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St George's University Hospitals NHS Foundation Trust

Trust Board Meeting in Public
Agenda

Date and Time: **Thursday 12 January 2023, 10:00 – 13:00**
Venue: **Hyde Park Room, 1st Floor Lanesborough Wing, St George's, Tooting**

Time	Item	Subject	Lead	Action	Format
FEEDBACK FROM BOARD VISITS					
10:00	**A**	**Feedback from visits to various parts of the site**	**Board Members**	-	Oral
1.0 OPENING ADMINISTRATION					
10:30	**1.1**	**Welcome and apologies**	**Chairman**	Note	Verbal
	1.2	**Declarations of interest**	**All**	Note	Verbal
	1.3	**Minutes of previous meeting**	**Chairman**	Approve	Report
	1.4	**Action log and matters arising**	**All**	Review	Report
10:35	**1.5**	**Group Chief Executive Officer's Report**	**GCEO**	Inform	Report
2.0 CARE					
10:45	**2.1**	**Quality Committee-in-Common Report**	**Committee Chair**	Assure	Report
		2.1.1 Learning from Deaths Q2 2022/23	**GCMO**	Assure	Report
		*2.1.2 Healthcare Associated Infection (Infection Control) update Report**	**GCNO**	Assure	Report
11:05	**2.2**	**Maternity Services**	**GCNO**	Assure	Report
11:25	**2.3**	**Integrated Quality and Performance Report***	**GDCEO**	Assure	Report
11:40	**2.4**	**Emergency Preparedness, Resilience and Response Annual Submission**	**MD-SGUH**	Assure	Report
3.0 CULTURE					
11:50	**3.1**	**People Committee-in-Common Report**	**Committee Chair**	Assure	Report
4.0 COLLABORATION					
12:00	**4.1**	**Finance Committee-in-Common Report**	**Committee Chair**	Assure	Report
12:10	**4.2**	**Finance Report (Month 8)***	**GCFO**	Review	Report
5.0 CLOSING ADMINISTRATION					
12:25	**5.1**	**Questions from Governors and Public**	**All**	Note	Verbal
	5.2	**Any new risks or issues identified**	**All**	Note	
	5.3	**Any Other Business**	**All**	Note	
	5.4	**Draft Agenda for Next Meeting**	**Chairman**	Note	Report
	5.5	**Reflections on meeting**	**All**	Note	Verbal
12:30	**5.6**	**Patient Story**	**GCNO**	Inform	Verbal

These reports were reviewed, discussed and endorsed by the relevant Board Committees and the Committee provided an assurance overview in the reports to the Board.

Time	Item	Subject	Lead	Action	Format
13:00	CLOSE				

Date of Next Meeting: 2 March 2023

Hyde Park Room, 1st Floor, Lanesborough Wing, St George's Hospital, Tooting

These reports were reviewed, discussed and endorsed by the relevant Board Committees and the Committee provided an assurance overview in the reports to the Board.

Trust Board
Purpose, Meetings and Membership

Trust Board Purpose:	The general duty of the Board of Directors and of each Director 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	Chairman	Chairman
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Ann Beasley	Non-Executive Director/Vice Chairman	AB
Stephen Collier	Non-Executive Director	SC
Paul da Gama	Group Chief People Officer	GCPO
Andrew Grimshaw	Group Chief Finance Officer	GCFO
Jenny Higham	Non-Executive Director (St George's University Representative)	JH
Richard Jennings	Chief Medical Officer	GCMO
Stephen Jones	Chief Corporate Affairs Officer	GCCAO
Peter Kane	Non-Executive Director	PKa
Dame Parveen Kumar	Non-Executive Director	NED
Pui-Ling Li	Associate Non-Executive Director	ANED
James Marsh	Group Deputy Chief Executive Officer	GDCEO
Thirza Sawtell	Managing Director – Integrated Care	MD-IC
Kate Slemeck	Managing Director – St George's	MD-SGUH
Tim Wright	Non-Executive Director	NED
Arlene Wellman	Group Chief Nursing Officer	GCNO
In Attendance		
Carolyn Cullen	Interim Corporate Governance Project Manager	ICGPM
Apologies		
Tim Wright	Non-Executive Director	NED
Quorum:	*The quorum of this meeting is a third of the voting members of the Board which must include one non-executive director and one executive director.*	

These reports were reviewed, discussed and endorsed by the relevant Board Committees and the Committee provided an assurance overview in the reports to the Board.

Board Walkabout - Action Tracker Status as at 11/1/2023

Meeting Date	Action Ref	Area	Action	Lead
01/09/2022	BWA01.09.22/01	Neonatal unit	Explore issues relating to the workstations on wheels with circa 30% of workstations out of service.	GCFO
01/09/2022	BWA01.09.22/02	Neonatal unit	Explore reported Wifi and software issues.	GCFO
01/09/2022	BWA01.09.22/03	Neonatal unit	Explore challenges in recruiting sonography staff as this is leading to increased pressure on the team.	GCPO
01/09/2022	BWA01.09.22/04	Cardiac Cath Labs	Explore concerns of senior staff regarding the pace of recruitment services offered by the SWL Recruitment Hub.	GCPO
03/11/2022	BWA03.11/01	Vernon Ward	Sluice macerator was not reliably working, and this was causing issues, although the Estates team were aware of the problem and were waiting for parts - check progress.	MD-SGUH
03/11/2022	BWA03.11/02	Vernon Ward	GCNO and MD-SGUH to consider the green ward status while maintaining beds ringfenced for surgery.	GCNO/MD-SGUH
03/11/2022	BWA03.11/03	Surgical Assessment Unit	MD-SGUH to get underneath the issues with communication and determine if there is an opportunity to improve patient experience.	MD-SGUH
03/11/2022	BWA03.11/04	Heberden Ward	Follow-up on blind repairs logged in February that had still not been resolved and the use of duct tape on the ward which presented IPC issues.	GCFO/MD-SGUH
03/11/2022	BWA03.11/05	Gordon Smith Ward	Explore issues with IClip bar code scanning.	GCFO
03/11/2022	BWA03.11/06	Gordon Smith Ward	Review arrangements for on-call cover and payment.	GCPO
03/11/2022	BWA03.11/07	Gordon Smith Ward/Surgical Assessment Unit	Explore impact on staff morale when being reallocated to other wards to work to ensure safe staffing levels.	GCPO/GCNO

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Minutes of the St George's University Hospitals NHS Foundation Trust Board Meeting in Public

Thursday 3 November 2022

Hyde Park Room, 1st Floor, Lanesborough Wing, St George's Hospital, Tooting

PRESENT		
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Ann Beasley	Non-Executive Director/Vice Chairman	AB
Stephen Collier	Non-Executive Director	SC
Paul Da Gama*	Group Chief People Officer	GCPO
Andrew Grimshaw	Group Chief Finance Officer	GCFO
Jenny Higham	Non-Executive Director	JH
Richard Jennings	Group Chief Medical Officer	GCMO
Stephen Jones*	Group Chief Corporate Affairs Officer	GCCAO
Peter Kane	Non-Executive Director	PKa
Parveen Kumar	Non-Executive Director	PKu
Pui-Ling Li*	Associate Non-Executive Director (from 11:00)	PL
James Marsh	Group Deputy Chief Executive Officer	GDCEO
Kate Slemeck*	Managing Director – St George's	MD-SGUH
Arlene Wellman	Group Chief Nursing Officer	GCNO
Tim Wright	Non-Executive Director	NED
IN ATTENDANCE		
Shazia Khan	Nurse SGUH (Patient Story)	NSGUH
Wendy Doyle	Head of Patient Experience and Partnership (Patient Story)	HPEP
Patricia Morrissey	Head of Corporate Governance Manager (minutes)	HoCG
OBSERVERS		
John Hallmark	Governor, Wandsworth	JH
Hilary Harland	Governor, Merton	HH
Julian Ma	Appointed Governor, St George's University	JM
Adil Akram	Governor, Wandsworth	AA
Joan Adegoke	Corporate Governance Officer	CGO
Anna Macarthur	Director of Communications and Engagement	DCE
Anna Wickins	Senior Business Manager to the GCEO	SBM
APOLOGIES		
Thirza Sawtell*	Managing Director- Integrated Care	MD-IC

** Non-voting members of the Board*

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Feedback from Board Visits

Board members provided feedback from the visits conducted in the following areas:

• Acute Medical Unit/Emergency Department – Chairman, Stephen Collier. Parveen Kumar and GCCAO

• Vernon Ward – Ann Beasley and GCEO

• Surgical Assessment Lounge – Jenny Higham and GDCEO

• Heberden Ward –GCFO and COO-SGUH

• Gordon Smith Ward – Pui-Ling Li, Tim Wright and GCPO

On this occasion the visits had been arranged as unexpected visits.

The Board noted that the highly organised and competent staff in AMU were effectively managing the significant peaks and troughs in activity and were able to offer capacity to the Emergency Department. The staff on shift were largely employed and bank staff and the Matron was aware of the cost distinction between hiring agency versus bank staff, staff were also shared with the Caesar Hawkins Ward making the most effective use of resources. Board members were also given a demonstration of the IClip system and how ambulance handover at ED is managed, and it was reported that over the past week ambulance handover had been between 0-5 hours. The Chairman reflected that on arrival at the Emergency Department the first person to meet patients was a security guard and queried whether this sent the right message to patients and carers. The MD-SGUH responded that it was the intention to move away from this approach but that it reflected the reality of increased aggression aimed at healthcare workers and that staff in ED were resistant to altering the model in the short-term.

The Ward Sister on the Vernon Ward reported feeling well supported by the surgical division and knew how to escalate issues including via Freedom to Speak up. However, there was a lack of awareness of the organisation's values. The sluice macerator was not reliably working, and this was causing issues, although the Estates team were aware of the problem and were waiting for parts. While the ward was not meant to host patients for longer than 2 days there were times when patients were unable to be discharged either because there was no support at home or packages of care in place. As the visit was unexpected, it was reflected that this may not give staff sufficient time to consider any questions for Board members. Information from eating charts was visible on the main ward and while this did not include the patient's name, it did raise a query regarding patient confidentiality. The ward was still operating as a green ward where patients were swabbed prior to admission and were not sent to the discharge lounge to await discharge, and it was queried whether this was still appropriate. In response, the GCNO noted that the number of green wards had significantly reduced and that in this case it had been retained for higher risk patients, which was the right thing to do. The MD-SGUH also reflected that there was a reluctance to let go of the green ward status as the beds were ringfenced for surgery, but that this could be achieved without retaining the status of a green ward. The GCNO and the MD-SGUH agreed to take this as an action.

The element of the surprise visit impacted on the level of engagement with staff on the Surgical Assessment Unit and may have led to confusion with members of staff mistaking Board members for patients. In speaking to patients on the Unit, it was clear that there was admiration and support for the level of care at SGUH. However, all patients reported issues with the information provided on where to go and the signage on site was challenging. There were also challenges reported with patient letters and how this communication needed to be more effective. It was also noted that the admissions lounge was also being used for patients recovering from surgery and whether this was right in terms of patient experience. The Lead Nurse reflected on meeting the challenges of maintaining safe staffing levels across the Trust and that this was impacting on morale as staff were turning up for work and being reallocated to other wards. The MD-SGUH agreed to take an action to

get underneath the issue with communication and determine if there was an opportunity to improve patient experience.

The visit to Heberden Ward was extremely positive and the engagement with staff highlighted a supportive work environment with opportunities for staff promotion. The physical environment was overall good following a recent refurbishment and there was adequate storage space. The ward had recently achieved sliver ward accreditation and was working on the issues relating to Infection Prevention Control flagged during that process. Despite the recent refurbishment there were some issues, including blind repairs logged in February that had still not been resolved, the use of duct tape on the ward which presented IPC issues, and more significantly a design flaw in the bathrooms where the toilet paper holder is too far from the toilet resulting in a number of patient falls. The GCFO noted that he had already fed back to Estate colleagues regarding jobs that had been logged but were not yet resolved.

Board members noted the very warm welcome to the Gordon Smith Ward and its Day Centre, which offered ongoing care to patients over months and years, offering staff the opportunity to build enduring relationships with patients. Staffing was under pressure and there was a business case currently pending for 3 additional staff. A member of the team had returned to work following retirement and found the option to work via bank provided the right level of flexibility. An issue was reported regarding IClip bar code scanning which meant that some manual input was required, taking up valuable time. In terms of the estate, the staff were very positive about the environment and the only point to note was ventilation in the summer months. Staff also reflected that the gym space had been used as an overspill area but that it had unfortunately been clawed back. They noted that if they were able to access additional bed capacity, they could ramp up activity. As reflected on the Surgical Assessment Unit, staff being pulled to provide cover on other wards was causing upset for staff and it was noted that further thought should be given to the risk that this may present over the winter months. It was noted that a number of staff had left the team as a result of burn out during the pandemic and while the team had been successfully rebuilt the potential to destabilise it over the winter months was a concern. There was also a query regarding the arrangements for on-call cover and payment which would be followed up by the GCPO. The GCPO also reflected the difficulties to recruit to this area of specialty with multiple campaigns failing to secure suitable appointments. He also noted that the service had moved in the previous year due to capacity and flow issues, evidencing the impact of the ED on a less obvious ward.

The Board welcomed and noted the updates.

		Action
1.0	**OPENING ADMINISTRATION**	
1.1	**Welcome, introductions and apologies**	
	The Chairman welcomed everyone to the meeting and noted apologies.	

1.2	**Declarations of Interest**	
	The standing interests in relation to the shared roles with Epsom and St Helier University Hospitals NHS Trust (ESTH) of the following directors was noted, which have previously been authorised by the Board: • Gillian Norton as Chairman-in-Common; • Ann Beasley and Peter Kane as Non-Executive Directors; • Jacqueline Totterdell, Paul Da Gama, Andrew Grimshaw, Richard Jennings, Stephen Jones, James Marsh and Arlene Wellman, as Executive Directors.	
1.3	**Minutes of the Previous Meeting**	
	The minutes of the meeting held on 1 September 2022 were approved as a true and accurate record.	
1.4	**Action Log and Matters Arising**	
	The Board noted the following updates on the open actions: PUBLIC220901.1 – An all staff message reiterating that staff do not have to tolerate abuse in any form was scheduled to be sent in the name of the GCMO and GCNO. The action would remain open. PUBLIC220901.2 – The GCPO informed the Board that three themes had emerged from the engagement with staff relating to pay, transport/car parking and food. A paper would be considered by the Executive ahead of consideration by the People Committee. The action would be closed. PUBLIC220901.3 – The GCMO confirmed that it was already in the public domain that St George's was not an outlier in respect of surgical site infection. However, he was still considering other data and a further update would be provided at the Board's January meeting. The action would remain open. PUBLIC220901.4 – The GCNO would circulate the ethnicity data for perinatal mortality following the Board meeting and the data would be included in future reports to Quality Committee. The action would be closed. PUBLIC220901.5 – The IQPR includes comparison data with other London Trusts. Further discussions would take place with the data team on other tertiary centre peers for SGUH in London. Nationally London compared favourably in relation to key metrics and within London St George's compared favourably across all metrics apart from challenges with diagnostics. The action would be closed. PUBLIC220901.8 – The action would be closed.	
1.5	**Group Chief Executive's Officer (GCEO) Report**	
	The Board received the report from the GCEO, who made the following points: • The Trust remained very busy as evidenced during the Board visits and there was a challenging winter ahead, compounded by planned industrial action, and a continued focus on balancing performance, quality and our finances.	

	• The Cath Labs were now up and running (including Cath Lab 5), and Board members who may not have visited were encouraged to see the state of the art facilities. • The Operating Framework for the NHS was published on 12 October 2022 and delineated how the NHS will operate within the new statutory context created by the Health and Care Act 2022. • Tara Argent had recently joined St. George's as the new Chief Operating Officer. In response to a request for more detail on the Bristol model, the GCEO set out that SGUH is one of 6 organisations trialling the 'Bristol Model' in London. The model aims to support better ambulance handovers in the Emergency Department and shares risk across the organisation rather than just in the Emergency Department and waiting ambulances. Another significant aspect is to share the risk across the whole patient pathway across the system. The MD-SGUH added that SGUH tended to discharge people late in the day and that embracing this new model would see a more active use of the discharge lounge. Further modelling work was taking place within the system to keep the outflow to community going in a timely way. It was planned to launch the new model in the following week. Managing the risks around the new model was supported by a risk matrix. Regular updates would be provided via the IQPR and considered at FIC. Peter Kane noted the growing pressures on the NHS and that the autumn statement was due and asked how the GCEO and other CEOs in London were feeling about the financial situation. In response, the GCEO explained that she did not believe that the 9000 staff at SGUH fully understood the financial situation and that there was a need to work in different and more efficient ways to meet this challenge. She noted that more staff had come into the organisation during Covid and that these posts had not yet been removed. As the Trust had more staff than pre pandemic but was now less efficient, the additional posts required reconsideration. This was an area that the Secretary of State for Health was likely to focus on too. Keeping patients and staff safe while becoming more effective was a key priority for the organisation. The Board noted the Group Chief Executive's report	
2.0	**CARE**	
2.1	**Quality Committee-in-Common Report** The Chair of the Committee, Professor Dame Parveen Kumar, presented the report of the meetings held on 22 September and 20 October 2022. From the items contained in the report, the following key matters of note from the Committee were highlighted: • Mental Capacity Act and Deprivation of Liberties (MCA/DoLs) Training Level 1 – had experienced a decline; C. difficile infections unfortunately remained significantly above trajectory; and the maternity unit had been experiencing staff shortages resulting in closure of the Birth Centre for significant periods. • Areas of good or improving performance, included positive responses for the Friends and family test for the ED which had increased to 78.5%; and patients admitted on a non-elective pathway stayed in a hospital bed for on average 7.5 days. Although above the upper control limit, length of stay remained consistent with	

	previous months. The percentage of complaints responded to within 25 working days was achieved with performance at 96% • With regards to cardiac surgery, the Committee was assured regarding the continued safe operation of the service and the NHSE Single Item Quality Surveillance Group had agreed with the Trust's proposal to lift the requirements outlined in May 2021. There was more work to do on the Trust's reputation and ensuring that patients return to the service. • The Committee considered one deep dive on Resuscitation Training and Compliance. Resuscitation mandatory training compliance had not achieved the required performance target of 85% despite targeted improvement initiatives over the last 15 months. Despite several initiatives to improve attendance, the rates of DNA were still high, and this was still an area of concern. • In terms of the Winter 2022/3 plan for St George's, demand and capacity modelling indicated that adult medical general and acute bed capacity could be short of approximately 55 inpatient beds at peak in winter, which would be a significant issue. In response to a question from AB regarding the complaints service and the fragility of the service when multiple contractors leave at the same time, the GCNO agreed to look at the issue in more detail and report back to the Board. In response to a question from TW about the take up of flu and COVID vaccinations by staff, the GCNO confirmed that around 36% of staff had been vaccinated for flu and a similar and increasing number for COVID. A communications campaign featuring the GCEO had commenced and would continue. A detailed breakdown of the numbers for patient facing staff vaccinated for flu and COVID would be shared with the People Committee at its next meeting. The GCNO also updated the Board on maternity staffing and efforts to improve staffing numbers. A new group of midwives who had qualified in the summer had joined the Trust and were getting up to speed quickly. Nurses had also provided additional capacity for relevant tasks. Further work across the Group was taking place and discussions were ongoing about sharing staff, when it is possible to do so. The Board noted the updates from the September and October 2022 Committee meetings.	**GCNO**
2.1.1	**Learning from Deaths Report Q1 2022/23** The GCMO presented the paper which provided an overview of the work of the Mortality Monitoring Group (MMG) and Learning from Deaths in Q1 2022/23. The following key matters of note were highlighted: • The Medical Examiner Service had been expanded and had considered 358 non-coronial deaths in Merton and Wandsworth. • Particular work to scrutinise mortality was taking place in relation to Acute Myocardial infarction, intracranial injury) and trauma. • The Standardised Hospital Mortality Indicators (SHMI) for the last year was as expected and a close eye would be kept on it. The Hospital Standardised Mortality Ratio was lower than expected.	

	• The Mortality teams across the Group were working well together and sharing best practice. In response to a question from PLL regarding the extension of Medical Examiner scrutiny to the non-acute sector and the pilot which had started in July, the GCMO confirmed that an update on the outcomes would be provided in the next quarterly report to the Quality Committee. The Board noted: • The progress against the objectives for MMG and Learning from Deaths, particularly around the implementation of the Learning from Deaths template. • The assurance provided by the TIAA review of mortality and to support the associated recommendations. • And supported progress with the expansion of the ME service to include non-acute deaths in preparation for the move to a statutory system from April 2023.	
2.2	**Maternity Services: Perinatal Quality Surveillance Measures September 2022** The GCNO presented a paper setting out the Trust's compliance with Safety Action 9 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS): the requirement for Trusts to complete the Perinatal Quality Surveillance Report. In terms of compliance with the full CNST requirements, the GCNO highlighted the following areas of non-compliance: • Safety Actions 2 and 6 - the Trust's Euroking system did not allow for a data upload to the national system and an exemption had been requested. • Safety Action 5 - due to the inability to retain 100% supernumerary status of the B7 shift coordinator. Staffing challenges were an issue and it meant that this post was being used when necessary to keep mothers and babies safe. In terms of continuity of carer, a Directive had been received from NHS England outlining essential and immediate changes to be made to the national maternity programme regarding the provision of continuity of carer. In response to the Directive, SGUH would continue to provide MCoC within the existing MCoC team provision and to pause implementation of further CoC teams until staffing levels improved. Focus on women from the Black, Asian and Mixed Ethnicity background and those from a vulnerable group would continue within our existing teams. JH informed the Board of the recent discussion at Quality Committee where the data was interrogated in light of the recent maternity failings at other Trusts and where assurance had been given regarding the safety of the service. In response to a comment from PKu noting that IT issues were a recurrent problem and querying when the issue would be resolved, the GCFO explained that IT had significantly improved over the last 5 years and the recovery target for IT was 5-10 years. The whole hospital required rewiring for WiFi, while this would be an extremely disruptive exercise it would allow the systems to work more effectively. A complete review of IT risks had been considered by the Finance Committee and there is a clear action plan	

	to address each risk and move IT to a more stable footing. Individual system requirements, including for maternity, were part of the planned programme of work. The GCEO asked what the financial penalty for non-compliance with CNST was and the GCFO explained the incentive scheme funding was approx. £1m, Trusts that were non-compliant would not receive the full amount of funding, but it was not clear how much the Trust would potentially lose regarding its non-compliance. The Chairman reiterated that the Trust should seek to maximise the funding related to compliance. Stephen Jones flagged that the Kirkup report had recently been published regarding maternity and neo natal services in East Kent and asked what measures were planned for SGUH in light of the report. In response, the GCNO outlined that a gap analysis was due to be conducted as to how the Trust performed in the areas highlighted and flagged that it might be difficult to measure against some of the issues which related to softer skills and culture. The GCEO added that the OD team could help to provide some metrics on team working, relationships, openness, transparency, and a culture of learning. Focusing on the relationship between midwives and obstetricians was a key area. The GCNO noted that there was little in the report around staffing levels but rather it focused on how staff worked together and treated each other. The Chairman reiterated that the Board would need to challenge itself and ask hard questions to assure itself about the service provided. The Board would discuss the Kirkup Report at its next Board meeting on 12 January 2022. The Board noted the report.	**GCNO**
2.3	**Integrated Quality and Performance Report** The Board received and noted the IQPR for September 2022 which had been scrutinised at both the Finance Committee and Quality Committee prior to the Board meeting. The MD-SGUH introduced the report and highlighted the following: • Four Hour Performance in September was 79.1% and SGUH was the second best in London. However, SGUH was performing poorly with regards to patients waiting for more than 12 hours for a hospital bed following a decision to admit. Regularising flow using the Bristol Model was a key area of focus. • There was a reduction in ambulance handover times and 12 hour trolley waits in September and this coincided with a reduction in the number of ready to discharge patients. • Elective underdelivered in September was 7% under plan with a number of specialties underperforming. Individual service recovery plans will be developed with the support of the new COO. • Theatre productivity is slowly improving, but there is more work to be done at QMH. • Outpatients performance is tracking 19/20 delivery levels. There is a high non admitted PTL which is not being utilised. A tripartite approach will be taken looking at validation, recovery work and transformation. Patient Initiated follow-up (PIFU) was not well utilised	

at SGUH but there was a plan to accelerate PIFU as it would help to utilise capacity more effectively. The new COO would help to drive patient transformation along with the local leadership team.

- Cancer remained a challenge and there was growth in the backlog particularly in dermatology and breast. While there was a credible recovery plan for dermatology, the 2 week wait figures for breast were pulling down the overall 2 week wait figures. A report on breast cancer would be brought back to Finance Committee.
- With regards to diagnostic performance, 11.6% of patients were waiting longer than six weeks to have a diagnostic test in September. This was largely being driven by gynaecology ultrasound and there was a good recovery plan in place, and it was expected to be recovered by November. There were also challenges with endoscopy, but Saturday lists would be run to help recover the position.
- The position regarding pressure ulcers showed deterioration over the past year and there was a renewed focus on improvement by the Matrons and Heads of Nursing.
- C. difficile infections remained significantly above trajectory and in response a focus on antimicrobial stewardship and cleanliness of medical devices continues.

SC emphasised that turning around indicators that were heading in the wrong way was critical to ensuring that the Trust meets its budgeted activity at year end and that it was important to maintain momentum.

AB queried what the current position was in respect of the return to green plan for cancer which had previously been considered by Finance Committee, and whether there were opportunities to call on spare capacity within the system. In response, the MD-SGUH confirmed that the return to green plan for cancer set out a return to compliance in Q1 2023/24, and while the recovery of the backlog had gone off track the main concern was the very significant issues in the breast cancer service around engagement, behaviours and resistance which were longstanding and had not yet been resolved. The focus remained to deliver the green plan in Q1 2023/24 but this was not without risk. With regards to mutual aid within the system for dermatology, there had been a deluge of referrals over the summer and the appetite for spreading these across the system could be explored. However, the GDCEO noted that there was a surge in referrals across the whole of SWL since June. The teams across SWL were focusing on referrals of suspected cancer but this had come at the cost of referrals which were not suspected to be cancer. Embedding tele-dermatology was hoped to provide rapid triage without patients needing to come to hospital. IT challenges at SGUH had delayed the roll-out of tele-dermatology but a pilot was being undertaken at Kingston.

PKa highlighted that the return to green plan for cancer might require amendment in light of the latest developments, and the MD-SGUH noted that the plan was being constantly evaluated and was dynamic. PKa also noted the value of the Group-wide approach to the IQPR.

PLL flagged that the time lag in the available data meant that Board members required assurance when discussing the winter plan and that the trajectory would have been secured. She also raised the issue of partner working and the impact of this on the flow of patients in and out of the

	hospital. She also flagged that the DNA rate was high in older and BME community patients and asked what the Trust was doing about these wasted resources. In response, the MD-SGUH confirmed that there were regular meetings at place at both a macro and micro level, but acknowledged that more work could be done, particularly with regards to patient discharge. In terms of DNAs the number had come down but more active checking via telephone with patients regarding their appointments was about to commence. It was noted that overbooking took place to mitigate some of the impact and waste of precious resource. The GCEO reiterated the need to balance quality, performance and money, and advised the Board of the weekly scorecard for London and the position of SGUH as regularly being 4/5 out of 20 organisations, but recognised the need to always do more. The Chairman noted the positive Acute Provider Collaborative meeting that had been held recently and the confidence that our partners had in the Trust tackling the issues outlined and the commitment to deliver. The GCPO highlighted: • MAST performance and in particular that there were no core topics that were red which had been the case for 3 years. • Turnover – a nurse retention toolkit had been completed and the results would be shared with People Committee. • Agency spend was on target and there had been a reduction in the spend on interims. The Trust Board noted the IPQR.	
2.4	**Winter Plan** The MD-SGUH introduced the paper setting out the winter 2022/3 plan for SGUH as both a provider of local acute care and of tertiary pathways, and highlighted the following: • Bed modelling indicated that adult medical G&A bed capacity could be as high as 55 inpatient beds short at peak winter, which could be further exacerbated by the significant delay in completing the refurbishment of the new trauma ward. In the meantime, some trauma beds would be made available in December ahead of a further closure of the ward in the spring to complete the works. • The plan would also be further updated in light of the ongoing Industrial action. • Working with system partners remained a critical focus and included constructive challenge, as required, as capacity at SGUH was often dependent on partners delivering. The Board noted: • The risks identified in sustaining sufficient capacity to meet all non-elective emergency need that presents to the Trust in a timely and effective manner. • The Place-based approach to developing community-based frailty clinical pathways. • The actions underway within the Trust to:	

	i) maximise clinically appropriate admission avoidance ii) sustain elective and cancer recovery iii) support effective and timely flow of patients from the Emergency Department into hospital beds where needed and home when medically optimised and ready.	
3.0	**CULTURE**	
3.1	**People Committee-in-Common Report** Stephen Collier, Chair of the Committee, provided an update on the People Committee meetings held in September and October 2022 and highlighted the following: • The culture programme continues and there are some early indications of joint working with ESTH, as well as a good focus on living our values and the development of middle managers. • Medical education had been a real concern 12-15 months ago but the most recent GMC survey indicated improvement to the education environment for postgraduates, which was also echoed in the feedback from undergraduate trainees. • Good and fast progress had been made on catching up on the backlog of DBS checks and the Committee suggested re rating the risk from 16 to 8. • The metrics for bank and agency spend were going in the right direction. • Efficiency remained an area of tension and the Committee continued to review the workforce improvement plan, including the expected delivery of up to £600m of efficiencies. • The Committee had started to review the increase in the establishment, which included 500 more wte posts since April 2021. 250 of the posts had been TUPED in, but the remaining 250 posts required further consideration. The GCCAO noted that the DBS risk mapped to SR9 on the BAF which would remain as a 16 as it related to broader risks around sustainability of the workforce. The GCEO also noted that the responsibility to review the 250 posts added to the establishment since April 2021 was a collective executive action and was not solely down to the GCPO. PKa highlighted the possibility that turnover could get worse in light of the forthcoming pay announcements and continued cost of living pressures, and he suggested that it might be worth targeting recruitment campaigns at those aged over 50 who had left the workforce and were now finding that pensions were no longer adequate. In response, the GCPO agreed that providing flexibility with working patterns was an area that the Trust needed to get better at. The Board: • Noted the report.	

