing it was observed that no leaver form/email documentation was retained for 8 leavers in our sample. Our understanding is that for starters and leavers that in addition to the change request on the portal, that the Trust would also complete starter/leaver forms and issue a letter/email for the termination, which we would expect would be retained as an audit trail. **Risk** 1) Poor record keeping/audit trail retention in HR could lead to disputes with employees and legal issues later on.	We recommend that the Trust ensures that in HR for leavers/joiners/changes in circumstances that business processes are clarified and are observed, particularly with respect to record keeping. **Management response** Recommendation agreed. This will be included as part of the review of the HR team structures and processes that is currently underway. Given the importance of this all staff will be reminded of the importance of effective record management. The automation of systems and processes through revised and new systems is the key to resolving this issue, this will form part of wider system improvement across 2024/25. This action will be updated by August 2024.

B. Action Plan

Assessment	Issue and risk	Recommendations
● Medium	**Fully depreciated Assets** We have identified there are several assets that are fully depreciated within the trusts Fixed Asset Register (FAR) representing a Gross Book Value of £13.3m. Although these assets have no impact on the Statement of Financial Position, the gross cost and depreciation could overstate the PPE note. Our view is that there should be a regular review of the FAR should be regularly reviewed for assets which are fully depreciated and no longer in use by the Trust so that the FAR and PPE note accurately state the assets in use by the Trust. **Risk** The Trust may be overstating the gross cost and accumulated depreciation within PPE due to the fully depreciated assets being reflected in the accounts.	We would recommend that the Trust regularly review assets which are fully depreciated to write out assets which are no longer in use/which have been disposed of. **Management response** The Trust has a robust periodic process for disposing of assets with a net book value (NBV) of zero. However, the operations team requires time to validate these assets, making it impractical to dispose of all NBV zero assets within a single year. Consequently, we are following a phased approach to dispose of these assets within the current fiscal year, consistent with our approach in previous years. This action will be updated by September 2024.
● Medium	**Impairment Review for Intangible assets** From the review of intangible assets register and inquiry from the management we identified assets amounting to £2m which are no longer in use by the Trust and are still recognised as having a valuation in the accounts. **Risk** The Trust may be overstating the Net book value of intangible assets.	Trust should implement impairment testing of intangible assets to write out those assets which no longer have value or which are no longer in use. **Management response** The Trust conducts periodic impairment assessments of intangible assets. However, operational teams require adequate time to validate finance-related requests. Consequently, the Trust has adopted a pragmatic approach by impairing intangible assets from the prior year in the current financial year, consistent with the precedent set in the previous year. This action will be updated by September 2024.

C. Follow up of prior year recommendations

We identified the following issues in the audit of St George's University Hospital NHS Foundation Trust 2022/23 financial statements, which resulted in 2 recommendations being reported in our 2022/23 Audit Findings Report**. We are pleased to report that management have implemented our recommendation.**

Assessment	Issue and risk previously communicated	Update on actions taken to address the issue	Actioned?
● Medium	Capital Payables/Additions Recognition In the prior year several errors were identified which overstated capital payables and additions where these were recognised where the asset was not received prior to the year end and therefore risks and rewards of ownership had not transferred to the Trust..	As per the trust management, they have been committed to addressing the issue of overstated capital payables and additions in 23/24. Robust actions were taken to monitor this and reduce the risk of receiving assets prior to the year-end, with impact on a debate on transfer of ownership. They continue to monitor and access all additions with this in mind. As part of our testing of capital payables and assets addition, we will continue to check that where these have been accounted for during the year, risk and rewards in relation to the associated assets have also been transferred to the trust.	✓
● Medium	Aged NHS Debtor Balances not Written Off In our prior year testing of accruals and debtors we noted that the Trust has a large amount of NHS debtors outstanding for longer than one year, dating as far back as 2011. Creditor accruals have been transacted recognising the risk that these invoices may not be paid, where there are reduced prospects of recoverability. This leads to the overstatement of debtors and creditors without impact on the Statement of Comprehensive Income.	As per the trust management in the financial year 2023/24 they reviewed the creditor accruals transacted that recognised the risk on NHS debt not being recovered. Following this review the Trust wrote off £3.7m of NHS debt considered irrecoverable and is continuing to review the outstanding NHS debt on a monthly basis. We have confirmed this based on our review of the financial statements where we identified the £3.6m write off. Moreover, as per the trust management, Creditor accruals made at year end 2022/23 are no longer in place in 2023/24 in accordance with this recommendation, which removes the overstatement of debtors and creditors noted in 2022/23. As part of our scanning analytics, we have identified a drastic reduction in accruals from prior year and therefore as part of our testing for accruals booked at 31 March 2024, we will continue to evaluate their actualisation in the post year end period.	✓

D. Fees

We confirm below our final fee charged for the audit and confirm there were no fees for the provision of non-audit services.

Audit Fees	
Audit of Trust	£ 179,355
Additional work related to Trust being a sampled component in the NHSE Group return	£4,000
Additional work related to delays in receiving sample evidence/documentation and responses to audit queries (see page 5)	£2,000
Total	£ 185,355

The fees reconcile to the financial statements as follows:

fees per financial statements: £215,226

Less VAT: £35,871

Total fees per above: £179,355

Add the additional fee variances above:

Additional work related to Trust being a sampled component in the NHSE Group return £3,000

Additional work related to delays in receiving sample evidence/documentation and responses to audit queries £3,000

Total: £185,355

This covers all services provided by us and our network to the Trust, its directors and senior management and its affiliates, and other services provided to other known connected parties that may reasonably be thought to bear on our integrity, objectivity or independence. (ES 1.69)

Grant Thornton

St George's University Hospitals NHS Foundation Trust

Auditor's Annual Report for the year ended 31 March 2024

June 2024

Contents

We are required under Schedule 10 paragraph 1(d) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.
The Code of Audit Practice issued by the National Audit Office (NAO) requires us to report to you our commentary relating to proper arrangements.

We report if significant matters have come to our attention. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

The contents of this report relate only to those matters which came to our attention during the conduct of our normal audit procedures which are designed for the purpose of completing our work under the NAO Code and related guidance. Our audit is not designed to test all arrangements in respect of value for money. However, where, as part of our testing, we identify significant weaknesses, we will report these to you. In consequence, our work cannot be relied upon to disclose all irregularities, or to include all possible improvements in arrangements that a more extensive special examination might identify. We do not accept any responsibility for any loss occasioned to any third party acting, or refraining from acting, on the basis of the content of this report, as this report was not prepared for, nor intended for, any other purpose.

Introduction

Purpose of the Auditor's Annual Report

This report brings together a summary of all the work we have undertaken for St George's University Hospitals NHS Foundation Trust during 2023/24 as the appointed external auditor. The core element of the report is the commentary on the value for money (VFM) arrangements. Here we draw the reader's attention to relevant issues, recommendations arising from our work and how the Trust has responded to recommendations made in previous years. The responsibilities of the Trust are set out in Appendix A.

Responsibilities of the appointed auditor

Opinion on the financial statements

Auditors provide an opinion on the financial statements which confirms whether they:

- give a true and fair view of the financial position of the Trust as of 31 March 2024 and of its expenditure and income for the year then ended
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2023/24, and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We also consider the Annual Governance Statement, the relevant disclosures within the Annual Report including the remuneration report and undertake work relating to the Whole of Government consolidation exercise.

Value for money

We report our judgements on whether the Trust has proper arrangements in place regarding arrangements under the three specified criteria:

- financial sustainability
- governance
- Improving economy, efficiency and effectiveness

Other powers

Auditors of a Foundation Trust have a duty to consider whether there are any issues arising during their work that indicate possible or actual unlawful expenditure or action leading to a possible or actual loss or deficiency that should be referred to the relevant NHS regulatory body.

Auditors of Foundation Trusts also have the duty to consider whether to issue a report in the public interest (PIR), where it is appropriate to do so

The Value for Money Auditor responsibilities are set out in Appendix B.

Executive summary

Executive summary

Under Schedule 10 paragraph 1(d) of the National Health Service Act 2006, we are required to be satisfied whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources (referred to as Value for Money). The National Audit Office (NAO) Code of Audit Practice ('the Code'), requires us to assess arrangements under three areas as set out below.

Financial sustainability

The 2023/24 financial plan agreed in May 2023 was a £15.7m deficit. Following receipt of £24.7m of non-recurrent funding the plan and forecast outturn was updated to a £9m surplus, and the Trust has reported a £3.6m deficit for 2023/24 which is £12.6m adverse to the updated plan. The latest 2024/25 financial plan is a £50.1m deficit, which is part of a Southwest London ICS £120m deficit plan. The 2024/25 plan includes a £68.5m CIP. In May 2024, a significant element of the CIP programme is rated high risk (£27.2m) and/or is unidentified (£6.6m). The Trust medium term financial plan requires further development with support of system partners to identify a path to financial sustainability which needs to be driven by both organisational and collaborative system actions. Due to the significance of the short and medium-term financial challenges, we have raised one Key recommendation which has been accepted by Management. We include further detail on the following pages.

Governance

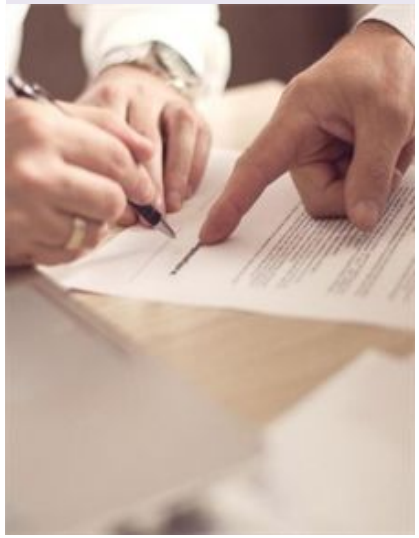
The Trust Board Assurance Framework (BAF) consolidates strategic risk information and aligns with the recently updated five-year strategy. The Trust's Risk Management Policy outlines approaches and accountability, with risks recorded in the Datix system and reviewed by sub-committees before Board presentation. From our work the Trust has evidenced appropriate arrangements in place to monitor and maintain standards, such as meeting legislative and regulatory requirements.

Our work has not identified evidence of significant weaknesses within the arrangements in place. We have identified areas where the Trust could improve governance arrangements and as such, have raised two improvement recommendations which have been accepted by Management. We also note the four recommendations we made in 2023/24 have been substantially repeated this year, and so it is important progress is made to action these in 2024/25 and this is tracked by the Audit Committee.

Improving economy, efficiency and effectiveness

The Trust is assessed by NHS England as being in segment 2 for performance and overall is rated requires improvement by the CQC. An unannounced CQC inspection of maternity services in March 23 led to a section 29a notice being served on the Trust and an 'inadequate rating' for the service. The monitoring and oversight of the CQC maternity services action plan has been undertaken by the CQC Maternity Services Steering Group, chaired by the Group Chief Nurse, with regular update reports on maternity services provided to the Quality Committee and Trust Board. An independent external review of quality governance across the Group has been commissioned by the Trust, with phase 1 focused on the effectiveness of quality governance in the service and upwards from the maternity service to the Board currently underway. Overall, our work has not identified evidence of significant weaknesses within the arrangements in place. We have however raised one improvement recommendations which has been accepted by Management.

We are currently completing our audit of your financial statements and we expect to issue an unqualified audit opinion in June 2024, following the Audit Committee meeting on 12 June 2024. Our findings are set out in further detail on page 8 and 9.



Executive summary (continued)

Overall summary of our Value for Money assessment of the Trust's arrangements

Criteria	2023/24 Risk assessment	2023/24 Auditor judgement on arrangements		2022/23 Auditor judgement on arrangements	
Financial sustainability	Risk of significant weakness regarding the Trust's arrangements to secure financial sustainability was identified.	R	We identified a significant weakness in the Trust's financial sustainability arrangements and have made a key recommendation relating to the identification and delivery of CIPs in 2024/25 and development of the medium-term financial plan.	R	Significant weakness in arrangements for financial sustainability identified and one key recommendations made relating to deliverability of the CIP in 2023/24.
Governance	No risks of significant weakness identified	A	No significant weaknesses in arrangements identified, but two improvement recommendations have been made to support the Trust in improving arrangements in areas such as updating policy documents and undertaking an effectiveness review of governance arrangements.	A	No significant weaknesses in arrangements identified, but one improvement recommendation was made relating to an effectiveness review of Trust governance arrangements.
Improving economy, efficiency and effectiveness	No risks of significant weakness identified	A	No significant weaknesses in arrangements identified, but one improvement recommendation arising from the CQC review of maternity services.	A	No significant weaknesses in arrangements identified, but one improvement recommendations made relating to enhanced oversight following a recent CQC inspection.

G No significant weaknesses in arrangements identified or improvement recommendation made.
A No significant weaknesses in arrangements identified, but improvement recommendations made.
R Significant weaknesses in arrangements identified and key recommendations made.

Opinion on the financial statements and use of auditor's powers

Opinion on the financial statements

Audit opinion on the financial statements

We expect to issue an unqualified opinion on the Trust's financial statements in June 2024.

The full opinion will be included in the Trust's Annual Report for 2023/24, which can be obtained from the Trust's website.

Grant Thornton provides an independent opinion on whether the Trust's financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2024 and of its expenditure and income for the year then ended
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2023/24, and
- have been prepared in accordance with the requirements of the National Health Service Act 2006

We conducted our audit in accordance with:

- International Standards on Auditing (UK)
- the Code of Audit Practice (2020) published by the National Audit Office, and
- applicable law

We are independent of the Trust in accordance with applicable ethical requirements, including the Financial Reporting Council's Ethical Standard.

Findings from the audit of the financial statements

The Trust provided draft accounts in line with the national deadline.

Draft financial statements were of a reasonable standard and supported by detailed working papers. We note there has been a improvement in management responses to audit queries and the quality of working papers provided compared the prior year. However we have still encountered some delays in the responses to the return of full return of sample documentation and to audit queries during the audit that has delayed our progress.

Specific areas which have presented a delay are the resolution of sample and audit queries around: variable income samples, starter/leaver/change of circumstances in employees sampling and capital additions/payables/reclassifications.

We planned our resourcing on the audit to complete the audit by the 14 June 2024 ; a target communicated to the Trust finance team. As at the date of writing this report we are working collaboratively to try to meet this target, but some of the delays in receiving samples and query responses could delay completion beyond this target date.

Audit Findings Report

We report the detailed findings from our audit in our Audit Findings Report. A final version of our report was presented to the Trust's Audit Committee on 12 June 2024. Requests for this Audit Findings Report should be directed to the Trust.

Other reporting requirements and use of auditor's powers

Remuneration and Staff Report

Under the Code of Audit Practice (2020) published by the National Audit Office, we are required to audit specified parts of the Remuneration and Staff Report included in the Trust's Annual Report for 2023/24. Some minor changes/amendments were made to the tables in the remuneration report as a result of our testing carried out. On updating of these issues we were satisfied that these specified parts of the Remuneration and Staff Report have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2023/24.

Annual Governance Statement

Under the Code of Audit Practice (2020) published by the National Audit Office, we are required to consider whether the Annual Governance Statement included in the Trust's Annual Report for 2023/24 does not comply with the guidance issued by NHS England, or is misleading or inconsistent with the information of which we are aware from our audit. We have nothing to report in this regard.

Annual Report

Under the Code of Audit Practice (2020) published by the National Audit Office, we are required to consider whether, based on the work undertaken in the course of the audit of the Trust's financial statements for 2023/24, the other information published together with the financial statements in the Trust's Annual Report for 2023/24 is consistent with the financial statements. We have nothing to report in this regard.

Whole of Government Accounts

To support the audit of Consolidated NHS Provider Accounts, the Department of Health and Social Care group accounts, and the Whole of Government Accounts, we are required to examine and report on the consistency of the Trust's consolidation schedules with their audited financial statements. This work includes performing specified procedures under group audit instructions issued by the National Audit Office. We are still completing our work in this area but to date our work has not identified any significant issues.

We bring the following matters to your attention:

Referrals to the relevant regulatory body

We did not make a referral under Schedule 10 paragraph 6 of the National Health Service Act 2006. We do not consider that any unlawful expenditure has been made or planned for.

Public Interest Report

Under Schedule 10 paragraph 3 National Health Service Act 2006, auditors have the power to make a report if they consider a matter is sufficiently important to be brought to the attention of the audited body or the public as a matter of urgency, including matters which may already be known to the public, but where it is in the public interest for the auditor to publish their independent view.

We did not issue a report in the Public Interest with regard to arrangements at St George's University Hospitals NHS Foundation Trust for 2023/24.

Value for Money
Commentary on arrangements

The current NHS landscape

National context

In 2023/24, the NHS has continued to show commitment to patient care and service delivery. Advancements in digital health technologies including virtual wards have the potential to support service redesign, reduce waiting times, and improve patient outcomes. Data published by NHS England in April 2024 indicates that performance against key metrics for elective waiting times, diagnostic tests access, and A&E 4 hour waits all improved year on year, though performance is still some way from target. These achievements demonstrate the resilience and adaptability of NHS staff amidst ongoing pressures.

Integrated Care Systems, established on 1 July 2022, remain at varying stages of maturity. Some systems have developed changes to patient pathways designed to improve outcomes, create efficiencies, tailor services to the needs of their local population and address local health inequalities. Most systems continue to face significant challenges, including workforce shortages, rising demand for healthcare services, and efficient resource management, all resulting in financial sustainability uncertainties.

Pay and productivity remain key challenges nationally. Staffing numbers have increased significantly since 2019/20 with staff costs now exceeding the funding available in many systems, exacerbated by industrial action costs. At the same time, activity growth has not kept pace, leaving a "productivity gap" that is not yet fully understood. This is further hampered by staff absences and pressures in social care staffing. NHS England has requested that all systems formally review the workforce increases seen over recent years. Many NHS bodies are already recognizing an urgent need to manage down their temporary and agency staff costs, and recruit and retain the substantive staff they need to deliver services. There also needs to be a continued focus on quality and ensuring system governance is sound. Learning from public inquiry reports and maintaining high standards of behaviour is key to improving patient safety and building public trust.

These challenges are likely to make 2024/25 another challenging year for all local health services. However, the NHS is focusing on the recovery of core services through continuous improvement in access, quality, and productivity whilst transforming the way care is delivered and creating stronger foundations for the future.

Local context

St George's is the largest healthcare provider in southwest London providing many tertiary services operating from two hospital sites at St George's Hospital, Tooting and Queen Mary's Hospital in Roehampton. It is one of the four major trauma centres for London, and home to hyper acute stroke and heart attack centres.

The Trust has operated in a hospital group with Epsom and St Helier since 2021/22. The two Trusts remain separate legal entities but are now led by a single executive team and have put in place harmonised governance arrangements which enable and support closer collaborative working. A new five-year strategy for the group, published in May 2023, has been approved by the Trust Board.

The Trust is part of the Southwest London Integrated Care System (SWL ICS), which is assessed as being in SOF2. Each ICS has a statutory NHS Integrated Care Board (ICB) and a wider Statutory Integrated Care Partnership (ICP). The ICB, is responsible for making decisions about health services across its ten constituent boroughs and cities. The ICP, meanwhile, brings together a wider range of health and social care partner organisations, including local authorities, and wider public sector and community organisations, to improve the health and wellbeing of the population of Southwest London.

It is within this context that we set out our findings on the Trust's value for money arrangements in 2023/24 and make recommendations to support improvements in its management of value for money in 2024/25.

Financial sustainability

We considered how the Trust:	Commentary on arrangements	Assessment
Identifies all the significant financial pressures that are relevant to its short and medium-term plans and builds these into them	We raised a key recommendation last year in respect of the size of the £62.1m 2023/24 CIP target, the level of development of schemes in May 2023 and risks to delivery. After receiving additional non-recurrent funding to reduce the planned deficit and costs associated with industrial action, the Trust reported a deficit of £3.6m for 2023/24 which was £12.6m adverse to the revised £9m surplus plan. The Trust has set a £50.1m deficit plan for 2024/25, which includes a challenging £68.5m CIP programme, and is part of a wider South-West London system deficit of £120m. Given the short and medium-term financial challenges we have raised a key recommendation.	R
Plans to bridge its funding gaps and identify achievable savings	The Trust's delivered £60.1m CIP in 2023/24 against a total £62.1m CIP target, although we note £37.9m of the CIP delivered was non-recurrent. As at May 2024, a significant element of the 2024/25 £68.5m CIP programme is red RAG-rated as opportunities (£27.2m) and £6.6m remains unidentified. Work is ongoing to identify additional opportunities, but this represents a significant risk to delivery of the 2024/25 plan. We note £13m of CIP plans are fully delivered and £23m are plans in progress (RAG rated amber). The scale of CIP and current development status has been included as part of the key recommendation noted above.	R
Plans finances to support the sustainable delivery of services in accordance with strategic and statutory priorities	We are satisfied with the arrangements in place to ensure the Trust's plans support the sustainable delivery of services in accordance with strategic and statutory priorities.	G
Ensures its financial plan is consistent with other plans such as workforce, capital, investment and other operational planning which may include working with other local public bodies as part of a wider system	The Trust planning process considers consistency of plans with strategic objectives, and we are satisfied that the financial plan and assumptions are triangulated with workforce, activity, and operational performance assumptions.	G
Identifies and manages risk to financial resilience, e.g. unplanned changes in demand, including challenge of the assumptions in underlying plans	The Trust has a satisfactory framework for managing financial risks, overseen by the Finance Committee (FC) and the Board. Financial risks are captured in the corporate risk register and reported to the FC. Financial risks are separately reported FC in a monthly finance report and financial planning papers. We are satisfied with the arrangements in place to identify and manage risk to financial resilience.	G

G No significant weaknesses in arrangements identified or improvement recommendation made.
A No significant weaknesses in arrangements identified, but improvement recommendations made.
R Significant weaknesses in arrangements identified and key recommendations made.

Financial sustainability (continued)

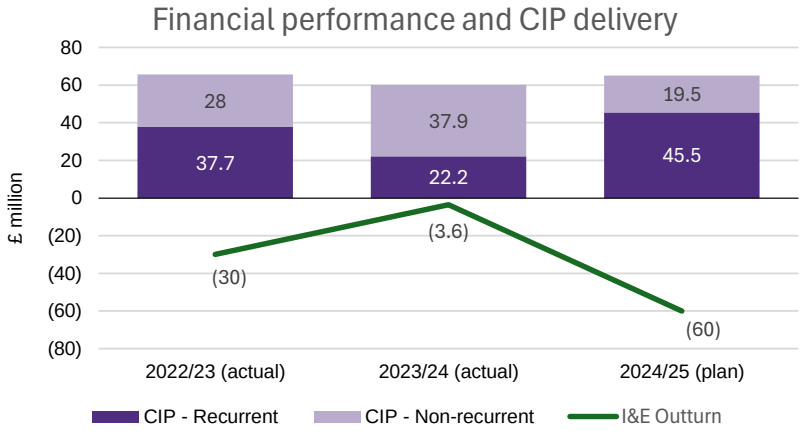
Significant weakness identified

The Trust has delivered a £3.6m deficit in 2023/24, which follows a £30m deficit in 2022/23. The unwinding of non-recurrent measures in 2023/24 means that the Trust has agreed a £50.1m deficit plan for 2024/25, which includes a CIP target of £68.5m and is part of a wider South-West London system deficit of £120m. At 5.5% of expenditure the CIP target is consistent across the SWL providers. The Trust recent financial performance and plan for 2024/25 underlines the need for interventions and system support to address the operational and financial challenges faced by the Trust in 2024/25 and the medium term.

The Trust delivered £60.1m CIP in 2023/24 against a £62.1m plan. The 2023/24 CIP delivery included £10.6m income and delivery was split £37.9m non-recurrent and £22.2m recurrent. Financial performance in 2023/24 was also supported by non-recurrent income and several wider grip and control measures to improve financial performance.

Identification of schemes to support delivery of the £68.5m CIP target is ongoing. As at May 2024, a significant element of the 2024/25 is red RAG-rated as opportunities (£27.2m) and £6.6m remains unidentified. We note £13m of CIP plans are fully developed and £23m are plans in progress (RAG rated amber). The scale of CIP and current development status has been included as part of the key recommendation noted opposite.

In our 2022/23 AAR, we raised an improvement recommendation for the Trust to create a Medium-Term Financial Plan. Based on our review this year we note better collaboration and working across the South-West London system, but further work is required to develop a sustainable medium term financial plan. By implementing a more effective framework for the development, monitoring, and evaluation of the MTFP, the Trust can significantly enhance its ability to manage the escalating financial challenges it faces. This initiative is important for the Trust to not only help mitigate its current financial position but also to pave the way for achieving reported and underlying financial sustainability over the next 3-5 years. The Trust medium term financial plan requires further development with support of system partners to identify a path to financial balance/sustainability - expected to be driven by both organisational and collaborative actions.



Key Recommendation 1:

As part of our review, will have raised one key recommendation:
We recommend the development and execution of a plan that encompasses both short-term and medium-term strategies to achieve financial sustainability. This will include:

- Developing a pipeline of CIP schemes ensuring that the arrangements are embedded quickly so that recurrent efficiencies are identified, and all budget holders are held to account for the delivery of savings throughout the year. The Trust should also look to develop a multi-year pipeline of efficiency/ transformation programmes in conjunction with system partners and to support earlier identification of annual savings.
- A credible medium term financial plan should be developed to provide assurance that the Trust can achieve a breakeven position in the next 3-5 years.