	• Endorsed the proposed reduction in the current risk rating on compliance with Disclosure and Barring Service requirements from 16 to 8. This was separate to the BAF risk SR9. • Approved the Committee's decision to finalise the content of the Trust's WRES and WDES annual statements.	
3.1.1	**Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) Key Findings** The GCPO introduced the paper which had been previously considered at the People Committee, and to which the Board had delegated authority, to approve publication. In advance of the People Committee meeting all Board members had been given the opportunity to comment on the plans. The GCPO highlighted the following: • The indicators within the WRES were all moving in the right direction. Although there was still more to do around senior level representation. • With regards to WDES there was more of a mixed picture. The number of staff that self-declare as having a disability was very low at 2%. Improving the level of self declaration would be a focus for the coming year. In response to a question from the GCNO about whether staff had been educated on what could be declared as a disability, the GCPO agreed that further work could be done to educate staff on the criteria for a disability and also to ask staff at regular intervals to capture disabilities that arise during their employment. During discussion, it was also noted that the NHS was not very good at making reasonable adjustments and that this might also put staff off from making a declaration. Maintaining a central rather than local budget for reasonable adjustments would be considered. The Board noted the plans and that the supporting paperwork was in a better place than previous years.	**GCPO**
3.1.2	**Nursing Revalidation** The GCNO introduced the paper setting out the revalidation and renewal of professional registrations for registered nurses, nursing associates, midwives and allied health professionals, and highlighted the following: • The system for monitoring allied health professional registrations requires strengthening. • There were no records of lapses in NMC registration. • Regular relationship meetings had been established for SGUH with the NMC and the HCPC. The Board received the revalidation paper for assurance.	
3.2	**Fit and Proper Person Test update** The paper was withdrawn and would be considered at the Board's January meeting.	**GCPO**
4.0	**COLLABORATION**	
4.1	**Audit Committee Report**	

	Peter Kane, Chair of the Committee, provided an update on the meeting held on 27 October and highlighted the following: • The Internal Audit plan was progressing well. However, there was some concern with delays with management responding to draft reports and the lack of timely responses to IA regarding the progress on actions. • The internal audit on procurement had received limited assurance as a result of a lack of evidence that the tender or quotation process had been applied as per the policy. • A report setting out the themes arising from the review of governance-related recommendations from 2021/22 indicated that policies were a regular issue. • The Committee received its annual update on Trust compliance with the Managing Declarations of Interest Policy. • The tender for internal audit would proceed on a SWL basis and it was hoped that the bigger contract would attract more bidders. With regards to the procurement of internal audit, the GCFO noted that it had been a failure to engage with the auditors rather than a process failure, and that the matter was being addressed with the department. The GCCAO confirmed that the majority of governance-related recommendations from 2021/22 were related in some way to policies, either that the relevant policy had not been reviewed by the review date, had not been updated in light of external developments, or was not being followed by staff. A review of policy governance across the Group would be undertaken. The Board noted the report.	
4.2	**Finance Committee-in-Common Report**	
	Ann Beasley, Chair of the Committee, provided an update on the meetings held in September and October 2022 and reminded the Board that the remit of the Finance Committee is extensive covering all aspects of finance, IT and Estates. The following points were highlighted: • Strategic risks were reviewed in rotation and covered operational IT risk, financial sustainability, investment and estates. While some of the fundamental risks around IT had been addressed over the last few years, new issues were likely to arise. • Huge progress had been made with capital investment in the Trust estate and a number of projects were now live and delivering services to patients, including the Cath Labs and the MRI unit. • A review of the learning from the fire caused by the hot weather was undertaken. • In terms of performance, the cancer path to green, and the underlying increases in the PTL and the potential impact of any further increases would be revisited by the Committee. • Unusually the Trust was still in the position of planning for the current financial year, and while there is some reported deficit, the	

	position is as expected year to date, demonstrating financial grip and control. • The Committee was focused on the Trust's cash resources and managing the impact of making savings on the Trust's cash balance. The Committee received assurance that the Trust had sufficient cash for the current financial year. • The outturn for the current financial year is very challenging and the planning for next year and potential I&E deficit was similarly daunting. TW reflected that the BAF risk score was not a very good indicator of progress and that despite the score progress had been made in a number of areas, including data centre resilience and cyber. He acknowledged that while it may be disincentivising for staff to see the scores remaining static, it was the right thing to do. The Board noted the updates from the September and October 2022 Committee meetings.	
4.3	**Finance Report (Month 6)**	
	The Board received and noted the Trust's financial performance at month 6 and the following points were made: • The Trust was largely on plan for a £29m deficit. • The challenge would continue into the second half of the year and achieving a break-even position would require significant improvement on the run rate. Finding the actions to achieve the necessary improvements was a significant challenge. • The pressures would continue into 2023/24 along with further withdrawal of COVID funding which will exacerbate the challenges. Sufficient time for discussion of the financial position would be allocated to the Board agenda for future meetings. The Board noted the month 6 financial position.	
4.4	**Corporate Objectives 2022/23** The GDCEO introduced a paper setting out the Trust's proposed corporate objectives for H2 22/23 and highlighted that: • The proposed objectives were based on the agreed objectives for 2021/22 with minor amendments to reflect changes to the landscape in which the Trust operates. • New Group corporate objectives for 2023/24 would be developed and agreed in line with the new Group Strategy by April 2023. In response to a query from Pka whether the objectives were aligned with and could be delivered in light of the current resource constraints, the GDCEO confirmed a pragmatic approach had been taken to refresh the objectives and that challenge by staff as to the level of alignment was unlikely at this stage given that there would be a fundamental refresh in a few months' time. The Board agreed the proposed H2 22/23 corporate objectives.	

4.5	**Horizon Scanning Report** The GCCAO introduced the report providing an update on emerging policy, legislative, and regulatory issues with relevance to the Trust over the period between April and November 2022, and highlighted the following: • The Health and Care Bill received Royal Assent in April 2022 and has significant implications for system working. • NHS England published its new Operating Framework in October 2022 which sets out how NHSE will operate in the new structure created by the Health and Care Act 2022. • A review of healthcare leadership had been published in June and the Government had accepted the seven recommendations to Government to improve the quality of leadership in the NHS. • The annual CQC State of Care report published in October 2022 highlights the "gridlock" in the health and care system, access to care, inequalities and the scale of workforce challenges. • The paper deliberately excluded reference to the Kirkup report and the priorities of the new Secretary of State for Health which were pending. The Board noted the report.	
4.6	**Board Assurance Framework Q2 (2022/23) Review** The GCCAO introduced Board Assurance Framework (BAF) quarter 2 2022/23 report, and the following points were made about strategic risks (SRs): • With the exception of Strategic Risk 4, which was reserved to the Board, the information set out for each strategic risk has been reviewed by the relevant Board Committee. • There were no proposed changes to the risk scores or assurance ratings for the strategic risks on the BAF at Q1 2022/23. However, further more granular reviews of the Corporate Risk Register were taking place at Committee level. • While there is still considerable flux in the system it would not be appropriate to reduce the risk score for SR4 at this time. The GCEO reflected that given the uncertainty in the system, particularly in light of the Trust's financial situation, further thought should be given to increasing the score for SR4. AB agreed that the likelihood of the risk materialising was more aligned to the score of 4 rather than 3. In response the GCCAO clarified that the finance risk, which included a system element, was itself on the BAF with a risk score of 25. The Board agreed that it would be premature to increase the score of SR4 at the present time and noted that there would be an opportunity to discuss the ICS and the risk environment in part II of the meeting, which would then inform the Board's next discussion of the BAF and consideration of options as to the score and wording of SR4. For the Strategic Risk (system working) reserved to itself (SR4), the Board: • Agreed the proposed score of 12 (4C x 3L) (no change). • Agreed the proposed assurance rating of 'good' (no change).	**GCCAO**

	For the remaining 9 strategic risks assigned to its Committees, the Board: • Agreed the proposed risk scores, assurance ratings and statements from the relevant assuring committee. • Noted the progress in mitigating identified gaps in control and assurance.	
5.0	**CLOSING ADMINISTRATION**	
5.1	**Questions from Governors and the public** No questions were received from the public. HH commented on the positive use of the microphones at the meeting and welcomed being back on site. AA commented on the C difficile rates and asked what action was being taken to address the rate of infection. In response, the GCNO commented that the trajectory was not a national benchmark and was set based on the rate of infection at the Trust in the previous year. In 2021/22 the trajectory was set at 44 cases and as the Trust managed to come in under that figure, it was reduced for 2022/23 to 43 cases. The Trust was now at 42 cases and for each case a root cause analysis has been conducted and no obvious lapses in care or cause had been found. In only 2 cases was there a query highlighted relating to whether antibiotics should have been stopped and this was being looked at in more detail. In general, the team were confident that antibiotics have been prescribed appropriately. It was noted that C difficile rates were also rising across London. AA also welcomed the discussion of the BAF and the risk within the system and asked whether issues like cancer performance and delays with diagnostics were also considered under the BAF, or elsewhere. In response, the GCCAO confirmed that the Corporate Risk Register included specific risks around ED waiting times, patient flow etc and that SR3 on the BAF also included operational performance and IT risks. JH asked about the discharge into care fund and if the money was now available. The Chairman noted that the money had not yet reached the Trust. In response to a further query regarding the renal build, the GCFO confirmed that the Trust had been given informal approval to proceed to the full business case stage and it was expected that the building stage would commence in 2-3 years, if agreed. The GDCEO also reflected that the renal build was not limited to just the physical building but also included bringing together 2 clinical and managerial teams and that opportunities were already being explored for effective collaboration ahead of the build.	
5.2	**Any new risks or issues identified** No new risks or issues were identified.	
5.3	**Any Other Business** No other business was raised.	
5.4	**Draft Agenda for Next Meeting** The draft agenda was noted and items on the Fit and Proper Procedure and the Kirkup report would be added.	

5.5	**Reflections on meeting** The GCNO provided her reflections on the meeting and highlighted: • How welcome it was to be back on site for face-to-face Board meetings. • That aside from some logistical issues with the Board visits, the feedback was incredibly useful and provided important insight - a number of issues would be taken away for further consideration. There was a sense from the Wards that things had improved. • The Board reports were well written and there had been good levels of debate and challenge, which was particularly important in light of the Kirkup report. • There was a clear understanding of the financial position and the discussion around the BAF was helpful in focusing on the challenges. • Reports from the Committee Chairs were particularly helpful to those that had not attended the meetings in allowing them to get up to speed on the matters discussed and agreed. TW reflected on the Board visits and whether the surprise element was appropriate and helpful in all cases. The MD-SGUH also stressed the importance that the Board visits should not feel like an inspection. The Chairman noted that further consideration would be given to the visit arrangements. PKa mentioned the length of the meeting and whether a break at the mid-point might be appropriate. The Chairman agreed to give this consideration but noted that the requirements of a public meeting made it more difficult. Keeping discussions on point and succinct was noted as a constructive means to limit the meeting time while maintaining appropriate levels of assurance.	**GCNO**
5.6	**Patient Story** The Board welcomed Wendy Doyle, Head of Patient Experience and Partnership and Shazia Kahn, a member of the ward team who relayed the patient experience of Mike and his wife Jackie, following Mike's stay at SGUH. The Board noted that Mike was admitted in January and spent 2.5 weeks in ICU and later stayed on the Dalby and Heberden Wards for a total stay of 4.5 months. Mike had a complex history, including 2 lung cancers, Parkinson's, COPD, AF, and severe dysphagia, as well as a hearing impairment. Jackie had relayed to the team that overall, Mike's care was very good, and she was particularly mindful that the Trust was still coping with Covid at the time of his stay time, impacting on staffing levels, visiting and capacity. **Emergency Department** Jackie stated that the co-operation at ED was phenomenal around Mike's needs and the family were allowed to be present when visitors were restricted due to the pandemic. Mike's care was considered, holistic and well co-ordinated. **Parkinson's medication**	

	Mike requires Parkinson medication every 4 hours. He was listed for a procedure (PEG insertion) but waited all day (from 10pm until approx. 3.00pm) for the procedure therefore missing 2 doses of medication. By the time this was complete, Mike was stiff, and it took a long time for Mike to recover as a result. Shazia informed the Board that staff should have been more proactive about Mike's medication as it would have been possible to have requested a prescription from a doctor. The GCEO also noted that missing medications for Parkinson's could have extreme effects on the patient and questioned whether staff were made sufficiently aware of this. In response Shazia confirmed that IClip flags critical drugs. The GCNO also noted that simple things like a pocket timer could help staff and suggested a QI project. **Ward stay** Mike shared with Jackie that he found it hard to sleep on the ward due to noise. Shazia noted that welcome packs were available which included ear plugs but more action was needed to make staff aware that they were available. Mike was an inpatient for 4 months and had little to no stimulation and only 1 visitor a day due to restrictions. As a result of lack of stimulation, his mood was low on discharge. Shazia informed the Board that therapies had restarted and that volunteers were being sought to help support the activities. **Discharge** Jackie explained that Mike was discharged with a peg feeding tube and the 16-page discharge report was overwhelming for the family to follow. Shazia agreed that more should be done on the ward to prepare carers so that they didn't feel reliant on the letter and that in this case while staff had spent time preparing the family on the peg, more could have been done. In response to a question from the GCMO as to whether there had been enough notice of discharge, as complex patients required a higher degree of planning for discharge, Shazia explained that it would be ideal to have more time but that patients are discharged when it is safe to do so. The Board noted that updated discharge guidance had been issued and a toolkit was being developed by NHSE. The Board passed on its thanks to Mike and his family for sharing their feedback.	
	CLOSE	
Date of next meeting: Thursday, 12 January 2023, Hyde Park Room		

The meeting closed at 13:30

Trust Board (Public) - 12 January 2023

St George's University Hospitals NHS Foundation Trust

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Action Log

ACTION REFERENCE	MEETING DATE	ITEM NO.	ITEM	ACTION	WHEN	WHO	UPDATE	STATUS
PUBLIC220901.1	1 Sep 2022	1.5	Chief Executive's Report	The GCMO offered to coordinate an all-staff message reiterating that staff do not have to tolerate abuse in any form and to provide staff with the confidence to respond to incidents and escalate, as required.	1 Sep 2022	GCMO	3 November: An all staff message reiterating that staff do not have to tolerate abuse in any form was scheduled to be sent in the name of the GCMO and GCNO. The action would remain open. GCMO to confirm.	DUE
PUBLIC220901.3	1 Sep 2022	2.1.2	Infection Prevention and Control Annual Report	GCMO to check statistical benchmarking data and provide an update to the Board as to whether the Trust was an outlier in terms of surgical site infection.	1 Sep 2022	GCMO	3 November: The GCMO confirmed that it was already in the public domain that St George's was not an outlier in respect of surgical site infection. However, he was still considering other data and a further update would be provided at the Board's January meeting. The action would remain open. GCMO to confirm.	DUE
PUBLIC221103.01	3 Nov 2022	2.1	Quality Committee-in-Common Report	Update on fragility of the complaints service given the recent situation when multiple contractors left at the same time, the GCNO agreed to look at the issue in more detail.	12 Jan 2023	GCNO	Verbal update to be provided at meeting.	DUE
PUBLIC221103.05	3 Nov 2022	5.5	Reflections on meeting	Consider visit arrangements and whether they should be unannounced.	12 Jan 2023	GCNO	Verbal update to be provided at meeting.	DUE
PUBLIC220901.6	1 Sep 2022	2.3	Integrated Quality and Performance Report	Following discussions at Quality Committee and People Committee, IQPR to include health inequalities data.	31 Dec 2022	GCMO	The Trust appraoch to health inequalities reporting and data will be picked up as part of Board Development programme.	PROPOSED FOR CLOSURE
PUBLIC220901.7	1 Sep 2022	2.3	Integrated Quality and Performance Report	An update on outpatient transformation to be provided to the Board in 3 months' time.	12 Jan 2023	GDCEO/MD-SGUH	Oral update to be provided at meeting. Proposal to defer and delegate to March Finance Committee meeting due to current oeprational pressures.	PROPOSED FOR CLOSURE
PUBLIC221103.02	3 Nov 2022	2.2	Maternity Services	The Board would discuss the Kirkup Report at its next Board meeting on 12 January 2022.	12 Jan 2023	GCNO	On Agenda - See item 2.2.	PROPOSED FOR CLOSURE
PUBLIC221103.03	3 Nov 2022	3.1.1	Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) Key Findings	Maintaining a central rather than local budget for reasonable adjustments would be considered.	1 May 2023	GCPO	It is suggested that this action be monitored by the People Committee, which is overseeing the delivery of the WRES and WDES action plans. An update on the position on a central budget would be reported to the Board via the People Committee report from the Committee Chair.	PROPOSED FOR CLOSURE
PUBLIC221103.04	3 Nov 2022	3.2	Fit and Proper Person Test update	Paper to be considered at January 2023 meeting.	12 Jan 2023	GCPO	On Agenda - See item 4.1 Board Meeting in Private.	PROPOSED FOR CLOSURE
PUBLIC221103.06	3 Nov 2022	4.6	Board Assurance Framework Q2 (2022/23) Review	The Board agreed that it would be premature to increase the score of SR4 at the present time. Consider options as to the score and wording of SR4 as part on next BAF discussion in light of discussions around ICS and the risk environment in part II of the meeting.	3 Mar 2023	GCCAO	BAF next due at Board at the March 2023 meeting.	NOT YET DUE

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St George's University Hospitals NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	12 January 2023	**Agenda No**	**1.5**
Report Title:	**Chief Executive Officer's Report**		
Lead Director/ Manager:	Chief Executive Officer		
Report Author:	Jacqueline Totterdell, CEO		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	A summary of key events over the past two months to update the Board on strategic and operational activity at SGUH.		
Recommendation:	To note the update.		
Committee Assurance:	The Committee is also asked that in considering contents of this report, its supporting documents and the discussion at the meeting which of the following assurance rating it would provide to the Trust Board. • **Substantial Assurance:** The report and discussions assured the Committee that there are robust systems of internal controls operating effectively to ensure that quality and safety risks are managed to deliver high quality services and care to patients. • **Reasonable Assurance:** The report and discussions assured the Committee that the system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that quality and safety risks are managed to deliver high quality services and care to patients. • **Limited Assurance:** The report and discussions supported the Committee's conclusion that that the system of internal controls is generally inadequate or not operating effectively and significant improvements were required to ensure that the quality and safety risks are managed effectively to improve the position and ensure that high quality services and care is provided to patients. • **No Assurance:** The report and discussions led the Committee to conclude that there was a fundamental breakdown or absence of core internal controls and systems to enable the Trust to deliver high quality services and care to its patients.		
Supports			
Trust Strategic Objective:	Well-led		
CQC Theme:	Leadership and improvement capability (well-led)		
Single Oversight Framework Theme:			
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Equality and Diversity:	N/A		

Previously Considered by:	N/A	**Date**	N/A
Appendices:	Appendix A: CEO's Report		

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NHS
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APPENDIX A

Chief Executive Officer's Report
Trust Board

Introduction

As I reported to you at our last Trust Board, we were expecting a challenging winter, and that is exactly what we have faced over the past two months. The pressures the NHS is currently facing cannot be overstated, and here at St George's we are no exception. As ever, our teams have tirelessly faced these challenges with talent, hard work and commitment – always reflecting the values of the Trust in our ways of working.

Our Emergency Department has received record numbers of incoming patients, with over 12,000 patients attending ED in December alone. The focus on managing the flow through the hospital reflects the importance of moving patients through to release vital capacity to deal with this demand. It is also our focus to ensure that resources are used most effectively and efficiently, including ensuring that medically fit patients are discharged on time, and that other cohorts of patients – including the very frail and elderly – are treated in the most appropriate setting for their needs (which often means not in the hospital). In addition, we are working hard to ensure that our patients are managed safely in the context of rising Covid and flu infection rates, as well as RSV and Group A Streptococcal infections.

Further to these strains on our capacity, we are also managing the impact of multiple industrial actions. This included the strike of the London Ambulance Service on 21st December, with further strike dates planned in January. Further Royal College of Nursing strikes are due to take place at St George's later this month on 18th and 19th January. As ever, our focus is to always ensure patient safety throughout any industrial action.

At this time of increased strain and challenge to our teams, I have been continually humbled by the hard work and commitment of the teams across the Trust, particularly over the Christmas period. Communicating directly with our staff has been a key focus of mine in managing our pathway forward and getting through this crisis. We have launched daily communications bulletin to keep everyone abreast of our activity on emergency care, including providing our daily key statistics across the Group, sharing what we are doing to tackle the crisis and discussing what this means for St George's, as well as Epsom and St Helier.

What Are We Doing Differently to Support Winter Emergency Care Challenges?

Tackling these challenges in the context of budget constraints means trying to do things differently to make a change. Whilst there are more things that we can do, our teams have been working on new approaches to support winter emergency care challenges, including the following:

- St George's has been one of a few, select Trusts in the UK to trial a new **Regularised Patient Flow** system to support expedited patient flow throughout the hospital to reduce risk and keep patients safe. This regularised flow model, developed at North Bristol Trust, has already been trialled in other hospitals and led to some reduction in delays for ambulance handovers and patients reaching their inpatient beds, which we know reduces the risk of harm. By regularly moving patients in the Emergency Department, we even out flow and minimise the build-up that creates difficulties for the department. To support our wards in receiving more patients, we have invested in additional staffing resource, portering, cleaning, catering and transport, and enhanced use of the Departure Lounge. We will continue to work in a multidisciplinary way to ensure patients are ready for discharge in a timely fashion.
- We have introduced a team to assess elderly and frail patients attending ED to be able to discharge them home without admission – where this is right – always ensuring that this is

done with the right equipment, treatment and support that may be required. This is crucial as we know that often the condition of the elderly can deteriorate in a hospital setting, so it is key to ensure they move to the best possible environment for them.

- Our **Hospital at Home** scheme with our community partners includes an assessment for patients who arrive at our front door to investigate if they are suitable for the Hospital at Home scheme. Patients in this category may be patients requiring antibiotics, for example. Most patients using this service are classified as severely frail. Working with our partners, we are able to monitor people at home with community nursing and virtual consultant care – leveraging digital capabilities to provide an efficient and effective service which will enable the healthiest setting for these patients.
- Discharging medically fit patients has also been a key challenge, and we have been working with our community partners to ensure our patients are able to safely move to appropriate care facilities as needed. Our **Transfer of Care** team works on a patient-by-patient basis with partners to get people home. They help to identify patients who require more support with onward care, then work with partners such as charities with resources including Age UK to expedite discharges where possible, and identify social care packages.
- We host **MADE** events (multi agency discharge events) to support and resolve some of the discharge issues with our stakeholders from a system approach. We have increased the frequency of these meetings to once a week (from once a quarter) to expedite progress.

A Rise in Flu, Covid and Strep A Infection Rates

We are seeing more people with respiratory conditions and viruses requiring hospital care including children, and these illnesses are also impacting our staff. We are continuing to promote our roll-out of the flu vaccine to support greater protection levels and reduce the risk of requiring hospital care for these conditions over the winter months. There has also been a rise in cases of Strep A recently, but overall, there are still fewer cases than this time two years ago. We saw a real decline in the pandemic as people were not mixing which is why there are more reported cases in children under four, who have not previously been exposed to infection during the pandemic. We are working closely with our clinical partners in the community to support families in managing Strep A infections.

Elective Care Recovery Performance

Throughout the challenges that we are currently facing, we are committed to continuing our elective care recovery too. SW London meets weekly to discuss the elective care recovery activity and seeks to distribute activity where it can be managed most efficiently. Our system network is crucial in managing the winter pressures and ensuring elective activity remains on track despite the disruptions. We have set up surgical hubs with protected theatre space, which has been vital in supporting our vision of working through high volume, low complexity cases across SWL to aid recovery and allow other spaces – such as St George's – to focus on specialist and complex cases. We continue to make positive progress on elective activity and continue to focus on tackling our cancer performances too.

NHS England's Priorities and Operational Planning Guidance 2023-2024

NHS England has published its priorities and operational planning guidance for 2023-2024. The plan sets out the key priorities for the next financial year and will be incorporated into our business planning activity for the Trust, with more to follow from our Group Chief Finance Officer, Andrew Grimshaw. The guidance states that NHS England will continue to support "local decision-making, empowering local leaders to make the best decisions for their local populations and set out fewer, more focused national objectives". The guidance also outlines the three over-arching tasks for the coming year:

1. Recover our core services and productivity.
2. As we recover, make progress in delivering the key ambitions in the Long-Term Plan (LTP).
3. Continue transforming the NHS for the future.

Within the guidance, new targets are included for Trusts to aim to see 76% of Emergency Department patients within four hours by the end of 2023-24.

The guidance also includes a payment by results system for elective activity. The guidance notes that the default between ICBs and providers for most planned elective care (not including follow-ups) will be to pay unit prices for activity delivered.

I look forward to keeping you updated as we incorporate these goals and objectives into our Trust business planning process.

Events & Awards

Our staff and teams have recently been successful in a range of award programmes. Just a few of the successes include:

- **Health Service Journal (HSJ) NHS Partnership of the Year Award shortlist**
  - The St George's Musculoskeletal (MSK) Physiotherapy team has been shortlisted for a HSJ award for their involvement in the GetUBetter project. GetUBetter is a digital tool which helps musculoskeletal patients self-manage their symptoms - giving them more independence and freeing up time for clinicians. The team's project is called "A HealthTech partnership - meeting the needs of patients, clinicians and the health system across an ICS".

- **Healthcare Excellence Through Technology (HETT) Innovation Awards**
  - Our Functional Neurologic Disorder team won "Best designed virtual service" at the HETT awards ceremony. The service was set up to provide a digital first approach to treating functional neurological disorders. The outcomes have been excellent, reducing waiting times by 90% and is delivered at 10% of the cost of usual treatment.

We have also held a number of key events at St George's recently, below are a few examples:

- **Disability History Month celebrations**
  - From mid-November our Disability and Wellness Network (DaWN) ran activities to raise awareness, including a celebration event featuring music, food, free massages, and presentations from staff. As well as this, we had mindfulness sessions, British Sign Language courses and talks from members of the DaWN network about their disability and how it affects them.
- **Homelessness Inclusion team one year celebration**
  - We celebrated the success of our Homelessness Inclusion team at St George's, which has now been running for a year. The teamwork in collaboration with the homelessness charity Pathway, providing support to our patients by working with local authorities to find them more secure housing and registering them with a GP. Richard Jennings, Our Group Chief Medical Officer, attended the celebration and congratulated the team for their hard work – they have helped over 246 patients, seeing a 66% fall in these patients returning to rough sleeping.

- **World AIDS Day**
  - At the beginning of December, we celebrated World AIDS Day by highlighting the successes of HIV opt out testing in our Emergency Department. Our executives met with key teams involved in HIV prevention and detection initiatives at St George's. They visited our floral installation of Undetectable = Untransmissible, which our estates team and volunteers from Positively UK planted as a reminder of the progress made in the treatment of HIV.

- **Christmas on Us**

- We were very pleased to be able to offer staff working on Christmas Day, Boxing Day or New Year's Eve a free festive hot meal thanks to funding from St George's Hospital Charity's grant programme.

Meeting Title:	**Trust Board**		
Date:	12 January 2023	**Agenda No**	**2.1**
Report Title:	**Quality Committee in Common Report**		
Lead Director/ Manager:	Dr Richard Jennings, Group Chief Medical Officer Arlene Wellman, Group Chief Nursing Officer		
Report Author:	Prof. Dame Parveen Kumar, Chair of the Quality Committee in Common		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues covered by the Quality Committee at its meetings in November and December 2022. The Committee has been operating as a Committee-in-Common with the Epsom and St Helier University Hospitals NHS Trust Quality Committee since April 2022. This report highlights only those issues related to St George's although some issues were relevant to both Trusts.		
Recommendation:	The Board is asked to note the update from the November and December 2022 meetings of the Committee.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	All CQC domains		
NHS System Oversight Framework Theme:	Quality of care, Operational Performance, Leadership and Improvement Capability		
Implications			
Risk:	Relevant risks considered.		
Legal/Regulatory:	CQC Regulatory Standards		
Resources:	N/A		
Previously Considered by:	N/A	Date:	N/A
Appendices:	N/A		

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St George's University Hospitals NHS Foundation Trust

Quality Committee Report
Trust Board, 12 January 2023

Matters for the Board's attention

The Quality Committee met on 17 November and 15 December 2022. As the Board is aware, chairing of meetings of the Quality Committees-in-Common rotates between the respective chairs of the Committees at ESTH and SGUH. I chaired the November 2022 meeting and the ESTH Chair chaired the December 2022 meeting.

The Committee considered the following matters of business at these meetings:

November 2022	December 2022
• Quality Performance Report (M7) • Serious Incidents Report • Maternity Services Report • Group Infection Prevention and Control Update • Nursing Staffing Report • Annual Reports ○ Complaints 2021/22	• Quality Performance Report (M8)* • Serious Incidents Report • Maternity Services Report* • Group Infection Prevention and Control Update • Deep Dive into Major Trauma Service provided at SGUH • Corporate Risk Register emerging risks • Learning from Deaths Quarter 2 2022/23*

This report covers the key issues that the Committee would like to bring to the attention of the Board.

1. Quality Performance Report: Months 7 and 8 2022/23

The Committee considered the key areas of quality and safety performance in months 7 and 8 and would like to highlight the following issues; recognising that the Board will discuss the performance data at month 8 later on the agenda:

Areas of challenge:

- Influenza- The trust had seen an increase in cases in November 2022, 55 cases in comparison to 37 cases in October 2022, Influenza A was the predominant strain. There was an increase in bay closures, with 2 reported outbreaks in November 2022.
- Mental Capacity Act & Deprivation of Liberty Level 2 Training – Medical and Dental staff were currently 53% compliant (increase from 52% last month).
- Analysis provided by NHS Digital of Standard Hospital Mortality Indicator (SHMI) data indicated that in June there were more deaths than expected in the fractured neck of femur diagnosis group was observed. The Hospital Standard Mortality Rate (HSMR) for this group of patient was as expected

Areas of good or improving performance:

- Complaints performance for November 2022 improved to 86% despite significant operational pressures.

- Fall rates remain lower than average, reporting 113 falls in November. Rates per 1,000 Occupied Bed Days are currently at 4.7, a slight decrease from October and lower than the mean.
- Latest Hospital Standardised Mortality Rates (HSMR,) shows the mortality to be lower than expected. Looking at emergency admissions, mortality was lower than expected for those patients admitted during the week and as expected for those admitted at the weekend.
- The Birth Centre reopened on 7th November and so we have water birth facilities once more. The Homebirth Service was reinstated in September and active throughout October.
- The number of RTT patients waiting for more than 52 weeks continued to fall and is meeting plan. The Trust was on track to deliver year end targets in both 52+ and 78+ waits
- The Trust launched the regularising flow programme in November to support exit from the Emergency Department and enable timely ambulance handover.

The Committee received reasonable assurance from the report and the discussion.

2. Serious Incident Reporting

The Committee considered and noted the new style serious incident (SI) report which provided an overview of the SIs reported by SGUH in September and October 2022. It aimed to provide assurance on the trust's commitment to learning from SI investigations and embedding that learning in everyday practice to improve patient safety.

- Three serious incidents were declared in September 2022 and one in October 2022.
- Four serious incident investigations were concluded in September 2022, and also in October 2022.

The Committee discussed in some detail the investigations which had been closed in month. This included the actions put in place from a SI involving a homeless patient who absconded from the Emergency Department (ED). They included changes being made to practices within the department, including the introduction of safety net touchpoints.

3. Infection Prevention Control

The Committee continued its monthly focus on infection prevention and control (IPC), through receiving a monthly update report.

Covid-19 continued to be the major focus of the IPC team, although the incidence of patients having to be admitted with the illness was continuing to slowly reduce. A total of 63 Covid-19 infections were detected in November 2022.

In relation to *C.difficile*, a threshold of 43 cases had been set for the Trust by NHS England for 2022/23 as a whole, which equated to around 3.5 cases a month. In October there had been three cases, all of which were classified as Hospital Onset Healthcare Associated (HOHA). In November, there had been four cases, of which three were classified as HOHA and one was Community Onset Healthcare Associated (COHA). This meant that the cases in year continued to be significantly above trajectory. The focus continued on antimicrobial stewardship.

4. Maternity Services Report

The Committee received assurance from the Group Chief Nursing Officer setting out the Trust's position in relation to the actions in the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) as well as the Group wide Gap Analysis as a result of the Kirkup Investigation into Maternity Services in East Kent.

In respect of the planned submission for the CNST scheme, which was due to be made in February 2023 a review against the current technical guidance had recently taken place. The Committee noted that SGUH would be non-compliant with several of the required safety actions. Details of these concerns will be covered under the separate Agenda Item on Maternity at the Board meeting.

The Committee also received the SAP Analysis and action plan in relation to the recommendations from the Kirkup Report. It was particularly noted that the recommendations from the Report related to culture, leadership and appropriate MDT Leadership. The areas where it was felt the trust could make improvements were detailed within the report received by the Committee.

5. Deep Dive – Major Trauma Service provided by SGUH

At the meeting held in December 2022, the Committee received a Deep Dive Report into the Major Trauma Service provided by SGUH. The GCMO confirmed noted that in August 2022 the CEO had received a letter from the Trauma Audit & Research Network (TARN) informing the Trust that it was considered a negative outlier for case-mix adjusted mortality outcomes for the period April 2019 to March 2021. This followed a similar alert received in June 2020 for the period July 2017 to June 2019, which had initially improved. Also, in April 2022 the St George's Major Trauma Centre and Southwest London & Surrey trauma network underwent a major trauma peer review which highlighted some concerns around outcomes, trauma infrastructure and neuro trauma service.