Governance – commentary on arrangements

We considered how the Trust:	Commentary on arrangements	Assessment
monitors and assesses risk and how the Trust gains assurance over the effective operation of internal controls, including arrangements to prevent and detect fraud	The Trust has well developed Board reporting and has a robust framework for risk management, governance, and internal control, including arrangement to prevent and detect fraud. In 2022/23 we raised an improvement recommendation for the Trust Board to undertake an initial effectiveness review of its new BAF management arrangements. The Trust has achieved this by putting together a new BAF with is aligned with GESH Group and which aligns with the new 5-year strategy 2023-2028. The internal audit review of risk management completed in April 2024 provided 'reasonable assurance' in respect of controls in place.	A
approaches and carries out its annual budget setting process	The Trust's annual budget setting process works alongside the business planning and top-down work on the Trust and system 2024/25 financial plan. The financial plan is developed through an iterative process of Trust and ICS-wide planning meetings and reporting to Finance Committee and Trust Board. Identification and development of CIP schemes to support delivery of the 2024/25 budget is ongoing and given the status of 2024/25 CIP schemes we recommend earlier identification and development of efficiency to support the annual budget setting process and covered by Key Recommendation 1.	A
ensures effective processes and systems are in place to ensure budgetary control; to communicate relevant, accurate and timely management information; supports its statutory financial reporting; and ensures corrective action is taken where needed, including in relation to significant partnerships	Budget managers reviewing budget reports monthly in a formal process. Finance reports are also reported at a divisional level, with budget managers identifying key areas to manage from the reports through divisional bi-weekly meetings. The Trust produces a monthly finance report which is reported to the Trust Board and Finance Committee. The finance report provides analysis and information to support the conclusions made on the financial position and key variances are explained.	G
ensures it makes properly informed decisions, supported by appropriate evidence and allowing for challenge and transparency, including from audit committee	The Trust Board receives comprehensive reports on standing agenda items and key issues, with clear indications of whether items are for information, decision, approval, or assurance. Based on our work we are satisfied that the information provided allows for sufficient challenge and debate to support strategic decision-making. The harmonisation of governance arrangements between the Trust and Epsom & St Helier University Hospitals NHS Trust continued in 2023/24 with the board and committees meeting in-common supported by a common agenda which permits for ongoing scrutiny of Trust and group-wide items. The Audit Committees of the two Trusts is meeting in common in 2024/25. We note that these arrangements are continuing to embed, and we have recommended an external effectiveness review is undertaken in 2024/25.	A

G	No significant weaknesses in arrangements identified or improvement recommendation made.
A	No significant weaknesses in arrangements identified, but improvement recommendations made.
R	Significant weaknesses in arrangements identified and key recommendations made.

Governance – commentary on arrangements

We considered how the Trust:	Commentary on arrangements	Assessment
monitors and ensures appropriate standards, such as meeting legislative/regulatory requirements and standards in terms of staff and board member behaviour	The Trust has established processes to ensures compliance with appropriate standards, including legislative and regulatory requirements. Policies and procedures are in place to uphold these standards including a fit and proper persons policy, and the standards of business conduct, which is incorporated into the Trust's Managing Conflicts of Interest Policy. We have raised an improvement recommendation relating to the update of the Trust policies.	A

G	No significant weaknesses in arrangements identified or improvement recommendation made.
A	No significant weaknesses in arrangements identified, but improvement recommendations made.
R	Significant weaknesses in arrangements identified and key recommendations made.

Governance (areas for improvement)

Areas for improvement

Review of governance arrangements

As part of its transition to Group working arrangements with SGH, there have been updates to key governance arrangements over the last couple of years including:

- Establishing new leadership and governance structures for example a single executive, site leadership teams, group board and committees in common.
- A shared vision/strategy across the Group
- Merger of some corporate departments (comms, corporate affairs, performance, strategy) with others planned.

We made an improvement recommendation in our 2022/23 AAR to undertake an effectiveness review of its governance arrangements to identify what works well and what needs to be changed. This has been delayed in 2023/24 due to the need for further governance changes to embed and so this recommendation is outstanding from last year.

Improvement opportunity 1 – We recommend the Trust undertakes an external effectiveness review of its group governance arrangements in 2024/25 to identify what works well, and what needs to be changed to maximise opportunities to improve the effectiveness of the governance arrangements in place. The scope of the review should consider any relevant findings for the ongoing maternity services governance review as noted on page 18.

Updating key policy documents

The Trust hosts the South West London Procurement Partnership which was formed in 2021/22 as a single procurement service acting directly on behalf of providers in south west London. Work is ongoing to finalise a standard procurement policy across the service and from our work we have noted that the standing orders, reservation and delegation of powers and standing financial instructions are out of date and due for review.

Improvement opportunity 2 – We recommend the Trust reviews and updates as appropriate its Standing Orders, Scheme of Reservation and Delegation of Powers and Standing Financial Instructions and concludes the production of the SWLPP procurement policy as soon as possible.

Improving economy, efficiency and effectiveness – commentary on arrangements

We considered how the Trust:	Commentary on arrangements	Assessment
uses financial and performance information to assess performance to identify areas for improvement	The Trust's Integrated Quality and Performance Report (IQPR) provides oversight of performance across various areas including quality and safety, operational, integrated care and workforce. A separate finance report is also presented to the Board and Finance Committee.	G
evaluates the services it provides to assess performance and identify areas for improvement	The Trust has a well-developed process for assessing its performance and is currently grouped into segment 2 of the NHS oversight framework. An unannounced CQC inspection of maternity services in March 23 led to a section 29a notice being served on the Trust and an 'inadequate rating' for the service. The Trust overall CQC rating remains 'requires improvement'. The monitoring and oversight of the CQC maternity services action plan has been undertaken by the CQC Maternity Services Steering Group, chaired by the Group Chief Nurse, with regular update reports on maternity services provided to the Quality Committee and Trust Board. In February 2024, the CQC published the results of its Maternity Survey for 2023 within which St George's scored joint second best in the capital for its maternity care and treatment. An independent external review of quality governance across the Group has been commissioned by the Trust. Phase 1 of the review is currently underway and is focused on the effectiveness of quality governance in the service and upwards from the maternity service to the Board, considering quality governance structures, processes, systems and controls. Subject to the findings of phase 1, a second phase will consider the wider effectiveness of quality governance from individual service level to Divisional, Site, Executive and Board level across both SGUH and ESTH and across the Group as whole. We have raised an improvement recommendation in respect of this.	A
ensures it delivers its role within significant partnerships and engages with stakeholders it has identified, to assess whether it is meeting its objectives	The Trust has appropriate arrangements in place to support partnership working and engagement with stakeholders. The Trust is part of the GESH group structure for two years now which facilitates partnership working with SGH. The Trust engaged with stakeholders and staff during the development of the Group Strategy 2023-28. The Trust is part of the SWL Acute Provider Collaborative and actively participates in ICS governance, collaborating on joint forward planning.	G
commissions or procures services, assessing whether it is realising the expected benefits	The Trust has arrangements in place to monitor procurements and to seek procurement efficiencies and is part of the Southwest London Procurement Partnership (SWLPP). Performance of key contracts is monitored by individual contract managers and at more senior level through outcome reporting and budget monitoring. Matters for escalation for senior oversight are managed at the SWLPP Steering Board which is attended by the partner Trust's CFOs and meets monthly.	G

G	No significant weaknesses in arrangements identified or improvement recommendation made.
A	No significant weaknesses in arrangements identified, but improvement recommendations made.
R	Significant weaknesses in arrangements identified and key recommendations made.

Improving economy, efficiency and effectiveness –areas for improvement

Areas for improvement

CQC Review of Maternity Services

The Trust had a s29a notice served following a CQC review of Maternity Services. The final report was published in August 2023 and a rating of inadequate was given by the CQC in respect of the services. The Trust responded to the immediate actions arising from the s29A notice and an action plan was developed to further respond to the 15 'Must Do' recommendations and 6 'Should Do' recommendations set out in the final. There was a substantial amount of 'read across' between the 21 CQC recommendations and the Section 29A Action Plan's 21 Action Areas. The monitoring and oversight of the CQC maternity services action plan has been undertaken by the CQC Maternity Services Steering Group, chaired by the Group Chief Nurse. Regular update reports on maternity services are provided to the Quality Committee and Trust Board. In February 2024, the CQC published the results of its Maternity Survey for 2023 and St George's scored joint second best in the capital for its maternity care and treatment. An independent external review of quality governance across the Group has been commissioned by the Trust. Phase 1 of the review is currently underway and is focused on the effectiveness of quality governance in the service and upwards from the maternity service to the Board, considering quality governance structures, processes, systems and controls. Subject to the findings of phase 1, a second phase will consider the wider effectiveness of quality governance from individual service level to Divisional, Site, Executive and Board level across both SGUH and ESTH and across the Group as whole.

Improvement opportunity 3 – The Trust should ensure the actions arising from the external review of maternity services quality governance arrangements and the CQC action plans are progressed as soon as possible to provide assurance to the Board that changes in arrangements will improve performance. The Trust should continue enhanced oversight of the area with progress against the actions regularly reported to the Trust Board. Effectiveness of arrangements put in place should be considered on an ongoing basis, and if these are not deemed to be improving performance, they should be revisited. .

Value for Money Recommendations raised in 2023/24

Recommendations raised in 2023/24

	Recommendation	Type of recommendation *	Criteria impacted	Evidence	Impact or possible future impact	Actions agreed by Management
1	We recommend the development and execution of a plan that encompasses both short-term and medium-term strategies to achieve financial sustainability. This will include: • Developing a pipeline of CIP schemes ensuring that the arrangements are embedded quickly so that recurrent efficiencies are identified, and all budget holders are held to account for the delivery of savings throughout the year. The Trust should also look to develop a multi-year pipeline of efficiency/ transformation programmes in conjunction with system partners and to support earlier identification of annual savings. • A credible medium term financial plan should be developed to provide assurance that the Trust can achieve a breakeven position in the next 3-5 years.	Key	Financial sustainability	Financial Plan 2024/25 & Cost Improvement Programme	Inability to deliver the financial plan and further deterioration in the underlying financial position of the Trust.	Actions: Focus on system actions to be increased to address the structural problems whilst building on the robust Trust governance and reporting. Responsible Officer: Site CFO Executive Lead: Group CFO Due Date: March 2025

* Explanations of the different types of recommendations which can be made are summarised in Appendix B.

Recommendations raised in 2023/24

	Recommendation	Type of recommendation *	Criteria impacted	Evidence	Impact or possible future impact	Actions agreed by Management
2	We recommend the Trust undertakes an external effectiveness review of its group governance arrangements in 2024/25 to identify what works well, and what needs to be changed to ensure efficient and timely process and challenges such as duplication of agenda items are corrected/minimised. This should consider any relevant findings for the ongoing maternity services governance review.	Improvement	Governance	Review of board meeting minutes, joint audit, finance and quality committee papers and discussions with the head of operational governance (Stephen Jones).	Challenges with duplication of agenda items, inconsistency of papers.	Actions: Management agrees with this action. As reported in its management response to the 2022/23 Value for Money report, management considered it important to undertake an external quality governance review across the Group following issues identified in the SGUH maternity service in a CQC inspection. Management said at that time that it considered the appropriate time to undertake an external review of its group governance arrangements would be after that review had concluded. The review was completed in April 2024 and was discussed by the Board in June 2024. Management will develop proposals for reviewing its group governance arrangements following this. Given the costs involved in commissioning an external governance review, this will be subject to approval through the triple lock process. As a result, the Trust has in any case incorporated into its 2024/25 internal audit plan an internal audit review of group governance arrangements in order that it can test what is working well and what needs to be further improved to maximise the effectiveness of the Group governance arrangements for the future. This internal audit has a scheduled start date of October 2024. Responsible Officer: Group Chief Corporate Affairs Officer Executive Lead: Group Chief Corporate Affairs Officer Due Date: March 2025

* Explanations of the different types of recommendations which can be made are summarised in Appendix B.

Recommendations raised in 2023/24

	Recommendation	Type of recommendation *	Criteria impacted	Evidence	Impact or possible future impact	Actions agreed by Management
3	We recommend the Trust reviews and updates as appropriate its Standing Orders, Scheme of Reservation and Delegation of Powers and Standing Financial Instructions and concludes the production of the SWLPP procurement policy as soon as possible.	Improvement	Governance	Review of documents and discussions with Management	The lack of up-to-date policies enhances risk and may lead to inappropriate decision making.	Actions: Management accept these findings. The review of the Trust's Standing Orders, Scheme of Delegation, and Standing Financial Instructions to reflect the evolving Group operating model is currently in train and is scheduled for completion in the autumn, and this has been previously reported to the Audit Committee. Responsible Officer: Group Chief Corporate Affairs Officer Executive Lead: Group Chief Corporate Affairs Officer Due Date: End Q2 2024/25
4	The Trust should ensure the actions arising from the external review of maternity services quality governance and the CQC action plans are progressed as soon as possible to provide assurance to the Board that changes in arrangements will improve performance. The Trust should continue enhanced oversight of the area with progress against the actions regularly reported to the Trust Board. Effectiveness of arrangements put in place should be considered on an ongoing basis, and if these are not deemed to be improving performance, they should be revisited.	Improvement	Improving economy, efficiency and effectiveness	Review of committee minutes and reports and meetings with Management	Impact on patient safety, service quality, and the ability of the Trust to meet its objectives.	Actions: The Trust has appointed a Group Chief Midwifery Officer (GCMidO) who will support the monitoring of the CQC action plan, providing updates on progress to the Quality Committee in Common and Trust Board. The GCMidO will also work with the GCNO and GCMO to develop and implement the action plan based on the findings of the Governance review of Maternity. The plan will be presented to the October 2024 Quality Committee and November 2024 Trust Board Responsible Officer: Group Chief Midwifery officer Executive Lead: GCNO Due Date: October 2024

* Explanations of the different types of recommendations which can be made are summarised in Appendix B.

Appendices

Appendix A:
Responsibilities of the NHS Trust

Public bodies spending taxpayers' money are accountable for their stewardship of the resources entrusted to them. They should account properly for their use of resources and manage themselves well so that the public can be confident.

Financial statements are the main way in which local public bodies account for how they use their resources. Local public bodies are required to prepare and publish financial statements setting out their financial performance for the year. To do this, bodies need to maintain proper accounting records and ensure they have effective systems of internal control.

All local public bodies are responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness from their resources. This includes taking properly informed decisions and managing key operational and financial risks so that they can deliver their objectives and safeguard public money. Local public bodies report on their arrangements, and the effectiveness with which the arrangements are operating, as part of their annual governance statement.

The directors of the Trust are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

The directors are required to comply with the Department of Health & Social Care Group Accounting Manual and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another entity. An organisation prepares accounts as a 'going concern' when it can reasonably expect to continue to function for the foreseeable future, usually regarded as at least the next 12 months.

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Appendix B:
Value for Money Auditor responsibilities

Value for Money arrangements work

All NHS Trusts are responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness from their resources. This includes taking properly informed decisions and managing key operational and financial risks so that they can deliver their objectives and safeguard public money. The Trust's responsibilities are set out in Appendix A.

NHS Trusts report on their arrangements, and the effectiveness of these arrangements as part of their annual governance statement.

Under Schedule 10 paragraph 1(d) National Health Service Act 2006, we are required to be satisfied whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The National Audit Office (NAO) Code of Audit Practice ('the Code'), requires us to assess arrangements under three areas:

Financial Sustainability

Arrangements for ensuring the Trust can continue to deliver services. This includes planning resources to ensure adequate finances and maintain sustainable levels of spending over the medium term (3-5 years).

Governance

Arrangements for ensuring that the Trust makes appropriate decisions in the right way. This includes arrangements for budget setting and management, risk management, and ensuring the Trust makes decisions based on appropriate information.

Improving economy, efficiency and effectiveness

Arrangements for improving the way the Trust delivers its services. This includes arrangements for understanding costs and delivering efficiencies and improving outcomes for service users.

2023/24 is the fourth year that we have reported our findings in this way. We undertake and report the work in three phases as set out in the Code.

Phase 1 – Planning and initial risk assessment

As part of our planning, we assess our knowledge of the Trust's arrangements and whether we consider there are any indications of risks of significant weakness. This is done against each of the reporting criteria and continues throughout the reporting period.

Information which informs our risk assessment	
Cumulative knowledge of arrangements from the prior year	Key performance and risk management information reported to the Board
Interviews and discussions with key officers	NHS Oversight Framework (NOF) rating
Progress with implementing recommendations	Care Quality Commission (CQC) reporting
Findings from our opinion audit	Annual Governance Statement including the Head of Internal Audit annual opinion

Phase 2 – Additional risk-based procedures and evaluation

Where we identify risks of significant weakness in arrangements, we will undertake further work to understand whether there are significant weaknesses. We use auditor's professional judgement in assessing whether there is a significant weakness in arrangements and ensure that we consider any further guidance issued by the NAO.

Phase 3 – Reporting our commentary and recommendations

The Code requires us to provide a commentary on your arrangements which is detailed within this report. Where we identify weaknesses in arrangements we raise recommendations. A range of different recommendations can be raised by the Trust's auditors as follows:

- **Key recommendations** – the actions which should be taken by the Trust where significant weaknesses are identified within arrangements.
- **Improvement recommendations** – actions which should improve arrangements in place but are not a result of identifying significant weaknesses in the Trust's arrangements.

Appendix C:
Follow-up of previous recommendations

	Recommendation	Type of recommendation *	Date raised	Progress to date	Addressed?	Further action?
1	We recommend that the Trust progress at speed to develop a pipeline of CIP schemes so that the Trust can be confident that it will deliver the £62.1m CIP target and provide remedial action if CIP delivery is off track in 2023/24. The pipeline of CIP schemes will also support delivery into 2024/25 and beyond.	Key	June 2023	The Trust reported a deficit of £3.6m in 2023/24 which was £12.6m adverse to the updated plan. Total CIP delivery in 23/24 was £60.1m, split £37.9m non-recurrent and £22.2m recurrent which was £2m adverse to the plan.	This has been superseded by key recommendation 1 in 2024/25	We have re-raised a key recommendation to ensure that the Trust is focused on delivering against its financial deficit, CIPs and medium-term financial plan. See recommendation No. 1 on page 15.
2	We recommend the Trust and system develop a credible medium term financial plan to provide assurance that the Trust can achieve reported/underlying breakeven position in the next 3-5 years. The Trust plan should be: - updated with the latest 2023/24 financial plan and assumptions; - aligned with other Trust plans (for example workforce, operational plans and estates) and be aligned with the system medium term financial plan and assumptions; and - underpinned by a detailed pipeline of financial opportunities over the 3–5-year period.	Improvement	June 2023	Based on our review this year we note better collaboration and working across the South-West London system, but further work is required to develop a sustainable medium term financial plan.	This has been superseded by key recommendation 1 in 2024/25	We have re-raised a key recommendation to ensure that the Trust is focused on delivering against its financial deficit, CIPs and medium-term financial plan. See recommendation No. 1 on page 15.

* Explanations of the different types of recommendations which can be made are summarised in Appendix B.

Appendix C:
Follow-up of previous recommendations

	Recommendation	Type of recommendation *	Date raised	Progress to date	Addressed?	Further action?
3	We recommend the Trust undertake an internal or external effectiveness review of its governance arrangements in 2023/24 to identify what works well, and what needs to be changed.	Improvement	June 2023	The Trust has made further updates to GESH Group governance arrangements in 2023/24 and has been waiting for these to embed before undertaking a review. Based on discussions with Management we understand a review is scheduled to take place in 2024/25 and so this recommendation remains in place.	No	We have re-raised an improvement recommendation to ensure that the Trust is focused on undertaking a governance review in early 24/25. See improvement recommendation on page 18.
4	The Trust should review the effectiveness of arrangements put in place to address the issues highlighted by the CQC to provide assurance to the Board that changes in arrangements will improve performance.	Improvement	June 2023	Refer to comments on page 18.	Remains in progress and superseded by the recommendation on page 18.	Yes

* Explanations of the different types of recommendations which can be made are summarised in Appendix B.

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Council of Governors

Meeting in Public on Thursday, 18 July 2024

Agenda Item	6.1	
Report Title	**Report from the Membership Engagement Committee**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Sandhya Drew, Governor	
Previously considered by	n/a	-
Purpose	**For Noting**	

Executive Summary

The Council of Governors is asked to note the matters considered by the Membership and Engagement Committee at its meeting on 27 June 2024.

Committee Assurance	
Committee	Not Applicable
Level of Assurance	Not Applicable

Appendices

Appendix No.	Appendix Name
Appendix 1	MEC Terms of Reference
Appendix 2	Membership Report paper considered at MEC meeting on 27 June 2024
Appendix 3	Membership activities paper considered at MEC meeting on 27 June 2024

Implications

Group Strategic Objectives

☐ Collaboration & Partnerships
☐ Right care, right place, right time
☐ Affordable Services, fit for the future
☐ Empowered, engaged staff

Risks

N/a

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☐ Well Led

NHS system oversight framework

☐ Quality of care, access and outcomes	☐ People
☐ Preventing ill health and reducing inequalities	☐ Leadership and capability
☐ Finance and use of resources	☐ Local strategic priorities

Financial implications
N/a
Legal and / or Regulatory implications
N/A
Equality, diversity and inclusion implications
As set out in paper.
Environmental sustainability implications
N/A

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Report from the Membership and Engagement Committee

Council of Governors, 18 July 2024

1.0 Purpose of paper

1.1 This report sets out the key matters considered by the reconstituted Membership and Engagement Committee at its meeting on 27 June 2024.

2.0 Items considered by the Committee

2.1 The Committee received a report on Membership first from the Group Chief Corporate Affairs Officer, so as to inform its discussion. The report contained detailed demographic and geographic information. It was divided by constituency. The Committee agreed with the Report's conclusion that overall quantity of membership was over what was required (minimum membership levels established in the Trust's Constitution), was healthy and was socially representative. The prime challenge was in achieving quality of engagement rather than quantity of members. Membership statistics tell us about characteristics and location but not about membership motivation. However, the Committee did note four quantitative aspects: (1) There is underrepresentation of 16-25 year olds; (2) SW Lambeth was 35 members above the minimum membership level and currently had no Governor, with elections scheduled to take place following the general election; (3) Staff are automatically members but awareness of this among staff was very low; (4) CL pointed out underrepresentation of BAME members of public in Merton. It was noted that the picture was more nuanced, with some BAME representation higher than the constituency average in some areas, but this would be looked into. **[AP]**

2.2 There was discussion, which started at this point and was returned to through the meeting, about the differences between the 4 main constituencies: (1) Local Constituencies (Merton, Wandsworth, SW Lambeth); (2) Stakeholder Constituencies (which appointed rather than elected Governors); (3) Rest of England; (4) Staff. Thus, a "everything is super" message which we might send out in our monthly email to members in Sussex might irritate staff who are working desperately hard and who see up close the current problems. Another example was an event in a local library will work for a Merton governor but not for a rest of England governor, which might need either a digital approach or an approach via a tertiary service organisation. The Committee agreed with the point (made in relation to emails) that a bespoke approach is more engaging. The Committee considered that each action we have to decide whether we adopt one size fits all for all members or we break our action into constituencies, with a slightly different approach to each, or we make sure our one size does indeed fit all. Importantly, each Governor is not confined to the constituency from which they were elected, and could and should participate in other events.

Developing an active membership engagement plan

2.3 The Committee received a report setting out proposals for re-starting membership engagement activities. These proposals included activities including regular Meet Your Governor events at both St George's and Queen Mary's Hospitals, Member Talks introduced by Governors, and

piggybacking on events in our local communities. It also included proposals for engaging with local schools and colleagues as a means of promoting membership among younger members.

2.4 JP reported back on membership engagement at Kingston and Maudsley, for which the Committee thanked her. HS proposed recruitment activity at University during induction week. There were lots of reasons students might sign up and they were in the 16-25 group. **[AP]** There was discussion about Associate Governors, which JP had mentioned. This could be a non voting role and aimed at encouraging 16-25 membership. SJ noted there had been discussion in the past about Shadow Governors. The Committee did not reach a conclusion on this and it was agreed that the Committee would oversee further work to explore options on this, with a view to brining proposals back to the Council of Governors following engagement with other trusts. Another idea was promoting membership in schools to Year 12-13 students who might be considering medicine. Another relatively easy way to raise the profile of membership, AB pointed out, was guest attendance at other organisations eg Healthwatch. **[AP]** The AGM was an important event to promote. **[AP]** There was discussion on aiming for a well-attended AGM, something which had not happened since the outbreak of Covid (eg 80+ attendees). In terms of newletters, SJ agreed that a monthly newsletter to members could restart and he would engage with the Communications team to ensure there was a joined up approach. One option was to use the weekly newsletter to Governors as the basis of a membership newsletter. Note: if we are including staff members, we need to consider the content and tone of that content carefully eg not a superficial feel good approach. SD to liaise with SJ. **[AP]** Agreed by SJ that it was feasible to have email addresses by constituency (i.e. one for Wandsworth, Merton, SWL Lambeth and Rest of England) rather than generic members' email **[AP]**. This was seen as a proportional way of providing a local connection with Governors, while not overburdening Governors with managing email correspondence with potentially large numbers of constituents. Agreed this would be supported and monitored by the Trust's Governors support team and emails addressed to Governors, or relevant to that constituency, would be forwarded to governors.