The report outlined the trust's response to the initial outlier alert from TARN, the learning from another trauma centre (Royal London) which has excellent outcomes and the current and future work (including a longer term workforce strategy) designed to improve the trauma outcomes from bottom quartile to top quartile nationally. It was particularly noted that a specialist Trauma Ward was in the process of being developed and work was taking place to make improvements in cranial surgery. These changes should lead to improvements of the metrics for the service.

Overall some improvements had been made but some degree of investment would be needed to make more. This should include employing more specialist trauma consultants, as opposed to consultants who were providing these additional specialist services as part of their main role.

Whilst it was agreed that there was a need for investment it was noted that there would be no ongoing additional funding to increase staffing for the service. This was due to the overall, well documented, financial constraints within the NHS. Lack of any funding to invest in service improvements was a continuing issue for both the Group and the trusts. There was the need to do as much as possible within the available funding / resources.

The Committee confirmed that it was of concern that the trust was 5th from bottom in the metrics. Also, there was a need to be assurance that there was adequate priority relating to leadership and time was provided for this within job plans.

The Committee agreed that the ongoing development of the SGUH Major Trauma Service should be a focus of the January 2023 Board discussions on the Group Strategy.

6. Corporate Risk Register

At the December 2022 Quality Committee in Common discussion took place regarding emerging risks and concerns across the Group. These included:

- Ensuring adequate support and training was in place in relation to dealing with patients with a learning disability. This was a required of the Health Act 2022
- Continually increasing demands on the Emergency Department, including if necessary, the need to cohort patients arriving by ambulance.

- High number of flu cases.
- Need to regularise the flow of patients through the hospital, including being clear on the number of expected and definite discharges.
- Dealing with the increased Paediatric presentations at the EDs relating to the possible cases of Strep A. These were being widely publicised within the national press.
- Concerns relating to strikes, currently relating to the Ambulance Services, but also in the future possibly nursing staff.
- Lack of availability of specialist trained Cardiac Anaesthetists. The number of medical staff available to undertake this work would further reduced in February 2023 and mutual aid may be required to continue the service
- Pressures on ITU impacting on the ability to book in patients requiring major surgery

All these concerns would be reviewed in detail, for consideration within the trust's Corporate Risk Register.

7. Annual Reports

The following Annual Reports were received and discussed:

- Complaints Annual Report 2021/22

  **This report will be made available in the Board reading room.

8. Recommendation

The Board is asked to note the updates from the November and December 2022 meetings.

Dame Parveen Kumar
Committee Chair
January 2023

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Meeting Title:	**Trust Board**		
Date:	12 January 2023	**Agenda No**	**2.1.1**
Report Title:	**Learning from Deaths Quarterly Report (Q2 July – Sept 22)**		
Lead Director/ Manager:	Richard Jennings, Group CMO Luci Etheridge, Site CMO		
Report Author:	Ashar Wadoodi, Learning from Deaths lead, SGUH Kate Hutt, Head of Mortality Services, SGUH		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	Trusts are required to collect and publish specified information on deaths on a quarterly basis. This paper summarises the Trust's policy and approach to learning from deaths, and the key data and learning points. The total number of deaths within this quarter was 372, from which 42 (11%) patients underwent the SJR process. There was only one death that was classified as probably avoidable in the quarter; this was related hospital acquired COVID. There were no deaths that were deemed definitely avoidable. The SHMI for this quarter was as expected. The HSMR for the period Aug 2021 – July 2022, was 88.7, which is lower than expected. HSMR data has shown an alert in the crush injuries and perinatal mortality categories, and these two specific alerts are boing specifically reviewed and analysed, as is the normal process when individual conditions generate an HSMR alert. An update on these reviews will be included in the next report. A new standardised approach to Morbidity and mortality meetings (M&M) has been rolled out across the trust, including a new terms of reference and template to discuss all unexpected deaths within care groups. Through the SJR process we have recognised issues with DVT prophylaxis which have contributed to patient deaths. This triangulates with recent SI data. From now on, DVT prophylaxis will be specifically reviewed in all SJR reviews to inform further learning and quality improvement work. At present almost all referrals to learning from death come from the ME office. The learning from deaths team intends to expand its referral pool by engaging with different departments withing the hospital. Meetings with Wandsworth and Merton general practices continue, with the aim of further community ME rollout in the coming year.		
Key abbreviations:	**SJR**: structured judgement review; **ME**: medical examiner; **TARN**: trauma audit research network; **HSMR**: hospital standardised mortality ratio; **SHMI**: summary hospital level mortality indicator; **CoW**: Consultant of the week; **TOR**: terms of reference; **M&M**: mortality and morbidity; **SOP**: standard operating procedure **MMG**: Mortality Monitoring Group; **TOR**: Terms of reference;		
Recommendation:	That the Board note the continued compliance with the Learning from Deaths framework and the key areas of learning and development identified, along with the actions taken to address these.		
Committee Assurance:	The Committee is also asked that in considering contents of this report, its supporting documents and the discussion at the meeting which of the following assurance rating it would provide to the Trust Board. • **Substantial Assurance:** The report and discussions assured the Committee that there are robust systems of internal controls operating effectively to ensure that		

	quality and safety risks are managed to deliver high quality services and care to patients. • **Reasonable Assurance:** The report and discussions assured the Committee that the system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that quality and safety risks are managed to deliver high quality services and care to patients. • **Limited Assurance:** The report and discussions supported the Committee's conclusion that that the system of internal controls is generally inadequate or not operating effectively and significant improvements were required to ensure that the quality and safety risks are managed effectively to improve the position and ensure that high quality services and care is provided to patients. • **No Assurance:** The report and discussions led the Committee to conclude that there was a fundamental breakdown or absence of core internal controls and systems to enable the Trust to deliver high quality services and care to its patients.
Supports	
Trust Strategic Objective:	Reducing avoidable harm.
CQC Theme:	Safe, effective, well led
Single Oversight Framework Theme:	Safe
Implications	
Risk:	Failure to achieve high standards in mortality governance presents a risk to the delivery of safe patient care.
Legal/Regulatory:	'Learning from Deaths' framework is regulated by CQC and NHS Improvement, and demands trust actions including publication and discussion of data at Board level.
Resources:	
Equality and Diversity:	
Previously Considered by:	PSQG Quality Committee **Date** 30/11/22 15/12/22
Appendices:	1. National quality dashboard

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Learning From Deaths Quarterly Report
July-September 2022

1.0 PURPOSE

1.1 The purpose of this paper is to provide the Board with an update on progress against the Learning from Deaths agenda, as outlined in the national guidance on learning from deaths. The paper also summarises the activity of the Medical Examiner office.

1.2 The report describes sources of assurance that the Trust is scrutinising mortality and identifying areas where further examination is required. In line with the Learning from Deaths framework, we are working to ensure that opportunities for learning are identified and where appropriate, action is taken to achieve improvements.

2.0 NATIONAL PUBLISHED RISK-ADJUSTED MORTALITY

2.1 There have been 372 deaths in the period 1st July 2022 to 30th September 2022.

2.2 **Summary Hospital-level Mortality Indicator (SHMI)** [source: NHS Digital]
The latest SHMI data covers discharges from 1st July 2021 to 30th June 2022. For this period our SHMI is 0.92, which is as expected. This is consistent with previous quarters.

2.3 **Hospital Standardised Mortality Ratio (HSMR)** [source: Dr Foster]
The most recent Dr Foster data covers August 2021 to July 2022. Our HSMR is 88.7, which is lower than expected. The following areas have been discussed at Mortality Monitoring Group in more detail and actions taken as described.

Signals from Dr Foster:

Diagnosis or Procedure Group		Current understanding of signal	
Diagnosis groups	Crushing injury or internal injury	Signal has been observed in last 5 updates. A high level review of 10 deaths in the period June 2021 – May 2022. Summarised in paper MMG(22) OCT 3.5 – review complete. Summary: All emergency admissions following trauma, including 4 transfers from other hospitals. All scrutinised by ME. No concerns were identified. Coronial referral made for all cases. No SJRs. Major Trauma reviews accessed for 5 -judged to be expected and no further review required. Revised MTC mortality review process now in place which would include these cases.	
	Genitourinary congenital anomalies	New signal October. For this period (August 2021 – July 2022) there were 413 cases and 2 deaths (0.2 expected).	Will be investigated as part of wider review, agreed in MMG.
	Haemolytic jaundice and perinatal jaundice	New signal October. For this period (August 2021 – July 2022) there were 615 cases and 2 deaths (0.1 expected).	
	Nervous system congenital anomalies	New signal. For this period (August 2021 – July 2022) there were 90 cases and 5 deaths (1.4 expected).	

	Short gestation, low birth weight and fetal growth retardation	Signal seen intermittently. For this period (August 2021 – July 2022) there are 232 cases and 12 deaths (5.2 expected).	

3.0 LEARNING FROM DEATHS OBJECTIVES

3.1 The Mortality Monitoring Group has agreed a number of priorities to improve processes around mortality governance, with the aim of maximising learning and improving patient care. These cover each of the workstreams incorporated in our local Learning from Deaths framework and progress against these objectives is monitored by MMG and reported to Patient Safety and Quality Group, Quality Committee and ultimately Trust Board.

Current areas of investigation following mortality alerts:

Workstream	*Priority area*	*Key updates*
Mortality investigations to be concluded	***Cardiology diagnosis and procedure groups, principally Acute myocardial infarction***	Cardiology care group has internally verified the Dr Foster signal. Greater than 60% of deaths are related to coronary artery disease or other anatomical pathology. 70% of deaths were following ST elevation myocardial infarction and of these 60% presented in shock. The main focus for development in the service is development of protocols and pathways for the management of cardiogenic shock. A shock group is now in operation and there is a defined pathway for managing patients presenting with cardiogenic shock. It provides a standardised framework for managing this high risk patient group. It involves both cardiology and CTICU teams. The initial experience was discussed at the relevant Governance meeting on 2nd December.
	Intracranial injury diagnosis group	The Dr Foster signal for ICH has now been absent for at least 6 months. We will continue to monitor the situation; however, this has also become part of a bigger signal within major trauma. This is discussed below.
	Major trauma (TARN)	This is part of a major undertaking by the trust following a letter from TARN identifying St Georges as an outlier for trauma outcomes. Anthony Hudson who has led on this has split the overhaul into: **Infrastructure**: New Trauma Ward (building work commenced), CoW model for major trauma, Neurosurgeon appointment in Feb 23 with an interest in trauma. **Governance:** New major mortality review process now in place. Code red focused clinical governance meeting starting Feb 2023

		Clinical: Groups working on improving SOPs in major haemorrhage, chest wall injury and prevention of secondary brain injury A deep dive paper on this major trauma work is being taken to the QCIC meeting on 15th Dec 2022.
Mortality and Morbidity meetings development	***Continue pilot of M&M template, refine and implement more widely***	The M&M template has now been implemented throughout the trust. Feedback via the coordinators has largely been positive with minor teething issues being supported by coordinators and the Learning from deaths lead.
	Define minimum standards for M&M meetings	A minimum standard has now been set for mortality governance across the trust. This is being embedded into culture with the assistance of the coordinators and the learning from deaths team. The specifics of the morbidity element will be developed outside of the learning from death framework.
	Engage with clinical governance leads to ensure that minimum standards are being met	This is ongoing work for all care groups to meet the minimum standards of the terms of reference. At this point the majority of care groups are meeting the TOR, any outliers are being supported to adopt the TOR.
	Explore ways to collate and share learning, possibly including development of a database and reporting to MMG	At this moment we don't have a dedicated data base to record SJRs or outcomes. We have explored the possibility of using a newer version of Datix which is currently being used by our sister unit, St Heliers Hospital.
Learning from Deaths agenda	***Review MMG terms of reference***	The TOR has now been through MMG and been shared with the governance leads.
	Review Learning from Deaths policy	The learning from deaths policy has been reviewed in the last year and will be due for renewal at the end of 2023. The intention is to create a single learning from deaths policy for the group (SGUH & ESTH).
	Train and induct new reviewers so that we have a full mortality review team	We have 3 reviewers and the learning from deaths lead who also reviews cases. We aim to appoint another reviewer in the new year from STNC division and reviewers with a nursing background in order to increase the expertise within the team.
	Define standard operating procedures for Learning from Deaths processes	We now have a SOP for providing feedback on all reviews carried out under the learning from deaths umbrella. This will ensure that all reviews will generate some feedback to the clinical team.
	LeDeR review National Learning Disabilities Review Program	Standard SJR methodology is used to assess all deaths. In this period there have been 4 deaths that met this criteria. None of those deaths were deemed to be avoidable and

		overall care for all cases was judged good or excellent.

4.0 OUTPUTS OF MORTALITY GOVERNANCE PROCESSES

4.1 Local Morbidity and Mortality Meetings

The M&M team supports establishment of a quality, safety and learning culture through support for monthly patient safety, mortality and morbidity meetings for every clinical specialty. Until recently not all care groups were carrying out regular M&M meetings and there were no terms of reference. With the support of the M&M coordinators the TOR was developed and has now been circulated across all governance leads. The majority of care groups have now adopted this with support from the M&M team under the supervision of the team leader Maureen Ijomoni.

4.2 Mortality Review Team

During this quarter, independent reviews using the structured judgement review (SJR), have been completed for 42 deaths, which represent 11.3 % of all deaths. 38 of these were referred to the Learning from Deaths Lead by the Medical Examiner Office and 4 from other sources including directly from the clinical team or from the Patient Safety Team. It should be noted that all child deaths are reviewed locally by clinical teams and by the Child Death Overview Panel.

Reasons for Structured Judgment Review:

Triggers for review	
Confirmed learning disability	4
Significant mental health diagnosis	6
ME or clinical team detected possible learning or potential issue with care	9
Deaths following elective admission	7
Areas subject to enhanced oversight	6
Family raised significant concerns	7
Death occurred within 30 days of discharge	1
Review requested by Serious Incident Declaration Meeting	2

At present the majority of reviews come through the ME office. In the last year we have conducted a grand round in order to make our role better known throughout the hospital. We are now planning some more focused presentations within different departments and areas within the hospital. The hope is that this will increase the number of reviews coming directly from clinical areas and not only from ME scrutiny.

Problems in healthcare :

Problem in healthcare	No harm	Possible harm	Harm	TOTAL
Assessment	1	2	0	3
Medication	2	0	0	2
Treatment	0	3	1	3
Infection control	0	4	0	4
Procedure	1	1	0	2
Monitoring	0	4	0	4
Resuscitation	0	0	0	0
Communication	6	0	0	6
Other	0	2	0	0

Total	10	16	1	27

The SJR methodology requires reviewers to identify problems in healthcare and to assess whether these have caused harm. Of the 42 deaths reviewed this quarter problems were identified in relation to 10 (24%) of the patients reviewed. The majority of these are related to communication between clinical team members; this is routinely fed back to the clinical team for commentary before the SJR is closed. Two others were related to DVT prophylaxis. DVT prophylaxis is an area in which it is recognised tha the Trust needs to improve over all, and so this will be adopted as a specific question within the SJR template going forward.

Overall care:

Overall care judgement	Number	Percentage
Excellent care	7	16.7
Good care	24	57.1
Adequate care	9	21.4
Poor care	2	4.8
Very poor care	0	0
Total	**42**	

Overall care was judged to be good or excellent in 31 (74%) of the 42 cases. Only two cases were categorised as poor care, and both of these cases were escalated for either specialist input or to the Patient Safety team.

A judgement regarding avoidability of death is made for all reviews:

Avoidability of death judgement	Number	Percentage
Definitely not avoidable	25	61.0
Slight evidence of avoidability	9	22.0
Possibly avoidable but not very likely (less than 50:50)	6	14.6
Probably avoidable (more than 50:50)	1	2.4
Strong evidence of avoidability	0	0
Definitely avoidable	0	0
Total	**41**	

For 1 case it was not possible to give a judgement on avoidability as the death occurred post discharge from St George's and an SJR was conducted to look at care prior to discharge. Out of all cases reviewed only one case fell into the category of probably avoidable, this was death following hospital acquired COVID and is being looked at separately through the SI process. Any cases where there is more than a 50% chance of death being 'probably' avoidable, this is referred to the risk team to carry out further assessment and conclude whether an SI should be declared.

4.3 **Learning from mortality:**

There has been specific learning that has been generated from individual cases reviewed by the SJR team. These findings are routinely discussed at MMG and actions tailored accordingly. Most recently, this included a case where the presence of urinary catheter passport may have enabled better management of a patient in urinary retention. Now that the trust has transitioned to a paperless system, some elements of care (ie catheter passport) remain on paper format and this has the potential to create gaps in patient management. A second issue highlighted through the use of SJRs is appropriate timing of treatment

escalation plans and communication regarding patients who are not for resuscitation, in order to avoid unnecessary CPR on patients who are unlikely to make a meaningful recovery. Finally, the most recent case was of a patient who died of a DVT from recent lower limb fracture while awaiting transfer from the emergency department to a secure psychiatric unit. The ED team have an internal policy of all psychiatric patients undergoing medical review prior to psychiatric input, however that was not undertaken in this case. The emergency department are revisiting this protocol. This unexpected death was not declared a serious incident (DW178918) when it was discussed at the SIDM on 05/12/22, but any additional major learning from the investigation that is currently underway will be reported in the relevant paper to QCIC in the future.

5.0 MEDICAL EXAMINER SERVICE

5.1 In addition to flagging areas where there are potential concerns the Medical Examiner (ME) service highlights cases where best practice was observed. The service was pleased to pass on the gratitude of a number of families to clinical teams for the kindness and professionalism they displayed.

5.2 A key function of the ME service is to support the appropriate referral of deaths to the coroner. This quarter 99 deaths were referred. In 43 (43%) of these cases the coroner felt no further investigation was required.

5.3 Meetings continue to be held monthly with the Merton and Wandsworth GP task and finish group. The first pilot began on 18/07/22 in a practice of over 30,000 patients (15% of the population of Merton) and the second pilot in September. There is an agreed implementation plan to on-board in excess of 70 healthcare providers and a full engagement programme is underway with a number of start dates agreed.

5.4 Each quarter all ME offices are required to make a return directly to the office of the National ME, as summarised below. There were 2 cases where the service did not speak to families following a rapid release over a weekend. The ME team continue to try and improve processes and this is a reduction from the previous quarter.

DEATHS OCCURING AT THE ME OFFICE SITE THAT HAVE BEEN SCRUTINISED BY THE ME	
Number of in-hospital deaths scrutinised	**372**
Adult deaths	
Cases not notified to the Coroner and MCCD issued directly	269
Cases notified to the Coroner and MCCD issued following agreement by Coroner	43
Cases referred to the Coroner and taken for investigation	54
Child deaths	
Cases not notified to the Coroner and MCCD issued directly	4
Cases notified to the Coroner and MCCD issued following agreement by Coroner	0
Cases referred to the Coroner and taken for investigation	2
Timeliness and rejections by registration service	
Number of MCCDs not completed within 3 calendar days (NB: no account of BH or weekend and requirement is 5 days)	41
Number of MCCDs rejected by registrar after ME scrutiny	0
Number of cases where urgent release of body is requested and achieved within requested time	25
Number of cases where urgent release of body is requested and NOT achieved within requested time	1
Achieving communication with the bereaved	

Number of deaths in which communication did not take place		19
Reasons for no communication:	Declined	0
	No response	13
	No NOK	4
	Not documented	2
Detection of issues and actions		
ME referred for structured judgement review		38
ME referred to other clinical governance processes		4
ME referred to external organisation		0
Families referred to PALS		5

6.0 RECOMMENDATION

6.1 That the Board note the continued compliance with the Learning from Deaths framework and the key areas of learning and development identified, along with the actions taken to address these.

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APPENDIX A

Learning from Deaths Dashboard

St George's University Hospitals NHS Foundation Trust: Learning from Deaths Dashboard - September 2022-23

Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

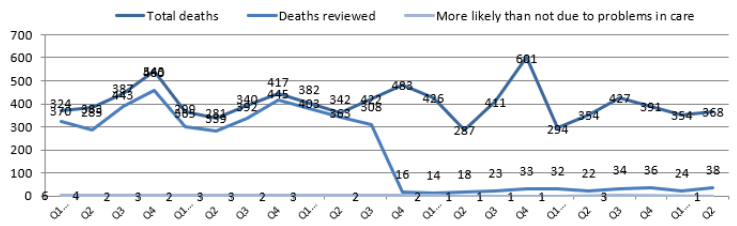
Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths deemed more likely than not due to problems in care (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered more likely than not due to problems in care PRISM Score<=3 or equivalent measure	
This Month	Last Month	This Month	Last Month	This Month	Last Month
119	117	13	4	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
368	354	38	24	1	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
722	1466	62	124	1	4

Time Series: Start date 2017-18 Q1 End date 2022-23 Q2

Mortality over time, total deaths reviewed and deaths considered more likely than not due to problems in care
(Note: Changes in recording or review practice may make comparison over time invalid)



Total Deaths Reviewed, categorised by SJR Avoidability Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	2	16.7%	This Month	2	16.7%	This Month	8	66.7%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	2.7%	This Quarter (QTD)	6	16.2%	This Quarter (QTD)	9	24.3%	This Quarter (QTD	21	56.8%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	1	1.6%	This Year (YTD)	6	9.8%	This Year (YTD)	11	18.0%	This Year (YTD)	43	70.5%

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St George's University Hospitals NHS Foundation Trust: Learning from Deaths Dashboard - September 2022-23

Department of Health & Social Care

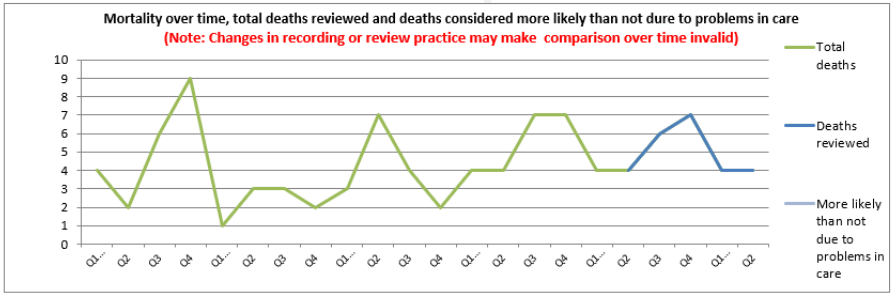
Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology. Please note that all LD deaths are reviewed using our standard approach, pending reviews as directed by the LeDeR process. The outcome of these local reviews is displayed in the second data grouping below.

Total Number of Deaths, Deaths Reviewed and Deaths Deemed more likely than not due to problems in care for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered more likely than not due to problems in care	
This Month	Last Month	This Month	Last Month	This Month	Last Month
2	1				
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
4	4				
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
8	21				

Total Number of Deaths in scope		Total Deaths Reviewed Through the Local Review Methodology		Total Number of deaths considered more likely than not due to problems in care	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	2	1	2	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
4	4	4	4	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
8	22	8	22	0	0

Time Series: Start date 2017-18 Q1 End date 2022-23 Q2



Meeting Title:	**Trust Board**		
Date:	12 January 2023	**Agenda No**	**2.1.2**
Report Title:	**Healthcare Associated Infection (Infection Control) update Report**		
Lead Director/ Manager:	Arlene Wellman, Group Chief Nurse and Director of Infection Prevention and Control		
Report Author:	Prodine Kubalalika, Director of Nursing/ Deputy Director of Infection Prevention and Control (ESTH) Ruth Law, Senior Nurse, Infection Prevention and Control (SGUH) Alison Benincasa, Group Director of Compliance		
Presented for:	Assurance		
Executive Summary:	This paper provides an update of key issues/ concerns arising in Infection Prevention and Control (IPC) at site level up to and including November 2022 as summarised in table 1 below. The paper supplements the IPC key performance measures and summary contained in the Integrated Performance Reports for both Trusts.		

Table 1: IPC issues/ concerns at site

IPC Issue/ Concern	ESTH	SGUH
C. *difficile* infection	Oct: 1 HOHA, 2 COHA Nov: 3 HOHA, 3 COHA **YTD:** 18 HOHA, 8 COHA	Oct: 3 HOHA 0 COHA Nov: 3 HOHA, 1 COHA **YTD:** 36 HOHA, 10 COHA
Covid-19	YTD total cases: 1619 YTD deaths: 191 Total cases Nov: 148 Total deaths Nov: 33 Nosocomial: Nov 40	YTD total cases: 1616 YTD deaths: 125 Total cases Nov: 63 Total deaths Nov: TBC Nosocomial Nov: 0
Mpox (note name change as agreed by WHO)	0 confirmed (2 suspected cases confirmed negative)	0 cases, 0 exposure incidents, 0 contacts
MRSA bacteremia	Zero – YTD = 0	August: 1
Aspergillus	April: 5 cases Aug/ Sept: 3 cases November 2 cases	Zero
Carbapenemase-producing Enterobacterales (CPE)	1 CPE case – no linked cases	CPE ward outbreak – 2 linked cases
Group A Streptococcus (GAS)	Reporting to commence from January 2023	3 cases – maternity (October 2022) 1 case of invasive GAS – day case hand surgery (November 2022)
Flu	Reporting to commence from January 2023	Sep: 9 Oct: 27 Nov: 55

In addition, the following points are drawn to the attention of the Board:

1.0 ESTH

1.1 Aspergillus; close report ESTH: Two cases were identified with aspergillus (one with mixed growth) at the end of August/early September in

ITU 3. An incident meeting chaired by the Group DIPC was held with relevant stakeholders including UKHSA. One patient died, however the clinical team reported that aspergillus was not the cause of death. The second patient recovered well and was discharged home.

A total of 5 cases in both ITU 1 and 3 were identified between April and September 2022. It should be noted that the 3 cases identified in April 2022 were reviewed at the time and all patients had risk factors and were not thought to be associated with the cases identified in August/ September 2022.

The incident review findings were:

- Level of cleaning/dust on the Unit including storage rooms; dedicated staff who manage/clean equipment across the Unit was reinstated
- Ventilation non-compliance. ITU 2 is still being used as a storage room due to poor ventilation. ITU 3 does not meeting the national ventilation requirements, however the air exchanges are higher than those on ITU 2
- Working conditions for staff is very poor particularly during the heat wave when temperatures rose to 36 on the Unit. This led to doors being opened to allow some natural ventilation
- Actions from the April 2022 incident (mainly Estates) have not been addressed

The two cases reported were incidental findings and not deemed to be hospital acquired. The incident has been closed.

1.2 Legionella – 2nd floor Langley wing - Epsom

As part of the capital programme, a major refurbishment is being undertaken to create a 20 bedded ward in the space that was used for medicine clinical admin on the 2nd floor in Langley wing. As the project is nearing completion, water samples were taken for routine testing on two outlets on the new Croft ward where high legionella counts were identified. There were no patients occupying this area.

Immediate actions were taken including:

- twice daily flushing for all water outlets
- resampling of both hot and cold outlets
- point of use filters on all showers and a report/advise from the external authorized engineer for water

2.0 SGUH

2.1 C. difficile infection (CDI)

RCA have been completed for 35 of 46 cases between 01/04/22 and 30/11/22. Two CDI cases were noted to have a lapse in care, which may have potentially been causative of the infection. In both cases the lapse appeared to relate to prescribing antimicrobial therapy to a microbiology result and not necessarily to the clinical picture of the patient. Lapses are subject to further multidisciplinary meeting and the lapse may be challenged by the clinical team if it can be demonstrated the antimicrobial therapy was necessary. MDT meetings for these two cases were carried out on 08/11/2022 and 09/11/2022 but the relevant medical staff did not attend – further information is being sought. Outcomes will be reported to a subsequent Trust Infection Prevention and Control Meeting.

3.0 Staff Vaccination Update

The performance data below has been updated since the last Quality Committee in Common to reflect the staff vaccination position as of 3 January 2023.

3.1 Flu Vaccination: ESTH performance is 54.96% (compared with 53.16% in the December 2022 report) against the 70% CQUIN target and SGUH performance is 47.1% (compared with 43.7% in the December 2022 report) against the 80% CQUIN target.

Table 1 Flu vaccination by staff group

Staff Group	ESTH		SGUH	
Add Prof Scientific and Technic	178	59.55%	727	46.6%
Additional Clinical Services	1337	44.43%	1212	36.6%
Administrative and Clerical	1412	56.66%	1956	38.3%
Allied Health Professionals	549	64.30%	729	53.1%
Estates and Ancillary	485	37.11%	279	40.5%
Healthcare Scientists	70	61.43%	427	34.7%
Medical and Dental	917	65.65%	1524	61.9%
Nursing and Midwifery Registered	1956	57.26%	2934	50.5%
Students	14	28.57%		
TOTAL	**6918**	**54.96%**	**9788**	**47.1%**

Table 2 Flu vaccination by ethnicity (staff)

Staff Group	ESTH		SGUH	
Asian/Asian British	1430	57.41%	2289	48.1%
Black/Black British	842	33.37%	1656	24.0%
Chinese/Other	287	59.23%	594	55.7%
Mixed Race	217	49.77%	444	40.3%
Not Stated	556	40.29%	284	38.0%
White/White British	3586	61.29%	4521	55.1%
TOTAL	**6918**	**54.96%**	**9788**	**47.1%**

3.2 Covid Vaccination: ESTH performance is 43.05% (compared with 43.3% in the December 2022 report) and SGUH performance is 34.0% (compared with 32.1% in the December 2022 report).

Table 3 Covid vaccination by staff group

Staff Group	ESTH		SGUH	
Add Prof Scientific and Technic	178	52.25%	727	37.6%
Additional Clinical Services	1337	31.26%	1212	20.5%
Administrative and Clerical	1412	50.57%	1956	32.8%
Allied Health Professionals	549	52.46%	729	41.8%
Estates and Ancillary	485	27.01%	279	25.4%
Healthcare Scientists	70	48.57%	427	34.7%
Medical and Dental	917	52.78%	1524	46.7%
Nursing and Midwifery Registered	1956	41.56%	2934	31.8%
Students	14	21.43%		
	6918	**43.05%**	**9788**	**34.0%**

	TOTAL | | | | |

Table 4 Covid vaccination by ethnicity (staff)

Staff Group	ESTH		SGUH	
Asian/Asian British	1430	43.08%	2289	32.3%
Black/Black British	842	20.78%	1656	13.4%
Chinese/Other	287	44.25%	594	42.8%
Mixed Race	217	36.41%	444	26.8%
Not Stated	556	32.01%	284	28.5%
White/White British	3586	50.28%	4521	42.4%
TOTAL	**6918**	**43.05%**	**9788**	**34.0%**

Recommendation:

The Board is asked to:

1. Receive for assurance the Healthcare Associated Infection (Infection Control) Report from a site and Group perspective and make any necessary recommendations

2. Note the vaccination position for staff across the Group

Assurance:

The Committee is asked that in considering the contents of this report, and the discussion at the meeting, which of the following assurance rating it would provide to the respective Trust Boards.

- **Substantial Assurance:** The report and discussions assured the group that there are robust systems of internal controls operating effectively to ensure that quality and safety risks are managed to deliver high quality services and care to patients.
- **Reasonable Assurance:** The report and discussions assured the group that the system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that quality and safety risks are managed to deliver high quality services and care to patients.
- **Limited Assurance:** The report and discussions supported the group's conclusion that that the system of internal controls is generally inadequate or not operating effectively and significant improvements were required to ensure that the quality and safety risks are managed effectively to improve the position and ensure that high quality services and care is provided to patients.
- **No Assurance:** The report and discussions led the group to conclude that there was a fundamental breakdown or absence of core internal controls and systems to enable the Trust to deliver high quality services and care to its patients.

Supports

Trust Strategic Objective:	Build a Better St George's Treat the patient, treat the person

CQC Theme:	Safe, Well Led		
Single Oversight Framework Theme:	Quality of Care		
Implications			
Risk:			
Legal/Regulatory:	The Health and Social Care Act (2008): The Hygiene Code - code of practice on the prevention and control of infections. (Updated 2015) https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance Health and Social Care Act 2008) Regulated Activities Regulations 2014: Regulation 12 Safe Care and Treatment		
Resources:	N/A		
Equality and Diversity:	N/A		
Previously Considered by:	Quality Committee in Common	**Date**	15.12.2022
Appendices:	N/A		

Healthcare Associated Infection (Infection Control) Update Report
November 2022

1.0 Group wide initiatives/ developments

This paper provides a monthly update of key issues/ concerns arising in Infection Prevention and Control (IPC) at site level. (A full summary for all activity including for Healthcare Associated Infection is scheduled for Quality Committee (in Common) on a quarterly basis). The paper supplements the IPC key performance measures and summary contained in the Integrated Performance Reports.

1.1 Group Delivery Model: Infection Prevention and Control

Terms of Reference are now in place for the weekly Group Infection Control meeting. The Team is made up of the GCNO & DIPC (Chair) GCMO, Site Chief Medical Officers, Site Chief Nurses, Site lead for Infection Prevention and Control – Nursing and Site lead for Infection Prevention and Control – Medical.

This forum has the authority to make decisions on the application of national IPC guidance and to implement changes as appropriate across the Hospital Group or at site level (ESTH and SGUH) in regard to the application of universal standards for Infection Prevention and Control (IPC).

Members of the Group IPC forum have responsibility for delivery of any changes to IPC practice and to take the required actions through the normal operational management reporting lines.

The Infection Prevention and Control Meeting in Common will be operational from January 2023. It is anticipated that this meeting will be held bi-monthly and will be chaired by the Group Clinical DIPC.

IPC leads continue to work collaboratively across St George's, Epsom and St Helier University Hospitals and Health Group, with all Covid-19 guidance issued from June 2022 onwards having been agreed and published as guidance for the Group. The IPC Leads also continue to be proactive members of the weekly South West London IPC group where all Covid-related issues and other IPC issues are discussed to ensure consistency in guidelines and methods across SWL.

2.0 Epsom and St Helier University Hospitals NHS Trust

2.1 Covid-19 position

The IPC team continues to lead and ensure robust IPC control measures are in place including prompt identification and segregation of suspected cases of Covid-19 and minimising the risk of healthcare acquired Covid-19 infections.

In November 2022, consistent with national community prevalence, we continued to see high numbers of Covid-19 cases admitted into hospital and increased nosocomial infections.

A total of 148 Covid-19 infections were identified in November. Of these, 98 cases were detected within 2 days of admission; 10 cases between 3 and 7 days of admission; 18 cases between 8 and 14 days post admission and 22 cases detected 15 or more days post admission.

- YTD Covid-19 positive cases = 1619
- YTD Covid-19 deaths = 191
- Total Covid-19 positive cases this month= 148
- Total Covid-19 deaths this month = 33
- Nosocomial Covid-19 Infections this month = 40

To align processes across the Group ESTH has now implemented the revised nosocomial process for RCAs. In November two RCAs that met the new criteria were completed; for hospital deaths where the patient has a positive Covid-19 result and where Covid-19 is cited on Part 1a or 1b of the death certificate

(Hospital Onset definite Hospital Acquired (HODHA) cases only) and for case reviews of positive patients in the event of an outbreak.

IPC leads continue to work collaboratively across St George's, Epsom and St Helier University Hospitals and Health Group, with all guidance issued from June 2022 onwards having been agreed and published as guidance for the Group. The IPC Leads continue to be proactive members of the weekly South West London IPC group where all Covid-related issues and other IPC issues are discussed to ensure consistency in guidelines and methods across SWL.

2.1.1 Covid-19 guidance and updates
There was no new national guidance published in November 2022, however we continue to adhere to published guidance and monitor if changes are required to meet our local needs.

The following is a summary of the current Covid-19 guidance used across the Trust:

- All patients with a decision to admit are swabbed in A&E
- Swabbing can be undertaken for patients who develop new onset of symptoms.
- Swabbing is undertaken for patients being discharged to care facilities. (new nosocomial infections are often picked up in this group of patients).
- No swabbing or self-isolation required for elective admissions, no impact on theatre lists/positive cases identified since guidance was introduced in August 2022.
- Weekly testing in renal, ITU and C6 haematology
- All staff wear masks in clinical areas including outpatients. National guidance does not require the public to wear in healthcare settings, however patients/relatives are requested to wear masks in areas with ongoing clusters/outbreaks.
- Staff who test positive are required to self-isolate for 5 days and undertake a lateral flow test on day 5 and 6. Staff can return to work if both tests are negative and if positive isolate for 7 days and come back to work on day 8 from the day of positive result/onset of symptom.

2.1.3 Covid-19 Outbreaks/Clusters
There were 41 Covid-19 clusters in November 2022. Combined, these clusters generated a total of 124 contacts. As per new guidance, screening of Covid contacts was discontinued across the Group and only those who become symptomatic are to be swabbed. However, due to the number of positive cases on some of the wards, screening of contacts was undertaken to inform practice and reduce the risk of onward transmission.

The IPC team continues to monitor and follow up contacts up to day 5 following the exposure date.

2.2 Mpox Virus (MPV) national outbreak
There were no confirmed Mpox cases reported in November 2022. Change of name from monkey pox to Mpox as per World Health Organisation.

2.4 Surgical Site Infections (SSIs)
Due to concerns raised around surgical site infections following bowel surgery, the IPC team will undertake a 3 month surveillance for large bowel surgical patients commencing in January 2023. Results and outcomes will be shared in future reports.

2.5 FFP3 Mask Fit Testing
As of 30 November 2022, 2942 staff across the Trust and community have been fit tested (clinical and non-clinical) and 2900 have passed on currently available masks.

- Staff who have passed on one type/model of FFP3 mask - 1331
- Staff who have passed on two or more types/models of FFP3 masks - 1588
- Percentage of staff passing on 2 or more masks is 54%

Despite efforts from the fit testing team to have accurate data, information on ESR is not always up to date.

Attendance for fit testing continues to be a challenge, the Fit Testing team is actively contacting divisional leads to encourage uptake. The team offers block bookings for areas as requested as well as a daily walk-in service on both sites 5 days per week.

2.6 PPE Audit Compliance
Monthly PPE compliance audits are being undertaken in all clinical areas. A total of 88 inspections over 66 areas yielded a PPE compliance score of 95%. 21 areas have not had an inspection (76% completion compliance).

2.7 Hand Hygiene Compliance
Monthly hand hygiene compliance audits are being undertaken in all clinical areas. A total of 87 inspections over 71 areas yielded a hand hygiene compliance score of 98%. 16 areas have not had an inspection (82% completion compliance).

In cases of outbreaks, bay/ward closure, extra PPE and Hand Hygiene audits are undertaken by the ward staff and spot checks by the IPC team.

Due to the regular feedback received about the poor compliance with hand hygiene/bare below the elbows amongst medical staff, the site chief medical officer was informed and asked to help to raise awareness.

2.8 MRSA Bloodstream Infections
There were no Trust attributed MRSA bloodstream infections in October 2022. YTD = 0

***2.9 C diff* Infections**
In November there were 6 Trust attributed C diff cases, (3 Healthcare Onset Healthcare Associated and 3 Community Onset Healthcare Associated). The IPC team have collaborated with clinical staff to complete and review RCAs within 5 days of result. On review of the cases, there were no lapses in care identified with all cases. YTD C diff cases = 27.

Table 1: *C diff* Trust Acquired Cases 2022/3

C difficile	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Lapse in Care
Cumulative Internal Trajectory	7	11	15	18	21	23	27	31	36	40	45	50	3
HOHA	0	3	2	5	1	4	1	3					
COHA	1	0	1	1	0	0	2	3					
Total Trust C diff cases YTD	**1**	**1**	**7**	**13**	**14**	**18**	**21**	**27**					

Table 2: Healthcare Associated Infections – Surrey Downs Inpatient Wards 2022/3

HCAI	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
MRSA Bloodstream Infection*	0	0	0	0	0	0	0	0				
C difficile*	0	0	0	0	1	0	0	0				
Hospital Acquired Covid-19	0	0	1	9	1	0	7	1				

2.10 Carbapenemase-producing Enterobacterales (CPE)

There was 1 CPE case identified in November 2022 from a rectal screen collected for a known previous CPE patient that was being admitted onto the renal ward. On admission this patient was isolated in a single room. There were no contacts assigned to this case.

2.11 Aspergillus

There were two cases of aspergillus identified in children with cystic fibrosis who had been admitted to Ebbisham children's ward. The first case was from an induced sputum sample that grew aspergillus niger and the second case was a standard cough swab done in April 2022 that grew aspergillus fumigatus. Although they were different species of Aspergillus, therefore no cross transmission, in conjunction with the clinical staff, the IPC team investigated to check if there was a potential environmental link to the cases.

As part of the review of the clinical procedures (induction of sputum in cystic fibrosis patients) and the environment, there were no major issues identified, however the following were the recommendations from IPC:

- Repair windows in rooms used for this procedure to enable the windows to open without need for a wedge and allow natural ventilation
- Clean all vents/grills on the ward and including the toilets
- equipment cleaning logs to be kept by staff to evidence cleaning

2.12 Legionella – 2nd floor Langley wing - Epsom

As part of the capital programme, a major refurbishment is being undertaken to create a 20 bedded ward in the space that was used for medicine clinical admin on the 2nd floor in Langley wing. As the project is nearing completion, water samples were taken for routine testing on two outlets on the new Croft ward with high legionella counts. Immediate actions were taken including twice daily flushing for all water outlets, resampling of both hot and cold outlets, point of use filters on all showers and a report/advise from the external authorized engineer for water.
It should be noted that at the time of these findings there were no patients in this area.

2.13 Delivery Suite Operating Theatre, Epsom General Hospital

During routine servicing of the Air Handling Unit (AHU) in delivery suite theatre in Epsom it was highlighted that the unit was dust covered and was growing mould. The theatre was temporarily shut down, whilst the AHU was cleaned and the filters changed.

On investigation, the Estates team have reported that there are some issues with humidity within the AHU which would require shutdown of the theatre to allow further investigation. The Estates team are liaising with the maternity clinical and operational teams to identify suitable dates to have this work undertaken.

2.14 Mandatory infection control training

Table 3 below shows mandatory infection control training compliance per Division as of 30 November 2022. IPC team have arranged local bespoke training for different specialities with the aim of improving uptake. Assigned training requirements are being reviewed for some directorates listed below with poor compliance.

Table 3: Mandatory Infection Control Training – November 2022

DIRECTORATE	NHS|CSTF| Infection Prevention and Control Level 1 Non-clinical	NHS|CSTF| Infection Prevention and Control Level 2 Clinical
343 3 Board	62%	n/a
343 3 Chief Nurse	82%	74%
343 3 Clinical Operations	83%	42%
343 3 Clinical Services	84%	70%
343 3 Communications & PR	78%	100%
343 3 Corporate Affairs	88%	n/a
343 3 Digital Services	88%	n/a

343 3 EOC	85%	91%
343 3 EOC - Consultant	n/a	56%
343 3 EOC - Perioperative Care	97%	88%
343 3 EOC - Theatres	80%	93%
343 3 Estates & Facilities	87%	n/a
343 3 Finance	92%	n/a
343 3 Human Resources	76%	100%
343 3 Integrated Care Services	67%	94%
343 3 Medical Director	95%	50%
343 3 Medicine	83%	76%
343 3 Planned Care	87%	79%
343 3 Private Patients	89%	89%
343 3 Renal Services	70%	79%
343 3 Surrey Downs Health & Care	88%	86%
343 3 Sutton Health & Care	93%	81%
343 3 Transformation Director	89%	n/a
343 3 Women & Children's Services	86%	68%
Total Compliance	**88%**	**77%**

85%-100%
60%-84%
0-59%

2.15 ESTH IPC Activity Summary

- Trust MRSA bloodstream infections in November, 0. YTD = 0
- C diff in November = 3 HOHA, 3 COHA. YTD 27
- There were 148 Covid-19 infections detected in November and 40 nosocomial infections.
- New Covid RCA process has been implemented.
- There were 41 Covid-19 clusters which generated 124 contacts.
- As of 31st October, 2928 staff have passed fit testing, 1401 on one type/model of FFP3 mask and 1517 on two or more types.
- Mandatory infection control training compliance overall improved to 77% for clinical staff groups and 88% for non-clinical groups. Divisional Leads are responsible for monitoring training compliance.
- Two cases of aspergillus (different species) identified on Ebbisham ward. No further investigations were required.
- In light of the Ebola virus outbreak in Uganda, the IPC team reviewed the pathway to be used for suspected imported cases. On reviewing the identified pathway, (currently used for Mpox cases) it was agreed that this would not be suitable for a high consequence infectious disease such as Ebola. Following extensive discussions with ED clinical leads and Emergency Preparedness team, it was agreed that the safest option which would cause minimal disruption to the department would be to purchase one tent for each site similar to those used for CBRN.

2.16 Surrey Downs and Sutton Health & Care

- There were no Trust apportioned C diff cases reported in Alexandra Frailty ward. Community hospitals do not have nationally set objectives for MRSA or C diff .
- Surrey Downs hand hygiene audits compliance was 100% (12 of 12 service areas submitted).
- Sutton Health & Care hand hygiene audits compliance reported as 100% (18 of 18 service areas submitted).

- Mandatory infection control training compliance for Surrey Downs Health & Care was 86% for clinical and 88% for non-clinical staff.
- Mandatory infection control training compliance for Sutton Health & Care was 81% for clinical and 93% for non-clinical staff.

3.0 St George's University Hospitals NHS Foundation Trust

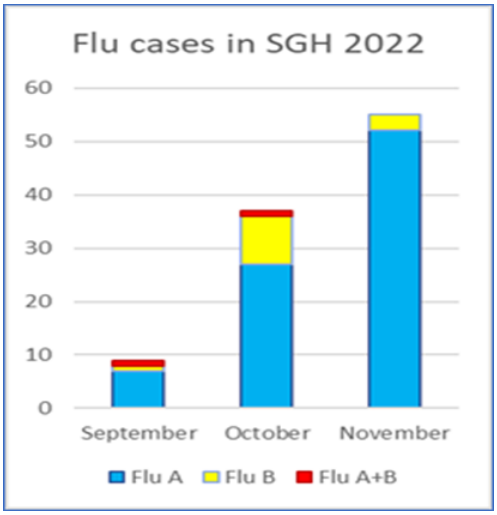
3.1 Influenza

The Trust is seeing rising influenza cases, primarily (if not entirely) composed of point-of-care tests for admitted patients. Cases rose again in November 2022 (Figure 1 and table 4) reflecting community prevalence. Influenza A is the predominant strain. There has been an increasing number of bay closures due to single cases and there have been two outbreaks in November 2022. The influenza guidance is under review but in the interim, patient isolation for positive cases has been reduced from 7 days to 5 unless immune-suppressed. Consideration is being given to the best way to manage increasing cases of influenza in the trust either by creating a flu ward or flu bays on wards.

Long-stay vulnerable patients should be offered the flu vaccine, prescribed by medical staff; further work is required to ensure that this embedded in the organisation, as the number of patients who have been vaccinated to-date is low.

Options for symptomatic staff testing by PCR are also being considered currently.

Figure 1 and Table 4 Influenza Incidence 2022



	Flu Incidence (2022)		
	September	October	November
Flu A	7	27	52
Flu B	1	9	3
Flu A & B	1	1	0
Total	**9**	**37**	**55**

3.2 Covid-19 position (data as of 05/12/22)
Covid cases are continuing to reduce in the Trust, which broadly reflects the national situation (see figure 2 overleaf) There are currently 47 Covid-19 cases, including recovered patients in the Trust. In November 2022, there were 4 ongoing outbreaks which commenced in October 2022, and 2 new outbreaks which commenced in November 2022. The outbreak on Cavell ward saw 16 Covid-19 cases (6 HOHA, 5 HOPA and 5 HOIA). This has resulted in bay closures. 63 Patients had a new Covid diagnosis in November 2022, Deaths for November 2022 is to be confirmed, however there were no covid related deaths from outbreaks in November 2022.

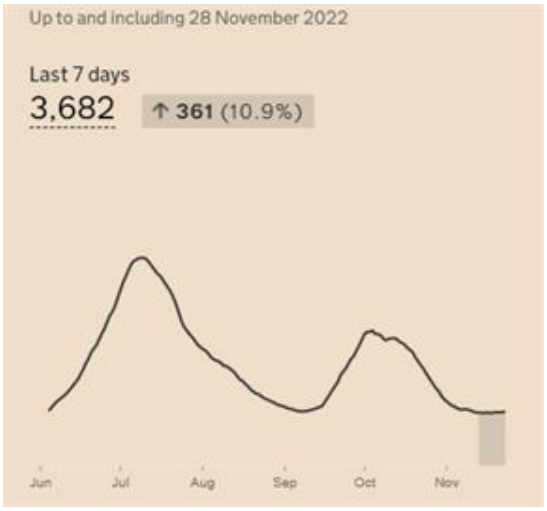


Figure 2 Patients admitted with Covid-19 in England

3.2.2 Covid-19 Key Issues

Hepa Filters: As agreed at the Group IPC meeting 26/10/2022 the Trust is conducting a trial of Hepa Filters on Rodney Smith medical ward to assess if (a) they are acceptable (noise and space) and (b) if it is possible to demonstrate a lower incidence of nosocomial Covid-19. The outcome of the trial will be included in future reports.

3.3 MRSA Bacteraemia

There were no MRSA BSI cases in November 2022, 1 case YTD on 19 August 2022.

3.4 Mandatory Reporting - *C. difficile* Infection (CDI)

There has been a total of 46 cases of *Clostridioides difficile* between April and November 2022. There is a NHSE trajectory of no more than 43 cases for 2022-23. This equates to no more than 3.5 cases per month or no more than 28 cases at end of November 2022. This means that the Trust has missed the trajectory for 43 cases. The 46 cases between April and November 2022 consist of 36 HOHA cases and 10 COHA cases. There were 4 *C. difficile* infections during November 2022; 3 were classified as Hospital Onset Healthcare Associated (HOHA) and 1 was classified as Community Onset Healthcare Associated (COHA).

The CDI cases have been predominantly in Medcard Division, 27 cases. There were 11 cases in the Division of Surgery and 8 cases in Children & Women's Division. CDI cases have occurred in 24 different locations across the Trust, many being sporadic by location. There have been no periods of increased incidence (PII) or CDI outbreaks in November 2022. The CDI rate per thousand bed days for the Trust is in line with comparable organisations (see figure 3 below.)

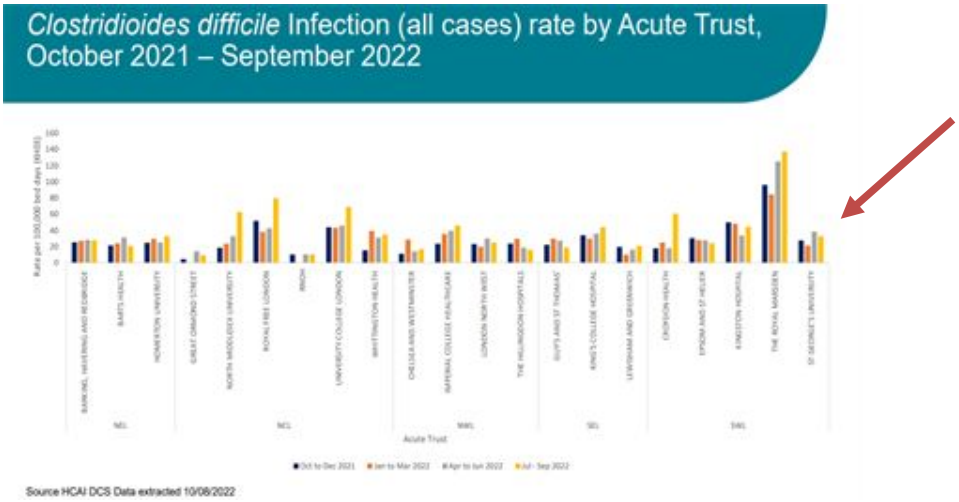


Figure 3 CDI rate by acute Trust per thousand bed days Oct. 2021 – Sept. 2022

It should be noted that thresholds were set based on historical figures for each healthcare organisation rather than the numbers of beds or complexity of the patients. It is possible that the Trust has a challenging CDI trajectory because the Trust made strenuous efforts to control the infection in the years leading up to the trajectory being set, so the baseline was already low, (see figure 4).

In addition,

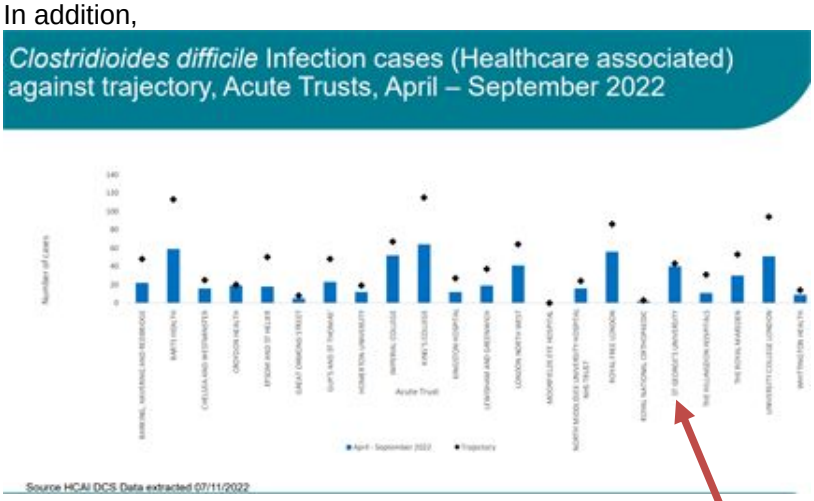


Figure 4 CDI Acute Trusts Apr-Sept. 2022 against trajectory.

3.4.1 RCA Case Reviews and Lapse in Care

As per CDI standard operating procedure (SOP), cases of *Clostridioides difficile* meeting the criteria for external reporting are subject to a root cause analysis (RCA). All isolates of *C difficile* are also sent for ribotyping to look for any evidence of cross-infection and outbreaks. Following an RCA review, feedback is given to the relevant Division and the outcomes of RCA are noted at the Trust Infection Prevention Control Meeting.

The CDI RCA process is currently under review as it is not effective in providing useful information. It can take time to identify the responsible consultant and to get the responsible consultant and pharmacy to complete the relevant parts of the RCA form, despite a requirement to return the RCA within 5 working days of receipt. The forms for HOHA and COHA cases request a lot of information and detail but do not necessarily give a narrative and overview of clinical events, ward movements and antibiotics.

A draft RCA tool has been devised to be much shorter and simpler, so that it can be completed in as near to real-time as possible, hopefully involving less work overall but still providing more useful information in a timely fashion. This draft is now being piloted. A microbiology registrar will now also attend the ward with an IPCN as soon as a CDI case is diagnosed. This is to assess the patient, the general IPC situation and for the micro registrar to discuss with the duty consultant. Once microbiology comments on antibiotic use have been made, they can be sent to the patient's team for their response.

35 of 46 cases between 01/04/22 and 30/11/22 have been reviewed following RCA return. The return of fully completed RCAs is awaited for 7 cases, although reminders have been sent to the clinical divisions. divisional Each case is reviewed to ascertain if there were any causative lapses in care e.g., inappropriate antimicrobial prescribing or serious lapses in environmental or medical devices cleaning which may have led to the acquisition of the case. However, most cases are likely to be attributable to the administration of appropriate antibiotics to patients with infections which were not preventable, and potentially life threatening if not treated with antibiotics.

Lapses in Care - Two CDI cases were noted to have a lapse in care, which may have potentially been causative of the infection. In both cases the lapse appeared to relate to prescribing antimicrobial therapy to a microbiology result and not necessarily to the clinical picture of the patient. Lapses are subject to further multidisciplinary meeting and the lapse may be challenged by the clinical team if it can be demonstrated the antimicrobial therapy was necessary. MDT meetings for these two cases were carried out on 08/11/2022 and 09/11/2022 but the relevant medical staff did not attend – further information is being sought.
Outcomes will be reported to a subsequent Trust Infection Prevention and Control Meeting.

3.5 *E. Coli* Bacteraemia

There were 5 cases of *E. coli* bacteraemia during November 2022, all 5 were classified as Community Onset Healthcare Associated (COHA), where the specimen was taken within admission day plus one day (and where the patient had also been an inpatient in the previous 4 weeks).

There is a NHSE trajectory of no more than 93 cases for 2022-23 or no more than 7.75 per month and no more than 62 at end of November 2022. There have been 66 cases between April and November 2022. The Trust is therefore over this trajectory.

There is a National piece of work relating to E. coli and our urology team in the Trust and GP teams in the community are participating with this. No further details are available at the moment, however internally we have a focus on E.coli as part of our back to the floor in January 2023.

3.6 Other mandatory Reporting

Klebsiella spp. and *Pseudomonas aeruginosa* bacteraemia remain within NHSI/E set trajectories.

3.7 IPC Mandatory Training performance (SGUH)

Infection Prevention and Control MAST data (as of 5 December 2022) by Division.

Table 7: MAST IPC compliance by Division

Division	Compliance
Children &Women's, Diagnostic and Therapy Services Division	**89%**
Medicine and Cardiovascular Division	**86%**
Surgery and Neurosciences Division	**88%**

3.8 Carbapenemase Producing Enterobacteriaceae (CPE) Outbreak - Brodie Ward

There was a CPE (*Enterobacter cloacae* NDM) outbreak on Brodie ward involving 2 patients, who overlapped in time during September and October 2022. The patients have been transferred to other healthcare facilities and are aware of the results. The patients do not appear to have come to any harm. One patient was not found to be positive until they were screened shortly after transfer from SGH.

The two cases were in different bays but in adjacent side-rooms while on Brodie ward. There is no obvious point where transfer was most likely to happen but transfer from the index case to the second case is a possibility as they were cared for by the same nursing staff.

A further case was identified with *Enterobacter cloacae* NDM gene from a urine specimen on 10/11/22 giving a total of 3 cases. The 3rd case was a long-stay patient, who was in the same bay as case 1. This patient also grew a Klebsiella NDM from urine.

All three patients have grown the same organism and same gene – *Enterobacter cloacae* MDM gene
The isolates from case 1 and case 3 have been sent for typing; case 2 was isolated at another hospital; we have requested that the typing result is sent to us and are awaiting results.

3.8.1 Outbreak meetings
Outbreak meetings have been held on 2/11, 9/11, 14/11, 21/11, next outbreak meeting due on 7/12

3.8.2 Patient Screening
A look-back exercise was conducted and 71 direct and indirect contacts were identified; 32 inpatients were screened by rectal swab and all were negative for *Enterobacter cloacae* NDM. Other organisations were informed of the index case for any contact patients transferred to them from SGH.

As per policy, all patients on Brodie ward are being screened twice weekly for two weeks, then weekly for another two weeks, in case there is a common source on the ward. If there are further cases environmental screening may be undertaken. Three contacts who are now on other wards will not be included in the extended screen as they are no longer exposed to a potential common source.

The second positive patient who had been in hospital elsewhere in the past 12 months should have had a rectal screen on admission but this was overlooked by the ward who were not aware of the policy, reflecting recent CPE audit results. Patients should be screened (rectal swab). More work is to be undertaken to communicate the policy.

CPE screening was commenced for contact patients to case 3 including urine screening for any patient on the ward with a urinary catheter.

3.8.3 Environmental screening was not undertaken initially as no plumbing issues were identified but after case 3 was confirmed environmental screening was completed. 31 areas screened – most reported negative; 1 screen, *Enterobacter* identified from SR1 clinical handwash basin (CHWB) but this was not cloacae and not NDM. CHWB at the nurses' station grew Klebsiella – awaiting sensitivity results to see if NDM

3.8.4 Urinary Catheter Care
Reviewed but no concerns, although some gaps in documentation.

3.8.5 Cleaning and Decontamination
Relevant bays and side-rooms have been double deep-cleaned. PISA results have improved since week 1, when there were issues with cleaning of equipment and commodes. PISA to continue until the ward has had 3 consecutive passes. Environmental cleaning is good, chlor-clean being used, including high touch points.

3.8.6 Bay Closure
The bay where case 3 was identified, was closed on 10/11/22 and case 3 moved to a side-room. Bay is now open and contacts moved side-rooms

3.9 Invasive Group A Streptococcus (iGAS)
The UKHSA is reporting increasing cases of invasive group A streptococcus (iGAS). The Trust has had two serious iGAS infection incidents recently, with a cluster in maternity. Updated summary guidance has been written and is to be published on the intranet.

3.9.1 Incident 1

A 41-year-old male patient was identified with an invasive Streptococcus pyogenes/group A Strep necrotising fasciitis of the back of the right hand. The patient presented and was subsequently admitted to Chelsea and Westminster (C&W) hospital on 09/11 with a serious hand infection at the site of an excision of a basal cell carcinoma carried out in at the surgical treatment centre, Queen Mary's hospital (QMH) the previous day, 08/11. The patient and close contacts/family members had no symptoms of group A Strep prior to attending hospital. He has had surgery to debride the hand and is currently making a recovery.

The initial surgery was described as routine and uneventful; the patient appeared well pre-operatively. The excised area was cleaned with chlorhexidine before closure; it is not usual to give antibiotic prophylaxis for this operation. Despite the very short interval, acquisition/inoculation around the time of surgery is the most likely portal of entry. The source could be the patient himself, or one of the operative team. The patient did not appear to have a throat swab sent at the time of presentation to C&W (which might have clarified if he was a carrier of the organism himself. Such unfortunate incidents as this are well described, though rare, and do not imply any negligence on the part of the surgical/theatre team.

An incident meeting was held on 16 November to discuss the case and to manage the hospital infection control aspects of the incident, the main concern being the possibility of inadvertent spread from a colonised staff member, which might pose an ongoing risk to other patients.

Actions

- Screened theatre team on the day – 8 staff identified and had bacterial throat swabs.
- Exposed staff questioned about symptoms. One staff member reported a sore throat on the 5th November but significant improvement by 8th. The same staff members also advised to be vigilant for any symptoms of Group A Strep infection in the coming weeks.
- Identified other patients on the same list – four such patients. They are all being followed up closely with GP checks of the wound at 1 week, and later reviews by the surgical team.
- Deep cleaning of the theatre area
- Requested C&W colleagues to ensure the organism is sent to the reference lab for typing.

Outcome

No cases identified from staff screening to-date. No further incident meetings planned.

3.9.2 Incident 2

Three cases of group A streptococcus in maternity. Due to the high number of cases identified in the community at present it is possible that the infections were not acquired in SGUH

- **Case 1:** iGAS in blood cultures 30/10/22, post-delivery at SGH on 26/10/22; Gwillim ward same day, later admitted to Croydon hospital (30/10/22) with 2-day history of fever, rigors, headache, nausea. Baby developed severe iGAS infection 23/11/22.
- **Case 2:** HVS positive on 30/10/22. Delivery at SGH on 24/10/22, 2nd degree tear, sutured. Went to Gwillim ward, discharged 25/10/22 and re-admitted 30/10/22 with fever requiring 3/7 IV antibiotics.
- **Case 3:** Wound swab positive 27/11/22. Caesarean section in SGH theatres on 16/11/22. Went to Gwillim ward for 24 hours before being discharged home. 26/11/22 presented to ED with 3-day history gradual onset lower abdomen pain/pain around incision site, radiating into right groin. Afebrile.

Actions

- Isolates sent for typing
- 20 staff to be screened by throat swab for GAS.
- Any staff members with active/ongoing symptoms, to be referred to OH
- Delivery suite to continue to monitor any re-admissions and send HVS, swab any wounds, as appropriate
- Community records to be reviewed to identify any contact with GAS of these cases in the community

Outcome: Staff screening in progress. No staff cases identified to-date.