2.5 The Committee agreed governors needed training on signposting eg speak up, complaints and PALS to support them in engaging with members, and this would be arranged. In addition, Governors undertaking membership engagement would be provided with details of contacts in the Trust to whom individual members could be signposted where appropriate. **[AP]** The Committee agreed that it was important to develop a calendar of events across the local communities of the Trust which would support Governors in engaging with members. Governors were asked to send through details of local events to the Governors support team, who would develop a calendar. It was also proposed that a shared calendar be developed so Governors could add events to it directly. SD Note: The system as current is that governance send out email requests for governors for events. We send in news of events we are going to. This is labour intensive. Is there scope for a common drive with a calendar? **[AP]**

Developing our new Membership Strategy

2.6 The Committee had the previous strategy before them, which was for 2019-2022. There was no current in-date strategy, as the Council heard at its meeting in March 2024. The options for the Committee were to recommend a one year holding strategy or to proceed to formation of a new 3 year strategy. The advantage with the one-year holding strategy, which could draw on

the previous strategy, was that it would provide a framework to support immediate membership engagement activities while providing a window to proactively engage with members in developing a strategy for the longer term, for example through surveys, focus groups etc. In this way, it would ensure that the longer-term strategy was informed by engagement with members. **The Committee recommends to the Council of Governors that the one year holding strategy be reviewed and adopted after work and minor finalisation on it during August**. **It can then be presented at the AGM. Council of Governors is asked to approve this course, including permitting any minor amendments to the current draft by the MEC Committee. [AP]** The Committee discussed the 2019-2022 strategy and considered the concerns raised by some MEC members, which were it was too ambitious; The Committee heard from the GCCAO that, rather than it being too ambitious, the challenge was that the Covid-19 pandemic had started 6 months after its launch and at just the point that the Trust was starting some new and innovative membership engagement work, e.g. local constituency events, membership engagement activities had needed to cease. The Committee concluded that despite these concerns, which were important to consider, the strategy was broadly right. It also noted the disadvantages of having no strategy pending a survey, that previous surveys resulted in the 2019 – 2022 strategy. The particular circumstances here were that furtherance of the 2019-2022 strategy was halted by Covid. It was agreed to recommend a 1 year holding strategy; to present this decision to CoG; to work further on the strategy after 18 July and to start work on the longer 3-year strategy **[AP].**

Survey

2.7 **The Following is for Council of Governors information only.** Although noted as survey of members on agenda, the Committee agreed that survey could also be wider and could target potential members, consistent with strategy objective. The overall view was that the proposed survey was not very engaging. Concern that survey should be as engaging as it could be. Particular issue with staff being unlikely to respond. Agreed for MEC members to consider improvements to questions for next meeting.

2.8 Discussion about using digital means to carry out survey of members and potential members. View expressed though no final agreement that survey should be one side and contain QR Code

2.9 Question if expense of postal survey needed CL asked re previous response rate to posted out survey costing £4500 **[AP]** Obvs more user friendly for some and we do have many members over 60 who may be included. Many members do not provide emails. There was discussion about opt in/ opt out on paper communication.

2.10 Agreed that a survey did not preclude social media promotion of membership eg as link beneath events eg AGM. SJ commented the membership page needed to be more user friendly and would be updated and modernised over the summer. **[AP].**

2.11 The Committee decided to build an events calendar. This would be set up by the Governor support team and governors could email in events they were attending/ organising. Equally, CG could issue calls to governors where governance attendance/ participation needed.

Update from Patient Partnership Experience Group

2.12 Wendy Doyle gave excellent presentation of PPEG. Example of great engagement and of events we could piggyback. AA offered to attend any armed service events. Work would be

undertaken between WD and SJ to develop a forward programme of issues and areas where Governors could provide input.

Terms of Reference Review

2.13 Proposed amendments recommended for agreement by Council of Governors on 18 July **[AP]**

Declarations of Interest

2.14 AA queried whether declarations of interest necessary at each meeting. **[AP]** SJ stated that this was a standard part of all agendas in order to ensure any relevant interests were identified. This matter would be discussed further.

3.0 Recommendations

3.1 The Council of Governors is asked to note the update on the matters considered by MEC at its June meeting and to consider the action points/recommendations below:

Action Points

For Council of Governors

- Agree amendments to the Terms of Reference at 18 July meeting.
- Agree that a 1 year holding strategy should be developed to provide a framework for membership engagement activity in the short term while developing a long-term membership strategy over the next year informed by extensive engagement with members.
- To provide guidance on way forward for Associate Governor roles.
- Governors are asked to provide the Corporate Governance team with details of events and stakeholder groups within their constituencies which could be used to develop an engagement calendar for the year ahead.

Action Points below for CoG information only

For Corporate Governance team

- Create email accounts for each constituency, to be monitored by CG (important).
- Design and consult with SD and Communications on first email newsletter out to ALL public constituencies (important). Contact email addresses for members to contact Governors to be promoted via this first newsletter. Use emails to governors as a starting point.
- Consider post out to all members asking whether digital contact acceptable to them and if so, for email address?
- To start mapping out schools and medical schools governors could speak at, in association with governors themselves.
- Modernise the members page and then create broad social media message on membership with link to page (urgent).
- Create and share tool kit for governors on signposting to support engagement activities (important].

- Answer CL query re survey % response and to discuss further BAME underrepresentation in Merton.
- Draft one year holding policy for discussion after 18 July if MEC recommendation approved.
- Plan and consult on September AGM.

For all Governors with immediate effect

- Consider – alone or with other governors for the same or any different constituency – events to attend or plan. Aim at between 1- 3? This can be piggybacking on events by other groups. To notify CG department of attendance or participation for information only, so that it can be added to the calendar of engagement. (important)

For Governors MEC members with immediate effect

- Consider interim strategy so that can be agreed after July 18.
- Consider survey questions for next meeting.
- Consider digital cf post communication for next meeting.

Outstanding care every time

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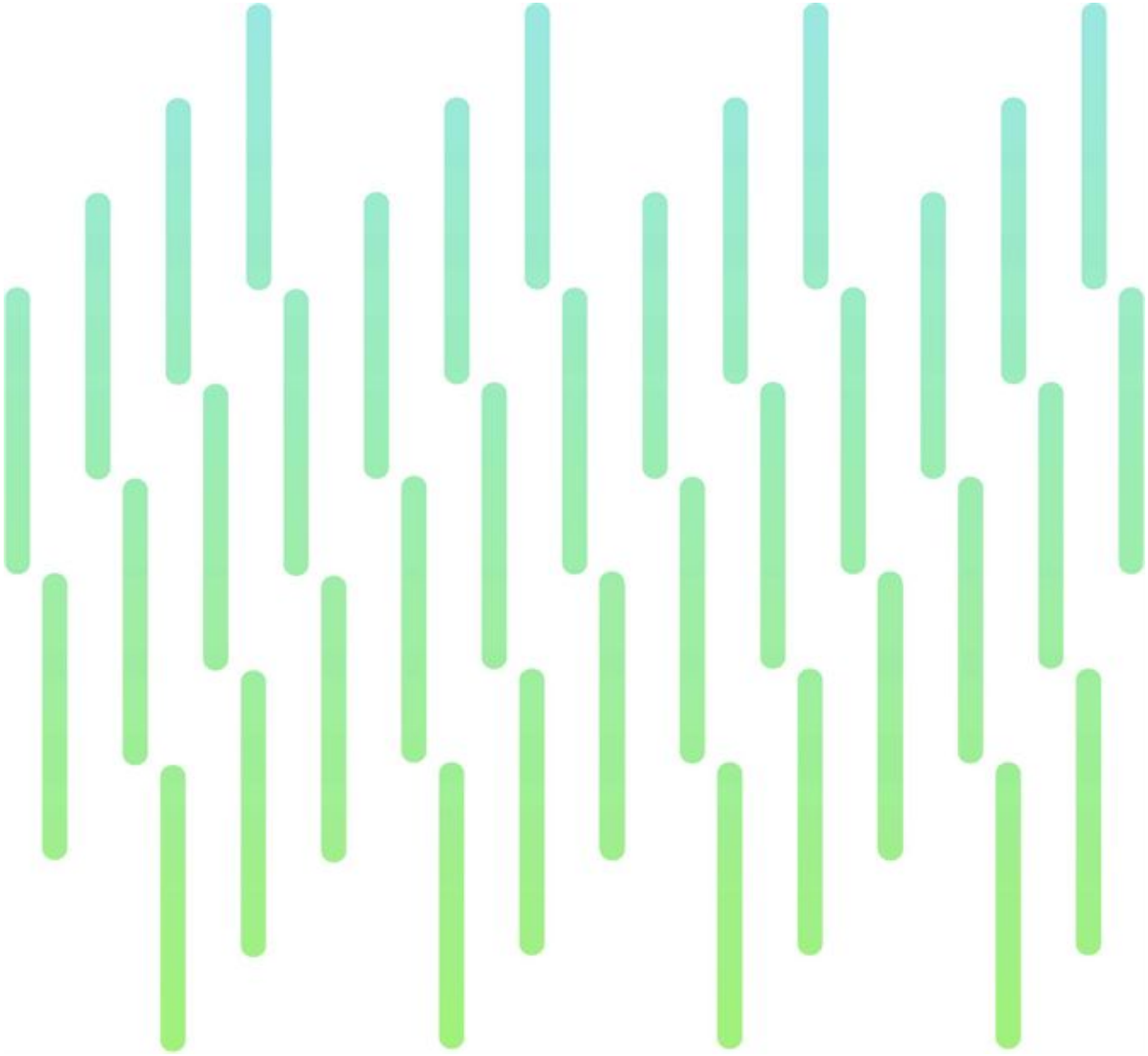
Membership Engagement Committee Terms of Reference

Approved by the Council of Governors 10 September 2020



Approval and review dates

Profile	
Document name	Membership Engagement Committee Terms of Reference
Version	2.0
Executive Sponsor	Chief Corporate Affairs Officer
Author	Head of Corporate Governance/Board Secretary
Approval	
Approval group	Council of Governors
Date of approval	10 September 2020
Date for next review	September 2021

Membership Engagement Committee Terms of Reference

1. Name of Group

The name of the group is the Membership Engagement Committee (MEC).

2. Authority

Establishment: The Council of Governors established the Membership Engagement Committee to support it with fulfilling its duties to engage with the Trust's members.

Powers: The Committee should support the statutory obligations of the Council of Governors in relation to reporting and must present key decisions for approval by the Council of Governors.

The Committee has the authority to act with the bounds of the Trust's Membership Engagement Strategy. The Committee will provide assurance on these matters to the Council of Governors.

Cessation: The Membership Engagement Committee may only be disbanded or its remit amended on the authority of the Council of Governors.

3. Purpose of the Group

The purpose of the Membership Engagement Committee is to develop and implement the Trust's Membership and Engagement Strategy, identify key actions for supporting effective engagement with members of the Trust and facilitate mechanisms and activities which would ensure that the Trust's membership is representative of the communities it serves. The Committee also plays a key role in ensuring that all members of the Council of Governors participate in activities which improve engagement and involvement with members. The Committee will provide assurance on these matters to the Council of Governors.

4. Duties of the Group

The key duties of the Committee include:

- Developing and overseeing the implementation of ~~implementing~~ the Trust's Membership Engagement Strategy on behalf of the Council of Governors.
- Developing an annual membership engagement plan to support the delivery of the Membership Engagement Strategy, which identifies engagement opportunities and plans engagement activities, and facilitates the participation of all members Council of Governors in these activities.
- Reviewing the Trust's membership data profile and ensure that the membership remains representative, and to consider the tailoring of membership engagement activities in the context of this data.
- ~~Support with the identifying and delivering key membership and engagement activities and facilitate the participation of all members Council of Governors in these activities.~~
- Ensure effective production of membership communication including:
  - ~~Suggesting content for the Trust's stakeholder newsletter, 'the Brief';~~ Developing proposals for regular newsletters to members.
  - Suggesting ways to develop the Membership and Council of Governors section of the Trust's website to support effective engagement with members
  - Exploring opportunities for the Trust to use social media channels to engage with members and the public
  - Support with the development of key membership information including Membership Application forms

- Reviewing key themes arising from membership engagement activities which are of interest to Trust members, and ensure effective communication of these to the Council of Governors and feedback on actions to members.

- Working with the Patient Partnership Engagement Group to ensure there is good understanding of wider community and stakeholder issues and support relates to improving engagement with the Trust's members and the public.

5. Chairperson

A member of the Committee will be appointed to Chair the Committee as determined by the Council of Governors.

6. Composition of the Group

The Committee shall comprise ten members with at least one Governor from each constituency. ~~The majority~~ At least half of the members of the Committee must be Governors from the public constituencies, and there should be at least one stakeholder Governor and one staff Governor.

Appointments to the Committee (other than the Chair) shall be for a period of three years (or for the remaining term of office of the Governor, where this is less than three years). Preference will be given to Governors who have not previously been a member of the Committee and to ensure that there is at least one stakeholder Governor and one elected Governor, and ideally one staff Governor on the membership at any given time.

In the event of there being more Governors who wish to be members than spaces available, the Council of Governors would be asked to decide whether or not to increase the membership of the Committee.

7. Regular and Other Attendees

The following individuals are not members of the Committee but will instead attend the Committee on a regular basis:

- Group Chief Corporate Affairs Officer (Executive Lead)
- Group Head of Corporate Governance
- Governors and Membership Engagement Officer
- Communications Manager

At the discretion of the Committee Chair, the Committee may also request other members of the Executive team and other relevant members of staff to attend meetings of the Committee or to attend for specific agenda items. The Committee may also invite others to attend for the purpose of receiving specialist and/or independent advice on any matter, relevant to its scope and function.

Members will be required to attend all of the meetings each year. An attendance register will be taken at each meeting to support this.

8. Quoracy

The quorum for any meeting of the Committee shall be four members, of which must be a member of each constituency. Regular or other attendees do not count towards the quorum.

Non-quorate meetings may go ahead unless the Chair decides not to proceed. Any decisions made by the non-quorate meeting must however be formally reviewed and endorsed either at the subsequent quorate meeting or on email circulation by sufficient number of Committee members to ensure the decision is valid.

In the absence of the Committee Chair, the Committee should nominate another Committee Member to chair the Committee's meeting(s).

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Developing a new membership engagement programme

Council of Governors Membership Engagement Committee

Stephen Jones
Group Chief Corporate Affairs Officer

June 2024

Introduction

Membership engagement activity has been ad hoc and limited since the Covid-19 pandemic and, in the context of the Membership Engagement Committee not meeting, structured engagement activities largely stalled in 2023/24. At its meeting in March 2024, the Council of Governors agreed to the reconstitution of the Membership Engagement Committee, with a refreshed membership and chair. It also agreed on the importance of reactivating membership engagement activities as a key area of focus for the Council over the coming year in order to ensure that the voice of Trust members is brought into and reflected in the work of the organisation.

This paper sets out initial proposals to inform the development of a re-energised programme for membership engagement. We do not propose to 'reinvent the wheel' but to start by putting in place some core elements of an active engagement programme in the short-term while developing a range of medium- and long-term proposals to strengthen membership engagement, learning from good practice at other Trusts. We also want to ensure that, in supporting Governors to engage with members, we focus our limited resources to those activities where Governors will get the maximum impact, for example:

- Supporting Governors to hold membership engagement stalls at St George's and Queen Mary's Hospitals
- Developing a programme of Members Talks on topical health issues of interest to members, and have a Governor introduce each session to help increase the profile of Governors.
- Identify a range of key partners and networks Governors have in their constituencies to work with and explore opportunities for joint work to help recruit new members and improve the quality of engagement.
- Develop a model for Governor engagement with members at Borough level, for example hoding constituency engagement event or 'surgeries' in the community and through 'piggy-backing' on existing community events.

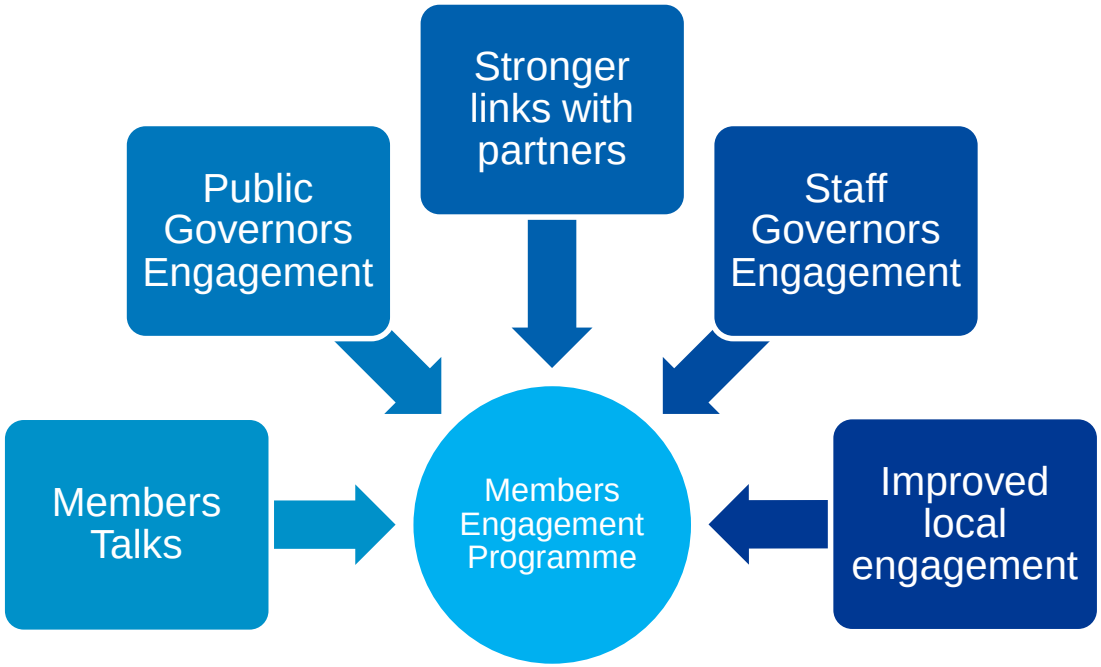
Recommendation:

The Committee is asked to:

- consider the proposals outlined in the report
- provide thoughts, comments and input on practical engagement activities to help build an active programme of membership engagement
- note that further work will be undertaken to finalise an active programme of engagement for the balance of 2024/25, particularly in light of the discussions to be undertaken on the development of a new strategy.

Potential key elements of a new, active membership engagement programme

St George's University Hospitals NHS Foundation Trust



Designing a programme of active membership engagement

We want Governors to help co-design an active and effective membership engagement programme for the coming year which works for you as Governors, works for the public, and helps the Trust deliver its responsibilities in relation to member and public engagement.. We are keen to hear your views, ideas and suggestions. As a starter for 10, we think the following might potentially constitute some of the key aspects of an active membership engagement programme:

- Promote the work of the Trust's Governors, as representatives of our members
- Develop new opportunities for members to express their views and provide feedback through Governors
- Refresh our existing communication channels with members and our approach to membership communication and engagement
- Promote membership opportunities to younger people in our communities
- Develop targeted campaigns to recruit members from any group which is under-represented
- Analyse our membership on a regular basis, and maintain an accurate membership database
- Have a clear Governor presence at our sites to speak to members and the public at our hospitals
- Work more innovatively with our partners to promote membership
- Refresh our membership recruitment material
- Improve our programme of engagement events

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Engagement by public and appointed Governors with public members

Designing a programme of active membership engagement

- Governors have access to wide networks within their local communities. We are keen to explore how we can help Governors to use these to help engage with members. So that we can support Governors in this way, we are keen to build an engagement plan of key engagement opportunities across the public constituencies. It is proposed that the Governors find out and share details of their local community networks and information about stakeholder events. The Trust can support Governors with engagement at these.
- Meet Your Governor event could be reinstated, with active promotional work and a clear forward schedule of dates for holding them; clarity about their purpose; and development of structured feedback forms – with reports on the issues raised being discussed by the MEC and presented to the CoG.
- Governors could introduce each Member Talk event (see overleaf for ideas to inform a programme) and the Trust would identify the relevant clinical lead who would lead the presentation.
- We could identify issues on which to seek the views of members e.g. through surveys and focus groups and build surveys of members into an annual programme of how we engage, potentially developing a “you said, we did” approach to help showcase the impact of membership.
- Governors previously engaged with Members stand at the AMM and the Lead Governor makes a presentation at each AMM. It is proposed that this feature is part of the publicity for the AMM and incorporated in the promotional material for Governors.

Establishing a new programme of "Meet Your Governor" events

St George's University Hospitals NHS Foundation Trust

- Prior to the Covid-19 pandemic, the Trust supported Governors to hold regular "Meet Your Governor" events across the Trust.
- These events took place on a monthly or twice monthly basis, depending on Governor availability, with a stall set up usually in either the Atkinson Morley reception or the Grosvenor Wing reception at St George's Hospital in Tooting or the reception of Queen Mary's Hospital in Roehampton.
- The purpose of these sessions was three-fold:
  - to speak to members and the public to understand the issues that mattered to them, their concerns, and their feedback on their experience of the Trust
  - to encourage the public to become members of the Trust
  - to help raise the profile of Governors
- Typically three or four Governors would attend a stand, supported by a member of the Corporate Affairs team who would assist with planning and delivery of the event and with recording member feedback.
- A log of issues raised would be taken, and issues would be followed up with the relevant Director or team, with answers provided to Governors and made available on the membership pages of the Trust website.
- To ensure these events are a success, we would need to:
  - Have a clear and agreed forward plan of dates and locations
  - Agree Governor presence at the events well in advance
  - Promote the events on our website and via social media channels
  - Develop structured feedback forms, and suggested questions

Do Governors want to proceed with holding a programme of Meet Your Governor events?

Establishing a new programme of Member Talks

St George's University Hospitals NHS Foundation Trust

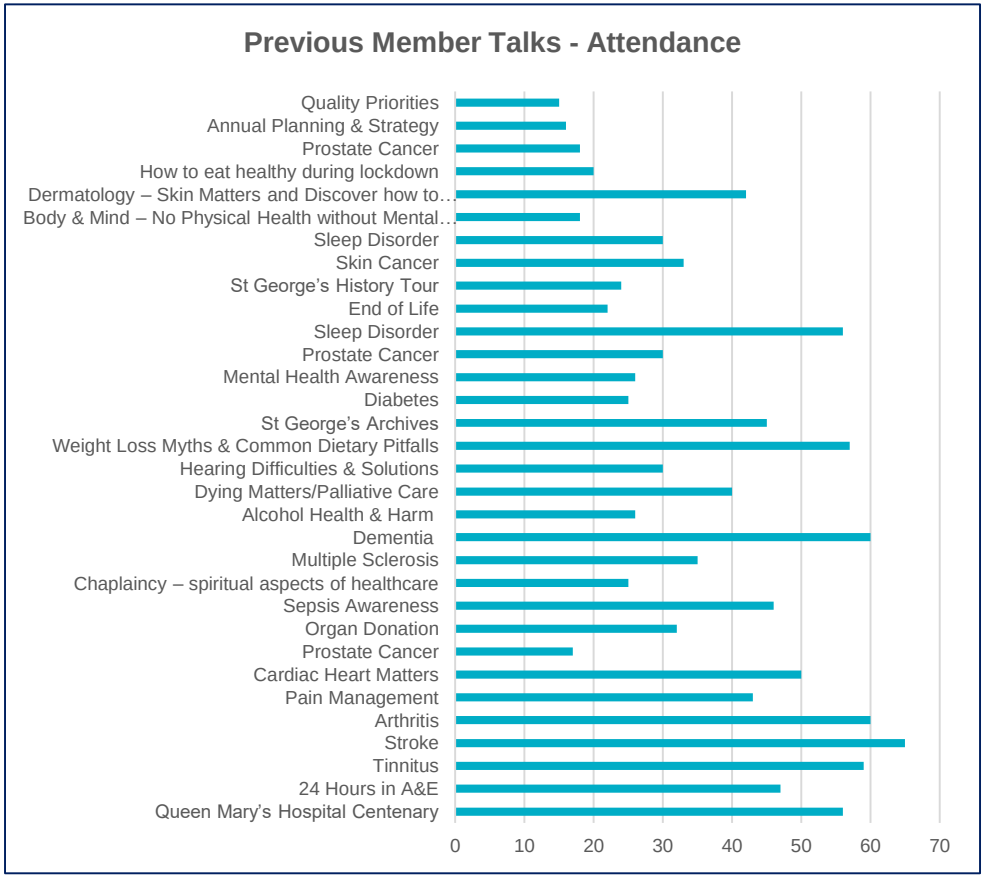
The engagement many Governors wanted to carry out with the community was restricted by the pandemic and have not as yet been reinstated. Governors could now pick this back up, making sure staff tell the stories and bring them to life. These events could be promoted via email and on social media. Although they are billed as membership talks, anyone can attend.

Governors would introduce each talk. We would plan to hold these sessions both in person and virtually. To manage capacity within the Governance Team, we suggest that the frequency of these events is initially scheduled for every other month.

The graph opposite shows a selection of the most popular Member Talks that have been held previously. The most popular are often those about specific health conditions. We may want to consider running some of these, based on some of the most popular themes to get the new programme of talks up and running, and use feedback forms and the members email address to get suggestions of future topics.

We would propose running these virtually to maximise opportunities for members to attend, and making the videos available on our website. Initially, we would suggest running these every other month and building up the frequency over time, while seeking feedback after each session in order to iterate the format and engagement.

Do Governors want to proceed with holding a programme of Meet Your Governor events?