Meeting Title:	**Trust Board**		
Date:	12 January 2023	**Agenda No**	**2.2**
Report Title:	**Maternity Services Report** • Gap analysis: The Kirkup Report – Reading the Signals October 2022 • Perinatal Quality Surveillance Measures for November 2022 • CNST Compliance (Clinical Negligence Scheme for Trusts) • ESTH Perinatal Mortality Review Tool (PMRT) Summary Report • SGUH PMRT Summary report		
Lead Director/ Manager:	Arlene Wellman, Group Chief Nurse and Director of Infection Prevention and Control		
Report Author:	Laura Rowe, Lead Midwife for Clinical Governance and Risk, Epsom and St Helier University Hospitals NHS Trust (ESTH) Jan Bradley, Director of Midwifery and Gynaecology Nursing, St George's University Hospitals NHS Trust (SGUH) Alison Benincasa, Group Director of Quality Governance and Compliance		
Presented for:	Assurance		
Executive Summary:	**1.0 Purpose** This report provides: **1.1 A high-level gap analysis on the position for each Trust with reference to the findings of the Kirkup report: Reading the Signals, published in October 2022** (Appendix 1) which set out the findings of an investigation at East Kent Hospitals University NHS Foundation Trust with reference to the outcomes for 202 mothers and families who received care between 2009 and 2020. In addition to the suggested improvement actions outlined in the report for implementation across the Group, the Quality Committee in Common has recommended an external review of the culture in Maternity Services at each Trust to gain a better understanding of cultural issues and to identify any improvement actions required. **1.2 Assurance on the compliance at ESTH and SGUH with Safety Action 9 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS):** the requirement for Trusts to complete the Perinatal Quality Surveillance Report and present this to the Board (Appendix 2) Table 1 below details the CNST MIS reporting measures for ESTH and SGUH and provides a comparison, where appropriate, on the quantitative data provided for Safety Action 9 for both Trusts.		

Safety Action 9 reporting measure (Quantitative information only)	ESTH	SGUH
1.Perinatal Mortality: Total number of deaths (year)	11	73
2. Perinatal Mortality reviews held	1	1
3. Cases referred to HSIB for review	3 open cases 1 closed	4 open cases 0 closed
4. Incidents graded at moderate harm and above	1	4
5. Serious incidents completed	1	1
6. Overdue serious incident report actions	0	0
7.Mandatory training compliance	Performance across staff groups from 41% to 79%	Performance across staff groups from 79.3% to 95.65%
8. Minimum safe staffing	91%	82%
9. Service user feedback	N/A	N/A
10.Staff feedback to maternity safety champions	N/A	N/A

The findings of MBBRACE-UK 2020 indicate that the 2020 stillbirth rate and the neonatal death at SGUH has changed since the last published figures and is now in the category of 'more than 5% higher than average for type of hospital'. The SGUH team will continue to review all stillbirths and neonatal deaths and report all findings via the peri-natal mortality tool. The Quality Committee in Common has requested further assurance on these findings in the form of an external review. The outcome will be received in quarter 4 2022-23.

1.3 The CNST Maternity Incentive Scheme Safety Actions assessment of compliance for each Trust (Appendix 3)

[**Note:** This section of the paper has been updated since it was received at Quality Committee in Common on 15 December 2022 and demonstrates an improved position at both Trusts to that reported to Committee. Although further improvement is expected in terms of individual safety elements for both Trusts, the overall compliance position for submission in February 2023 is as stated below].

Maternity Services and the Trust have to demonstrate and be able to evidence compliance for every aspect of each separate safety action as outlined in Table 2 below. If this is not possible, compliance cannot be submitted.

ESTH and SGUH will be reporting non-compliance with CNST as outlined in Table 2 below which provides a high-level assessment of the safety actions where the Trusts are non-compliant; the reasons why are outlined in Appendix 3.

Due to the timing of Trust Board and the CNST submission date it is requested that the sign off for the ESTH and SGUH CNST submissions is delegated to the Quality Committee in Common at its meeting on 19 January 2023.

Table 2: High level Assessment of CNST Compliance

CNST Safety Actions MIS	ESTH: assessment of compliance	SGUH: assessment of compliance
Safety Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	On track	On track
Safety Action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	On track	Compliant
Safety Action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal (ATAIN) units programme?	Non-compliant	Potentially non-compliant – business case for neonatal nursing not accepted
Safety Action 4: Can you demonstrate and effective system of clinical workforce planning to the required standard?	Compliant	On track
Safety Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Non-Compliant	Non-Compliant:
Safety Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?	Non-compliant .	Compliant
Safety Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?	Compliant	Compliant
Safety Action 8: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?	Non-compliant	Potentially non-compliant – change in denominators in Q3 and staffing challenges
Safety Action 9:	On track	On track

Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?		
Safety Action 10. Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022?	Compliant	Compliant

1.3.1 CNST Compliance Year 5 – 2023/34

To support the achievement of compliance for all 10 safety actions in MIS year 5 (next year) the assigned clinical leads for each Safety Action will attend the CNST update meetings throughout the year. The Safety Action lead will closely monitor the requirements of the Technical Guidance and provide monthly compliance reports via Maternity, Divisional and Trust Governance pathways.

For MIS Year 5, the recommendation will be progressed for the Group to have an identified project manager to support the demands of national compliance for a minimum of 0.6 WTE. The Group CNST project manager will oversee site CNST compliance with oversight from the Midwifery and Site leadership teams. The Group CNST project manager will also serve to protect current management workload and responsibilities such as governance and risk/engagement with LMNS.

1.4 Perinatal Mortality Review Tool Summary Report: for Board oversight

1.4.1 ESTH PMRT Summary report, Appendix 4

In two cases the panel reviewed care issues which they considered may have made a difference to the outcome for the baby. The themes that arose for the two cases were:

- At first presentation with reduced fetal movements the mother was not appropriately risk assessed and management was not in line with national guidance
- The baby was small for gestational age at birth and had been identified as IUGR (intrauterine growth retardation) prenatally and the management was not appropriate
- The baby was small for gestational age at birth, scans were indicated but had not been performed
- The mother missed some antenatal appointments but was not followed-up according to the local DNA policy

The themes that arose for the one of the two cases were:

- A CTG was performed during established labour, but the technical quality was poor
- During the first 24 hours of the baby's arrival on the neonatal unit appropriate lines were placed but their position was not radiologically confirmed

	• Estimated fetal weights from scans had not been plotted on a chart **1.4.2 SGUH PMRT Summary report, Appendix 5** In one case the panel reviewed care issues which they considered may have made a difference to the outcome for the baby. The themes that arose were: • The consent process for interstitial laser therapy is not sufficiently detailed or clear and Fetal Medicine Unit should inform delivery suite if they are undertaking this procedure and should ensure the patient has had the required blood tests and samples taken should they require an emergency delivery • Patients should be transferred to delivery suite on a trolley in emergency situations • Communication issues between two Trusts The panel reviewed one case where the care provided may have made a difference to the outcome of the mother • The mother was not screened antenatally for aspirin prophylaxis For both Trusts appropriate safety improvement actions were identified by the panel and implemented as outlined in the PMRT summary reports.
Recommendation:	The Board is asked to: 1. Note the report and make suggestions for any further action 2. Note that Quality Committee in Common has requested further assurance on the MBRRACE-UK 2020 findings in the form of an external review which will be received in quarter 4 2022-23 3. Delegate the sign-off of ESTH and SGUH CNST submissions to the Quality Committee in Common, due to the timing of Trust Board and the CNST submission date
Committee Assurance:	The Committee is also asked that in considering contents of this report, its supporting documents and the discussion at the meeting which of the following assurance rating it would provide to the Trust Boards. • **Substantial Assurance:** The report and discussions assured the Committee that there are robust systems of internal controls operating effectively to ensure that quality and safety risks are managed to deliver high quality services and care to patients. • **Reasonable Assurance:** The report and discussions assured the Committee that the system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that quality and safety risks are managed to deliver high quality services and care to patients. • **Limited Assurance:** The report and discussions supported the Committee's conclusion that that the system of internal controls is generally inadequate or not operating effectively and significant improvements were required to ensure that the quality and safety risks are managed effectively

	to improve the position and ensure that high quality services and care is provided to patients. • **No Assurance:** The report and discussions led the Committee to conclude that there was a fundamental breakdown or absence of core internal controls and systems to enable the Trust to deliver high quality services and care to its patients.
Supports	
Trust Strategic Objective:	All
CQC Theme:	All
Single Oversight Framework Theme:	Leadership and Improvement Capability (Well-led)
Implications	
Risk:	None
Legal/Regulatory:	Enforcement undertakings applicable to ESTH and SGH Compliance with the Health and Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations
Resources:	N/A
Equality and Diversity:	No issues to consider
Previously Considered by:	Quality Committee in Common **Date** 15.12.2022
Appendices:	Appendix 1: Kirkup Report October 2022: gap analysis Appendix 2: Safety Action 9: Maternity Services Perinatal Quality Surveillance Measures August 2022 for ESTH and SGUH Appendix 3: CNST compliance (Year 4) Appendix 4: ESTH Perinatal Mortality summary report Appendix 5: SGUH Perinatal Mortality summary report

gesh

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

Appendix 1

Kirkup Report October 2022: Reading the Signals

Summary position and Gap Analysis

Arlene Wellman, Group Chief Nursing Officer and Director of infection Prevention and Control

Trust Board, January 2023

High level findings: Kirkup Report October 2022
Maternity Services East Kent

- The Kirkup Report was published in October 2022 set out the findings of the investigation of maternity services at East Kent Hospitals University NHS Foundation Trust and the outcomes for 202 mothers and families who received maternity care at the Trust between 2009-2020. It describes how those responsible for the provision of maternity services failed to ensure the safety of women and babies, leading to repeated suboptimal care and poor outcomes

- The report highlights:
    - an unacceptable lack of compassion and kindness, impacting heavily on women and families both as part of their initial care and then afterwards; when the women and their families sought answers to understand what had gone wrong
    - flawed team-working among and between midwifery and medical staff, failures of professionalism and compassion and failures to listen
    - an organisational response characterised by internal and external denial and a failure to recognise and acknowledge the scale and nature of the problem with many missed opportunities to investigate and correct devastating failings

- The report identifies that had care been given to the nationally recognised standards, the outcome could have been different in 97 (**48%)** of the 202 cases assessed and in 45 of the 65 baby deaths (**69%** of these cases).

How to deliver outstanding care.

Four broad areas for action and associated recommendations

Key Action Areas	Associated Recommendations
1. Monitoring safety performance – finding signals among noise	1. The prompt establishment of a Task Force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers, for mandatory national use
2. Standards of clinical behaviour – technical care is not enough	2.1 Those responsible for undergraduate, postgraduate and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained through lifelong learning
	2.2 Relevant bodies, including Royal Colleges, professional regulators and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance
3. Flawed team working – pulling in different directions	3.1 Relevant bodies, including the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Paediatrics and Child Health, be charged with reporting on how teamworking in maternity and neonatal care can be improved, with particular reference to establishing common purpose, objectives and training from the outset
	3.2 Relevant bodies, including Health Education England, Royal Colleges and employers, be commissioned to report on the employment and training of junior doctors to improve support, teamworking and development
4. Organisational behaviour – looking good while doing badly	4.1 The Government reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies
	4.2 Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards
	4.3 NHSE reconsider its approach to poorly performing trusts, with particular reference to leadership
Recommendation for East Kent Hospitals University NHS Foundation Trust: The Trust accept the reality of these findings; acknowledge in full the unnecessary harm that has been caused; and embark on a restorative process addressing the problems identified, in partnership with families, publicly and with external input	

How to deliver outstanding care.

Key Action Area
ESTH and SGUH collective/ comparative summary position and suggested Group Improvement Action

	ESTH	SGUH	Group Improvement Action
1. Monitoring safety performance – finding signals among noise	1.1 . From a monitoring and reporting perspective both Trusts have identified a need for national initiatives to focus on patient outcomes rather than an emphasis on statistics through agreed KPIs in the form of local and national maternity dashboards and Integrated Quality and Performance report		1.1.1 To continue to focus on reviewing both good and poor outcomes irrespective of statistics which may benchmark favourably. Draw out themes for learning within the narrative described in the Quality Surveillance report to include case examples and to be presented alongside the IQPR and KPI dashboards
			1.1.2 To continue to work across the Group, with SW and Regional colleagues in London exploring all data sets to understand how well the service is performing with reference to patient outcomes. Retain incidences of avoidable harm for mother and baby and Hypoxic-ischaemic Encephalopathy (HIE) rates
	1.2 All maternity cases reported on datix as moderate and/or serious harm are discussed at the relevant serious incident escalation meetings and declared as serious incident together with referral to HSIB where indicated		1.2.1 With PSIRF implementation to continue to ensure that associated Improvement Action plans are visible and accessible and that there is strong engagement with families
	1.3 The perinatal mortality tool is consistently used by the multidisciplinary team and findings reported appropriately		

Key Action Area
ESTH and SGUH collective/ comparative summary position and suggested Group Improvement Action

	ESTH	SGUH	Group Improvement Action
2. Standards of clinical behaviour - technical care is not enough	2.1 A failure to listen to women has been a contributary factor in some investigations and complaints		2.1.1 Ensure the positive initiatives identified for ESTH are rolled out across the Group as appropriate (Call a midwife advice line, electronic notes with evidence-based information leaflets embedded, access to Maternity Voices Partnership, appointment of a Service Improvement and Transformation Lead Midwife)
		2.2 Issues with unprofessional conduct between colleagues, some historic in nature, have been raised and supported improvement work is currently underway	2.2.1 ESTH has recently drafted a new escalation policy based on the pan London Escalation guidance. To review the policy to support its adoption across the Group. Consider reporting audit of attendance at designated obstetric emergencies in KPI dashboard
			2.2.2 Consider if improvement work currently underway at SGUH can be included in the service objectives for ESTH
	2.3 There are no reports of disagreements between the medical and midwifery team with reference to care plans or decision making		
	2.4 There is a lack of development programme for new Band 7 co-ordinators which has led to an over-reliance on contact with the Manager On Call for issues which could be resolved locally	2.4 On-going challenges with staffing have had a negative impact on staff morale particularly with reference to the band 7 shift coordinators. This role is supernumerary and provides enhanced surveillance of any issues which could impact on patient safety but this protected characteristic has been vulnerable due to staffing challenges	2.4.1 The teams on both sites are working with the sector and regional leads to develop and implement a training programme for band 7 coordinators including an awareness of the significance of the role for all staff.
	2.5 Issues with poor staff behaviours at the Epsom site escalated by student midwives in 2021 which was managed at the time with the support from the university and HR. This is not a current challenge	2.5 Over previous years staff members have taken grievances against each other. This is not a current challenge	
	2.6 Due to a recent retirement there is currently an interim Director of Midwifery and Gynaecology Nursing in post	2.6 The midwifery leadership team has been stable since 2020	2.6 Consider reviewing the leadership structure across both Trusts to create an opportunity at Group to provide senior leadership support at site when required

Key Action Area
ESTH and SGUH collective/ comparative summary position and suggested Group Improvement Action

	ESTH	SGUH	Group Improvement Action
3. Flawed teamwork - pulling in different directions	3.1 Staff report a common purpose across the MDT and staff strive for clinical excellence		
		3.2 There is evidence of need for an improved medical HR model to support medical staff in the management of current and historic concerns	3.2.1 To review medical HR services at each site and look at the opportunity for improved capacity and resilience by provision at Group level
	3.3 There is a need to strengthen MDT attendance at training in order to be compliant with CNST	3.3 There is a need for improvement in training and development for medical staff in managerial roles within the service	3.3.1 To review the current training offer for medical managers across the Group and revised accordingly. Ensure that any revisions are reflected in the Education Strategy for the Group
		3.4 There is some evidence of staff experiencing difficulties when joining a well established team	3.4.1 Ensure the positive initiatives identified for SGUH are rolled out across the Group as appropriate: • Joint meeting slot for DoM and CD at all MDT inductions. • Undertaking 1:2 meetings with the DoM and CD for all Band 7 Clinical MW and Senior Registrars • Unit meetings promoting civility • Active Bystander training • Professional Midwifery Advocate support • NHSE Culture and Leadership/Health and Wellbeing pilots • Programme by Staff Support – pastoral group sessions • Active participations in service improvements • Preceptorship, Recruitment and retention Lead – non recurring

Key Action Area
ESTH and SGUH collective/ comparative summary position and suggested Group Improvement Action

	ESTH	SGUH	Group Improvement Action
4. Organisational behaviour – looking good while doing badly	4.1 The Board Safety Champion conducts monthly walkabouts to hear directly from staff. Midwifery services are also visited regularly by the Non Executive Directors of the Trust Board		4.1.1 Each site to hold sessions with staff and members of the maternity leadership team to discuss how maternity services can be improved to positively influence clinical outcomes for patients and health and well-being for staff (SGH has undertaken these sessions and is now half way through Drop in sessions for Reflections of the Kirkup report: Staffing and Civility; Team Working Performance – constant check and challenge; and Recruitment and retention) 4.1.2 Schedule a minimum of 4 visits a year to Maternity Services by Non Executive Director and Executive Directors
	4.2 The service values feedback from the Maternity Voices Partnership who are also actively involved in service developments		
	4.3 The service has provided direct feedback to the CQC on its self assessment against the CQC key lines of enquiry (is the service safe, well led, effective, responsive and caring) on two occasions in the last 18 months as part of the CQC and Hospital engagement meetings		
	4.4 Deep Dives have been conducted into 3rd and 4th degree tears and stillbirths and neonatal deaths from 2018 to 2021 at the request of Quality Committee		

gesh

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

Appendix 2

Maternity Services

Perinatal Quality Surveillance Measures November 2022

(CNST Maternity Incentive Scheme: Safety Action 9)

Arlene Wellman, Group Chief Nursing Officer and Director of infection Prevention and Control

Trust Board, January 2023

Internal and External Assurance Processes

Epsom and St Helier University Hospitals NHS Trust

The safety of Maternity Services is monitored on an internal and external perspective and has seen increased scrutiny at both National and local level in response to the Ockenden enquiry.

Internal Governance and Monitoring

- Monthly Division Risk Report monitored by Women's Health DMT
- Quarterly Quality Report to QCAC
- Attendance and RADAH and SI Panel
- Monthly Maternity update to QCiC including CNST compliance, Serious Incident Update, Perinatal Quality Surveillance data and other updates
- Maternity Specific Risk Management Policy and Guideline
- Weekly programme of risk and governance meetings and Quality Half Day

External Governance and Monitoring

- CQC (including the Maternity Survey)
- HSIB
- MBRRACE-UK (PMRT)
- CNST
- LMNS (Surrey Heartlands and SWL)
- Maternity Voices Partnership
- NHS Resolution (ENS scheme)

How to deliver outstanding care.

Perinatal Mortality

Epsom and St Helier University Hospitals NHS Trust

Rolling Report - Time Period	December 2021 – November 2022		Ethnicity
Total Number of Deaths		11	6 White British 2 Indian 1 Black Caribbean 1 Bangladeshi 1 Other
Type of Mortality	Antepartum Stillbirths	7	
	Intrapartum Stillbirths	1	
	Neonatal Deaths	3	
Gestational Age	<24 weeks	2	
	24-27 weeks	0	
	28 - 31 weeks	0	
	32 - 36 weeks	5	
	37-41 weeks	3	
	≥ 42 weeks	1	

- This data reflects the late miscarriages, antepartum stillbirths and neonatal deaths
- There were no cases of stillbirth or neonatal death in November 2022, therefore figures are the same as the October report
- Annual figures published by MBRRACE-UK indicate that the 2020 stillbirth rate and the neonatal death rate is in the ‘within 5% of the than average for type of hospital' category for the total births of 3991 (stillbirth 2.95/1000, neonatal death 1.22/1000 and extended perinatal (both together) 4.16/1000). Our rates were similar to or lower than similar Trusts
- A full review of all cases was undertaken and a report presented to the Board in November 2021
- All cases underwent a PMRT review and where applicable, a local/HSIB investigation

How to deliver outstanding care.

Perinatal Mortality Reviews

Epsom and St Helier University Hospitals NHS Trust

Details of reviews and learning from PMRT (Perinatal Mortality Review Tool)

- A PMRT panel was held on 18 November 2022 and one new case was discussed and an update given on 4 on-going cases. There were no care or service delivery issues identified which directly contributed to the outcome in the new case; multiple fetal abnormalities were identified during the antenatal period
- There have been no clear themes identified, but there are currently 2 open actions relating to appropriate referrals and the management of intrauterine growth restriction (IUGR) and completion is monitored by the Risk Team. Updates on completion of actions have been requested from the leads as the actions were not completed by the end of quarter 2 as expected due to sickness absence of the bereavement lead. This has been escalated to the Clinical Director and the Director of Midwifery
- A detailed report of PMRT cases and actions is submitted quarterly to the Quality Committee in Common (QCiC)

How to deliver outstanding care.

Cases referred to HSIB for review

Epsom and St Helier University Hospitals NHS Trust

HSIB are mandated to investigate cases of intrapartum stillbirth, neonatal death within 7 days of birth (not associated with a congenital abnormality) and incidences of severe brain injury, and focus on human factors.

- There are currently 3 open cases being reviewed by HSIB; one case was closed by HSIB during November 2022 and one new case was reported
- Details of all HSIB cases are presented to the Trust Serious Incident Panel and LMNS and the completion of actions are monitored through both
- There are currently 2 open actions; these relate to strengthening guidance around antepartum haemorrhage and triage. The first action is due to be completed at the next guideline group, and the management of triage is undergoing a wider conversation in relation to adopting the BSOTS system (Birmingham Symptom-specific Obstetric Triage System)
- The senior management team meet quarterly with HSIB; the top 5 recommendation themes are: Staffing; Holistic overview and management of women; CTG Interpretation; Escalation; and Communication

How to deliver outstanding care.

Incidents graded at moderate harm and above

Epsom and St Helier University Hospitals NHS Trust

There were no incidents reported in November 2022 which resulted in moderate or above harm.

Contributory Factors and Root Cause for Completed Serious Incident Reports

There was one SI completed in November 2022 and this will be presented to the SI panel in January 2023. The investigation was undertaken by HSIB. As HSIB use a systems-based approach they do not identify a route cause or contributory factors. They made the following recommendations and these are already in place within the Trust via CTG and PROMPT training:

1. The Trust to ensure that staff are supported to recognise an abnormal CTG in the context of the holistic clinical picture, so that this is escalated and actioned and an individualised plan is put in place.
2. The Trust to ensure that staff are supported to recognise and escalate obstetric emergencies.

Progress against Serious Incident Action Plans

Epsom and St Helier University Hospitals NHS Trust

There are no outstanding actions in relation to Serious Incident Reports.

How to deliver outstanding care.

Mandatory training compliance

Epsom and St Helier University Hospitals NHS Trust

The new Technical Guidance was published on 11 October 2022 and Maternity services are now asked to evidence training performance a month earlier and over a shorter period of time; any continuous 12 month period between 9 August 2021 and 5 December 2022. Previously the ask was to demonstrate 90% compliance for 12 months within any 18 month timeframe period and evidence the position as at 05 January 2023. This means any training planned in December 2022 is now discounted and 90% will need to be achieved in all categories by 5 December 2022.

In light of the change to Technical Guidance and we will not be compliant with CNST in 2022/23. For 2023/24 additional study days are planned for PROMPT and NLS and the low compliance amongst medical staff has been escalated to the Director of Women's Health and the Site CMO.

Type of Training	Staff Group	October 22	November 22	In month performance	Staff number trained
PROMPT	Midwifery Staff	85%	79%	- 6%	257/431
	Maternity Support Workers	42%	60%	- 8%	
	Consultant Obstetricians	56%	64%	+ 8%	
	Trainee and Staff Grade Obstetricians	31%	41%	+ 10%	
	Anaesthetics	17.5%	15%	- 2.5%	
CTG Training	Midwifery Staff	87%	76%	- 9%	208/296
	Obstetricians	13%	19%	+ 6%	
NLS (Newborn Life Support)		77%	76%	- 1%	TBC

How to deliver outstanding care.

Minimum safe staffing

Epsom and St Helier University Hospitals NHS Trust

The fill rate in November 2022 was 91% against the target of 94%. The following actions were implemented to maintain safety:

- Matrons, managers and specialist midwives working clinically alongside staff

Staff group	Measure	**Aug 22**	**Sept 22**	**Oct 22**	**Nov 22**
Midwifery	Fill Rate (target >94%)	87%	87%	89%	91%
Obstetric	Expected vs fill	100%	100%	100%	100%
	Number of step downs/pull across	N/A	N/A	N/A	N/A

Service User Feedback

Epsom and St Helier University Hospitals NHS Trust

The themes identified, and actions, from the Quarter 2 Improving the Patient Experience (IPEC) report included:

- Respecting privacy and dignity
- Evidence based information sharing
- Issues with the BadgerNet App
- Women feeling hot during the heatwave
- Lack of virtual tour on the website
- Women needing to travel across sites to access specialist consultant care
- Positive comments included infant feeding support, friendly and supportive staff, women feeling at ease and evidence-based information sharing

How to deliver outstanding care.

Staff feedback to Safety Champions

Epsom and St Helier University Hospitals NHS Trust

A staff engagement session was held this month and the items discussed were recorded on a separate Dashboard which is shared with all staff ahead of each meeting. Items raised included:

- Issues with delays in completing the NIPE examination (Newborn and Infant Physical examination)
- Concerns with the effectiveness of Staff bank
- Poor state of environment in back lift area on Labour Ward at St Helier
- Lack of office secure/private office space for the Safeguarding Service
- Issues with increasing number of unresolved payroll issues
- Challenges with clinic space in the community
- Poor state repair of delivery beds (with several out of commission)

Internal and External Assurance Processes

St George's University Hospitals NHS Foundation Trust

The safety of Maternity Services is monitored on an internal and external perspective and has seen increased scrutiny at both National and local level in response to the Ockenden enquiry.

Internal Governance and Monitoring

- Local Maternity Governance team, supported by Divisional Governance and Corporate Patient Safety team.
- Escalation and Education on Datix management with mandatory training for all staff.
- Quality, Safety and Assurance in incident management communicated weekly/monthly to disseminate learning for staff.
- Monthly Maternity Governance Meeting ~ Business Guidelines, Audit, Risk Management, Themes and Trends supported by QI team.
- Bi monthly Maternity Governance case meeting ~ Root Cause analysis for moderate or low grade harm that has identified learning.
- Serious Incident Decision Meeting Weekly for escalation of incidents that reach moderate harm or above.
- Monthly Risk Surgery Meetings with Divisional Team for discussion of Risk Register and level of harm with mitigating actions in place.
- Ensure that Confidential Enquiries and other national reports and guidelines are reviewed and acted upon where necessary.
- Divisional Board Governance Meetings for escalation of risk locally and shared learning across division.
- Governance presence in all local meetings across maternity to discuss learning and outcomes.
- PSQG Divisional board governance surveillance on quality and risk management.
- Maternity Dashboard Review Monthly

External Governance and Monitoring

St George's University Hospitals NHS Foundation Trust

SGUH is reporting to the following External Bodies:

- CCG notification and escalation with Serious Incidents escalated at Trust board level.
- LMNS governance and structure – Transformation Project
- Ockenden compliance and review, national standard and compliance required and evidence based.
- South West London LMNS Serious Incident Meeting Quarterly to discuss cases and share learning.
- Health Safety Investigation Branch Investigations escalated in accordance with criteria.
- CNST monitored and measured against 10 safety requirements
- PMRT – national requirement for mortality review of all deaths. The aim of the PMRT programme is introduce the PMRT to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales
- MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
- UKOSS A national system to study rare disorders of pregnancy
- NHSR escalation by legal team in conjunction with maternity services and governance investigations. NHS Resolution is an arm's length body of the Department of Health and Social Care. We provide expertise to the NHS on resolving concerns and disputes fairly, sharing learning for improvement and preserving resources for patient care.
- Better Births, adherence to the BB policy and transformation project commenced in 2016
- Infectious diseases in pregnancy screening: data and outcomes

ROLLING YEAR Perinatal Mortality

St George's University Hospitals NHS Foundation Trust

Rolling Report - Time Period	August 2021 – October 2022		Ethnicity for November 2022
Total Number of Deaths		73	11 in month
Type of Mortality	Antepartum Stillbirths	38	
	Intrapartum Stillbirths	5	
	Neonatal Deaths	25	
Gestational Age	<24 weeks	38	2 Black African 1 Black Caribbean 2 any Other white 2 White British 2 unknown
	24-27 weeks	10	
	28 - 31 weeks	6	
	32 - 36 weeks	11	1 White British
	37-41 weeks	11	1 White British
	≥ 42 weeks	0	

- This data reflects the late miscarriages, antepartum stillbirths and neonatal deaths
- Annual figures published by MBRRACE-UK indicate that the 2020 stillbirth rate and the neonatal death rate has changed since the last publication and is in the 'more than 5% higher than average for type of hospital' category (stillbirth 3.92/1000, neonatal death 2.52/1000 and extended perinatal (both together) 6.41/1000) - see next slide for further detail
- All cases undergo a PMRT review and where applicable, a local/HSIB investigation and learning is shared locally and at the SWL LMNS Serious Incident meetings

How to deliver outstanding care.

Perinatal Mortality – MBRRACE-UK 2020 (1)

(Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK)

St George's University Hospitals NHS Foundation Trust

MBRRACE-UK Perinatal Deaths for 2019 and 2020: The annual figures published by MBRRACE-UK indicate that the 2020 stillbirth rate and the neonatal death based on the total of 4679 births has changed since the last published figures and is now in the 'more than 5% higher than average for type of hospital' category (stillbirth 3.92/1000, neonatal death 2.52/1000 and extended perinatal (both together) 6.41/1000).

In the 2019 reporting period with a total of 4965 births the Trust position was slightly better and was in the 'between 5% and 15% lower than average for type of hospital' category (stillbirth 3.6/1000, neonatal death 2.10/1000 and extended perinatal (both together) 5.64/1000).

MBRRACE report year	Total births	Stillbirth rate/1000	Neonatal death rate/1000	Extended perinatal rate/1000
2020	4679	3.92	2.52	6.41
2019	4965	3.6	2.10	5.64

Internal and External assurance and monitoring: The published figures indicate a slight deterioration in patient outcomes. The team monitored stillbirth and neonatal death outcomes closely during 2019-2020 and reviewed these through internal clinical governance processes, as standard practice. These findings were shared, reviewed and scrutinised across the SWL Local Maternity Neonatal System and at the SWL Quality Council. This level of internal and external assurance and monitoring continues. The team will continue to review all stillbirths and neonatal deaths and report all findings via the peri-natal mortality tool together with any post mortem findings

Important to note: Classification/ Hospital category and data stratification: To account for the wide variation in case mix Trusts are classified hierarchically into 5 mutually exclusive comparator groups, based on their level of service provision:

1. Level 3 NICU and neonatal surgery
2. Level 3 NICU
3. 4,000 or more births per annum at 24 weeks or later
4. 2,000-3,999 births per annum at 24 weeks or later
5. Under 2,000 births per annum at 24 weeks or later

How to deliver outstanding care.

Perinatal Mortality – MBRRACE-UK 2020 (2)

(Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK)

St George's University Hospitals NHS Foundation Trust

Comparison with 'type of hospital' category: In addition to fulfilling classification 1 overleaf (Level 3 NICU and neonatal surgery) the Trust also provides a tertiary fetal medicine service, a placenta accreta service, a genetics service and paediatric surgery.

As the Trust has more patients with high complexity/risk than other Trusts it remains difficult to compare the Trust directly with reference to 'type of hospital' category despite the application of stablised and adjusted mortality rates by comparator group. In addition the national reporting systems work by recording the patient episode under the Trust's care even if they were transferred from elsewhere. This means that, being a specialist centre and accepting high complexity/risk patients from further afield can make the Trust's figures/rates appear higher/worse with a higher proportion of delivery of end of life care when compared with.

MBRACCE data also does not stratify the perinatal mortality rates outcomes according to gestation for individual Trusts, therefore does not reflect the number of babies who are delivered at extreme preterm gestations (less than 26 weeks). This is a significant contributor to both the stillbirth and neonatal mortality rates for the Trust.

Comparator group hospitals: The following example hospitals in the table below are in category 1 (level 3 NICU and neonatal surgery:

MBRRACE report year 2020		Total births	Stillbirth rate/1000	Neonatal death rate/1000	Extended perinatal rate/1000
SGUH	More than 5% higher than group average	4679	3.92	2.52	6.41
Oxford	Between 5 and 15% lower than group average	7220	3.68	1.84	5.34
Chelsea and Westminster	Between 5 and 15% lower than group average	10779	3.06	2.0	5.06
Kings College	Between 5 and 15% lower than group average	8164	3.06	1.89	4.96
Barts Health	Within 5% of group average	14733	3.75	1.92	5.70
University College London Hospitals	Within 5% of group average	5532	3.29	2.49	5.80
Guys and St Thomas	Within 5% of group average	6239	2.35	2.27	5.61
Southhampton	Within 5% of group average	5222	3.23	2.69	5.99

How to deliver outstanding care.

Perinatal Mortality Reviews

St George's University Hospitals NHS Foundation Trust

Details of reviews and learning from PMRT (Perinatal Mortality Review Tool)

- In November 1 PMRT Panel was held
- A total of 4 cases discussed: 2 Neonatal deaths and 2 Stillbirths
- 2 problems were identified: a safeguarding referral was not completed; and individualised postnatal information was not given at discharge. These issues have been highlighted and addressed in the relevant teams
- A detailed report of PMRT cases and actions is submitted quarterly to the Quality Committee in Common (QCIC)

Cases referred to HSIB for review

St George's University Hospitals NHS Foundation Trust

HSIB are mandated to investigate cases of intrapartum stillbirth, neonatal death within 7 days of birth (not associated with a congenital abnormality) and incidences of severe brain injury, and focus on human factors.

- 1 case was referred in November: baby born in poor condition with no respiratory effort or heart rate. Baby transferred to NNU and cooling therapy commenced. MRI reported as normal
- The senior management team meet quarterly with HSIB; the top 5 recommendation themes are: CTG management and interpretation, Escalation, Communication, Staffing Challenges, Holistic Review

How to deliver outstanding care.

Incidents graded at moderate harm and above

St George's University Hospitals NHS Foundation Trust

In November there were 4 incidents graded as moderate harm reported on Datix one of which was declared as a Serious Incident (the case referred to HSIB as outlined on the previous slide)

The 3 incidents categorised as moderate related to the following:

- Post partum Haemorrhage >2 litres
- Stillbirth 41+2
- Staffing Levels inadequate collective for 9 days/nights within month

St George's University Hospitals NHS Foundation Trust

Contributory Factors and Root Cause for Completed Serious Incident Reports

1 Serious Incident Completed and signed off in November 2022 – neonatal death

- **ROOT CAUSE:** The mother had a placental abruption resulting in an emergency admission to NNU for therapeutic cooling. Magnetic resonance imaging (MRI) of the baby's brain showed severe diffuse hypoxic ischaemic brain injury
- **LESSONS LEARNT :** This incident has highlighted the importance of ensuring that a holistic risk assessment is undertaken by a senior obstetrician with oversight of a mother's care when agreeing the method and timing of elective birth for high risk mothers
- **CONTRIBUTORY FACTORS:** The mother's care was provided across two trusts which complicated her care and an individualised plan for birth was indicated due to the mother's pre-existing health condition. The mother did not have access to handheld notes at Trust 1, who use electronic maternity records, and information sharing between the two Trusts was not systematic. This meant clinicians relied on the mother sharing the additional care she received.

Progress against Serious Incident Action Plans

There are no outstanding actions in respect of Serious Incident Reports.

There are 6 actions not yet due and relate to CTG training and management, Fetal monitoring equipment, education and feedback.

How to deliver outstanding care.

Mandatory training compliance

St George's University Hospitals NHS Foundation Trust

The new Technical Guidance was published on 11 October 2022 and Maternity services are now asked to evidence training performance a month earlier and over a shorter period of time; any continuous 12 month period between 9 August 2021 and 5 December 2022. Previously the ask was to demonstrate 90% compliance for 12 months within any 18 month timeframe period and evidence the position as at 05 January 2023.

NHS resolution has since revised the Technical Guidance further and training completed up to 3 January 2023 which now means that the training planned in December 2022 can be included. Although the Trust is working hard to maximise this opportunity 90% compliance for each staff groups may not be met.

		Oct 22	Nov 22	In month performance	Oct 22
Type of Training	Staff Group	%	%	%	Staff number trained
PROMPT	Midwifery Staff	83.50	85.92	+ 2.42	167/200
	Maternity Support Workers	77.27	95	+ 17.73	34/44
	Consultant Obstetricians	91.30	95.65	+ 4.35	21/23
	Trainee and Staff Grade Obstetricians	68.57	85.71	+ 17.14	24/35
	Anaesthetics	54.74	62.85	+ 8.12	19/35
CTG Training	Midwifery Staff	85.93	87.20	+1.27	171/200
	Obstetricians	77	79.3	+ 2.3	44/58
NLS (Newborn Life Support)	Midwifery Staff	92	85.92	- 6.08	184/200
	Maternity Support Workers	86.84	86.84	<>	33/38
	Consultant Obstetricians	91.30	91.30	<>	21/23
	Trainee and Staff Grade Obstetricians	69	86	+17	24/35
	Anaesthetics	85.45	95	+9.55	26/31

How to deliver outstanding care.

Minimum safe staffing

St George's University Hospitals NHS Foundation Trust

The following actions were implemented to maintain safety:

- Temporary closure of services (Birth centre, Homebirth or Delivery Assessment Unit)
- All specialist midwives working some clinical shifts
- Increased RN presence in maternity HDU and on the postnatal ward
- Use of agency Registered Midwife to support workforce on the wards

Staff group	Measure	**Oct 22**	**Nov 22**
Midwifery	Fill Rate (target >94%)	82%	82%
Obstetric	Expected vs fill	100%	100%
	Number of step downs/pull across	N/A	N/A

How to deliver outstanding care.

St George's University Hospitals NHS Foundation Trust

Service User Feedback

Themes identified from complaints and compliments:

- Many positive comments for postnatal ward
- Difference in care on the postnatal ward during the day and at night – to be addressed by Matron
- Visiting on the ward needs managed – too noisy
- Security could be enhanced
- Multiple requests for private rooms for postnatal care
- Commentary that staff were obviously very stretched
- More consistent messaging and advice

St George's University Hospitals NHS Foundation Trust

Staff feedback to Safety Champions

NED and Exec Maternity Safety Champion walk round in November 2022 and spoke with staff in all areas:

- Staffing levels in November remained challenging but felt a bit better due to an influx of new starters – skill mix needs to be monitored
- Midwives working in Midwifery led settings keen to get back to their predominant roles in the Birth Centre
- Estates continue to be shocking – significant controlled flood of sewage on Carmen led to further evacuation of patients and staff. Unbelievable that this is the NHS of 2022

Appendix 3

CNST Maternity Incentive Scheme Safety Actions
Compliance Assessment December 2022

Maternity Services and the Trust have to demonstrate and be able to evidence compliance for every aspect of each separate safety action outlined in Table 1 below. If this is not possible, compliance cannot be submitted.

Table 1 below provides a high-level assessment of the safety actions where the Trusts are non-compliant and the reasons why are highlighted below.

To support the achievement of compliance for all 10 safety actions in MIS year 5 (next year) the assigned clinical leads for each Safety Action will attend the CNST update meetings throughout the year. They will closely monitor the requirements of the Technical Guidance and report on compliance on a monthly basis via Maternity, Divisional and Trust Governance pathways.

For MIS Year 5, the recommendation will be progressed for the Group to have an identified project manager to support the demands of national compliance for a minimum of 0.6 WTE. The Group CNST project manager will oversee CNST compliance with oversight from the Midwifery and Site leadership teams. The Group CNST project manager will also serve to protect current management workload and responsibilities such as governance and risk/engagement with LMNS.

Table 1: High level Assessment of CNST Compliance and reason for non-compliance

CNST Safety Actions MIS	ESTH	SGUH
Safety Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	**Compliance: on track**	**Compliance: on track**
Safety Action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	**Compliance: on track**	**Compliance: on track** Previously the Trust was unable to demonstrate compliance due to issues of data collection via Euroking. Exemption received from NHS Digital following the provision of evidence of clinical compliance

Safety Action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal (ATAIN) units programme? 3b, 3f, 3g and 3h	**Non-Compliant** – Review of evidence undertaken and gaps in evidence were identified. **Gaps in evidence** • Whilst quarterly ATAIN reviews have been undertaken, there is a lack of evidence that the audit of the pathway into transitional care (TC) has been undertaken quarterly and included within the ATAIN presentations. There is a lack of evidence that the ATAIN and TC audits have been shared and presented at the LMNS meetings • There is no overarching ATAIN action plan, and the requirement for this to be signed-off by the Board by the deadline of 29 July 2022 did not happen	**Potentially non-compliant** **Gaps in evidence** • Neonatal Nurse staffing is not yet compliant with technical guidance and the business case to support this has not yet been accepted
Safety Action 4: Can you demonstrate and effective system of clinical workforce planning to the required standard?	Compliant	**Compliance: on track**
Safety Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?	**Non-Compliant** **Gaps in evidence** • Unable to evidence 100% supernumerary status of the B7 shift coordinator. There have been multiple levels of mitigation, but there have been ongoing challenges with staff sickness, vacancy's and staff maternity cover and the acuity on the unit • Services are currently provided on two separate acute sites and in addition postnatal care is provided to approximately 2,700 out of area women who have not delivered with us. This is the basis for the BR+ review and recommendations. Funded qualified establishment with	**Non-Compliant:** **Gaps in evidence** • Unable to evidence 100% supernumerary status of the B7 shift coordinator There have been multiple levels of mitigation, but there have been ongoing challenges with staff sickness/vacancy's and complex and high acuity in the unit • The funded workforce establishment does not currently meet the recommendations of the 2020 Birth Rate plus external review. The service should be staffed to a ratio of 1:24 midwives and is currently at 1:25.5 with an outstanding variance from Ockenden of 6.9 WTE midwives and 10 WTE midwifery support worker posts.

	the shortfall of 11 wte does not meet the recommendations of the most recent external staffing review and the Board have confirmed that the service will not receive funding to recruit to the recommended ratios which is3equireement of compliance with CNST and Ockenden • There is no Board signed-off an action plan showing how we are mitigating shortfalls in the interim together with the plan to achieve full establishment	Funding to the recommendations is a requirement of and compliance with CNST and Ockenden • There is no Board signed-off an action plan showing how we are mitigating shortfalls in the interim together with the plan to achieve full establishment
Safety Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?	**Non-compliant** **Gaps in evidence** • 80% target for CO monitoring not met due to change in practice during Covid and access to disposable mouth pieces. Compliance has been achieved from November 2022. However, the service was not compliant for October 2022 which is part of the final reporting period	**Compliant** Note: Previously the Trust was unable to demonstrate compliance due to issues of data collection via Euroking. Exemption received from NHS Digital following the provision of evidence of clinical compliance
Safety Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?	**Compliant**	**Compliant**
Safety Action 8: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff	**Non-compliant:** **Gaps in evidence** • Performance demonstrates 90% training target is not met • Evidence is awaited from the Neonatal Unit medical staff in respect of NLS training. However, this will not change overall compliance for this safety action	**Non-compliant** **Gaps in evidence** • The service is optimising every opportunity to achieve the 90% training target by the revised deadline of 3 January 2023. However, due to the shifting denominators and impact of staffing challenges the training target is at risk of not being met

group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?		
Safety Action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	**Compliant: on track**	**Compliant**
Safety Action 10. Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022?	**Compliant: on track**	**Compliant: on track**

Tables 2 and 3 below highlight the improvement actions each Trust will take to improve compliance with the non-compliant elements of the 10 safety actions. These improvement actions are intended to maximise the level of the incentive payment awarded to each Trust.

Table 2: SGUH action plan to address gaps in CNST compliance

Safety Action	Action Description	Owner	Timeline for completion
Safety action 3: ATAIN 3a	Report of ATAIN figures to be included on the Agenda for Clinical Governance Care Group meeting & Divisional Governance	Governance Team	31/01/2023
3b	Introduce Care bundle for first hour of life – to reduce variation	Care Group Lead	31/01/2023
3c	Timetable audits of transitional care procedures to enhance improved detection of babies at risk of deterioration	Care Group Lead	31/01/2023

3d	Develop and implement a work stream to investigate increasing our transitional care capacity to further reduce admissions and mother-infant separation with input from neonatal nurses, midwives and neonatal consultants, and develop a business case if the need was demonstrated.	General Manager	31/01/2023
3e	HEE e-learning package – targeted education of labour ward midwives and neonatal medical staff	Head of Nursing	31/01/2023
3f	Purchase and promote use of handheld transcutaneous bilirubinometers in the community	General Manager	31/01/2023
Safety action 5: Midwifery Workforce 5a	Apply for a cost pressure to match the staffing deficit and support safer staffing levels and KPI delivery - £900K	Director of Midwifery	~~31/12/2022~~ 31/01/2023
5b	Discuss BR plus with the Group CNO for an understanding and explanation of how the varied and unique ratios between SGUH and ESTH were reached	Director of Midwifery	~~31/12/2022~~ 31/01/2023
Safety action 8: Training 8a	Deliver additional training sessions organised in December 2022	Assistant Director of Midwifery	~~31/12/2022~~ 31/01/2023

Table 3: ESTH action plan to address gaps in CNST compliance

Safety Action	Action Description	Owner	Timeline for completion
Safety action 3: ATAIN 3b, 3f, 3g, 3h	Assign Neonatal lead to this Safety Action to track deadlines throughout the MIS period and submit a monthly compliance report to QCiC to ensure that the minimum evidence as set out in the technical guidance is met	Neonatal Safety Champion / Neonatal Matron / Paediatric Quality Manager Inpatient Midwifery Matrons (for TC)	31/01/2023
3a	Review the Transitional care policy (TC) and ensure the technical requirements are reflected	Neonatal lead	31/01/2023
3b	Establish a robust process for undertaking quarterly reviews and link these with quarterly TC audits and evidence that an overarching action plan has been developed and is being monitored by the Children's Health DMT.	Neonatal lead	31/01/2023
3b	Set ATAIN meeting dates for the year ahead and share with TC so TC audits can be completed to coincide with the reviews	Neonatal lead	31/01/2023
3b	Set a quarterly timetable of presentation of the audits to both the SH and SWL LMNS	Neonatal lead	31/01/2023
Safety action 5: Midwifery Workforce 5b	Review and confirm to the Group CNO that all possible mitigations have been considered and adopted and to consider service reconfigurations, if possible, to enable safe staffing to be maintained	Interim Director of Midwifery	~~31/12/2022~~ 31/01/2023

Safety action 6: Saving Lives Care Bundle Element One	Ensure the offer of CO2 monitoring for women is embedded in practice	Lead Midwife for Service Improvement	31/01/2023
All elements	Develop a programme of monitoring, audit and an overarching action plan to be monitored monthly by the Women's Health Divisional management team	Interim Director of Midwifery	31/01/2023
Safety action 8: Training 8b, 8c	For all new consultants include PAs for education in consultant job plans	Interim Director of Midwifery / Head of Paediatric Nursing / Divisional Medical Director	31/01/2023
8b, 8c	Publish the training schedule showing planned attendance of all relevant staff over the year to ensure that all sessions are MDT	Interim Director of Midwifery / Head of Paediatric Nursing / Divisional Medical Director	31/01/2023
8b, 8c	Escalate non-attendance at planned training to the Director of Midwifery/Clinical Director and make and monitor individual plans to mitigate for this	Interim Director of Midwifery / Head of Paediatric Nursing / Divisional Medical Director	31/01/2023

PMRT - Perinatal Mortality Reviews Summary Report

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool

Epsom and St Helier University Hospitals NHS Trust

Report of perinatal mortality reviews completed for deaths which occurred in the period:

1/1/2018 to 8/12/2022

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: *79*

Summary of reviews**

Stillbirths and late fetal losses

Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
99	36	4	58	2

Neonatal and post-neonatal deaths

Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
20	5	0	13	0

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACE-UK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Deaths following termination of pregnancy are excluded.

** Post-neonatal deaths can also be reviewed using the PMRT

*** Reviews completed and have report published

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Table 1: Summary information for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 71)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late Fetal Losses (<24 weeks)	0	9	--	--	--	--	9
Stillbirths total (24+ weeks)	0	0	14	8	13	14	49
Antepartum stillbirths	*0*	*3*	*13*	*8*	*11*	*11*	*46*
Intrapartum stillbirths	*0*	*5*	*1*	*0*	*2*	*2*	*10*
Timing of stillbirth unknown	*0*	*1*	*0*	*0*	*0*	*1*	*2*
Early neonatal deaths (1-7 days)*	0	1	1	1	2	6	11
Late neonatal deaths (8-28 days)*	0	0	0	0	1	0	1
Post-neonatal deaths (29 days +)*	0	0	0	0	1	0	1
Total deaths reviewed	0	10	15	9	17	20	71
Small for gestational age at birth:							
IUGR identified prenatally and management was appropriate	0	0	0	0	2	0	2
IUGR identified prenatally but not managed appropriately	0	0	0	0	1	1	2
IUGR not identified prenatally	0	0	0	2	5	3	10
Not Applicable	0	10	15	7	9	16	57
Mother gave birth in a setting appropriate to her and/or her baby's clinical needs:							
Yes	0	10	15	9	16	20	70
No	0	0	0	0	1	0	1
Missing	0	0	0	0	0	0	0
Parental perspective of care sought and considered in the review process:							
Yes	0	9	12	7	15	19	62
No	0	1	3	2	2	1	9
Missing	0	0	0	0	0	0	0
Booked for care in-house	0	1	1	1	3	5	11
Mother transferred before birth	0	1	0	0	0	1	2
Baby transferred after birth	0	0	0	0	1	1	2
Neonatal palliative care planned prenatally	0	0	0	0	0	1	1
Neonatal care re-orientated	0	0	0	0	2	4	6

*Neonatal deaths are defined as the death within the first 28 days of birth of a baby born alive at any gestational age; early neonatal deaths are those where death occurs when the baby is 1-7 days old and late neonatal death are those where the baby dies on days 8-28 after birth. Post-neonatal deaths are those deaths occurring from 28 days up to one year after birth

Table 2: Placental histology and post-mortems conducted for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 71)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late fetal losses and stillbirths							
Placental histology carried out							
Yes	0	8	11	5	12	12	48
No	0	0	3	0	1	1	5
Not answered	0	1	0	3	0	1	5
Hospital post-mortem offered	0	8	13	8	13	13	55
Hospital post-mortem declined	0	2	5	1	6	1	15
Hospital post-mortem carried out:							
Full post-mortem	0	5	6	5	6	11	33
Limited and targeted post-mortem	0	0	1	0	0	0	1
Minimally invasive post-mortem	0	0	0	0	0	0	0
External review	0	0	1	0	1	0	2
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
Neonatal and post-neonatal deaths:							
Placental histology carried out							
Yes	0	1	1	1	1	5	9
No	0	0	0	0	3	1	4
Death discussed with the coroner/procurator fiscal	0	0	0	1	3	5	9
Coroner/procurator fiscal PM performed	0	0	0	1	2	4	7
Hospital post-mortem offered	0	1	1	0	2	2	6
Hospital post-mortem declined	0	0	0	0	2	1	3
Hospital post-mortem carried out:							
Full post-mortem	0	1	1	0	0	1	3
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive PMpost-mortem	0	0	0	0	0	0	0
External review	0	0	1	0	1	0	2
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
All deaths:							
Post-mortem performed by paediatric/perinatal pathologist*							
Yes	0	5	8	4	7	11	35
No	0	0	0	0	0	0	0
Not Answered	0	0	0	1	0	0	1
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	5	7	4	8	11	35
No	0	3	4	1	4	1	13
Not Answered	0	1	0	3	0	1	5

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*Includes coronial/procurator fiscal post-mortems

Table 3: Number of participants involved in the reviews of late fetal losses and stillbirths without resuscitation

This table has not been generated as participants in the review were not fully identified by the PMRT during the period covered by this report.

Table 4: Number of participants involved in the reviews of stillbirths with resuscitation and neonatal deaths

This table has not been generated as participants in the review were not fully identified by the PMRT during the period covered by this report.

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Table 5: Grading of care relating to the babies who died in this period and for whom a review of care has been completed – number of babies (N = 71)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
STILLBIRTHS & LATE FETAL LOSSES							
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:							
A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	0	8	11	7	5	8	39
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	1	3	0	4	4	12
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	1	3	1	5
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	1	1	2
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following confirmation of the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	0	9	12	8	12	14	55
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	1	0	0	0	1
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	1	0	1
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	1	0	0	0	1
Not graded	0	0	0	0	0	0	0
NEONATAL AND POST-NEONATAL DEATHS							
Grading of care of the mother and baby up to the point of birth of the baby:							
A - The review group concluded that there were no issues with care identified up the point that the baby was born	0	0	1	1	1	2	5
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	1	0	0	3	3	7
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	1	1
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the baby from birth up to the death of the baby:							
A - The review group concluded that there were no issues with care identified from birth up the point that the baby died	0	1	1	1	3	5	11
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	1	1	2
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following the death of her baby	0	1	1	1	4	6	13
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0

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Table 6: Cause of death of the babies who died in this period and for whom a review of care has been completed – number of babies (N = 71)

Timing of death	Cause of death
Late fetal losses	**9 causes of death out of 9 reviews**
	Late miscarriage at 22+4/40 due to chorioamnionitis
	Late miscarriage following PPROM.
	The postmortem showed evidence of a long-standing haematoma within the placenta which is thought to be why the placenta could not sustain the pregnancy.
	Following the review which took into account the information from the post-mortem, placental histology and other investigations the cause of death of the baby was determined to be: Late miscarriage. The post-mortem results indicated chorioamnionitis and this was the likely cause of the late miscarriage.
	Both twins died as a result of TRAP sequence.
	The PMRT panel agreed that this was a late fetal loss at 22+2/40 before the age of viability.
	Acute chorioamnionitis with associated acute marginal haemorrhage
	Trisomy 13
	Findings of acute necrotising chorioamnionitis with a fetal inflammatory response and high grade fetal vascular malperfusion evident from the placenta.
Stillbirths	**46 causes of death out of 49 reviews**
	severe maternal acidosis as a consequence of diabetic ketoacidosis and maternal extremis condition led to the demise of the fetus.
	Fetal thrombotic vasculopathy with no obvious placental pathology to account for utero-placental insufficiency.
	The major cause of death was judged to be fetal malperfusion of the placenta due to thrombosis of the fetal umbilical and chorionic vessels resulting in collections of non-functioning fibrotic villi. The baby also had Trisomy 21, Down syndrome, which may have been a contributory factor to the death.
	The cause of death was undetermined
	The cause of death was undetermined
	Ascending genital tract infection resulting in severe chorioamnionitis
	The cause of death was undetermined
	Intrauterine pneumonia
	The cause of death was undetermined
	Fetal demise secondary to DKA at 23+6/40.
	Abnormalities identified at 12+4/40. Hydrops.
	The cause of death was undetermined
	The cause of death was undetermined
	The cause of death was undetermined
	The cause of death was undetermined
	The baby had a massive brain injury (antenatal) as a result of hypoxia secondary to anaemia.
	Intrauterine death following fetoscopic surgery at St George's for twin to twin transfusion syndrome (TTTS)
	Intrauterine death following fetoscopic surgery at St George's for twin to twin transfusion syndrome (TTTS)

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	The results of the post-mortem are awaited. However, the panel concluded that the stillbirth was likely a result of the uterine rupture.
	The cause of death was undetermined
	The cause of death was undetermined
	Ascending genital tract infection: chorioamniotitis.
	Stillbirth of a growth restricted female baby with the placental findings of a long, hypercoiled umbilical cord with stricture formation and fetal vascular malperfusion.
	The cause of death was undetermined
	The postmortem identified a hypercoiled umbilical cord, which is associated with a poor obstetric outcome.
	Fetal malperfusion attributed to a hypercoiled umbilical cord.
	Amniotic Band Sequence, where the amniotic band was wrapped tightly around the umbilical cord. Whilst the cause remains unknown in most cases, there is an associated with amniocentesis (which the woman underwent in this case).
	1.Bilateral severe hydronephrosis resulting from bilateral ureteropelvic junction obstruction (detected antenatally). 2. High-grade fetal vascular malperfusion and distal villous immaturity with the placenta and associated renal vein thrombosis.
	Asymmetrical IUGR attributed to fetal vascular malperfusion and chronic deciduitis
	The post-mortem showed a finding of chronic intervillositis.
	Patchy chronic intervillositis (of uncertain significance) Placental abruption (confirmed and delivery)
	Intrauterine death of a third trimester small for gestational age male fetus, the cause of which is attributed to the findings of a retroplacental haematoma, maternal vascular malperfusion and high-grade fetal vascular malperfusion on histological examination of the placenta.
	Fetal thrombotic vasculopathy.
	The cause of death was undetermined
	The mother's post-mortem examination stated that the cause of the Mother’s death was: 1a. Hypovolaemic shock 1b. Degenerate splenic artery rupture 2. Third trimester pregnancy Therefore baby died as a result of the mother's cardiac arrest.
	A growth restricted fetus with abnormal Dopplers.
	The baby was small for gestational age secondary to maternal vascular malperfusion, scattered foci of avascular villi and chronic deciduitis with plasma cells.
	Findings of an acute hypoxic mode of death, the cause of which is attributed to the findings of high-grade chronic villitis, high-grade fetal vascular malperfusion and acute chorioamnionitis with fetal inflammatory response on examination of the placenta.
	The cause of death was undetermined
	The cause of death was undetermined
	shoulder dystocia perinatal asphyxia
	Intra-uterine death of an asymmetrically growth restricted female baby at least 48 to 72 hours prior to delivery attributed to the placental findings of maternal vascular malperfusion.
	Intra-uterine acute hypoxic death of a late third trimester male baby between 3 and 7 days before delivery, with a small placenta showing early acute chorioamnionitis and delayed villous maturation.
	Likely placental abruption supported by a presentation with APH at 34+1 weeks' gestation.

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	Intra-uterine death of a male baby at around 34+ weeks attributed to the placental findings of an umbilical cord aneurysm with thrombosis, rupture and haematoma formation.
	Intrauterine death of a third trimester appropriately grown and developed female fetus. Small placenta with histological findings of delayed villous maturation and high-grade chronic villitis.
Neonatal deaths	**12 causes of death out of 12 reviews**
	1a Respiratory failure 1b Meconium aspiration
	Birth asphyxia secondary to antepartum haemorrhage/placental abruption.
	Congenital Cytomegalovirus
	Chorioamnionitis (ascending infection)
	Asphyxia secondary to uterine rupture.
	Pulmonary hypoplasia and acute chorioamnionitis attributable to PPROM.
	The cause of death was undetermined
	The post-mortem identified a retroplacental clot/placental abruption and this was thought to be the cause of the preterm labour/neonatal death.
	Severe HIE
	Extreme prematurity secondary to abruption.
	Sudden Unexpected Death in Infancy.
	Respiratory failure from lung hypoplasia. The cause for the lung hypoplasia was from anhydramnios (lack of amniotic fluid around the baby).
Post-neonatal deaths	**1 causes of death out of 1 reviews**
	1a Respiratory failure 2 Severe HIE (suspected antenatally)

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Table 7:Issues raised by the reviews identified as relevant to the deaths reviewed, by the number of deaths affected by each issue* and the actions planned

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned
At first presentation with reduced fetal movements this mother was not appropriately risk assessed	2	The woman reported reduced fetal movements to the sonographer but this information was not relayed to the midwife in MAU. The sonographers have agreed to telephone the MAU when referring women in order that a handover can be given.
		In this particular case there is good documented evidence that the midwife did assess the reduced fetal movements and was aware of the need for further monitoring, however the mother retracted the history. Unfortunately, this was not reflected in the report hence the HSIB safety recommendation.
The baby was small for gestational age at birth and had been identified as IUGR prenatally but the management was not appropriate	2	Drop down box implemented in astria to guide follow up. SWL antenatal CTG guideline in place. Feedback to registrar.
		A Standard Operating Procedure is required for women who are bereaved during their pregnancy to ensure they are referred to the Bereavement Midwife who can then coordinate further referrals eg to the woman's named midwife and counsellor and give support. A communication tool is required to inform MATAU of women who need additional appointments in MATAU ie for fetal growth restriction, so a diary appointment can be made. Subsequently if they DNA they are appropriately followed up and this documented on BadgerNet. This tool must be accessible to all clinicians to allow clinical information to be added from any clinical area and be viewed by staff working in MATAU.
The baby was small for gestational age at birth, scans were indicated but had not been performed	2	As above.
		As above.
This mother missed some of her antenatal appointments but was not followed-up according to the local DNA policy	2	As above.
		A Standard Operating Procedure is required for women who are bereaved during their pregnancy to ensure they are referred to the Bereavement Midwife who can then coordinate further referrals eg to the woman's named midwife and counsellor and give support. A communication tool is required to inform MATAU of women who need additional appointments in MATAU ie for fetal growth restriction, so a diary appointment can be made. Subsequently if they DNA they are appropriately followed up and this documented on BadgerNet. This tool must be accessible to all clinicians to allow clinical information to be added from any clinical area and be viewed by staff working in MATAU.
This mother presented with reduced fetal movements at >28 weeks and a CTG was not performed	2	As above.

		The maternity management team are satisfied that there are already sufficient safeguards in place for this recommendation. Badgernet automatically flags a risk assessment when reduced fetal movements are mentioned and mandatory training includes assessment of the fetal heart following a history of reduced fetal movements. In this particular case there is good documented evidence that the midwife assessed the reduced fetal movements and was aware of the need for further monitoring. Unfortunately, this was not reflected in the report hence the safety recommendation.
This mother presented with reduced fetal movements but management was not appropriate and was not in line with national guidance	2	As above.
		In this particular case there is good documented evidence that the midwife did assess the reduced fetal movements and was aware of the need for further monitoring, however the mother retracted the history. Unfortunately, this was not reflected in the report hence the HSIB safety recommendation.
A CTG was performed during established labour but the technical quality was poor	1	This has already been escalated to the manufacturer. We are now ordering more leads that we need to ensure we always have spares. There have been no further adverse incident in relation to this issue.
Despite not having the results of a post-mortem the review team are confident about the cause of the baby's death	1	No action entered
During the first 24 hours of the baby's arrival on the neonatal unit appropriate lines were placed but their position was not radiologically confirmed	1	No action entered
Estimated fetal weights from scans had not been plotted on a chart	1	As above.