Working with the Patient Partnership and Engagement Group

- There is an alignment between the role of Governors in representing the interests of members and the public by engaging with members of the Trust, patients and the public to understand their views and experiences of care and that of the Trust's Patient Partnership and Engagement Group (PPEG).
- PPEG is a group of volunteers who work in partnership with the Trust. It works with the hospital's staff in a number of ways and works to provide the patients' perspective into the design and delivery of hospital services.
- Previously, two members of the Governors' Membership Engagement Committee attended meetings of PPEG to ensure effective coordination between the two groups, and to understand the views and feedback of patients.
- Continuing the relationship between MEC and PPEG is an important part of the Governors getting a fuller picture of the views and feedback of member.
- **Do Governors agree that maintaining this link is important, and are there volunteers who are able to continue to attend meetings of PPEG?**

The Patient Partnership and Experience Group Charter

Our purpose

To drive and support inclusive patient and carer engagement across the Trust

Our aims

1. To ensure that patients and carers are actively involved in shaping and developing services
2. To review Trust performance addressing issues identified as important by patients, carers and relevant stakeholders

Our work

Aim 1: Active patient involvement

- Receive regular reports from all divisions setting out proposed service developments and patient engagement.
- To monitor how patients have been involved and how their views have informed service delivery and development, driving additional involvement where appropriate
- To create and maintain a database of patients willing to participate at various defined levels of engagement
- Support existing service user groups and encourage the development of new groups. Publish guidelines on establishing groups and create and disseminate good practice information. Work to capture a diverse range of views

Aim 2: Monitor on the actions taken in response to addressing issues identified by patients

- Scrutinise reports including national and local surveys, internal reports on patient experience, feedback from patient user groups, divisional reports, transformational projects, and wider NHS good practice on engagement
- Monitor Trust progress in addressing issues prioritised by patients and recommend specific actions where appropriate

Developing proactive engagement with our local communities

St George's University Hospitals NHS Foundation Trust

- Immediately prior to the onset of the Covid-19 pandemic, we began a pilot of engagement events in local constituencies, introduced by Governors. The first events were delivered in person prior to the first national lockdown. A number of constituency engagement events were then held remotely during the pandemic.
- The events were hosted by Governors from that particular constituency, and Executive Directors attended to give an overview of the Trust's services and key developments affecting local communities.
- While it was positive to undertake these, and significant work was put into promoting them, public attendance was generally low.
- Alternatively, or alongside this, other outreach opportunities are possible e.g. Governors attending University events like their Freshers Fair, or major St George's Charity events.
- There are also opportunities for Governors to undertake engagement activities with local schools.
- **We would like to get the views of Governors about whether you think a form of in-person or virtual engagement events held for each public constituency should be held, and how you think these can be delivered to best effect?**

Developing stronger links with local stakeholders across our communities

- The Trust will develop a detailed stakeholder engagement database using information from Governors about their local networks, current stakeholder data and by linking with the local stakeholder organisations.
- This information would be kept updated by the Trust and circulated to the Governors periodically. Governors would be able to use the database to engage at borough level. Where possible meeting dates and key contacts would be included in the database.
- The Trust would also develop a standard pack for governor to use at the events the want to added which would include updated presentation which includes recent highlights from the Trust, membership and promotional information.

Stronger Links with stakeholders

- Local GPs
- Healthwatch
- Local Schools and Universities
- Clinical Commissioning Groups
- Local Councils
- Other NHS Organisations
- Local Patient Groups

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Engagement by staff Governors with staff members

Developing a model for engagement with staff members

- The current Membership Strategy identifies the need to focus on staff engagement and the pictorial depicts the opportunities to increase staff governor profiles and increase the engagement of staff Members with Governor and wider Trust activities.
- These proposed areas will be explored and worked up with the current and incoming staff governors and a programme developed for the coming year.

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Membership Report – June 2024

Composition of the Trust's membership community

Council of Governors Membership Engagement Committee

Stephen Jones
Group Chief Corporate Affairs Officer

June 2024

Introduction

St George's University Hospitals NHS Foundation Trust

Purpose

This report provides an overview of the current membership profile of the Trust, including an analysis of the Trust's membership by constituency, gender, age, ethnicity and socio-economic background. Data is provided at individual constituency level so that Governors can better understand the composition of their local constituencies, and in particular identify any groups that are under-represented and the geographical distribution of members within the constituencies they represent. Previously, the Membership Engagement Committee received these reports at each meeting. It is proposed that this continues with the reconstituted MEC in order that Governors have a clear understanding of the membership of the Trust and any changes within the membership.

By providing Governors with this information on a regular basis is important to help Governors and the Trust as a whole to:

- Understand the profile of the constituencies of the Trust, which Governors represent
- Identify whether any groups are underrepresented across the membership of the Trust as a whole or any under representation within particular constituencies
- Inform the development of membership engagement activities, based on the profile of our different constituencies, and planning for how best to increase engagement with members.

The data provided will also help to inform the development of a new Membership Strategy. Governors will recall that the Trust's previous membership strategy set out an ambition to develop the quality of engagement with members, to ensure that the membership is representative of the communities served by the Trust, and to maintain and where possible increase the overall size of the Trust's membership.

Recommendation:

The Committee is asked to:

- Review and note the profile of the Trust's membership as a whole and the profile of each of the public constituencies.
- Identify any priority actions for membership engagement based on the analysis of membership set out in this report.

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Overview of the Trust's membership

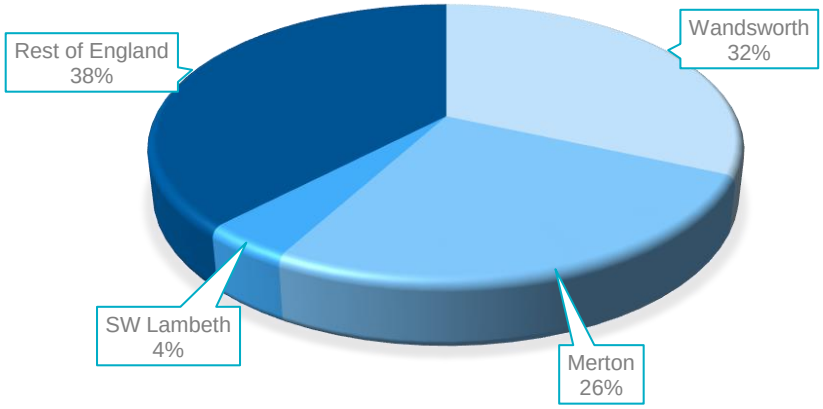
Current membership: Public members

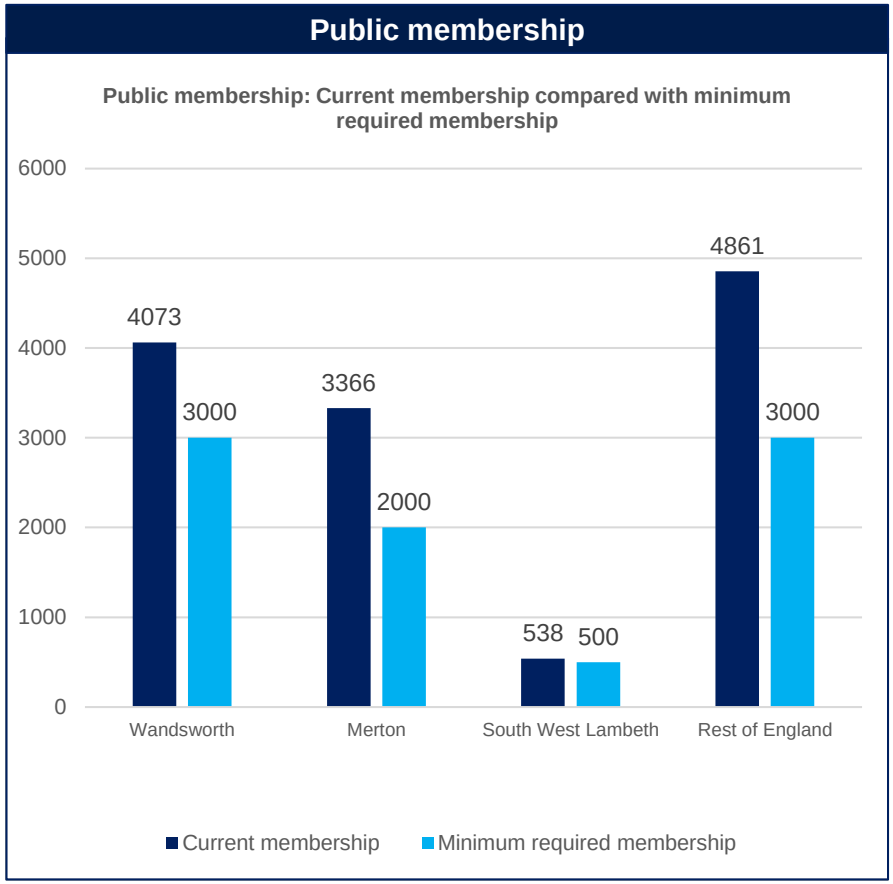
St George's University Hospitals NHS Foundation Trust

As at 19 June 2024, the Trust has a total of 12,838 public members. Our public members are distributed across the four public constituencies of the Trust:

- Wandsworth
- Merton
- South West Lambeth
- Rest of England

The Trust's Constitution sets out minimum numbers of members for each of the public constituencies of the Trust. The charts below and opposite reflect the current breakdown of members by constituency. In all constituencies the Trust's current membership was above the minimum required under the Trust's Constitution.





Current membership: Public members

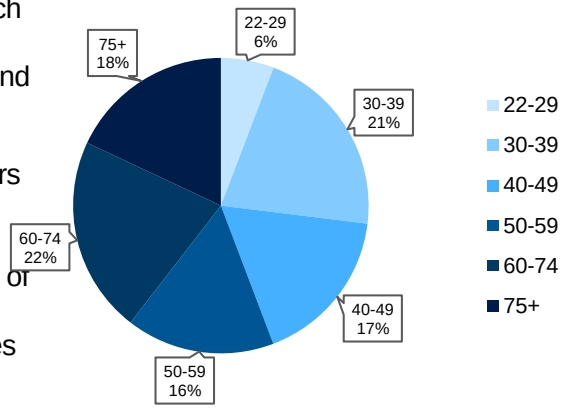
St George's University Hospitals NHS Foundation Trust

We record key demographic data relating to our members, which is gathered to the point at which members join the Trust. Civica, which supports the Trust with the management of our membership database, regularly reviews public records (e.g. records of births and deaths) to update membership numbers.

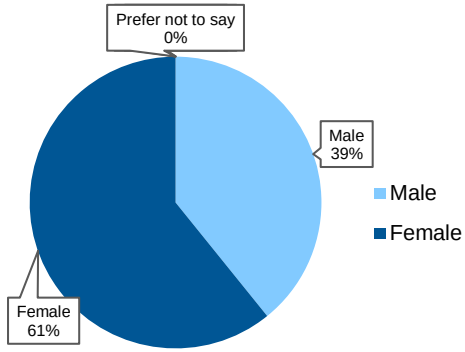
Our database allows us to analyse the composition of our members as a whole, and for each public constituency, by age, gender, ethnicity, socio-economic class, and geographic distribution within constituencies. This slide provides an overview of the composition of our public members as a whole. Later in the report, a similar analysis is provided separately for each of the public constituencies of the Trust.

- **Age:** 40% of the public membership is over 60 years of age (60-69 22%; 75+ 18%). Those aged 21 and younger make up 0.36% of the membership, ages 22-29 are 6%, 30-39 year olds are 21%, 40-49 year olds are 17%, and 50-59 year olds are 16% of the public membership.
- **Gender:** 61% of the public membership is female and 39% is male
- **Ethnicity:** 51% of the public membership is White, 5% Mixed, 25% Asian, 14% Black, 2% Other.
- **Socio-economic:** 30% of the public membership is from the AB ONS classification, 30% C1, 19% C2, and 22% DE.

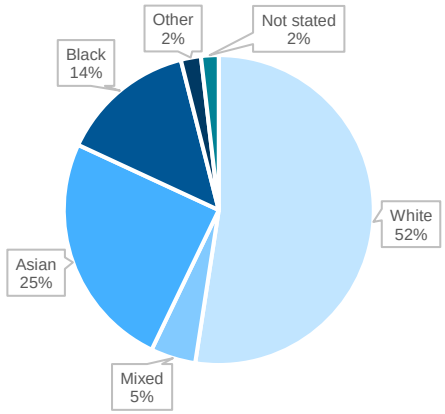
Public membership by age (years)



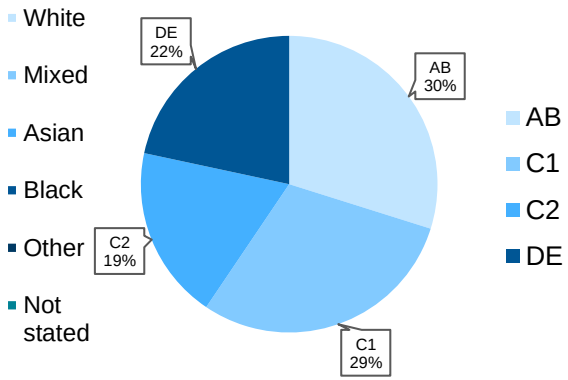
Public membership by gender



Public membership by ethnicity

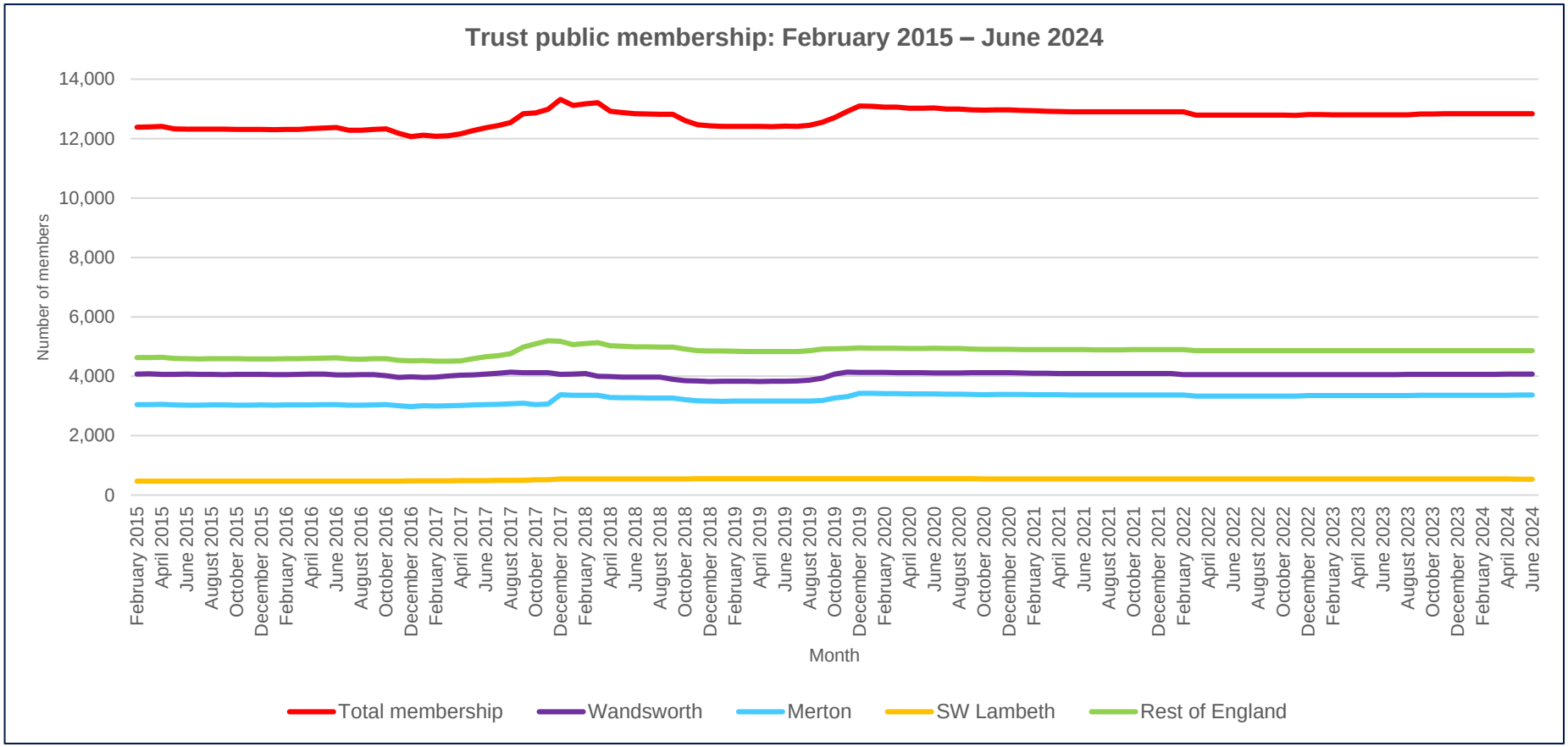


Public membership by ONS classification



Current membership: Public members

St George's University Hospitals NHS Foundation Trust



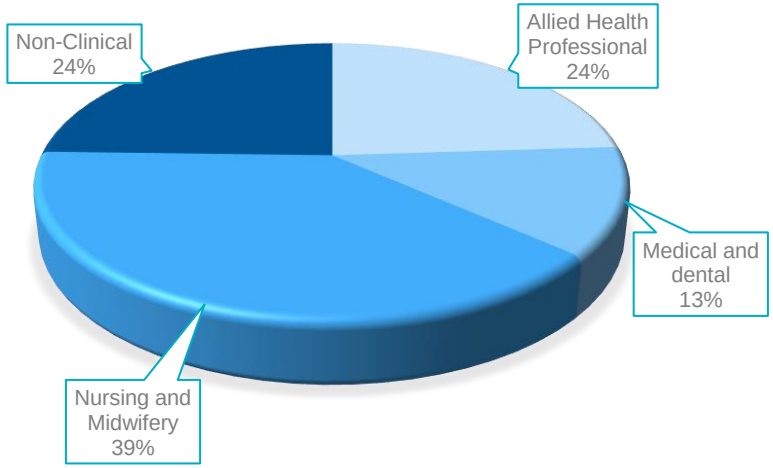
Current membership: Staff members

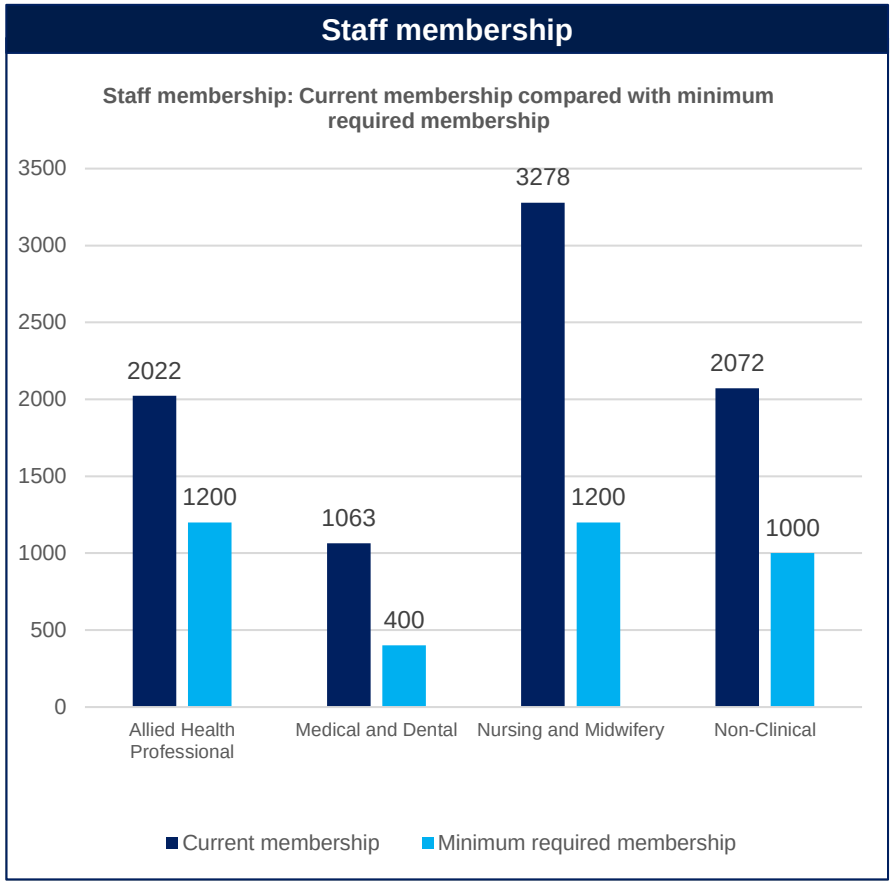
St George's University Hospitals NHS Foundation Trust

As at 19 June 2024, the Trust has a total of 8,435 staff members. Our staff members are distributed across the four staff constituencies of the Trust:

- Allied Health Professionals and other Clinical and Technical
- Medical and dental
- Nursing and midwifery
- Non-clinical

The Trust's Constitution sets out minimum numbers of members for each of the staff constituencies of the Trust. The charts below and opposite reflect the current breakdown of members by constituency. In all constituencies the Trust's current staff membership was above the minimum required under the Trust's Constitution.





Current membership: Staff members

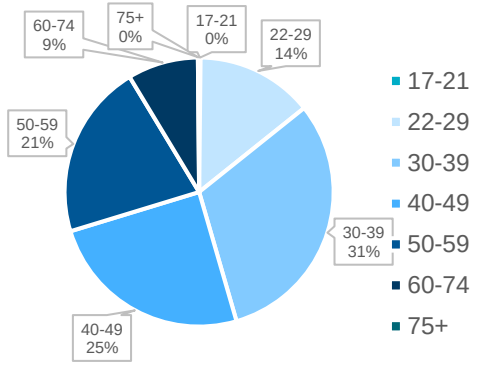
St George's University Hospitals NHS Foundation Trust

As with public members, we record key demographic data relating to our staff members, which is gathered to the point at which staff join the Trust.

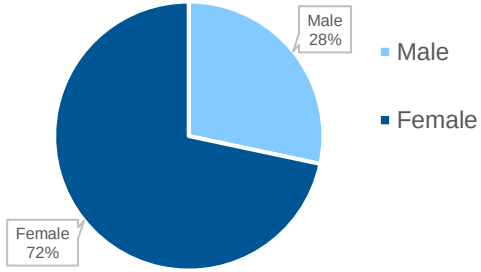
Information relating to staff members is held within the Trust's Electronic Staff Record (ESR).

- **Age:** 0.18% of staff are between 17 and 21 years of age; 14% are
- **Gender:** 72% of staff members are female, and 28% are male
- **Ethnicity:** 44% of staff members are White, 4% Mixed, 27% Asian, 18% Black, and 5% Other.

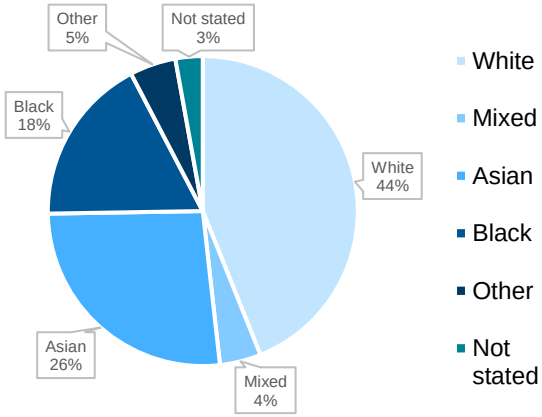
Staff membership by age (years)



Staff membership by gender



Staff membership by ethnicity



Current membership: Key areas to highlight

From the analysis of our membership, there are some key issues to highlight in the data, which the Committee may wish to reflect on when considering the planning of membership engagement activities and the development of a new membership strategy:

- **Membership numbers:** Overall, the number of members in each of the public and staff constituencies of the Trust exceed the minimum number of members required. There has been relatively little fluctuation in overall membership, or by constituency, in recent years; membership has remained broadly stable. The only area in which the total membership is close to the minimum required is South West Lambeth, which has been the case for some time. While it remains above the minimum, some focused membership recruitment in SW Lambeth may be helpful, and could be an area of focus for an incoming Governor for this constituency.

- **Age:** Young people (0-16 and 17-21, and 22-29 years age groups) are proportionately under-represented among the Trust's membership and older people (60-74, and 75+ years) are proportionately over-represented across all of our public constituencies:

    - Up to 21 years of age: There is very little representation across our membership from people under the age of 22 years. Just 0.36% of our membership is made up of people under the age of 22 (47 public members out of a total of 12,838).

    - 22-29 year olds: While there is wider representation among 22-29 year olds, the numbers of members in this age category are still well below the wider population composition for these areas. 4.5% of members in Wandsworth, 7.4% of members in Merton, 4.8% of members in SW Lambeth, and 5.9% of members in the Rest of England are 22-29 years age. But this age group constitutes a much higher percentage of the wider population make-up of each of these areas (15.7% Wandsworth; 15.7% Merton; 16.6% SW Lambeth, and 15.7% Rest of England). A total of 746 public member are aged 22 to 29 years old out of a total public membership of 12,838.

    - 60 years old and above: Older people make up a greater proportion of the public membership of the Trust compared with the wider composition of the population. For example, in Wandsworth 41.5% of public members are 60 years and above, in Merton 42%, in South West Lambeth, 37%, and Rest of England 36%. This compares with the wider population make up in these areas of around 15.5% for those aged 60 years and above.

Current membership: Key areas to highlight

St George's University Hospitals NHS Foundation Trust

- **Gender:** Our membership data shows that our membership comprises a higher proportion of female members when compared with the wider population. In Wandsworth, 63% of our members are female and 37% male, in Merton the split is 60% female and 40% make, in SW Lambeth 64% are female and 36% male, and in the Rest of England the split is 59 female and 41% male. Across the population as a whole, and across each of the constituencies of the Trust, the population is 52% female and 48% male. So males are disproportionately under-represented in the membership of the Trust.

- **Ethnicity:** Overall, the ethnic composition of the Trust's membership broadly reflects the wider composition of the populations served by the Trust. There are no major areas of under-representation or over-representation of particular ethnic groups. Overall, the Trust's membership has marginally fewer white members than the population as a whole, and marginally more members from an Asian or black ethnic group than populations in the various constituencies of the Trust.

The Committee may wish to reflect on these themes as it considers its approach to planning membership engagement activities over the coming year and in developing its new membership strategy.