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

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Table 8: Issues raised by the reviews which are of concern but not directly relevant to the deaths reviewed, by the number of deaths in which this issue was identified* and the actions planned

Issues raised which were identified as not relevant to the deaths	Number of deaths	Actions planned
The baby had to be transferred elsewhere for the post-mortem	29	No action entered
		No action entered
		No action entered
		No action entered
		No action entered
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		No action entered
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		No action entered
		No action entered
NICE guidance recommends carbon monoxide testing for all mothers at booking; this mother was not screened because carbon monoxide testing was paused due to COVID-19	24	No action entered
		No action entered
		No action entered
		No action entered
		No action entered

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		No action entered
		No action entered
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		No action entered
		No action entered
		No action entered
		No action entered
NICE guidance recommends carbon monoxide testing for all mothers at booking; this mother was not screened	23	No action entered
		We have introduced carbon monoxide monitoring for all women and booking.
		No action entered
		No action entered
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		No action entered
		No action entered
		No action entered
The opportunity to take their baby home was not offered to the parents as there is no local policy for this	14	No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
Placental histology was performed but was not carried out by a perinatal/paediatric pathologist	13	No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		Ensure consistency in sending placental histology to perinatal pathology in case with poor outcome. Currently there is no facility to do this however this is an action to formalise an arrangement.
		No action entered
The parents were not told that a review of their care and that of their baby is being carried out	11	No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered

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		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
The parents' perspectives and any concerns about their care and the care of their baby have not been sought	9	No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
This mother booked late. Are there any organisations to consider in relation to her booking late?	6	No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
This mother booked late. Did this affect her care?	6	No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		Cross site Midwife Lead for Early Pregnancy Services to devise a booking referral process for women who have attended EPAU and have a viable pregnancy confirmed. This will assist in seamless antenatal care and timely booking.
This mother lives with family members who smoke but they were not offered referral to smoking cessation services because there is no service available	6	No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

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Table 9: Top 5 contributory factors related to issues identified as relevant to the deaths reviewed, by the frequency of the contributory factor and the issues to which the contributory factors related

Issue Factor	Number of deaths	Issues raised for which these were the contributory factors
Task Factors - Guidelines, Policies and Procedures	1	Referrals for scans and/or further investigations were not undertaken when required
		At first presentation with reduced fetal movements this mother was not appropriately risk assessed
		This mother presented with reduced fetal movements, scans and and/or other investigations were indicated but were not caried out
		This mother presented with reduced fetal movements but management was not appropriate and was not in line with national guidance
		The type of fetal monitoring used in the latent phase of labour was not appropriate
		The fetal heart monitoring in the latent phase of labour was not carried out correctly
Task Factors - Guidelines, Policies and Procedures	1	This mother had a risk factor(s) for having a growth restricted baby but the plan to carry out serials scans was not followed
		This mother had a risk factor(s) for having a growth restricted baby but serial scans were not performed at correct times/intervals
		Estimated fetal weights from scans had not been plotted on a chart
		The baby was small for gestational age at birth, scans were indicated but had not been performed
		This mother missed some of her antenatal appointments but was not followed-up according to the local DNA policy
Task Factors - Guidelines, Policies and Procedures - Not adhered to / not followed	1	This mother was not assessed but in retrospect she was high risk and should have been prescribed aspirin
		This mother had a risk factor(s) for having a growth restricted baby or there were concerns about the growth of the baby but serial scans were not planned
		This baby was small for gestational age at birth, but appropriate growth surveillance had not been carried out
		This mother had growth restricted baby/small for gestational age baby which was not managed according to national or local guidelines
Communication - Verbal communication	1	At first presentation with reduced fetal movements this mother was not appropriately risk assessed
		This mother presented with reduced fetal movements at >28 weeks and a CTG was not performed
		This mother presented with reduced fetal movements but on the basis of her scans and/or other investigations an appropriate management plan was not put in place

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		This mother presented with reduced fetal movements but management was not appropriate and was not in line with national guidance
Task Factors - Guidelines, Policies and Procedures	1	There were concerns about the baby's growth rate but these were not investigated and acted upon appropriately
		The baby was small for gestational age at birth and had been identified as IUGR prenatally but the management was not appropriate
		This mother had a growth restricted baby (defined by estimated fetal weight <10th centile or reduced growth velocity on ultrasound) during her pregnancy which was not managed according to national or local guidelines
		This mother missed some of her antenatal appointments but was not followed-up according to the local DNA policy

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PMRT - Perinatal Mortality Reviews Summary Report

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool

St George's University Hospitals NHS Foundation Trust

Report of perinatal mortality reviews completed for deaths which occurred in the period:

22/12/2021 to 20/3/2022

To continue to support the delivery of safer maternity care NHS Resolution is operating a fourth year of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme. In order to receive a rebate on the yearly CNST premium, Trusts must demonstrate compliance with ten key safety actions. CNST Safety Action One measures compliance with the appropriate use of the National Perinatal Mortality Review Tool (PMRT). This tool supports systematic, multidisciplinary high-quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care. The reviews are used to understand, wherever possible, why the baby died and whether different actions would have led to a different outcome. Active communication with parents is central to this process. Parents are invited to contribute to the review and receive a plain English copy of the investigation once completed. To provide assurance that quality and safety are being reviewed to identify learning and drive change, whilst also satisfying CNST requirements, the service produce a quarterly report summarising progress against safety standards and any lessons learnt. The comprehensive report is considered at divisional governance meetings and is subsequently presented to MMC. A summary is included in this quarterly report to provide assurance to Patient Safety and Quality Group, Trust Management Group, Quality and Safety Committee and ultimately the Trust Board. Trust Boards are asked to sign a declaration to confirm the level of compliance against each standard.

a) i. All perinatal deaths eligible to be notified to MBRRACEUK from 6 May 2022 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the later.	We are **compliant** with this standard
ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies,	We are **compliant** with this standard (A review was started on 54.5% of deaths within two

suitable for review using the PMRT, from 6 May 2022 will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust.	months)
b) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6 May 2022 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death.	We are **compliant** with this standard (A draft report was generated for 45.5% of deaths within four months and published for 81.81%)
c) For at least 95% of all deaths of babies who died in your Trust from 6 May 2022, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and for taking actions as required.	We are **compliant** with this standard (100% of parents were informed that a review of their care was taking place)
d) Quarterly reports will have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.	We are **compliant** with this standard (there is no time scale on this standard)

Issues arising

There was one case that the panel reviewed care issues which they considered it may have made a difference the outcome for the baby. The themes that arose were:

- The consent process for interstitial laser therapy is not sufficiently detailed or clear.
- FMU should inform delivery suite if they are undertaking this procedure and should ensure the patient has had the required blood tests and samples taken should they require an emergency delivery.
- Patients should be transferred to delivery suite on a trolley in emergency situations.
- Communication issues between the two Trusts involved

The panel review one care where the care provided may have made a different for the outcome of the mother

- The mother was not screened for aspirin prophylaxis antenatally.

Adverse Incidents (DW170126)

There was one Adverse Incident report completed on one case reviewed by the PMRT tool in this quarter. The care issues identified have been previously mentioned and the actions following the review of this case have taken place or are in the process to be completed.

Actions Implemented

- Detailed pre-filled informed consent is obtained from patients undergoing FMU procedures to be developed.
- FMU staff should perform a pre-operative checklist with patients prior to procedures taking place and delivery suite to be informed when they occur.
- FMU staff should ensure preparations are made for emergency transfer to delivery suite, if necessary, in a quick and safe manner**.**
- Audit of LOCSIP compliance during procedures carried out on FMU.
- Accurate and relevant information is given to patients in relation to obtaining a copy of their notes.
- Feedback to local trust and network on timing of referral for chorioangioma to ensure future patients receive optimal care.
- FMU staff were reminded of importance of screening for prophylactic aspirin in pregnancy.

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: *6*

Summary of reviews**

Stillbirths and late fetal losses

Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
11	9	0	2	0

Neonatal and post-neonatal deaths

Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
9	0	2	7	0

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACE-UK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Deaths following termination of pregnancy are excluded.

**Post-neonatal deaths can also be reviewed using the PMRT

***Reviews completed and have report published

Table 1: Summary information for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 9)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late Fetal Losses (<24 weeks)	0	2	--	--	--	--	2
Stillbirths total (24+ weeks)	0	0	0	0	0	0	0
Antepartum stillbirths	*0*	*2*	*0*	*0*	*0*	*0*	*2*
Intrapartum stillbirths	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Timing of stillbirth unknown	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Early neonatal deaths (1-7 days)*	0	1	1	1	2	0	5
Late neonatal deaths (8-28 days)*	0	0	1	0	0	0	1
Post-neonatal deaths (29 days +)*	0	0	0	1	0	0	1
Total deaths reviewed	0	3	2	2	2	0	9
Small for gestational age at birth:							
IUGR identified prenatally and management was appropriate	0	0	0	1	0	0	1
IUGR identified prenatally but not managed appropriately	0	0	0	0	0	0	0
IUGR not identified prenatally	0	0	0	0	0	0	0
Not Applicable	0	3	2	1	2	0	8
Mother gave birth in a setting appropriate to her and/or her baby's clinical needs:							
Yes	0	2	2	2	2	0	8
No	0	1	0	0	0	0	1
Missing	0	0	0	0	0	0	0
Parental perspective of care sought and considered in the review process:							
Yes	0	2	2	2	2	0	8
No	0	1	0	0	0	0	1
Missing	0	0	0	0	0	0	0
Booked for care in-house	0	1	2	2	1	0	6
Mother transferred before birth	0	0	2	0	0	0	2
Baby transferred after birth	0	0	0	0	0	0	0
Neonatal palliative care planned prenatally	0	0	0	0	1	0	1
Neonatal care re-orientated	0	1	2	1	0	0	4

*Neonatal deaths are defined as the death within the first 28 days of birth of a baby born alive at any gestational age; early neonatal deaths are those where death occurs when the baby is 1-7 days old and late neonatal death are those where the baby dies on days 8-28 after birth. Post-neonatal deaths are those deaths occurring from 28 days up to one year after birth

Table 2: Placental histology and post-mortems conducted for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 9)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late fetal losses and stillbirths							
Placental histology carried out							
Yes	0	2	0	0	0	0	2
No	0	0	0	0	0	0	0
Hospital post-mortem offered	0	2	0	0	0	0	2
Hospital post-mortem declined	0	0	0	0	0	0	0
Hospital post-mortem carried out:							
Full post-mortem	0	2	0	0	0	0	2
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive post-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
Neonatal and post-neonatal deaths:							
Placental histology carried out							
Yes	0	1	2	2	2	0	7
No	0	0	0	0	0	0	0
Death discussed with the coroner/procurator fiscal	0	0	0	0	0	0	0
Coroner/procurator fiscal PM performed	0	0	0	0	0	0	0
Hospital post-mortem offered	0	1	2	2	2	0	7
Hospital post-mortem declined	0	0	2	1	1	0	4
Hospital post-mortem carried out:							
Full post-mortem	0	1	0	1	1	0	3
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive PMpost-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
All deaths:							
Post-mortem performed by paediatric/perinatal pathologist*							
Yes	0	2	0	0	0	0	2
No	0	0	0	0	0	0	0
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	2	0	0	0	0	2
No	0	0	0	0	0	0	0

*Includes coronial/procurator fiscal post-mortems

Table 3: Number of participants involved in the reviews of late fetal losses and stillbirths without resuscitation

Role	Total Review sessions	Reviews with at least one
Chair	0	0%
Vice Chair	0	0%
Admin/Clerical	1	50% (1)
Bereavement Team	2	100% (2)
Community Midwife	0	0%
External	0	0%
Management Team	0	0%
Midwife	7	100% (2)
Neonatal Nurse	0	0%
Neonatologist	5	100% (2)
Obstetrician	5	100% (2)
Other	3	100% (2)
Risk Manager or Governance Team	1	50% (1)
Safety Champion	0	0%

Table 4: Number of participants involved in the reviews of stillbirths with resuscitation and neonatal deaths

Role	Total Review sessions	Reviews with at least one
Chair	0	0%
Vice Chair	0	0%
Admin/Clerical	7	100% (7)
Bereavement Team	5	71% (5)
Community Midwife	0	0%
External	0	0%
Management Team	1	14% (1)
Midwife	36	100% (7)
Neonatal Nurse	5	71% (5)
Neonatologist	26	100% (7)
Obstetrician	19	100% (7)
Other	24	100% (7)
Risk Manager or Governance Team	1	14% (1)
Safety Champion	0	0%

Table 5: Grading of care relating to the babies who died in this period and for whom a review of care has been completed – number of babies (N = 9)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
STILLBIRTHS & LATE FETAL LOSSES							
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:							
A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	0	1	0	0	0	0	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	1	0	0	0	0	1
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following confirmation of the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	0	2	0	0	0	0	2
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
NEONATAL AND POST-NEONATAL DEATHS							
Grading of care of the mother and baby up to the point of birth of the baby:							
A - The review group concluded that there were no issues with care identified up the point that the baby was born	0	0	0	1	2	0	3
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	1	2	0	0	0	3
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	1	0	0	1
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the baby from birth up to the death of the baby:							
A - The review group concluded that there were no issues with care identified from birth up the point that the baby died	0	1	2	2	2	0	7
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following the death of her baby	0	1	2	0	1	0	4
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	1	1	0	2
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	1	0	0	1
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0

Table 6: Cause of death of the babies who died in this period and for whom a review of care has been completed – number of babies (N = 9)

Timing of death	Cause of death
Late fetal losses	**2 causes of death out of 2 reviews**
	Extreme Prematurity
	The cause of death was undetermined
Stillbirths	**0 causes of death out of 0 reviews**
Neonatal deaths	**6 causes of death out of 6 reviews**
	1A. Bilateral Intraparenchymal brain haemorrhage 1B. Extreme prematurity 1C. Twin to Twin Transfusion Syndrome
	Extreme prematurity
	1a Intracranial haemorrhage and spontaneous bowel perforation 1b Extreme prematurity - 26 weeks gestation twin 1c Twin to twin transfusion syndrome
	PM report confirms dysmorphology and congenital myopathy. Genetic investigations ongoing
	The PM showed hydrops fetalis and severe anaemia which were likely complications from a placental chorioangioma and prematurity. The post-mortem also noted signs of generalised congestion and haemorrhage to the liver, heart and intestines, and hypoxic brain injury which were chronic and most likely occurred days to weeks before the baby was delivered. The placenta showed evidence of vascular thromboses which although can be seen as secondary to interstitial laser therapy are thought likely to have occurred prior to the intervention
	Congenital heart disease
Post-neonatal deaths	**1 causes of death out of 1 reviews**
	1. Prematurity 2. Restrictive dermopathy

Table 7:Issues raised by the reviews identified as relevant to the deaths reviewed, by the number of deaths affected by each issue* and the actions planned

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

Table 8: Issues raised by the reviews which are of concern but not directly relevant to the deaths reviewed, by the number of deaths in which this issue was identified* and the actions planned

Issues raised which were identified as not relevant to the deaths	Number of deaths	Actions planned
NICE guidance recommends carbon monoxide testing for all mothers at booking; this mother was not screened because carbon monoxide testing was paused due to COVID-19	5	Suspended due to Covid
The opportunity to take their baby home was not offered to the parents as there is no local policy for this	5	Unable to offer when post mortem investigations are required.
It is not possible to tell from the notes whether during the early bereavement period use of a cold cot was offered/available	4	Cold cots are available, this needs to be added to the checklist to ensure we have written documentation of if this was offered.
Fundal height measurements had not been plotted on a chart	2	In accordance with local guidelines
Symphysis fundal height measurements were not performed at correct times/intervals	2	In accordance with local guidelines
The opportunity to take their baby home was not offered to the parents	2	It is not possible for parents to take the baby home if they wish a post mortem
There were no specific contraindications to organ donation but this was not discussed with the parents as part of end of life care for their baby	2	To be discussed with bereavement team during next review of guidelines.
This mother and her partner were not able to be cared for in either a sound proofed room or a room away from other mothers and crying babies because the necessary facililties are not available	2	No sound proof room available, bereavement suite refurbishment planned.
During the early bereavement period the baby was not cared for in a cold cot because the cold cot was not offered	1	Cold cots are available, this needs to be added to the checklist to ensure we have written documentation of if this was offered.
During the first 24 hours of the baby's arrival on the neonatal unit not all appropriate lines were placed and radiologically confirmed	1	Neonatal consultant to feedback to medical staff.

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

Table 9: Top 5 contributory factors related to issues identified as relevant to the deaths reviewed, by the frequency of the contributory factor and the issues to which the contributory factors related

Issue Factor	Number of deaths	Issues raised for which these were the contributory factors

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	12 January 2023	**Agenda No**	**2.3**
Report Title:	**Integrated Quality & Performance Report**		
Lead Director/ Manager:	James Marsh, Group Deputy Chief Executive Officer		
Report Author:			
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	This report consolidates the latest management information and improvement actions across St George's Hospital for the month of November 2022. **Safe High Quality Care** Successes In November, St Georges reported No Never Events. Complaints performance maintained at 86% in November despite significant operational pressures. Latest HSMR, shows our mortality to be lower than expected. Looking at emergency admissions, mortality is lower than expected for those patients admitted during the week and as expected for those admitted at the weekend. SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on England average figures. For St Georges' performance was 0.92 and is as expected. Challenges Analysis provided by NHS Digital of SHMI data indicates that in June a run of more deaths than expected in the fractured neck of femur diagnosis group was observed. The SHMI for this group of patients is as expected. Structured judgement reviews (SJRs) completed in recent months for a small number of deaths have indicated a potential issue with VTE prophylaxis. With sustained obstetric and medical complexity, staffing remained challenging across the month with significant mitigation actioned and implemented. This has been influenced by vacancies at band 5 and band 6 level, short term sickness/absences and covid isolation continuing. CNST compliance remains very unlikely due to significant changes in the third iteration in year for the technical guidance. The most challenging safety action relates to Midwifery staffing, reaching Ockenden/BR+ staffing recommendations. Influenza- The Trust has seen an increase in cases in November 2022, 55 cases in comparison to 37 cases in October 2022, Influenza A is the predominant strain. **Elective Care** **Successes** The number of RTT patients waiting for more than 52 weeks continue to fall and is meeting plan. The Trust is on track to deliver year end targets in both 52+ and 78+ waits Diagnostic waits above 6 weeks has reduced reporting 5.1% in November compared to 8.2% in October. All Gynae 6+ waiters have been eliminated and a 50% reduction in Cardiac MRI. Reduction in cancer 62 day backlog was seen and meeting plan for the month after a spike in September.		

	DNA rates have reduced for a consecutive month. Success of DNA audit in Therapies has enabled issues to be resolved. Theatre Utilisation and average cases per session remain above the mean **Challenges** RTT PTL continues to rise and not meeting plan. There is currently 526 patients, waiting over 40 weeks for a first appointment. Endoscopy continue to see a large proportion of patients waiting for more than six weeks for a diagnostic test reporting 71% of total Trust breaches. Breast continue to have a backlog of 352 patients waiting a first OPA for 2 week wait and a further 300+ patients booked passed day 15. The next clinic availability is 8 weeks. FDS Performance further deteriorated driven by Breast capacity, Gynae hysteroscopy capacity and Minor Ops capacity for Skin referrals. Radiology capacity is impacting CT Colon, MRI and other diagnostic delays affecting the GI and urology pathway. Productivity within theatres continues to be challenged, issues remain around flow caused by limited ward and ICU bed capacity leading to cancellations. The Trust is implementing an Elective Access Meeting that will meet weekly, chaired by the COO to oversee forward activity plans, utilisation and areas for escalation and mitigation against trajectories. **Non-Elective Care** **Successes** Overall 4 hour performance is still strong compared to peers (consistently in top ten nationally and top 2 in London) Performance in November increase achieving 81.1% The Trust launched the regularising flow programme in November to support exit from the Emergency Department and enable timely ambulance handovers. This has seen some improvements during the day with earlier movement of patients enabling easier decision making on how to use available capacity Frailty support within ED has begun and will continue to expand The expansion of the Urgent Treatment Centre's ability to see paediatric patients s helping to relieve the pressure on the main Children's and Young Persons ED. **Challenges** The number of 12 hour waits after a decision to admit rose again in November. The inability of the Department to admit patients to downstream wards impacts on capacity and therefore the ability to offload ambulances in a timely manner, this is intrinsically linked to the regularising flow model and early indications are showing some small improvement. Continued issues with ED nursing numbers caused by vacancies and sickness. Increase in Pathway 2 and 3A delays for Merton & Wandsworth due to a lack of onward availability and lack of homes willing to take complex patients. Pathway 1 delays for M&W and the lack of therapy capacity in Wandsworth Whilst reducing, still high numbers of patients in the acute Trust who are considered no longer meet the criteria to reside but are unable to move to their discharge destination in a timely way. **Our People** **Successes** The successful rollout of the Care Group leadership programme by the Organisational Development team has been very well received by our clinical leaders.

	Equally the online learning package "Management Fundamentals" developed in partnership with an external education delivery expert has seen good levels of take up. We need to monitor areas where the training has been taken up and encourage those areas of low take up to become involved. **Challenges** Industrial action across multiple staff groups has had limited impact on operational activity thus far, but we anticipate that the RCN will ramp up their activity in the new year which will have an effect on our patients and services. Other unions and staff groups including junior doctors are expected to follow up their ballots with industrial action. We have plans in place to manage this industrial action sensitively, supporting the staff's rights to protest whilst ensuring that patient care is maintained at all times
Recommendation:	The Board is requested to note the report.
Committee rAssurance:	The Committee is also asked that in considering contents of this report, its supporting documents and the discussion at the meeting which of the following assurance rating it would provide to the Trust Board. • **Substantial Assurance:** The report and discussions assured the Committee that there are robust systems of internal controls operating effectively to ensure that quality and safety risks are managed to deliver high quality services and care to patients. • **Reasonable Assurance:** The report and discussions assured the Committee that the system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that quality and safety risks are managed to deliver high quality services and care to patients. • **Limited Assurance:** The report and discussions supported the Committee's conclusion that that the system of internal controls is generally inadequate or not operating effectively and significant improvements were required to ensure that the quality and safety risks are managed effectively to improve the position and ensure that high quality services and care is provided to patients. • **No Assurance:** The report and discussions led the Committee to conclude that there was a fundamental breakdown or absence of core internal controls and systems to enable the Trust to deliver high quality services and care to its patients.
Supports	
Trust Strategic Objective:	Treat the Patient Treat the Person Right Care Right Place Right Time
CQC Theme:	Safe, Caring, Responsive, Effective, Well Led
Single Oversight Framework Theme:	
Implications	
Risk:	NHS Constitutional Access Standards are not being consistently delivered and risk remains that planned improvement actions fail to have sustained impact
Legal/Regulatory:	
Resources:	Clinical and operational resources are actively prioritised to maximise quality and performance

Equality and Diversity:			
Previously Considered by:	Quality Committee Finance & Investment Committee	**Date**	15/12/2022 16/12/2022
Appendices:			

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

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Group Integrated Quality & Performance Report

November 2022

Presented by: James Marsh Group Deputy Chief Executive Officer
November 2022

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

Executive Summary
Safe, high-quality care

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St George's Hospital

Successes

In November, St Georges reported No Never Events.
Complaints performance maintained at 86% in November despite significant operational pressures.

Latest HSMR, shows our mortality to be lower than expected. Looking at emergency admissions, mortality is lower than expected for those patients admitted during the week and as expected for those admitted at the weekend.

SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on England average figures. For St Georges' performance was 0.92 and is as expected.

Challenges

Analysis provided by NHS Digital of SHMI data indicates that in June a run of more deaths than expected in the fractured neck of femur diagnosis group was observed. The SHMI for this group of patient is as expected.
Structured judgement reviews (SJRs) completed in recent months for a small number of deaths have indicated a potential issue with VTE prophylaxis.

With sustained obstetric and medical complexity, staffing remained challenging across the month with significant mitigation actioned and implemented. This has been influenced by vacancies at band 5 and band 6 level, short term sickness/absences and covid isolation continuing.

CNST compliance remains very unlikely due to significant changes in the third iteration in year for the technical guidance. The most challenging safety action relates to Midwifery staffing, reaching Ockenden/BR+ staffing recommendations.
Influenza- The Trust has seen an increase in cases in November 2022, 55 cases in comparison to 37 cases in October 2022, Influenza A is the predominant strain.

Epsom & St Helier

Successes

No never events at ESTH in November. Pressure Ulcers: Some of the Improvement actions introduced include: A review of all incidents related to pressure damage to identify and share key learning to support improvements in all areas. Specialist experts are providing ward targeted support including education and training and continuous review of mitigation in place owned by divisions. Review of equipment contract to ensure quick turn around of alternating mattress especially in escalation areas. Trust induction pack to all new nurses will include pressure damage training.

From 1st December, Specialist Services and the Clinical Practice Team will be under the same management so there is reframing to look at how we take the work forward that has been started.

Nutrition: The insertion and Management of Nasogastric tubes policy has been ratified and training will be started. There will be a rollout of e-MUST to additional areas to support the development of a dashboard. There are monthly Spot audits that are reported on and will be sent to CQAC and Quality in Common. An overarching action plan has been developed to support the improvement

Challenges

Regarding the pressure damage acquired under our care, most were attributed to the complexity of patients under our care, although there were other contributing factors identified such as timely assessments , intervention and documentation. Hot spots identified are care of the elderly and orthopaedics' wards. There is currently a shortfall of mattresses which has been escalated for action. There is a shortage of cushions and agreement for purchase has been made by Senior Leadership Team.

Analyses on mortality ratio continues, with detailed actions summarised in the Mortality section.

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St George's, Epsom and St Helier
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Executive Summary
Elective Care

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St George's Hospital

Successes

The number of RTT patients waiting for more than 52 weeks continue to fall and is meeting plan. The Trust is on track to deliver year end targets in both 52+ and 78+ waits
Diagnostic waits above 6 weeks has reduced reporting 5.1% in November compared to 8.2% in October. All Gynae 6+ waiters have been eliminated and a 50% reduction in Cardiac MRI.
Reduction in cancer 62 day backlog was seen and meeting plan for the month after a spike in September.
DNA rates have reduced for a consecutive month. Success of DNA audit in Therapies has enabled issues to be resolved.
Theatre Utilisation and average cases per session remain above the mean

Challenges

RTT PTL continues to rise and not meeting plan. There is currently 526 patients, waiting over 40 weeks for a first appointment.
Endoscopy continue to see a large proportion of patients waiting for more than six weeks for a diagnostic test reporting 71% of total Trust breaches.
Breast continue to have a backlog of 352 patients waiting a first OPA for 2 week wait and a further 300+ patients booked passed day 15. The next clinic availability is 8 weeks.
FDS Performance further deteriorated driven by Breast capacity, Gynae hysteroscopy capacity and Minor Ops capacity for Skin referrals.
Radiology capacity is impacting CT Colon, MRI and other diagnostic delays affecting the GI and urology pathway.
Productivity within theatres continues to be challenged, issues remain around flow caused by limited ward and ICU bed capacity leading to cancellations.
The Trust is implementing an Elective Access Meeting that will meet weekly, chaired by the COO to oversee forward activity plans, utilisation and areas for escalation and mitigation against trajectories.

Epsom & St Helier

Successes

52 week waits reduce from 294 in Sep22 to 265 in Oct22.

Outpatient first activity remains above 104% of BAU (19/20), with 120% in Oct22.

The total patients waiting for a first attendance increased from 18k in Jun21 to 25k by Jun22 due to referrals being 10-20% above BAU levels since Sep21. The total has remained static at 25k each month since Jun22 with no further increase. The main reason for this, is the higher volume of first outpatient activity mitigating the majority of the increased referral demand.

Specialist advice requests delivered per 100 outpatient first attendances in Oct22 was 9.7, an increase from 9.0 in Sep22.

Patient initiated follow-up has increased from 1.62 in Sep22 to 2.13 in Oct22.

Cancer performance achieved against the key standards in October 2022: 14 day to first appointment standard, faster diagnosis standard , 31 day first treatment standard and GP 62 day first treatment standard.

Challenges

GP referrals remain above BAU levels with 109% received in Oct22.

Due to the high volume of referrals being received, not being fully mitigated by the outpatient activity volumes, the PTL continues to grow slowly with an increase of 282 in Oct22 compared to the previous month.

Community Paediatrics remains the most pressured speciality with 50 children waiting over 52 weeks for a first appointment (as of 01/12/22).

Endoscopic Ultrasound (EUS) at Royal Marsden Hospital (RMH) capacity continues to be challenging – current wait is up to 4-5 weeks.

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

Executive Summary Non-Elective Care

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St George's Hospital

Successes

Overall 4 hour performance is still strong compared to peers (consistently in top ten nationally and top 2 in London) Performance in November increase achieving 81.1%
The Trust launched the regularising flow programme in November to support exit from the Emergency Department and enable timely ambulance handovers. This has seen some improvements during the day with earlier movement of patients enabling easier decision making on how to use available capacity
Frailty support within ED has begun and will continue to expand
The expansion of the Urgent Treatment Centre's ability to see paediatric patients s helping to relieve the pressure on the main Childrens and Young Persons ED.

Challenges

The number of 12 hour waits after a decision to admit rose again in November. The inability of the Department to admit patients to downstream wards impacts on capacity and therefore the ability to offload ambulances in a timely manner, this is intrinsically linked to the regularising flow model and early indications are showing some small improvement.
Continued issues with ED nursing numbers caused by vacancies and sickness.
Increase in Pathway 2 and 3A delays for Merton & Wandsworth due to a lack of onward availability and lack of homes willing to take complex patients.
Pathway 1 delays for M&W and the lack of therapy capacity in Wandsworth
Whilst reducing, still high numbers of patients in the acute Trust who are considered no longer meet the criteria to reside but are unable to move to their discharge destination in a timely way.

Epsom & St Helier

Successes

The percentage of beds occupied by COVID positive patients is at 4.91% in November 2022, and is now below the ambition following 5 months of breaching the 5% threshold

Non-elective admissions for November 2022 are 2,145, remaining below the ambition of 2,292

Zero length of stay non-elective admissions for November 2022 are 395, remaining below the ambition of 439, reflecting the impact of SDEC

Challenges

The percentage of patients spending 12 plus hours in ED is over 9% in November 2022, having sat at circa 8% for the last 5 months

Mean daily super-stranded numbers over 62 in November 2022, but monthly reductions observed in the last 2 months

60 minute plus ambulance handovers of 246 in October 2022 and 220 in November 2022, the two highest monthly values on record.

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

Executive Summary
Our People

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St George's Hospital

Successes

The successful rollout of the Care Group leadership programme by the Organisational Development team has been very well received by our clinical leaders.

Equally the online learning package "Management Fundamentals" developed in partnership with an external education delivery expert has seen good levels of take up. We need to monitor areas where the training has been taken up and encourage those areas of low take up to become involved.

Challenges

Industrial action across multiple staff groups has had limited impact on operational activity thus far, but we anticipate that the RCN will ramp up their activity in the new year which will have an effect on our patients and services. Other unions and staff groups including junior doctors are expected to follow up their ballots with industrial action.

We have plans in place to manage this industrial action sensitively, supporting the staff's rights to protest whilst ensuring that patient care is maintained at all times.

Epsom & St Helier

Successes

From 3 January 2023, the Trust will be significantly investing in Bank staff pay rates, as part of important changes that will make these rates fairer, simpler and financially sustainable. We also hope these rates will attract our own staff members to join the Bank, reduce our agency usage, and support our care quality and patient safety commitments, by providing improved continuity of care.
Bank rates will be enhanced. Acute nursing and AHP rate cards will align with St George's. Rates cards for ancillary and admin and also clerical, will be set at a minimum of London Living Wage and rates above that uplifted in line with the pay award.

Challenges

The RCN at ESTH did not achieve a mandate to take industrial action, but we anticipate other unions will do so.
Vacancy rate remains consistently above the KPI target of 10%, averaging at 13.90% over the past 6 months. Estates & Ancillary and Healthcare Scientists (predominantly pharmacist vacancies) staff groups are consistently the top 2 staff groups for highest vacancy rate.

YTD Sickness absence (April - November) at 5.43% remains above the KPI threshold of 3.80%. Covid confirmed is now only the fourth most common cause of sickness absence accounting for 10% of all absences.