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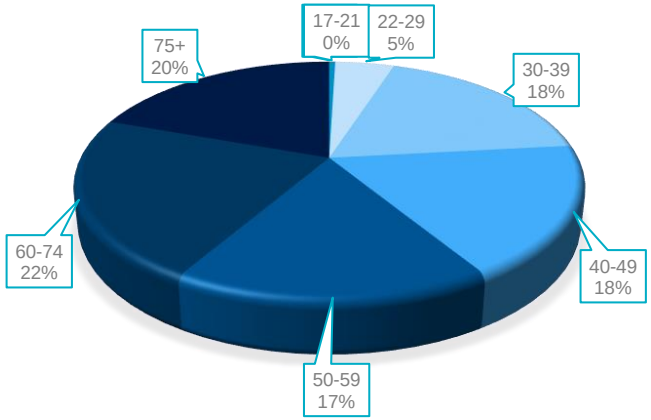
Membership profile by public constituency: Wandsworth

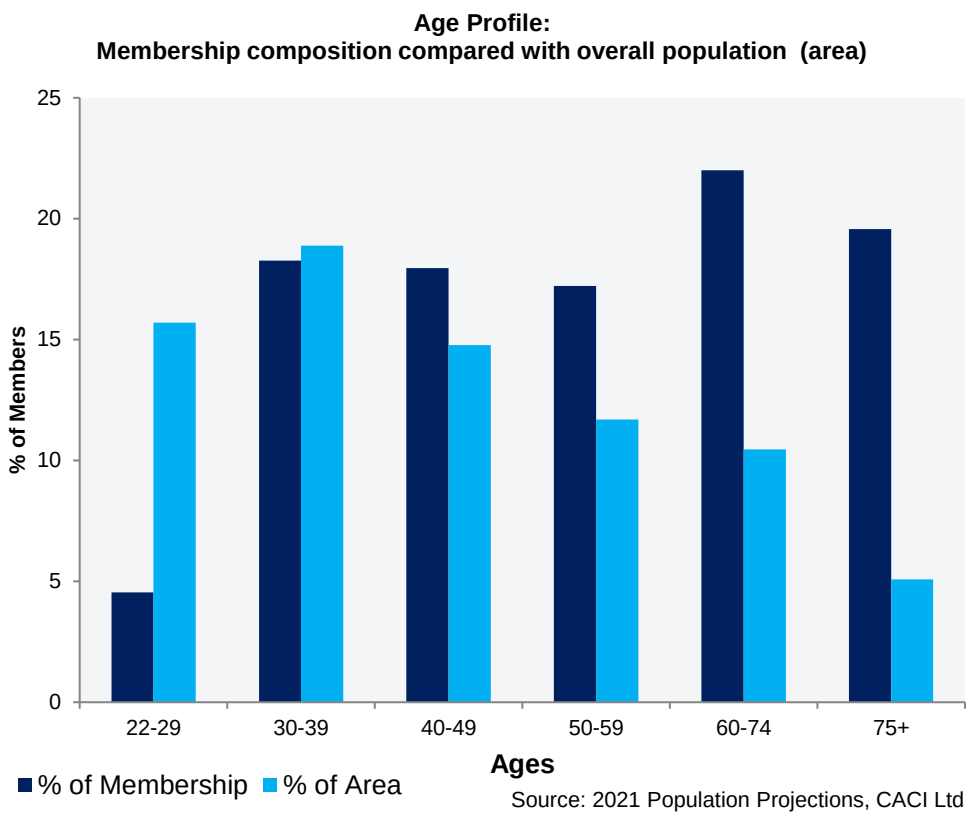
Membership profile: Wandsworth

St George's University Hospitals NHS Foundation Trust

Age

Age Group (years)	Number of members
0-16	1
17-21	18
22-29	185
30-39	744
40-49	731
50-59	701
60-74	896
75+	797



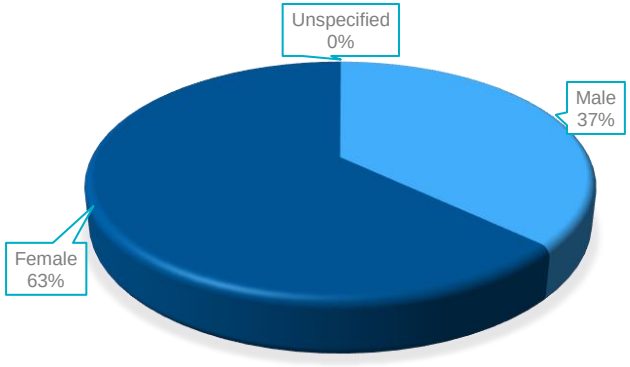


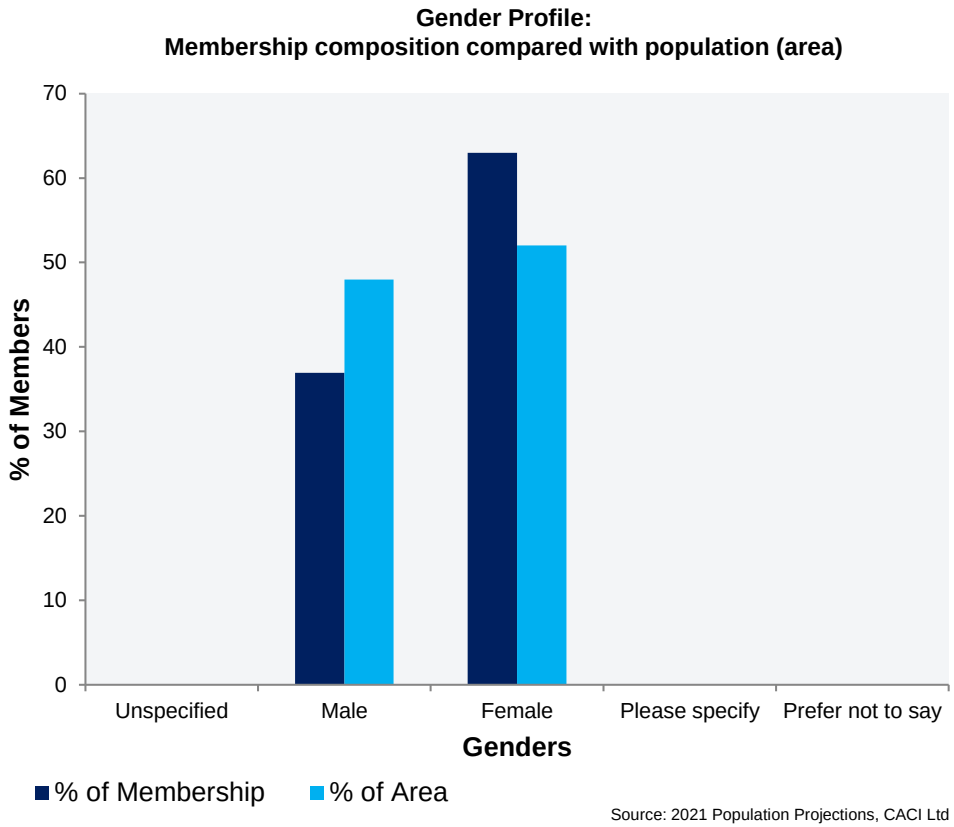
Membership profile: Wandsworth

St George's University Hospitals NHS Foundation Trust

Gender

Gender	Number of members
Unspecified	2
Male	1,505
Female	2,566
Prefer not to specify	0
Prefer not to say	0





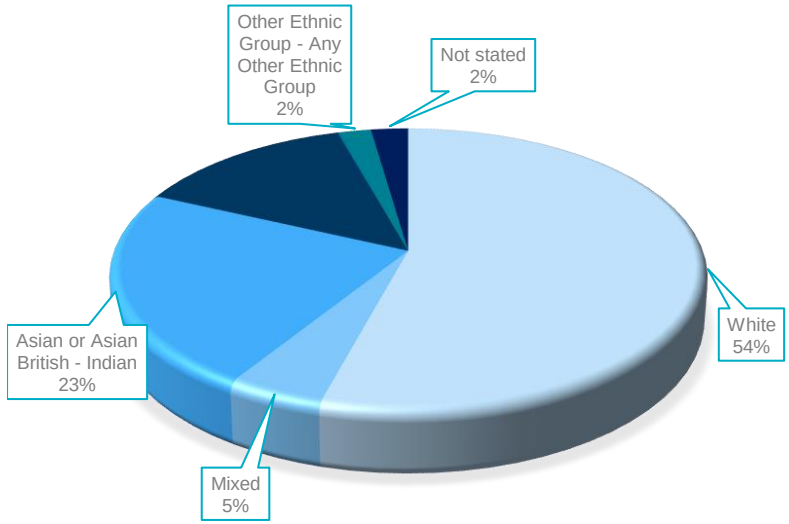
Source: 2021 Population Projections, CACI Ltd

Membership profile: Wandsworth

St George's University Hospitals NHS Foundation Trust

Ethnicity (1 of 2)

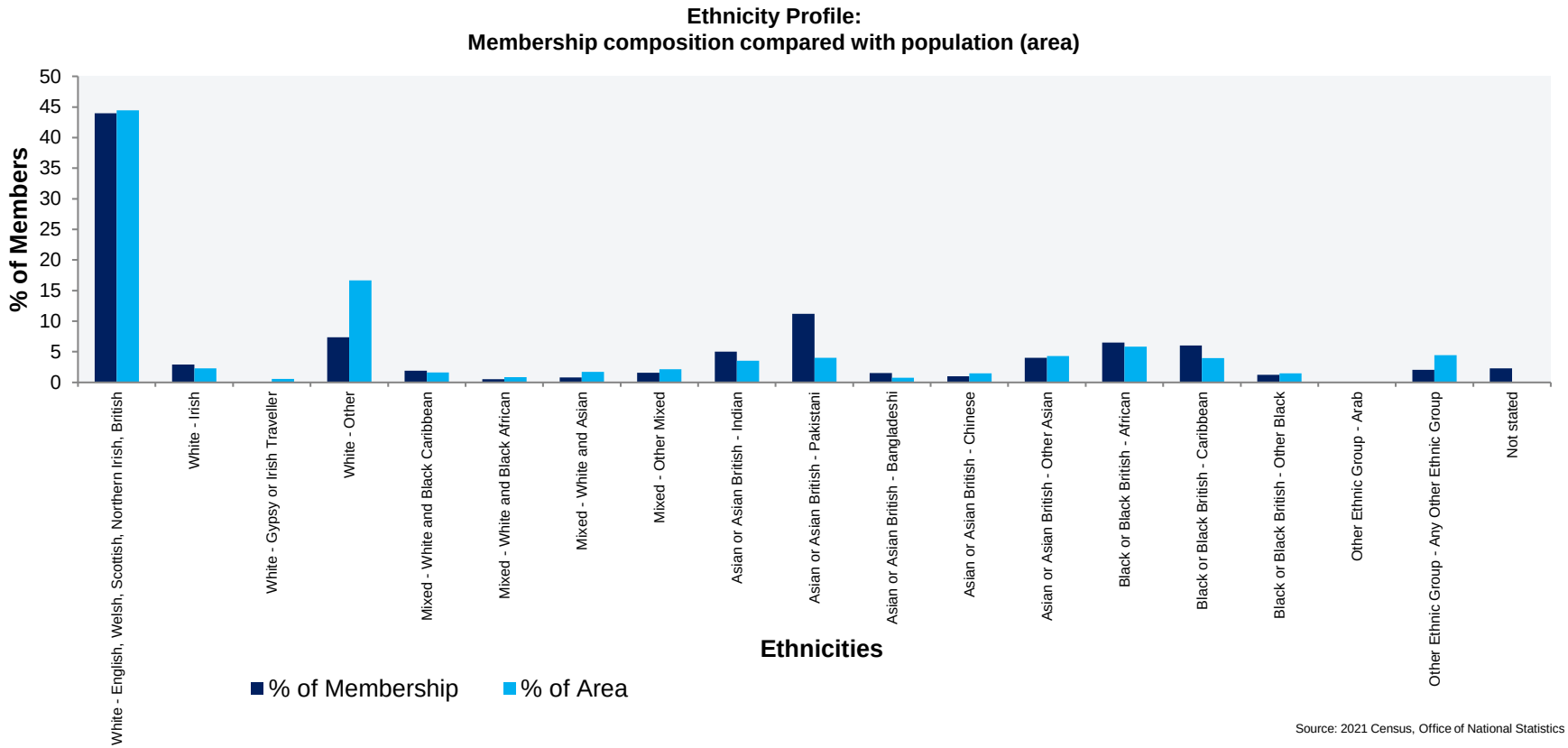
Ethnicity	Number of members
White – English, Welsh, Scottish, NI	1,791
White – Irish	118
White – Gypsy or Irish Traveller	0
White – Other	300
Mixed – White & Black Caribbean	77
Mixed – White & Black African	20
Mixed – White & Asian	33
Mixed – Other Mixed	64
Asian or British Asian – Indian	204
Asian or British Asian – Pakistani	457
Asian or British Asian – Bangladeshi	62
Asian or British Asian – Chinese	40
Asian or British Asian – Other Asian	164
Black or Black British - African	264
Black or Black British – Caribbean	245
Black or Black British – Black Other	51
Other Ethnic Group – Arab	3
Other Ethnic Group – Any other	83
Not stated	94



Membership profile: Wandsworth

St George's University Hospitals NHS Foundation Trust

Ethnicity (2 of 2)



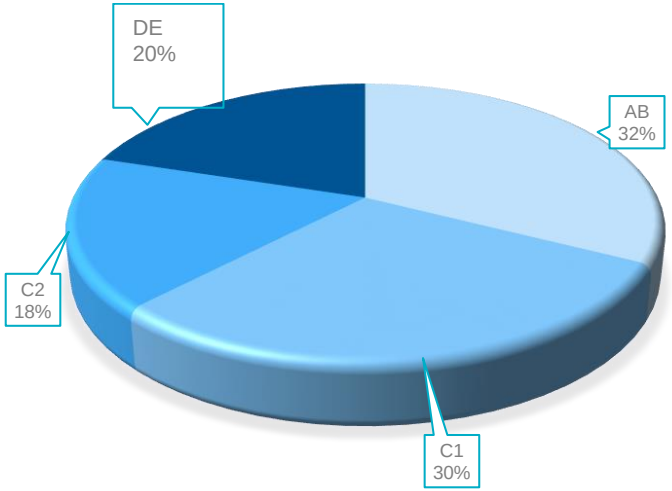
Source: 2021 Census, Office of National Statistics

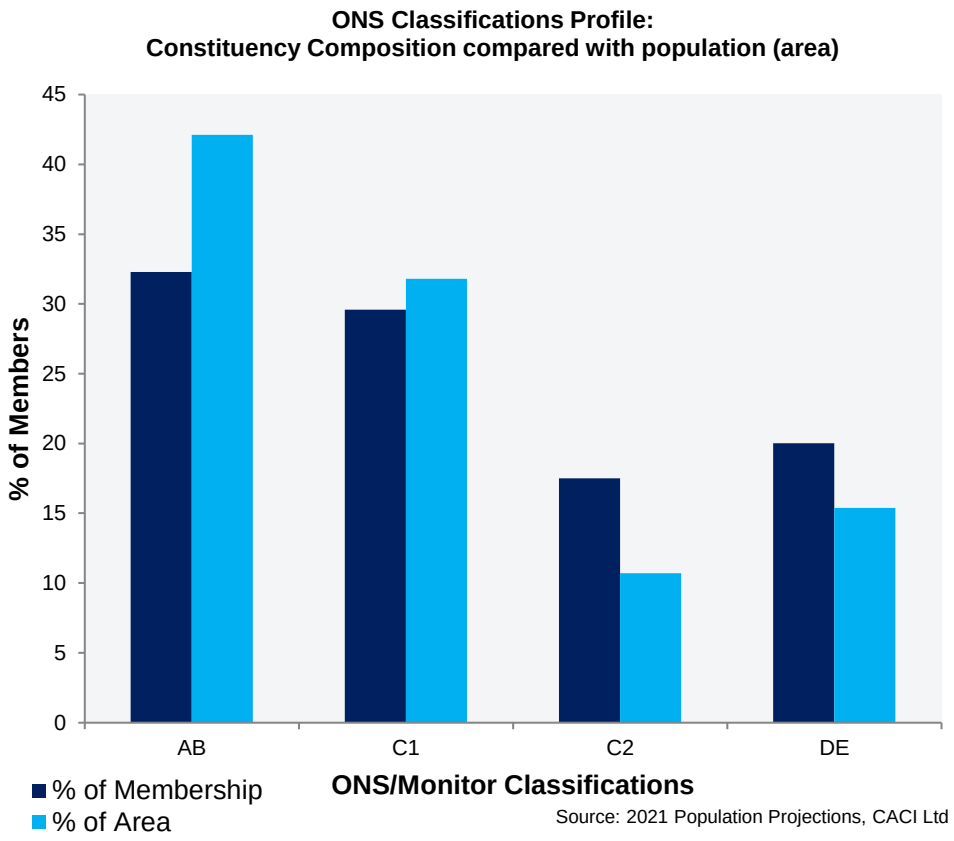
Membership profile: Wandsworth

St George's University Hospitals NHS Foundation Trust

Socio-Economic (ONS Classifications)

ONS Classification	Number of members
AB	1,315
C1	1,205
C2	713
DE	815



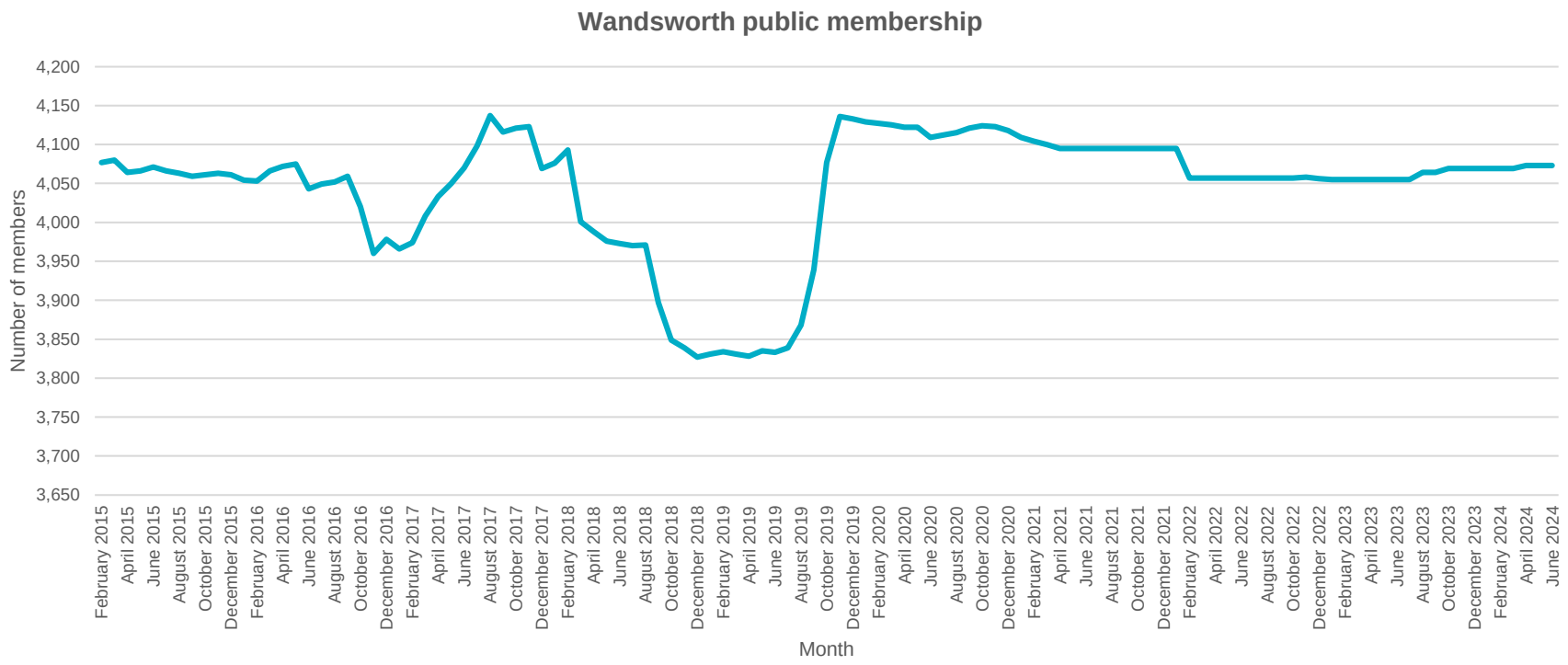


Source: 2021 Population Projections, CACI Ltd

Membership profile: Wandsworth

St George's University Hospitals NHS Foundation Trust

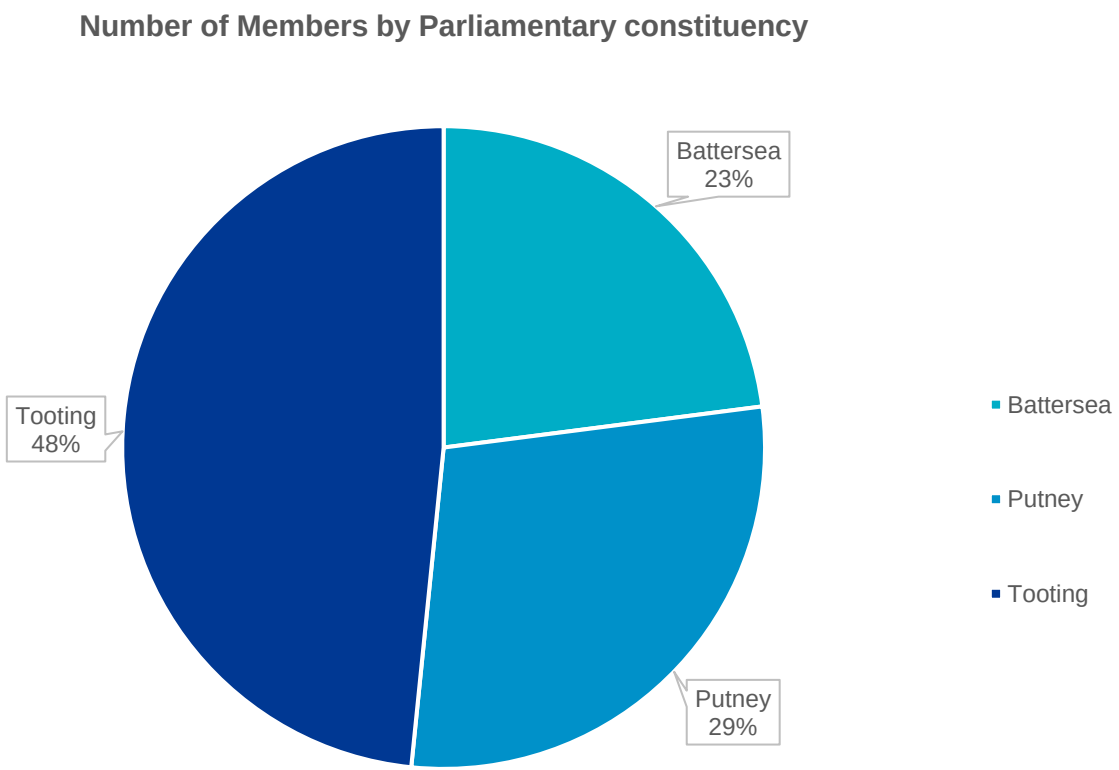
Membership history – February 2015 – June 2024



Membership profile: Wandsworth

St George's University Hospitals NHS Foundation Trust

Geographic distribution of members



NHS
St George's University Hospitals
NHS Foundation Trust

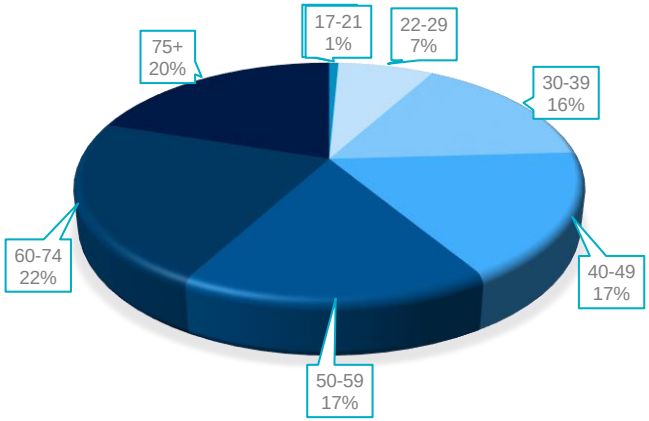
Membership profile by public constituency: Merton

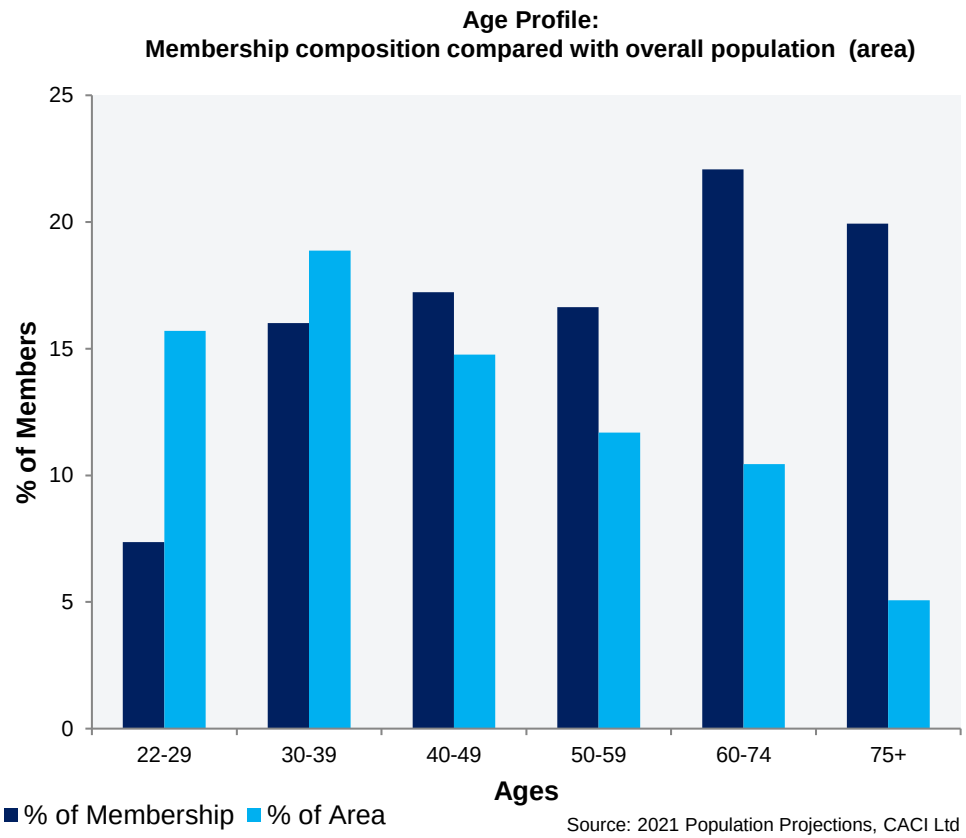
Membership profile: Merton

St George's University Hospitals NHS Foundation Trust

Age

Age Group (years)	Number of members
0-16	0
17-21	24
22-29	248
30-39	539
40-49	580
50-59	560
60-74	743
75+	671



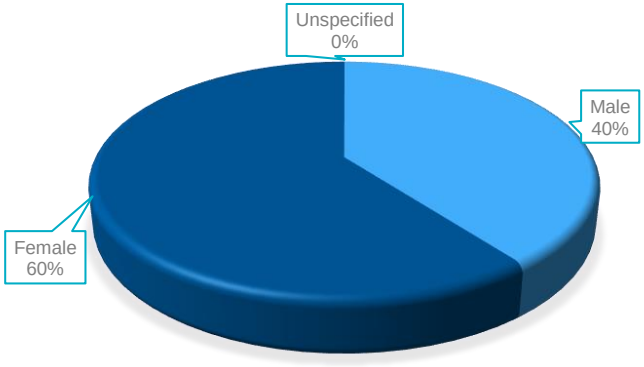


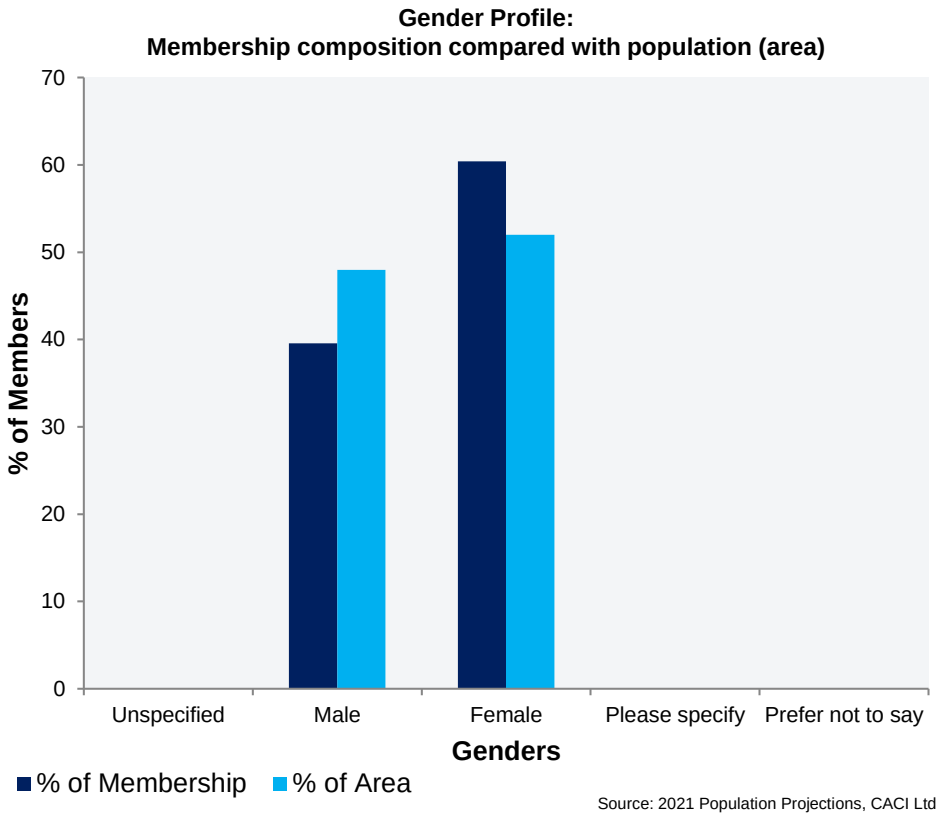
Membership profile: Merton

St George's University Hospitals NHS Foundation Trust

Gender

Gender	Number of members
Unspecified	1
Male	1,332
Female	2,033
Prefer not to specify	0
Prefer not to say	0





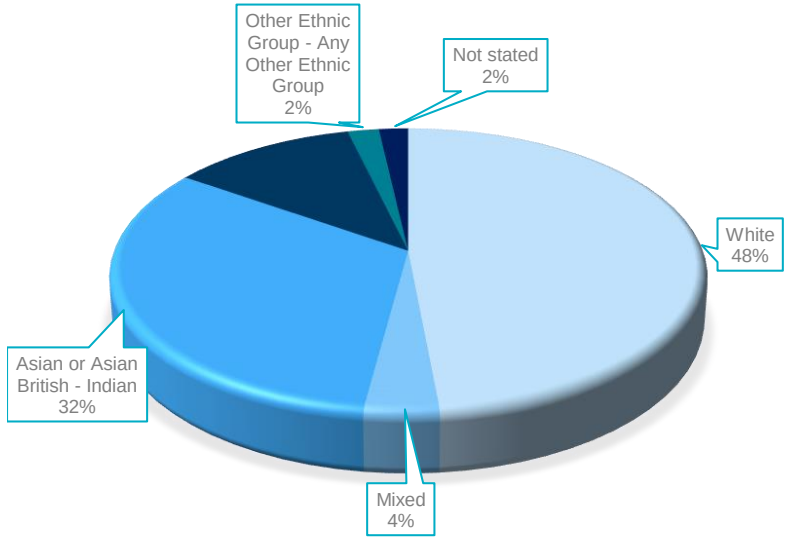
Source: 2021 Population Projections, CACI Ltd

Membership profile: Merton

St George's University Hospitals NHS Foundation Trust

Ethnicity (1 of 2)

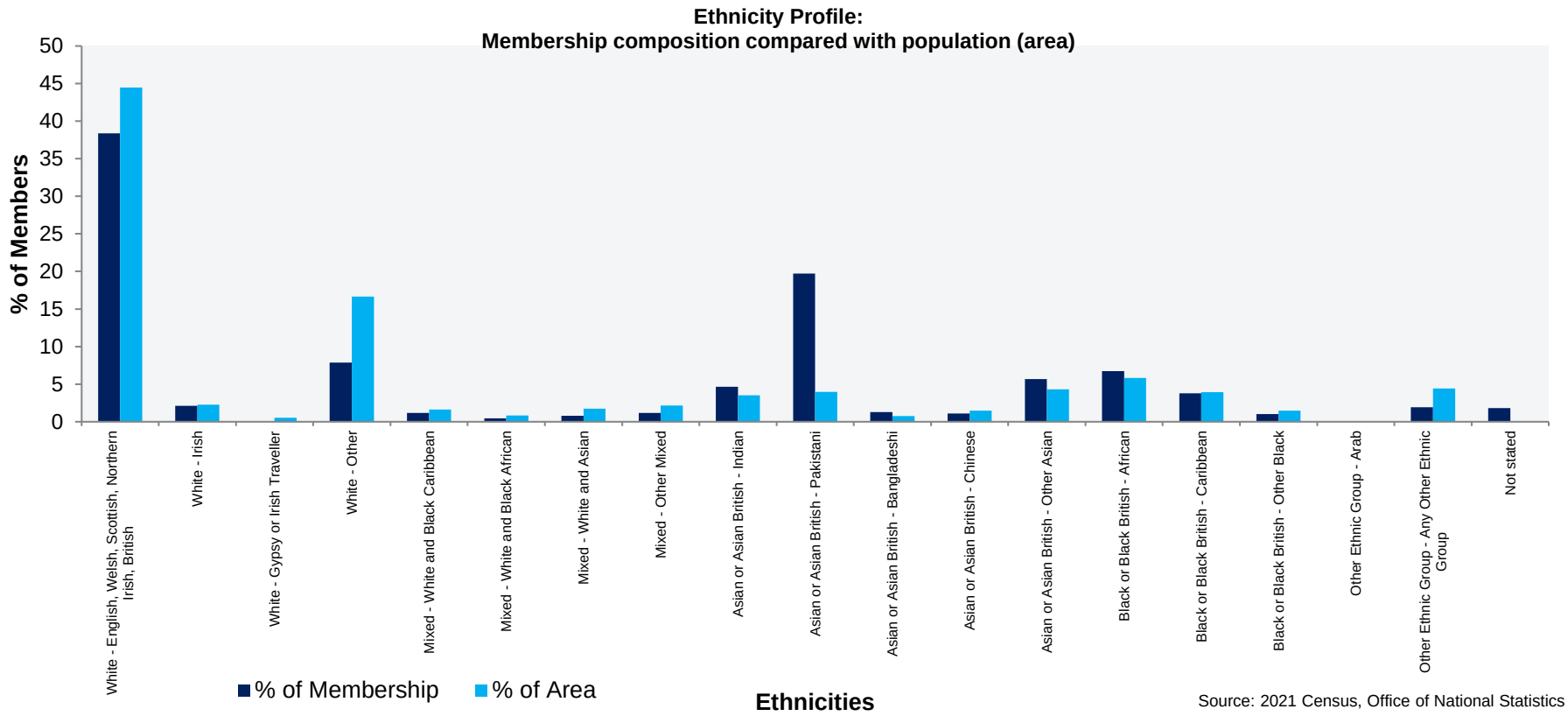
Ethnicity	Number of members
White – English, Welsh, Scottish, NI	1,291
White – Irish	72
White – Gypsy or Irish Traveller	0
White – Other	265
Mixed – White & Black Caribbean	40
Mixed – White & Black African	16
Mixed – White & Asian	27
Mixed – Other Mixed	39
Asian or British Asian – Indian	157
Asian or British Asian – Pakistani	663
Asian or British Asian – Bangladeshi	44
Asian or British Asian – Chinese	37
Asian or British Asian – Other Asian	191
Black or Black British - African	227
Black or Black British – Caribbean	127
Black or Black British – Black Other	34
Other Ethnic Group – Arab	1
Other Ethnic Group – Any other	65
Not stated	61



Membership profile: Merton

St George's University Hospitals NHS Foundation Trust

Ethnicity (2 of 2)

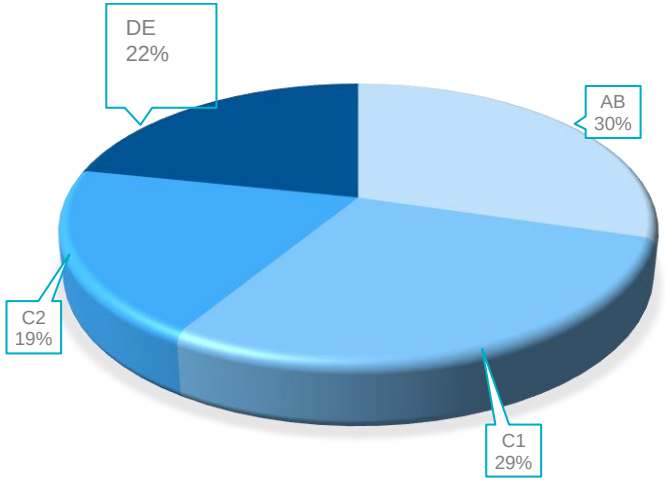


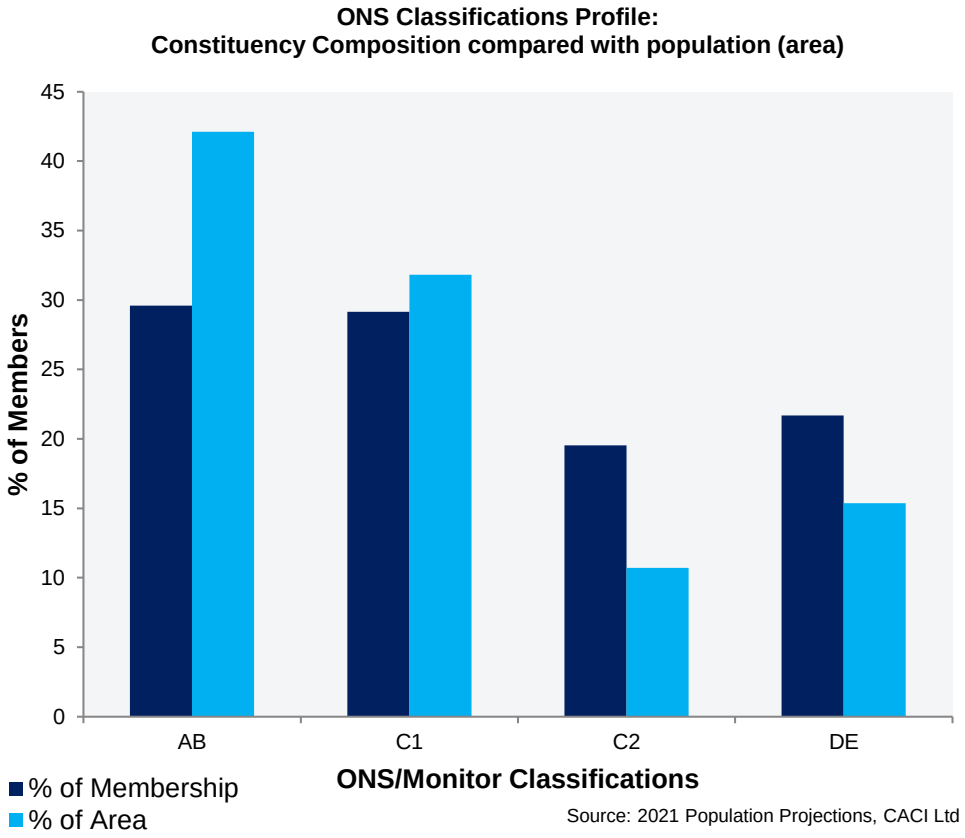
Membership profile: Merton

St George's University Hospitals NHS Foundation Trust

Socio-Economic (ONS Classifications)

ONS Classification	Number of members
AB	996
C1	981
C2	657
DE	730



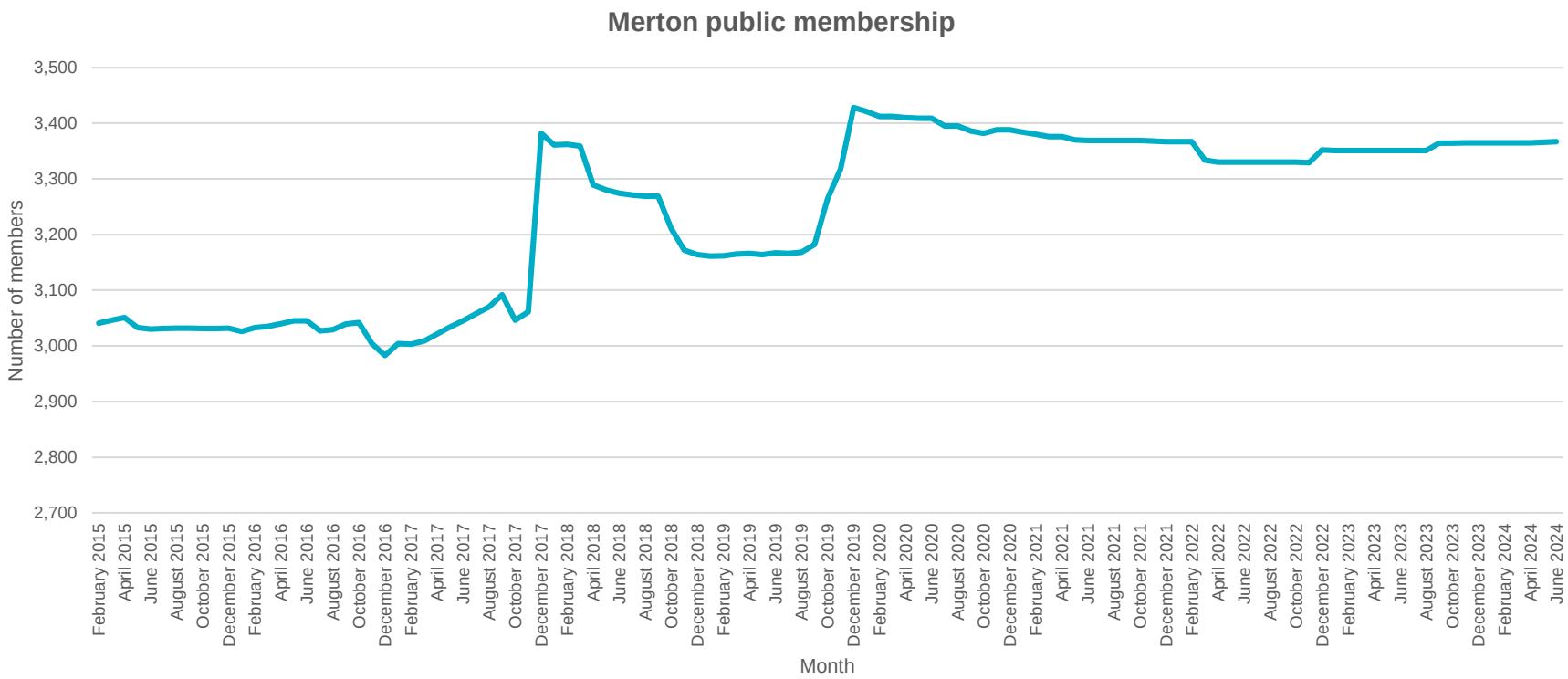


Source: 2021 Population Projections, CACI Ltd

Membership profile: Merton

St George's University Hospitals NHS Foundation Trust

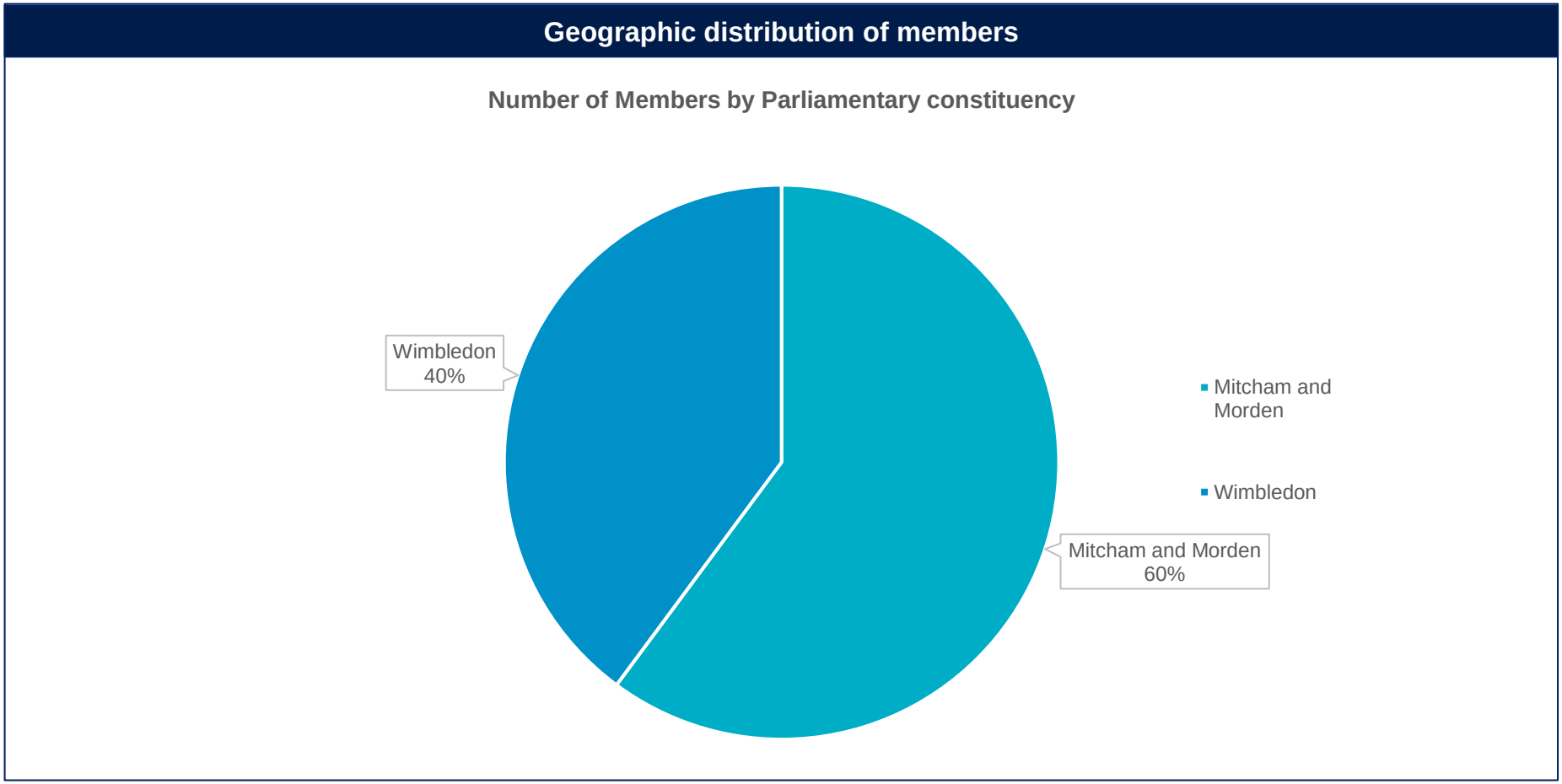
Membership history – February 2015 – June 2024



Membership profile: Merton

St George's University Hospitals NHS Foundation Trust

Geographic distribution of members



NHS
St George's University Hospitals
NHS Foundation Trust

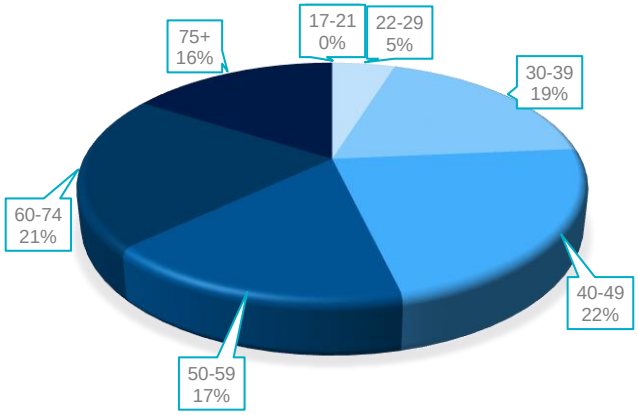
Membership profile by public constituency:
South West Lambeth

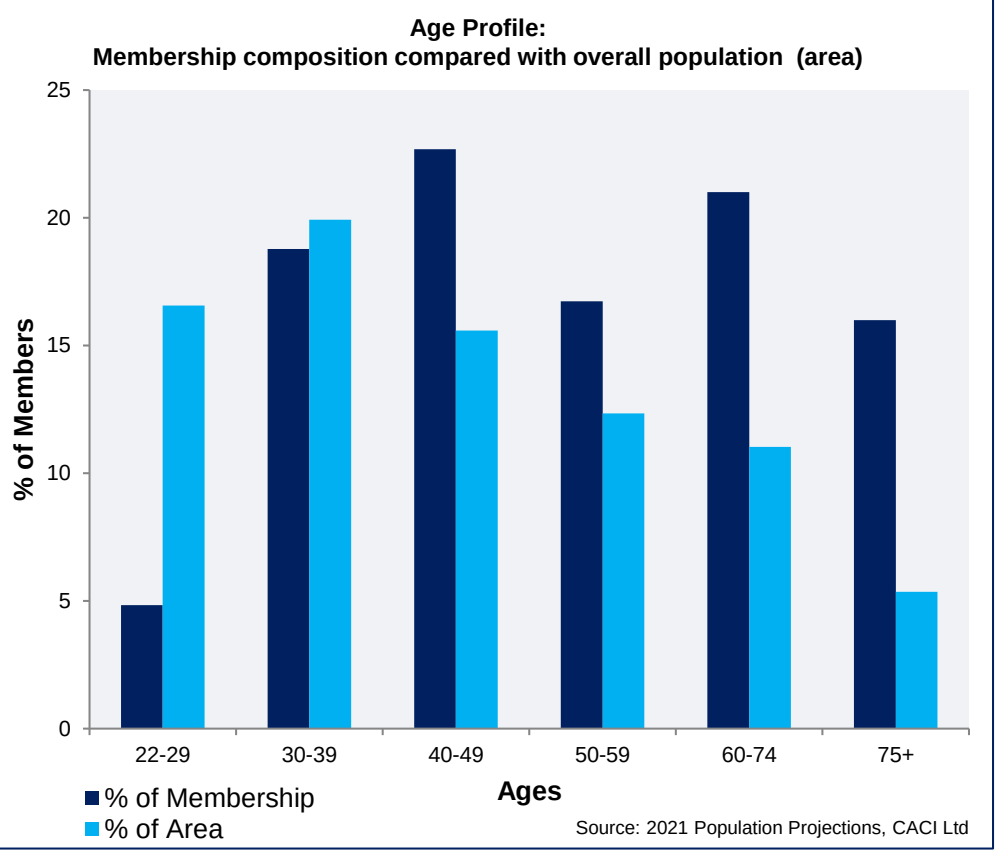
Membership profile: South West Lambeth

St George's University Hospitals NHS Foundation Trust

Age

Age Group (years)	Number of members
0-16	0
17-21	0
22-29	26
30-39	101
40-49	122
50-59	90
60-74	113
75+	86



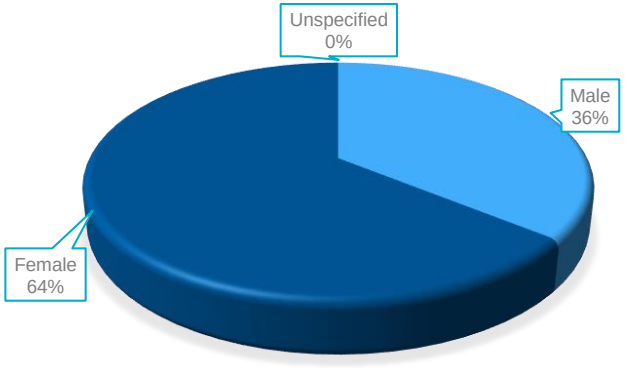


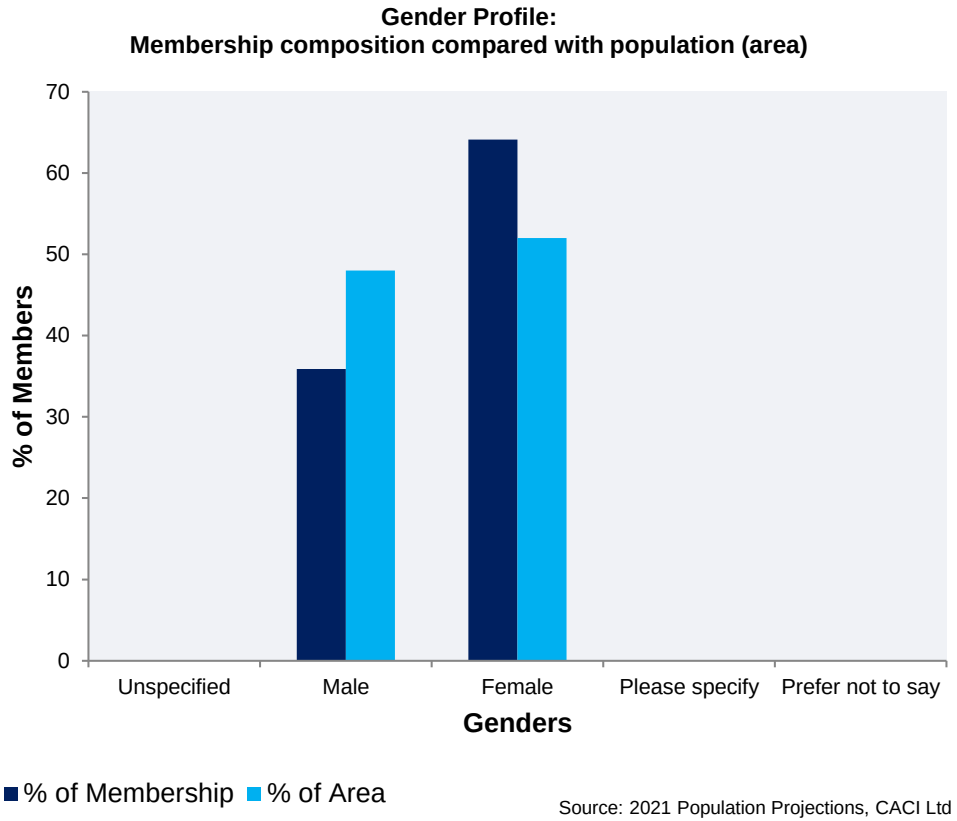
Membership profile: South West Lambeth

St George's University Hospitals NHS Foundation Trust

Gender

Gender	Number of members
Unspecified	0
Male	193
Female	345
Prefer not to specify	0
Prefer not to say	0





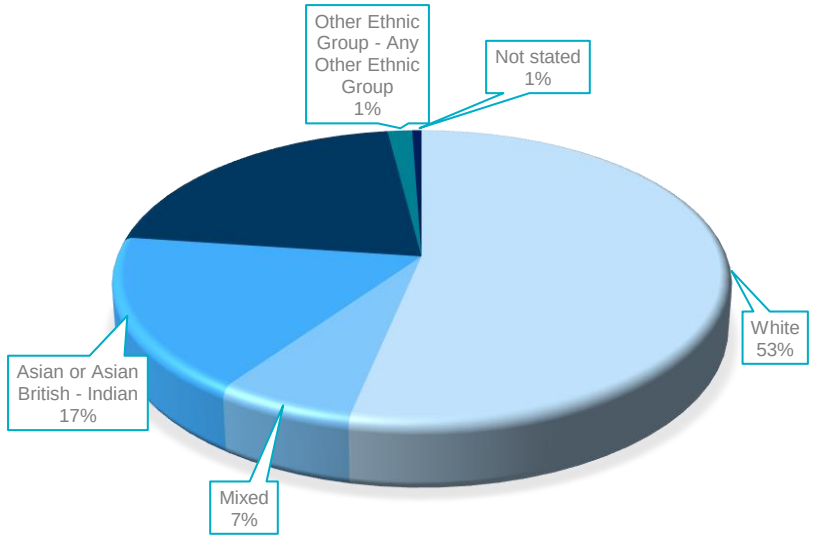
Source: 2021 Population Projections, CACI Ltd

Membership profile: South West Lambeth

St George's University Hospitals NHS Foundation Trust

Ethnicity (1 of 2)

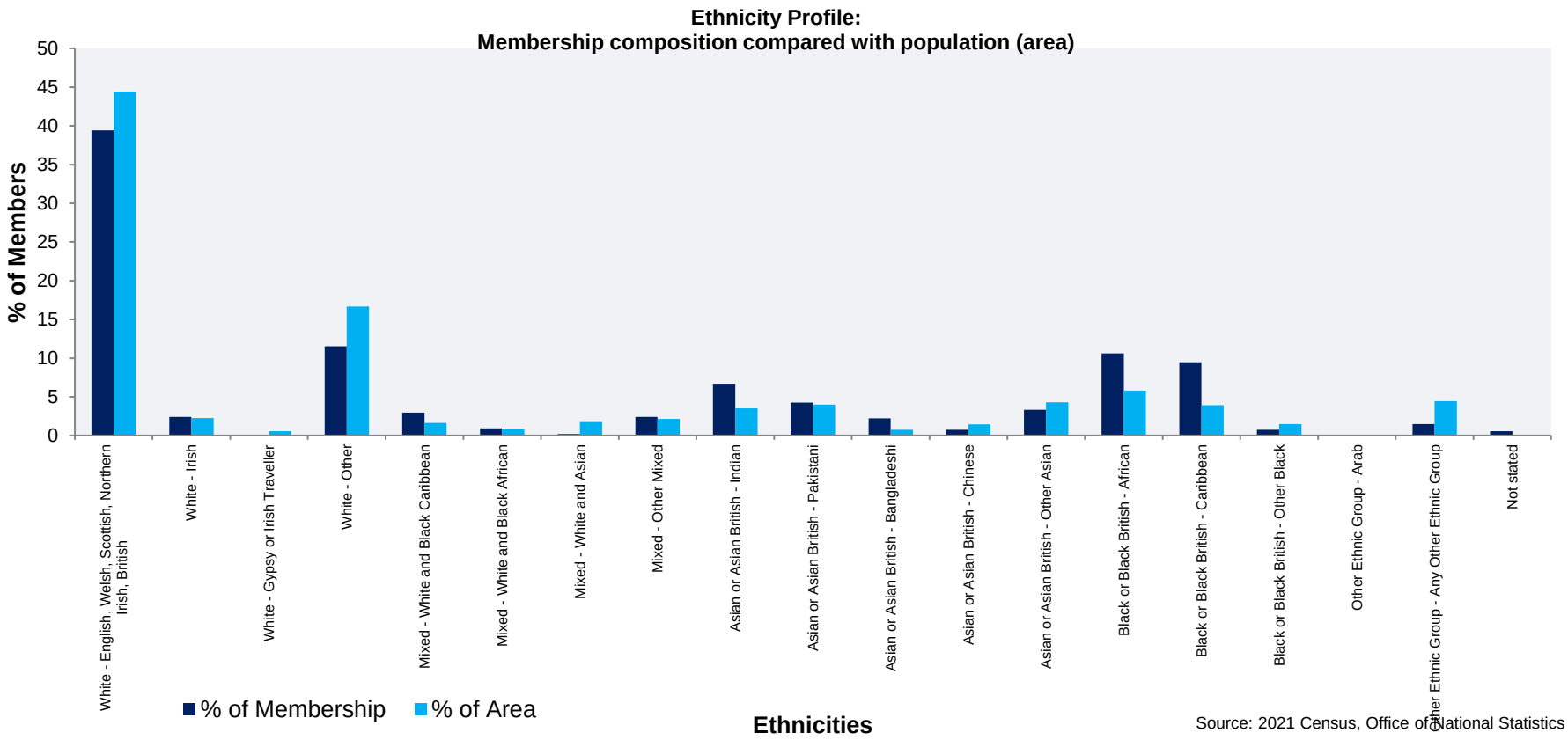
Ethnicity	Number of members
White – English, Welsh, Scottish, NI	212
White – Irish	13
White – Gypsy or Irish Traveller	0
White – Other	62
Mixed – White & Black Caribbean	16
Mixed – White & Black African	5
Mixed – White & Asian	1
Mixed – Other Mixed	13
Asian or British Asian – Indian	36
Asian or British Asian – Pakistani	23
Asian or British Asian – Bangladeshi	12
Asian or British Asian – Chinese	4
Asian or British Asian – Other Asian	18
Black or Black British - African	57
Black or Black British – Caribbean	51
Black or Black British – Black Other	4
Other Ethnic Group – Arab	0
Other Ethnic Group – Any other	8
Not stated	3



Membership profile: South West Lambeth

St George's University Hospitals NHS Foundation Trust

Ethnicity (2 of 2)

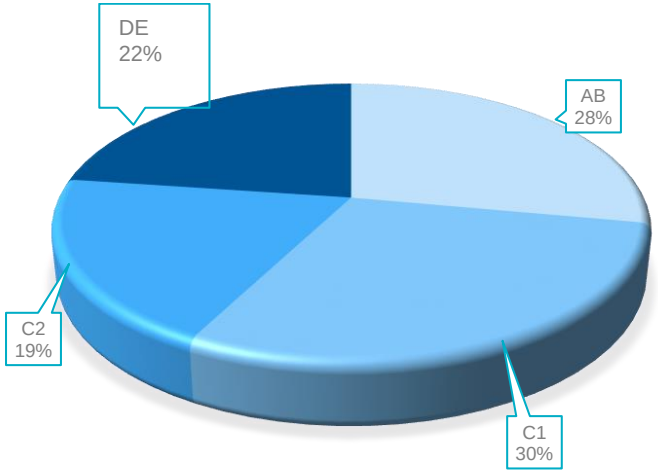


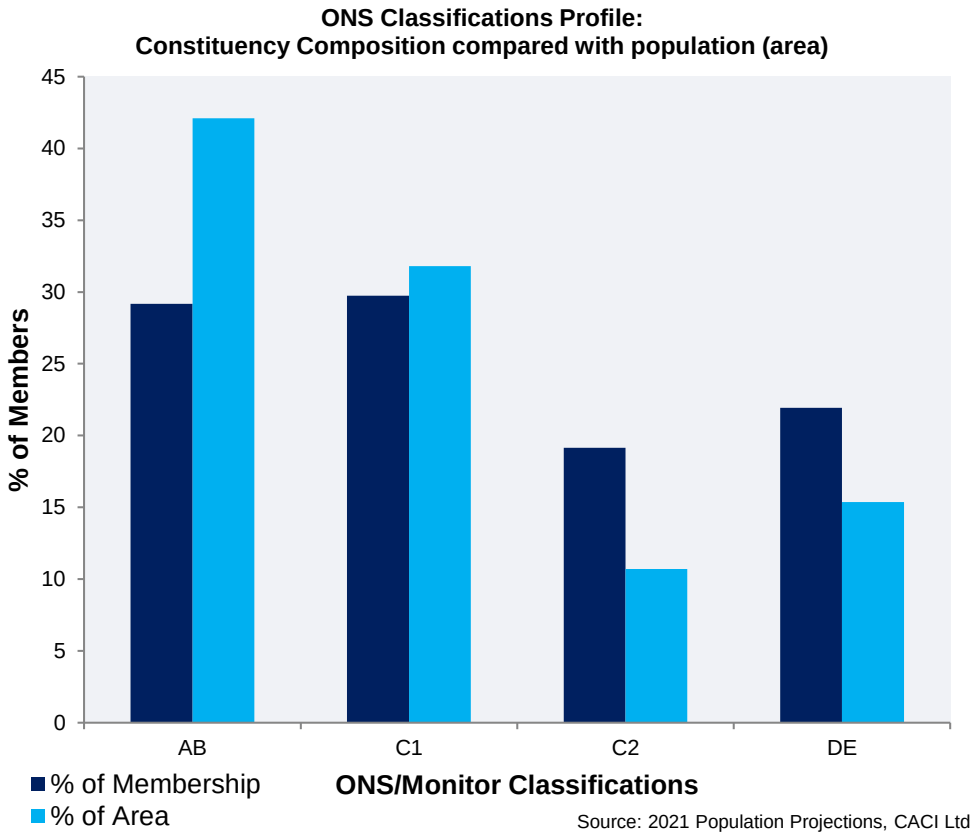
Membership profile: South West Lambeth

St George's University Hospitals NHS Foundation Trust

Socio-Economic (ONS Classifications)

ONS Classification	Number of members
AB	157
C1	160
C2	103
DE	118

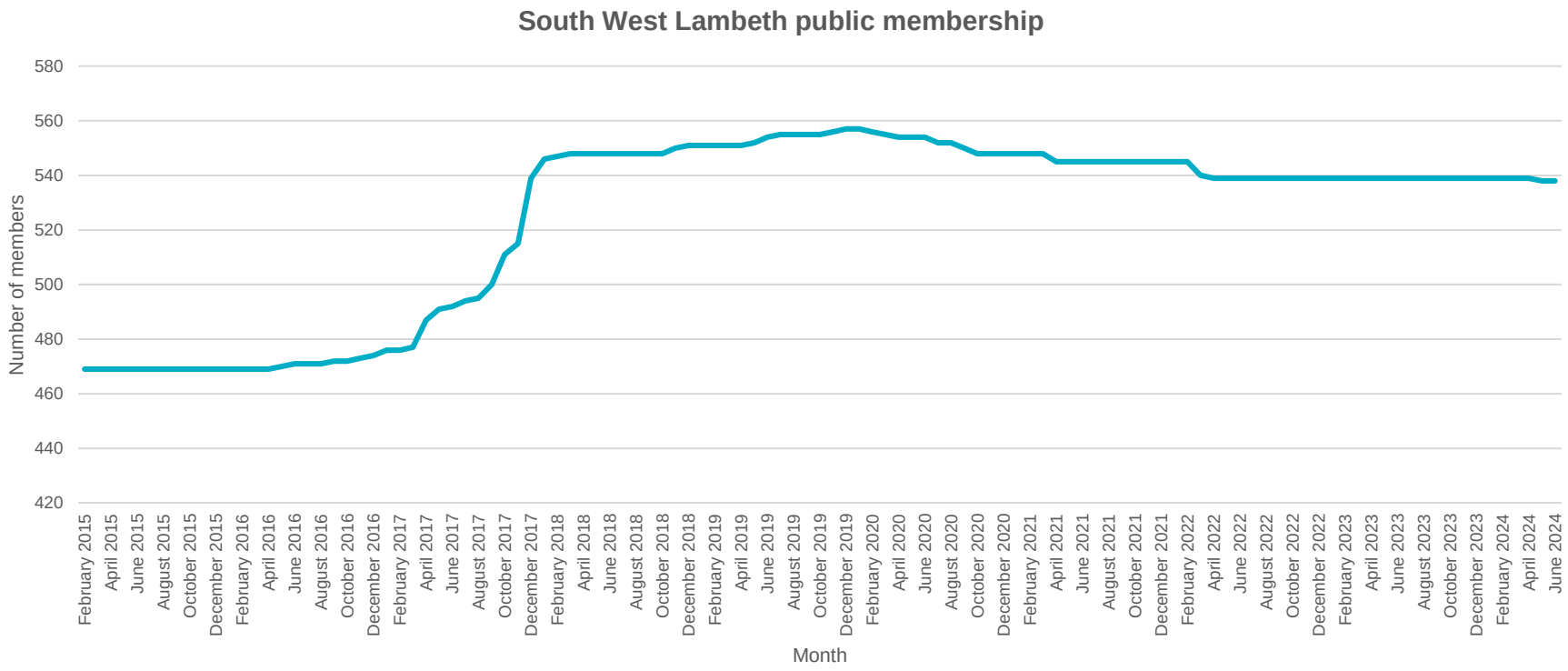




Membership profile: South West Lambeth

St George's University Hospitals NHS Foundation Trust

Membership history – February 2015 – June 2024



NHS
St George's University Hospitals
NHS Foundation Trust

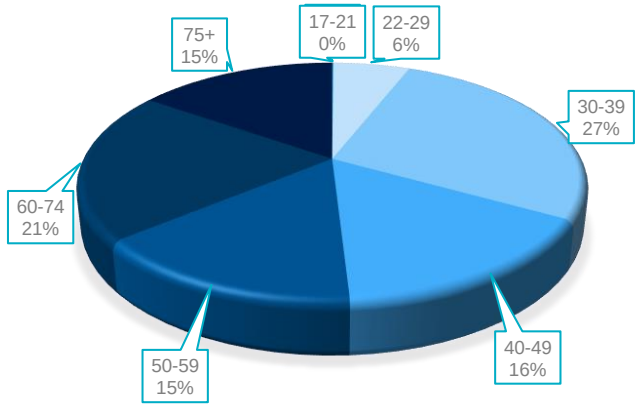
Membership profile by public constituency:
Rest of England

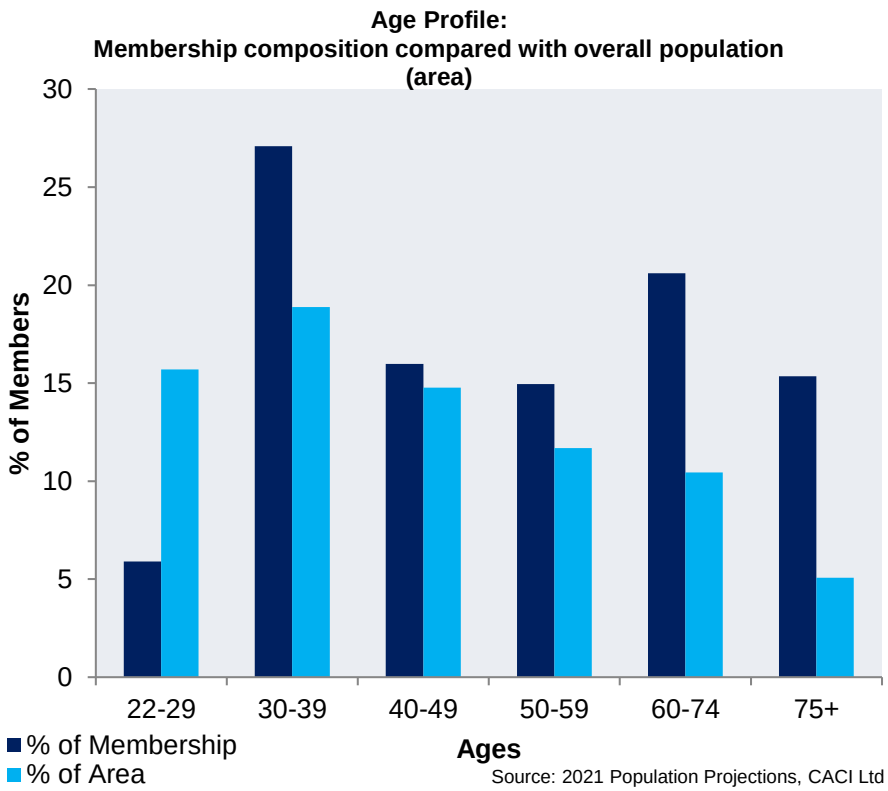
Membership profile: Rest of England

St George's University Hospitals NHS Foundation Trust

Age

Age Group (years)	Number of members
0-16	0
17-21	4
22-29	287
30-39	1,317
40-49	777
50-59	727
60-74	1,002
75+	746



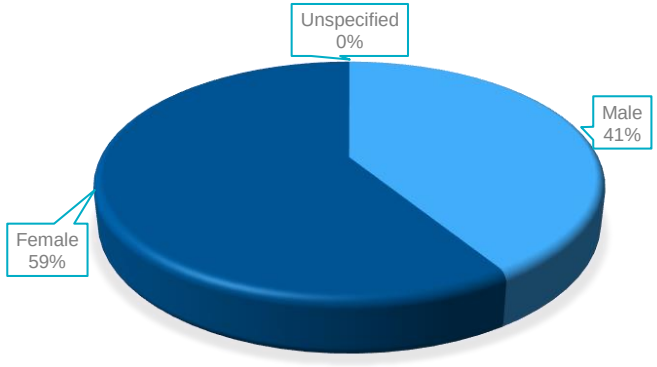


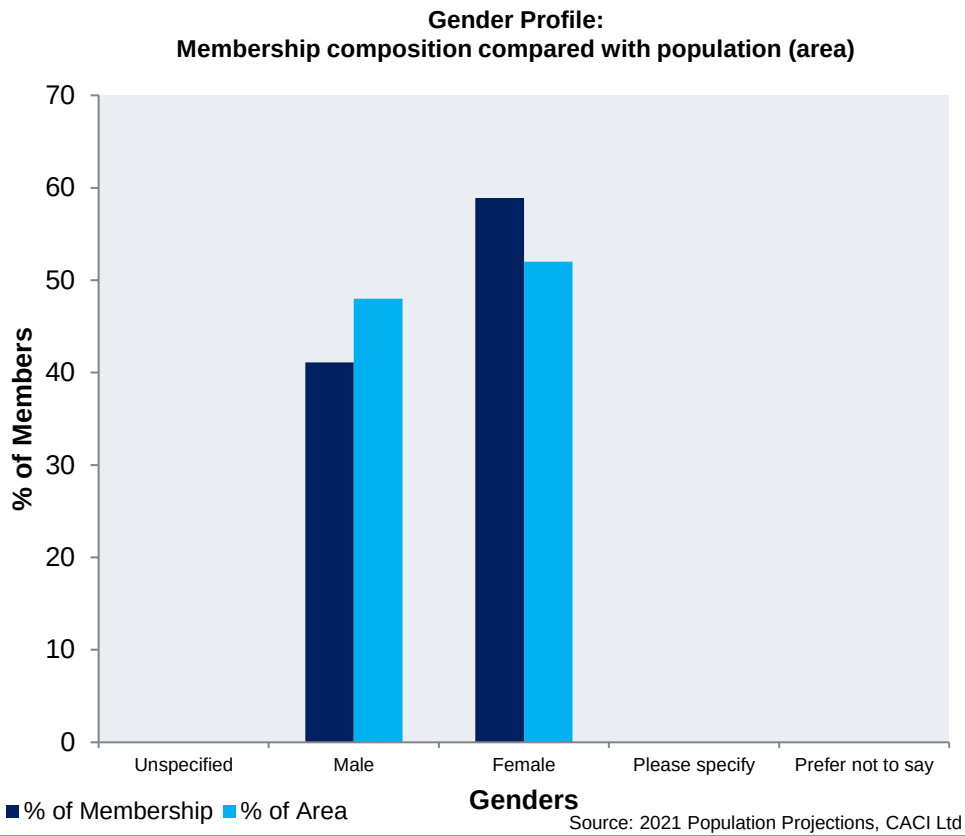
Membership profile: Rest of England

St George's University Hospitals NHS Foundation Trust

Gender

Gender	Number of members
Unspecified	1
Male	1,998
Female	2,862
Prefer not to specify	0
Prefer not to say	0





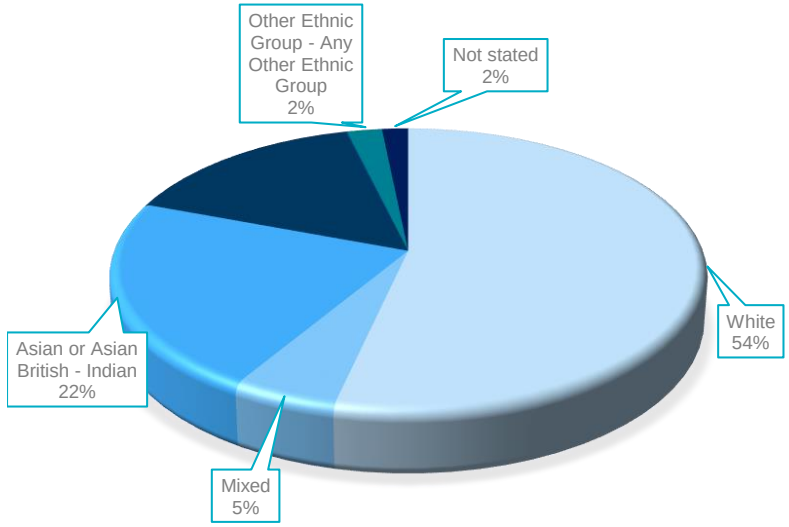
Source: 2021 Population Projections, CACI Ltd

Membership profile: Rest of England

St George's University Hospitals NHS Foundation Trust

Ethnicity (1 of 2)

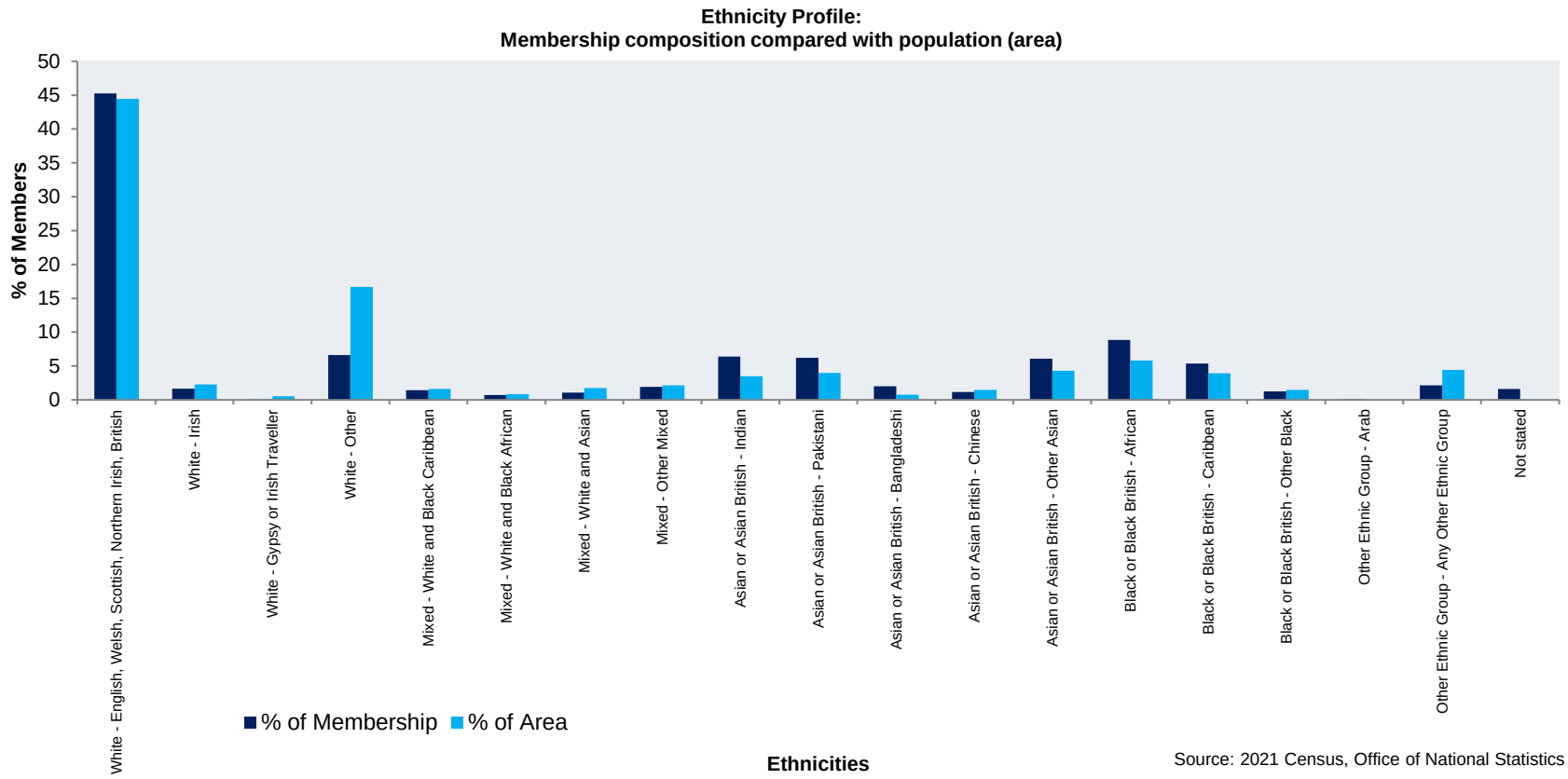
Ethnicity	Number of members
White – English, Welsh, Scottish, NI	2,200
White – Irish	81
White – Gypsy or Irish Traveller	1
White – Other	321
Mixed – White & Black Caribbean	70
Mixed – White & Black African	36
Mixed – White & Asian	52
Mixed – Other Mixed	93
Asian or British Asian – Indian	312
Asian or British Asian – Pakistani	303
Asian or British Asian – Bangladeshi	98
Asian or British Asian – Chinese	57
Asian or British Asian – Other Asian	295
Black or Black British - African	431
Black or Black British – Caribbean	260
Black or Black British – Black Other	61
Other Ethnic Group – Arab	4
Other Ethnic Group – Any other	105
Not stated	79



Membership profile: Rest of England

St George's University Hospitals NHS Foundation Trust

Ethnicity (2 of 2)

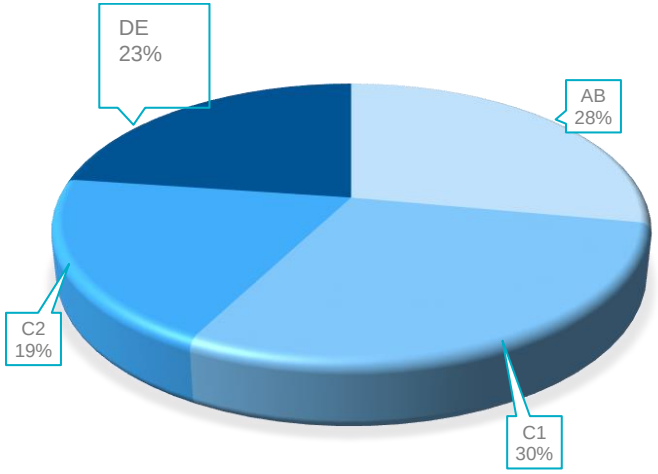


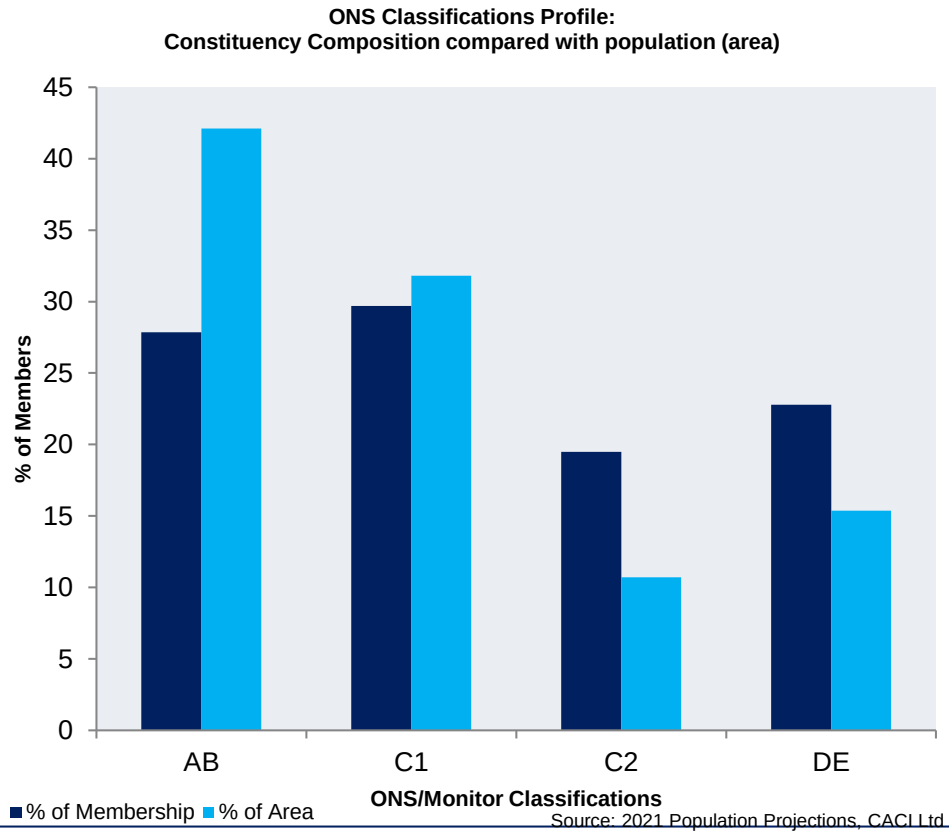
Membership profile: Rest of England

St George's University Hospitals NHS Foundation Trust

Socio-Economic (ONS Classifications)

ONS Classification	Number of members
AB	1,354
C1	1,444
C2	947
DE	1,107



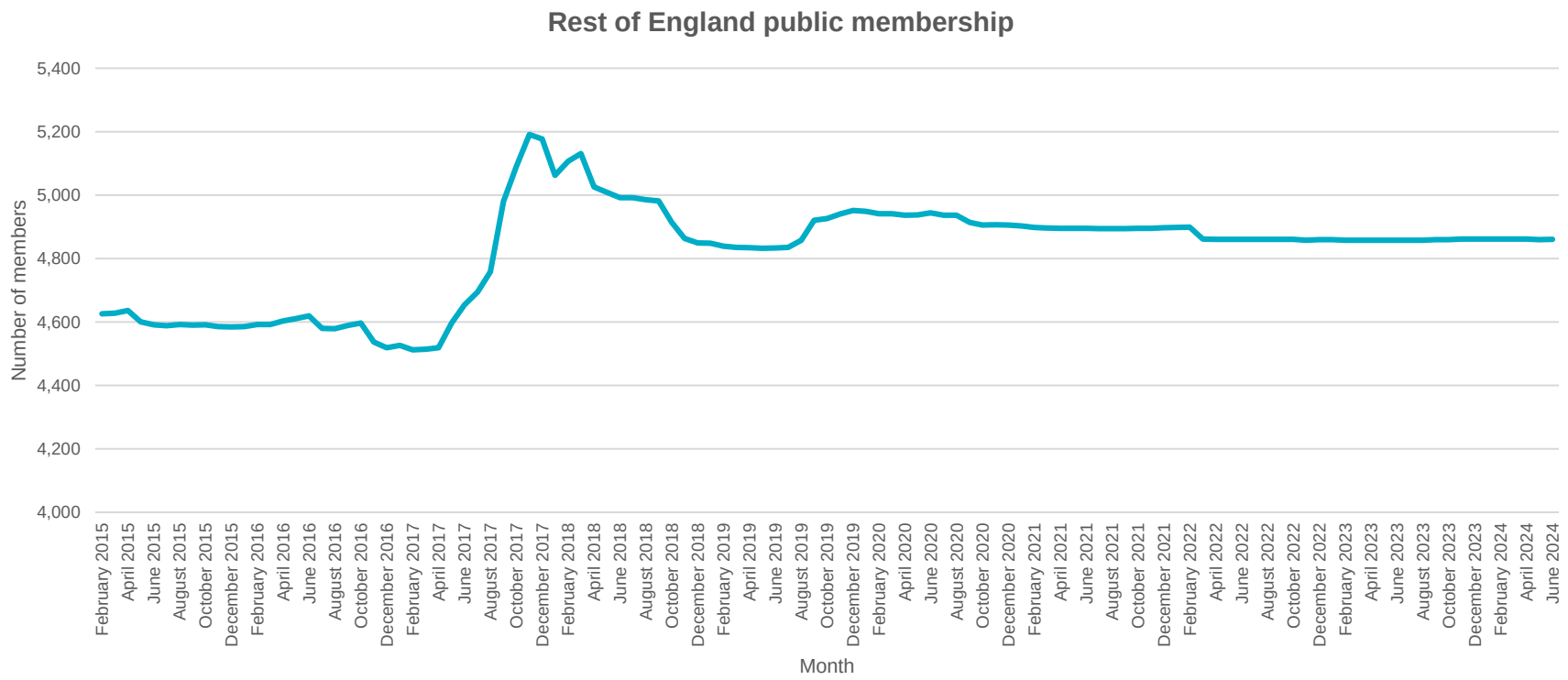


Source: 2021 Population Projections, CACI Ltd

Membership profile: Rest of England

St George's University Hospitals NHS Foundation Trust

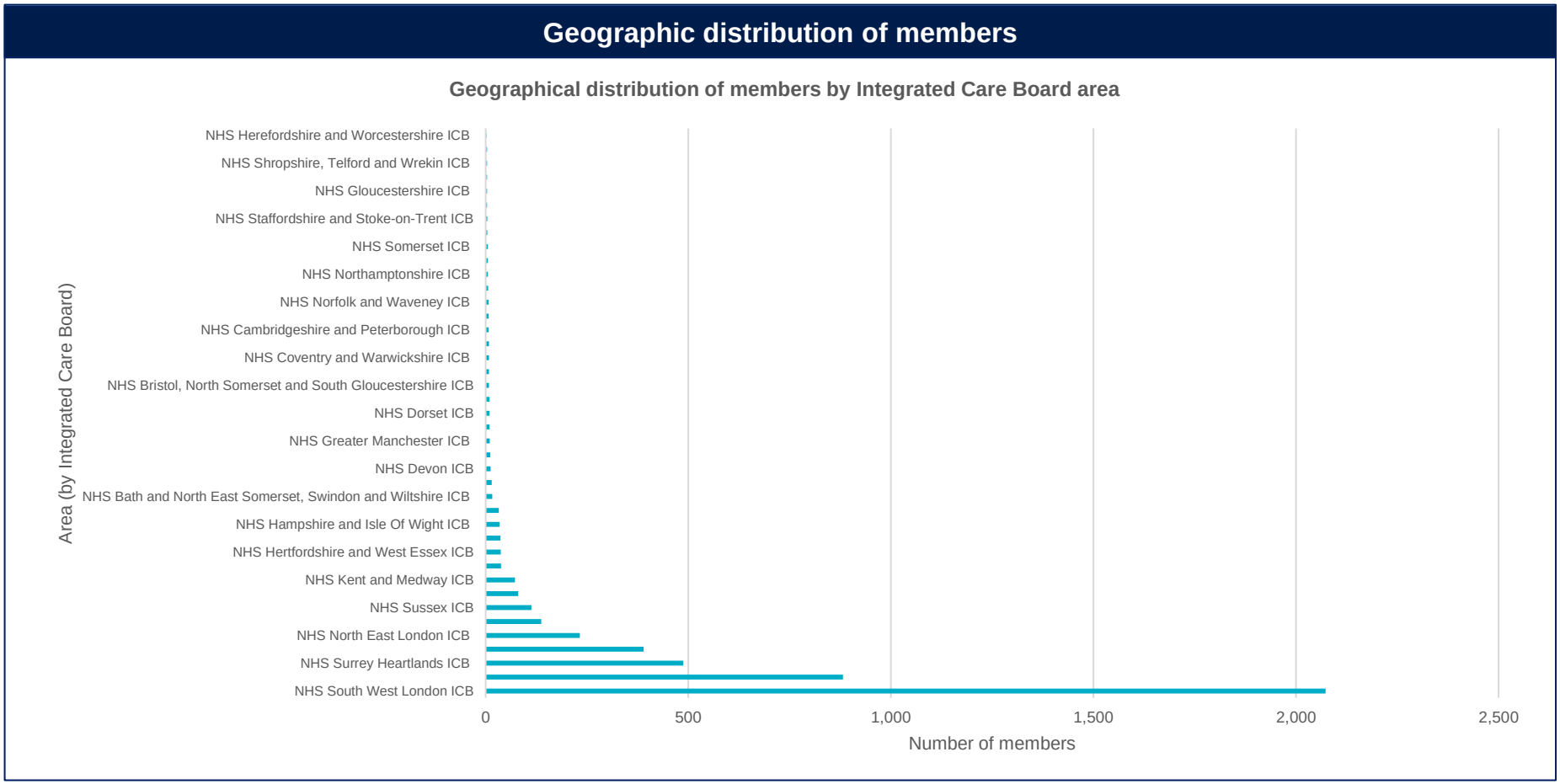
Membership history – February 2015 – June 2024



Membership profile: Rest of England

St George's University Hospitals NHS Foundation Trust

Geographic distribution of members



St George's University Hospitals
NHS Foundation Trust

Council of Governors

Meeting in Public on Thursday, 18 July 2024

Agenda Item	6.2	
Report Title	**Annual Members' Meeting proposal**	
Executive Lead(s)	Anna Macarthur, Group Chief Communications Officer	
Report Author(s)	Sumit Wadhia, group head of public affairs and Building Your Future Hospitals	
Previously considered by	N/a	
Purpose	**For Noting**	

Executive Summary

The Annual Members' Meeting for St George's University Hospitals NHS Foundation Trust will take place on Wednesday 25 September from 6.30-7.30pm, with additional activity taking place from 5.30pm at St George's Hospital.

The meeting is an opportunity to look back at the 2023-24 year and celebrate the progress made at the Trust, as well as formally receiving the Annual Accounts.

This paper provides an overview of the proposed activity as well as emerging plans for promoting the event to drive up attendance.

Action required by Council of Governors

The Council of Governors is asked to:

- Note the date of the Annual Members' Meeting.
- Encourage members of their local communities to attend the Annual Members' Meeting.

St George's University Hospitals
NHS Foundation Trust

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	N/a

Implications				
Group Strategic Objectives				
☒ Collaboration & Partnerships		☒ Right care, right place, right time		
☒ Affordable Services, fit for the future		☒ Empowered, engaged staff		
Risks				
Regulated activities				
CQC Theme				
☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led
NHS system oversight framework				
☒ Quality of care, access and outcomes		☒ People		
☒ Preventing ill health and reducing inequalities		☒ Leadership and capability		
☒ Finance and use of resources		☒ Local strategic priorities		
Financial implications				
Legal and / or Regulatory implications				
Equality, diversity and inclusion implications				
Environmental sustainability implications				

St George's University Hospitals
NHS Foundation Trust

Annual Members' Meeting proposal

Council of Governors, 18 July 2024

1.0 Purpose of paper

1.1 The purpose of the report is to provide an overview of the proposed outline of the Annual Members' Meeting taking place on Wednesday 25 September 2024.

2.0 Background

2.1 Our Annual Members' Meeting provides an opportunity for staff, Governors, Trust members and the public to learn more about the work across the Trust over the past year, our plans for the future, and to ask questions on the day to our Chairman and senior team. A reception will be held before the meeting, allowing attendees the opportunity for informal engagement with key programmes taking place at the Trust.

2.2 The Meeting will take place on Wednesday 25 September at St George's Hospital.

2.2 The Annual Members' Meeting is, in governance terms, a joint annual meeting of members and a general meeting of the Council of Governors. It will be where the Annual Report and Accounts will formally be received.

3.0 Proposed plan

3.1 **Proposed pre-event reception activities (5.30 pm to 6.30 pm)**

- Meet and greet with refreshments
- Health testing – blood pressure, glucose, cholesterol
- Building Your Future Hospitals programme stall
- Clinical trial stall
- Group strategy stall
- SGH Charity stall
- SIM stall

Time	Item
6.30 pm	**Welcome from our Chairman, Gillian Norton**
6.35 pm	**Patient and staff stories proposed – focus on CARE (collaboration and partnership, Affordable, Right Care, Empowered and engaged staff).** • Innovative care – staff tell story of VR for trauma patients (Affordable and fit for the future) • Staff stories – HIV testing.) or QMH CDC and surgical centre (collaboration and empowerment) • Patient story - `Incredible medics' – Sue Whitham or Zoe Magness (her story). (Right Care and empowerment)

	Introduced by Jacqueline Totterdell, Chief Executive
6.45 pm	**A Review of the Year and Forward View** Jacqueline Totterdell, Chief Executive
6.55 pm	**Trust Finance Review** Andrew Grimshaw, Chief Finance Officer
7.10 pm	**Governor's year in review** Alfredo Benedicto, Lead Governor
7.20 pm	**Q&A and closing comments** Jacqueline Totterdell, Chief Executive and Gillian Norton, Chairman
7.30 pm	Close

Promoting the Annual Members' Meeting

- We are developing a comprehensive communications plan encompassing staff, partners and community to help drive up attendance and engagement at the meeting. This will include:
  - Save the date invites to stakeholders from 25 July
  - Using key stakeholders to share the details to the meeting (eg Healthwatch)
  - Promoting across staff channels
  - Promoting across social media

6.0 Recommendations

6.1 The Council of Governors is asked to:

- Note the date of the Annual Members' Meeting.
- Encourage members of their local communities to attend the Annual Members' Meeting.

Council of Governors (PUBLIC): FORWARD PLAN 2024-25

SECTION	ITEM TITLE	THEME	LEAD	ACTION	FORMAT	FREQUENCY	May-24	Jul-24	Sep-24	Dec-24	Mar-25
OPENING ITEMS	Welcome and Apologies	Administration	Chairman	Review	Report	Every meeting	✓	✓	✓	✓	✓
OPENING ITEMS	Declarations of Interest	Administration	All	Review	Report	Every meeting	✓	✓	✓	✓	✓
OPENING ITEMS	Minutes of previous meetings	Administration	Chairman	Assure	Report	Every meeting	✓	✓	✓	✓	✓
OPENING ITEMS	Action Log and matters arising	Administration	Chairman	Assure	Report	Every meeting	✓	✓	✓	✓	✓
OPENING ITEMS	Welcome to New Governors	Administration	Chairman	Assure	Report	Annually					✓
REPRESENTATION	Feedback from Governors from constituencies and any key meetings attended including Board Committees and visits	Representation	Governors	Inform	Verbal	Every meeting	✓	✓	✓	✓	✓
STRATEGY	Group Chief Executive's Report	Strategy	GCEO	Inform	Report	Every meeting	✓	✓	✓	✓	✓
STRATEGY	Strategy Update	Strategy	GDCEO	Inform	Report	Every meeting	✓	✓	✓	✓	✓
STRATEGY	Corporate priorities 2024-25	Strategy	GDCEO	Inform	Report	Annually	✓				
STRATEGY	Trust Initiatives and Innovation (request from Atif Mian - timing to be confirmed)	Strategy	GDCEO	Inform	Report	Adhoc					
PERFORMANCE	Performance (Operational; People, Quality - alternating cycle)	Performance	GCNO/GCMO	Inform	Report	Every meeting	✓	✓	✓	✓	✓
PERFORMANCE	Theatre utilisation (as part of the operational performance item)	Performance	MC-SGUH	Discuss	Report	Adhoc		✓			
QUALITY	Quality Priorities 2024-25	Quality	GCNO/GCMO	Review	Report	Annually	✓				
QUALITY	Patient Safety Incident Response Framework Update	Quality	GCNO/GCMO	Review	Report	Biannually	✓			✓	
QUALITY	Working with the mental health trust to address ED pressures	Quality	GCNO/GCMO	Discuss	Report	Adhoc		✓			
QUALITY	Infection Prevention and Control Update	Quality	GCNO	Review	Report	Annually			✓		
QUALITY	Learning from Complaints	Quality	GCNO	Review	Report	Annually				✓	
QUALITY	Patient Experience and Engagement Update	Quality	GCNO	Review	Report	Annually					✓
QUALITY	Volunteers	Quality	GCNO	Inform	Report	Adhoc			✓		
FINANCE	Finance Update	Finance	GCFO	Discuss	Report	Every meeting	✓	✓	✓	✓	✓
FINANCE	Governor Input into Annual Plan	Finance	GDCEO	Review	Report	Annually				✓	✓
PEOPLE	NHS Staff Survey results, themes and actions	People	GCPO	Discuss	Report	Annually	✓				
PEOPLE	Culture programme update	People	GCPO	Discuss	Report	Annually		✓			
PEOPLE	Leadership	People	GCPO	Discuss	Report	Annually			✓		
PEOPLE	Raising Concerns Update	People	GCCAO	Discuss	Report	Annually				✓	
GOVERNANCE	Receive the Trust's Annual Report & Account and Quality Account (at a general meeting combined with the Annual Members' Meeting)	Governance, Risk, Audit	GCFO	Receive	Report	Annually			✓		
GOVERNANCE	Annual Report from External Auditor on Annual Accounts	Governance, Risk, Audit	GCFO	Receive	Report	Annually		✓			
MEMBERSHIP ENGAGEMENT	Report from the Membership Engagement Committee	Membership	Committee Chair	Inform	Report	Every meeting		✓	✓	✓	✓
MEMBERSHIP ENGAGEMENT	Review of plans for Annual Members' Meeting - September 2024	Membership	GCCEO	Review	Report	Annually	✓				
MEMBERSHIP ENGAGEMENT	Review new membership engagement strategy	Membership	GCCAO	Review	Report	Annually					✓
COUNCIL GOVERNANCE	Review of Council of Governors effectiveness	Council of Governors	GCCAO	Review	Report	Annually					✓
COUNCIL GOVERNANCE	Annual Review of Governor Skills and Training Needs	Council of Governors	GCCAO	Review	Report	Annually					✓
COUNCIL GOVERNANCE	Annual Review of CoG and Committee terms of reference	Council of Governors	GCCAO	Review	Report	Annually					✓
INFRASTRUCTURE	Estates/Building update	Infrastructure	GCOIE	Inform	Report	Ad Hoc			✓		
CLOSING ITEMS	Any Other Business	Administration	All	Note	Verbal	Every meeting	✓	✓	✓	✓	✓
CLOSING ITEMS	Council of Governors Forward Plan	Administration	All	Note	Verbal	Every meeting	✓	✓	✓	✓	✓
CLOSING ITEMS	Reflections on Meeting	Administration	All	Discuss	Verbal	Every meeting	✓	✓	✓	✓	✓