Training & Appraisal Compliance - Both metrics continue to increase marginally month on month. Training compliance is at 80% compared to a 85% target and staff appraisals 69% against a 90% target

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

Monthly Overview – Safe, high-quality care (1)

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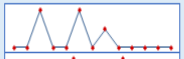
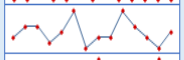
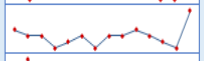
Safe, High Quality Care	St George's							Epsom and St. Helier						
	Monthly Target	Sep-22	Oct-22	Nov-22	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Sep-22	Oct-22	Nov-22	YTD Target	YTD Actual	13-Month Trend
Never Events	0	0	0	0	0	1		0	0	0	0	0	1	
Serious Incidents	8	3	1	4	96	24		TBC	2	10	3	TBC	14	
Number of Falls With Harm (Moderate and Above)	TBC	2	6	2	TBC	22		TBC	1	0	6	TBC	10	
Pressure Ulcers - Acquired catergory 3&4	0	9	4	9	0	97		0	0	2	2	0	10	
Dementia - Assessment & Investigation of Patients at risk of Dementia		NA	NA	NA	NA			90%	50%	44%	38%	90%	49%	
Mental Capacity Act & Deprivation of Liberties - Level 1	90%	87%	87%	89%	90%	88%			NA	NA	NA	NA	NA	
Mental Capacity Act & Deprivation of Liberties - Level 2	85%	70%	70%	73%	85%	70%			NA	NA	NA	NA	NA	
Infection Control - Number of Cdiff - Hospital & Community	4	7	3	4	43	42		TBC	4	3	6	TBC	21	
Infection Control - Number of MRSA	0	0	0	0	0	1		0	0	0	0	0	0	
Infection Control - Number of E-Coli	9	5	7	5	111	54		TBC	21	31	22	TBC	152	
VTE Risk Assessment	95%	96.6%	96.3%	96.7%	95%	96%		95%	89.3%	89.6%	82.2%	95%	90%	
Mortality - HSMR	<100	88.5	88.7	88.4	<100	88.53		<100	113.12	112.26	113.96	<100	111.65	
Mortality - SHMI	<1	0.93	0.92	0.92	<1	0.92		<1	1.11	1.14	1.15	<1	1.11	

Blank areas shown where data is not currently available

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University Hospitals and Health Group

Monthly Overview – Safe, high-quality care (2)

gesh

	St George's							Epsom and St. Helier						
Safe, High Quality Care	**Monthly Target**	**Sep-22**	**Oct-22**	**Nov-22**	**2022_23 Target**	**YTD Actual**	**13-Month Trend**	**Monthly Target**	**Sep-22**	**Oct-22**	**Nov-22**	**2022_23 Target**	**YTD Actual**	**13-Month Trend**
Number of Complaints Received	TBC	46	44	44	TBC	477		TBC	47	53	39	TBC	384	
Complaints responded to in 25 days	85%	95%	85%	80%	85%	92%		85%	58%	55%	69%	85%	57%	
Friends and Family Test - Inpatients Respose Rate	20%	25%	29%	24%	20%	32%		20%	30%	32%	21%	20%	29%	
Friends and Family Test - Inpatients Score	95%	98%	99%	99%	95%	99%		95%	93%	94%	96%	95%	94%	
Friends and Family Test - Emergency Department Respose Rate	20%	14%	12%	11%	20%	12.9%		20%	13%	12%	7%	20%	11.9%	
Friends and Family Test - Emergency Department Score	90%	76%	76%	74%	90%	73%		90%	83%	81%	79%	90%	79%	
Friends and Family Test - Maternity Respose Rate	20%	21.5%	11.4%	13.1%	20%	12.5%		20%	6.0%	7.0%	7.7%	20%	6.7%	
Friends and Family Test - Maternity Score	90%	90%	86%	81%	90%	86%		90%	100%	100%	98%	90%	97%	
Friends and Family Test - Community Respose Rate	20%	0.8%	0.3%	0.6%	20%	0.9%		20%	0.3%	0.2%	0.8%	20%	0.8%	
Friends and Family Test - Community Score	90%	92%	80%	100%	90%	94%		90%	98%	99%	97%	90%	98%	
Friends and Family Test - Outpatients Respose Rate	20%	4.6%	5.5%	3.8%	20%	4.2%		20%	3.2%	3.6%	3.0%	20%	3.1%	
Friends and Family Test - Outpatients Score	90%	91%	91%	92%	90%	91%		90%	93%	93%	94%	90%	93%	

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

Falls (Patient Falls- per 1,000 bed days)

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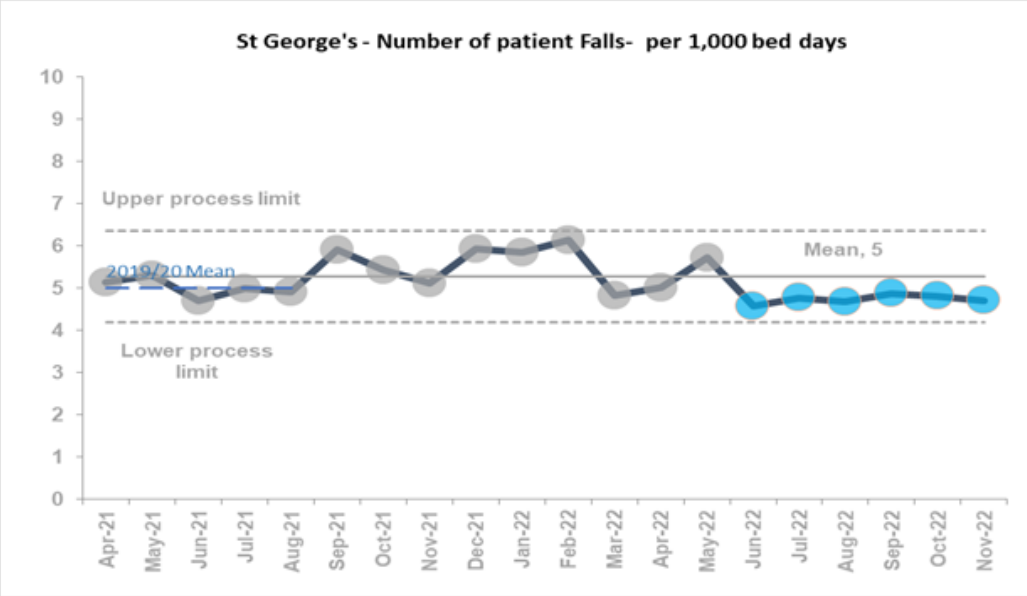
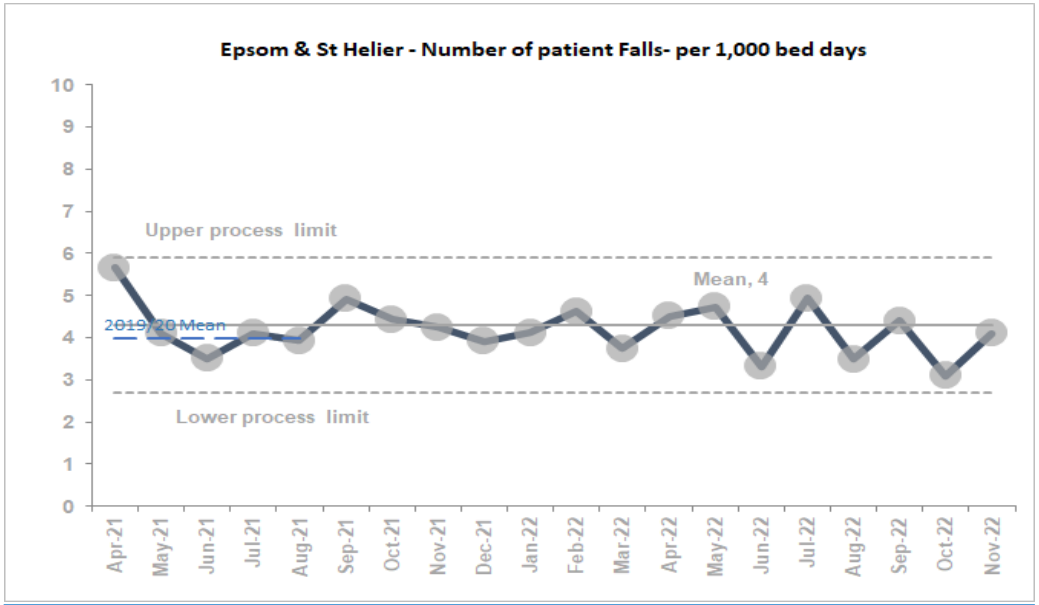
Target: TBC	SGH: 4.7	ESTH: 4.1





SGH updates since last month

Overall fall rates remain lower than average, reporting 113 falls in November. Rates per 1,000 Occupied Bed Days are currently at 4.7, a slight decrease from October and lower than the mean. The vast majority of falls were of low or no harm, however, there were 2 Moderate harm falls reported this month 1on an inpatient areas and 1 in ED.

ESTH updates since last month

There were 78 falls in November in acute inpatient areas, which is an increase from last month. Rates per 1,000 Occupied Bed days are currently 5.6 an increase on last month .Majority of the falls occurred in medical and orthopaedic wards. 6 falls resulted in moderate harm. 3 of these were in ED, 2 occurred in July and only reported in November. There were 25 falls in Community inpatients and falls per bed day of 4.28. Data quality issue remain and are being addressed.

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University Hospitals and Health Group

Pressure Ulcers - Grade 3 and above per 1,000 bed days

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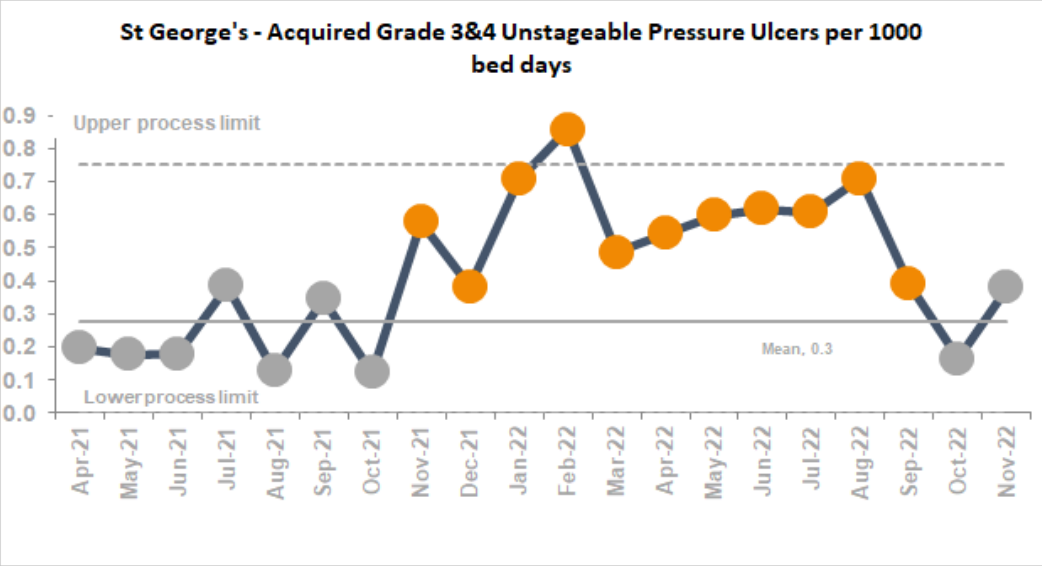
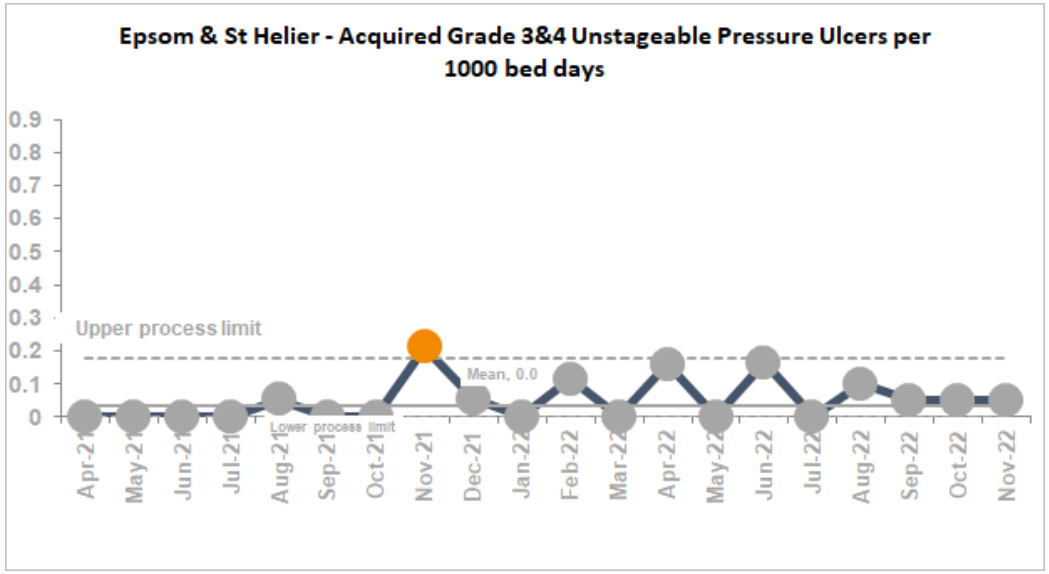
Target: TBC	SGH: 0.38	ESTH: 0.05





SGH updates since last month

There were a total of 9 Unstageable pressure ulcers; which is less than the previous month when 4 were reported.
Medical Devices Related PU saw a decrease in November to 23 in total (30 in October), with 13 occurring in Intensive care. The adult intensive care units are focusing on QI work in relation to medical devices and catheters in particular.

ESTH updates since last month

15 pressure damage cases were reported in November, a slight increase of 2 cases.

Two of these met the category for reporting (categories 3&4 unstageable equating to 0.05 / 1000 bed days). This is consistent with October's data.

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Complaints

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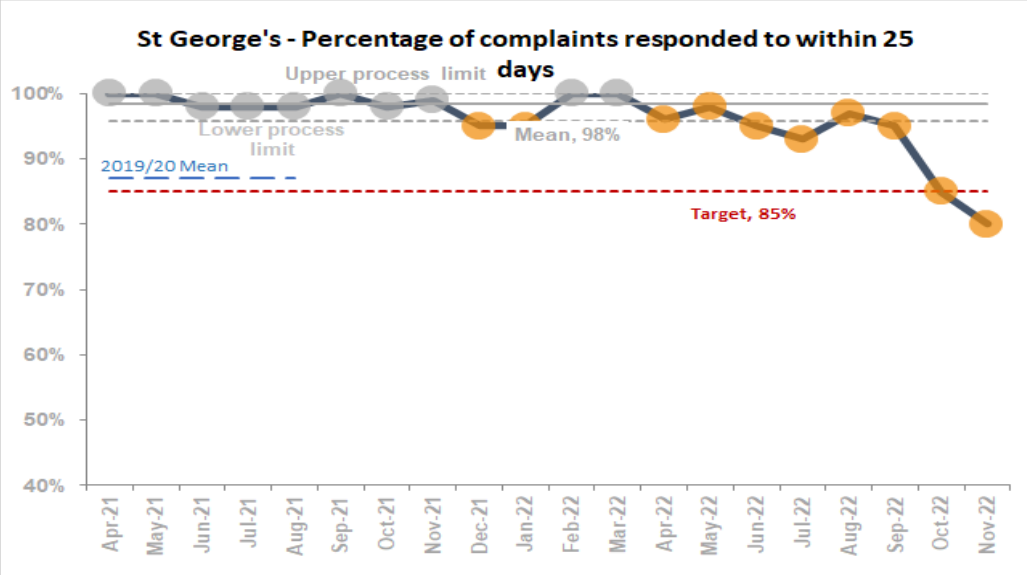
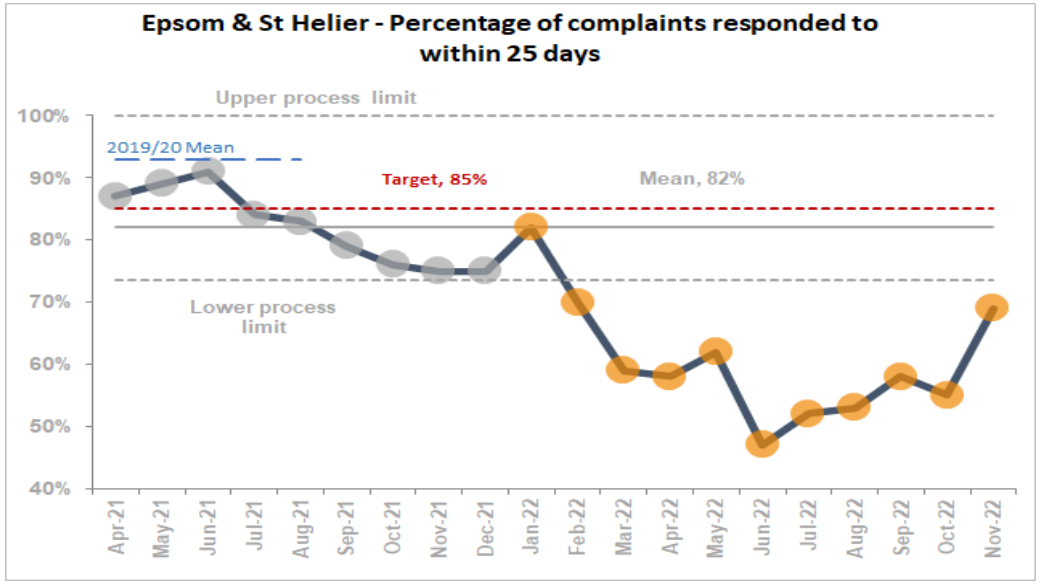
Target: 85%	SGH: 80%	ESTH: 69%





SGH updates since last month

There were 44 complaints in November with 80% of them being responded to within 25 days, The complaints team had vacancies and sickness in September and October. All vacancies are recruited to, just awaiting new team members to join.

ESTH updates since last month

39 formal complaints were received during the reporting period, 69% of these met the 25 days response timeframe. Good progress is being made in reducing the backlog reported previously, supported by 3 new members of staff who joined the team in September. 1The team is in a better position to manage complaints and policy changes which will streamline the overall complaints process. The GCNO and GMD are actively supporting the responses.

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Quality - Analysis and Action

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SGH current issues –

Infection control - 4 C. difficile infections during November 2022; 3 were classified as Hospital Onset Healthcare Associated (HOHA) and 1 Community Onset Healthcare Associated (COCA) There have been no periods of increased incidence (PII) or CDI outbreaks in November 2022. There have been a total of 46 cases between April and November 2022. There is a NHSE trajectory of no more than 43 cases for 2022-23. This equates to no more than 3.5 cases per month or no more than 28 cases at end of November. This means the Trust remains significantly above trajectory. A focus on antimicrobial stewardship and cleanliness of medical devices continues.
Influenza- The trust has seen an increase in cases in November 2022, 55 cases in comparison to 37 cases in October 2022, Influenza A is the predominant strain. There was an increase in bay closures, with 2 reported outbreaks in November 2022.
MCA & DoLS - Nursing Staff are at 90.2% compliance for Level 2 training, highlighting the value of ongoing work with Practice Educators, support from nursing colleagues and visibility of the MCA team in clinical areas. Meetings with Post Graduate Medical Education Lead and Site Chief Medical Officer to take place in November to discuss how to improve MCA compliance for Medics and Dental (currently at 53%). The Paediatric Nurse MCA education programme has supported 7 development days covering a total of 83 Band 5 & 6 RNs. This is a highly specialised area with complex legal interplay between Children's Act and MCA.

SGH future action -

Infection control - A focus on antimicrobial stewardship continues; a deep dive of current CDiff cases has been completed and an Antimicrobial audit paper has also been compiled-both will be presented in a future Quality Committee. The IPC Team continue walkabouts and spot checks of medical device and environmental cleanliness

MCA & DoLS -Work has been agreed with the Local Authority to support qualified Trust Best Interests Assessors to undertake assessments in preparation for LPS. Awaiting final insurance sign off from NHS Resolution.
Junior Doctor compliance rates have been sent to PGME for their follow up with this staff cohort.

ESTH current issues –

Infection Control: to be updated w/c 12-Dec

Pressure Ulcers: Regarding the pressure damage acquired under our care, most were attributed to the complexity of patients under our care, although there were other contributing factors identified such as timely assessments , intervention and documentation. Hot spots identified are care of the elderly and orthopaedics' wards. There is currently a shortfall of mattresses which has been escalated for action. There is a shortage of cushions and agreement for purchase has been made by Senior Leadership Team.

ESTH future action –

Pressure Ulcers: Some of the Improvement actions introduced include: A review of all incidents related to pressure damage to identify and share key learning to support improvements in all areas. Specialist experts are providing ward targeted support including education and training and continuous review of mitigation in place owned by divisions. Review of equipment contract to ensure quick turn around of alternating mattress especially in escalation areas. Trust induction pack to all new nurses will include pressure damage training.

From 1st December ; Specialist Services and the Clinical Practice Team will be under the same management so there is reframing to look at how we take the work forward that has been started.

Nutrition: The insertion and Management of Nasogastric tubes policy has been ratified and training will be started. There will be a rollout of e-MUST to additional areas to support the development of a dashboard. There are monthly Spot audits that are reported on and will be sent to CQAC and Quality in Common. An overarching action plan has been developed to support the improvement

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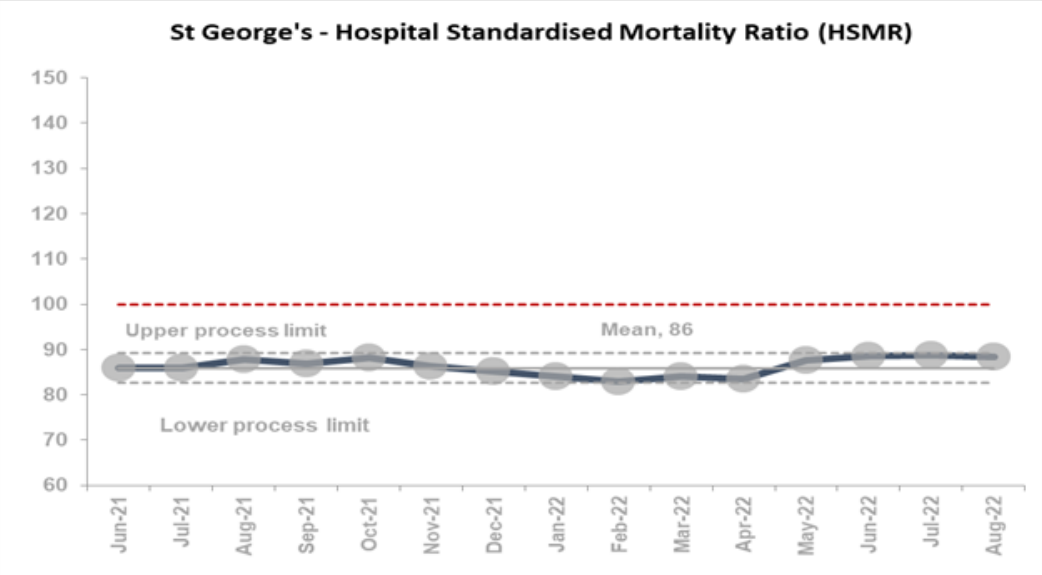
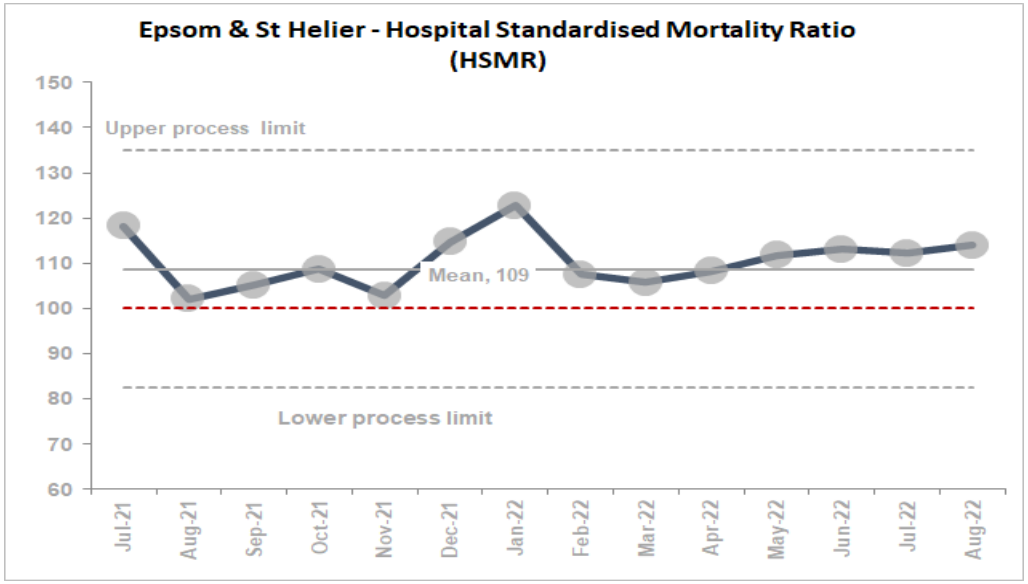
Mortality – HSMR

gesh

Target: <100	SGH: 88.4	ESTH: 113.9





SGH updates since last month

Latest HSMR, for the 12 months from September 2021 to August 2022 shows our mortality to be lower than expected. Looking specifically at emergency admissions, mortality is lower than expected for those patients admitted during the week and as expected for those admitted at the weekend.

Data source: Dr Foster

ESTH updates since last month

Latest HSMR, for the 12 months from September 2021 to August 2022 remains above expected level. As per previous months, elective HSMR is significantly lower than expected level at 41.0, and non-elective HSMR dominates the trend at 114.8.

Mortality ratio is slightly lower for those patients admitted during the week than over the weekend, but both cohorts remain above expected level.

Data source: HED

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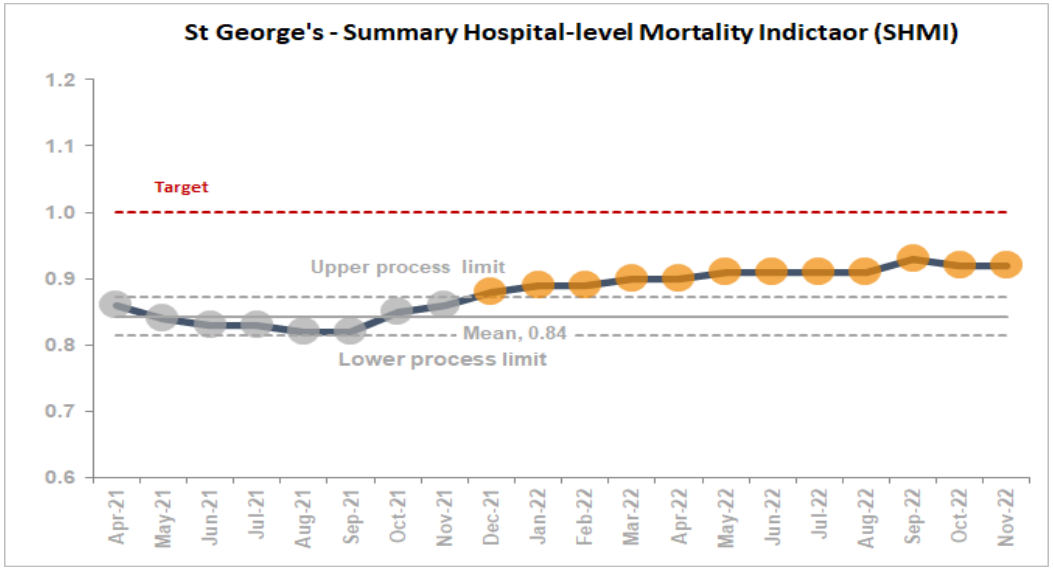
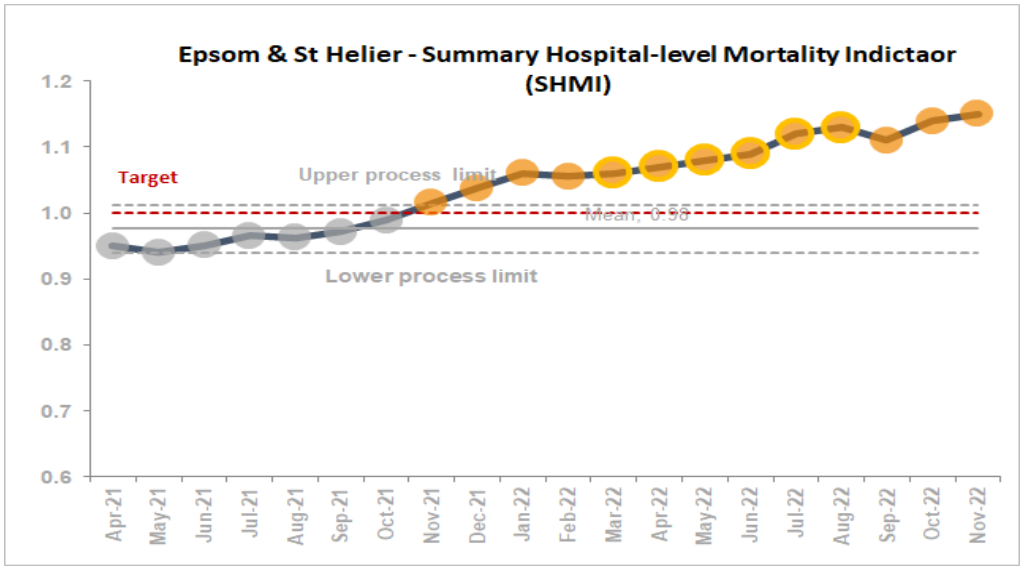
Mortality – SHMI

gesh

Target: <1	SGH: 0.92	ESTH: 1.15





SHMI data is based on a rolling 12-month period and reflective of period August21 to July 22 published (November)

SGH updates since last month

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures. For SGH performance was 0.92 and is as expected.
SHMI data is based on a rolling 12month period and reflective of period July 21 to June 22 (published November 22)

Source NHS Digital

ESTH updates since last month

SHMI includes all inpatient mortalities that occur within a hospital and deaths up to 30 days post acute trust discharges are considered using ONS data.

12 month rolling SHMI continues to rise at ESTH. Latest available data up to June 22 (published in November 22). There is no difference between the two sites.

Source NHS Digital

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Mortality - Analysis and Action

gesh

SGH current issues –

The Mortality Monitoring Group consider mortality at diagnosis and procedure group level. Investigation of the diagnosis groups 'Genitourinary congenital anomalies', 'Haemolytic jaundice and perinatal jaundice' 'Nervous system congenital anomalies' and 'Short gestation, low birth weight, fetal growth retardation' is underway.

Analysis provided by NHS Digital of SHMI data indicates that in June a run of more deaths than expected in the fractured neck of femur diagnosis group was observed. The SHMI for this group of patient is as expected.
Structured judgement reviews (SJRs) completed in recent months for a small number of deaths have indicated a potential issue with VTE prophylaxis.

SGH future action -

As agreed at MMG in October the diagnosis groups related to perinatal mortality are currently being investigated through cross-referencing with reviews completed as part of continuous perinatal mortality review work. This is being supported by the Risk and Governance midwives and will be presented to MMG in December. Previous investigations of this nature have not revealed issues of clinical concern, rather a reflection of our status as a tertiary centre.

The learning from deaths team are currently reviewing the SHMI fractured neck of femur data. This is being considered in conjunction with data provided by the clinical team for the National Hip Fracture Database. The initial outcome of this work will be presented to MMG in December for discussion of the need for additional analysis.

The SJR process is being used to focus on the quality of VTE prophylaxis. This will be triangulated with other sources of intelligence, such as patient safety incident data and clinical audit. This wider project is being overseen by the Chief Medical Officer.

ESTH current issues –

Trust Reducing Avoidable Death & Harm (RADAH) Committee review diagnosis level along with crude mortality rates. As reported previously, there has been a gradual increase in the HSMR and SHMI rates within ESTH since Summer 2021.

Work continues to identifying the cause, including deep dive into clinical outliers, ED prolonged stay, SDEC recording impact and clinical coding audit.

ESTH future action –

The Trust continues to review all unexpected deaths via mortality review and SJR processes and as reported last month, deep dive into bowel cancer continues.

External audit has completed in November and outcomes are being reviewed. The audit reviewed clinical coding and capturing of co- morbidities which has been identified as one of the potential issues, partly due to not having electronic patient record (EPR).

Review with NHS Digital and HED (Healthcare Evaluation Data) teams identified the activity shift of how the new SDEC (same day emergency care) activity is captured. Response from NHS Digital confirmed that Trusts that have previously removed SDEC activity from the APC (admitted patient care) data have seen an increase in their SHMI (the observed number of deaths remains approximately the same because the mortality rate for this cohort is very low and the expected number of deaths decreases because a large number of spells are removed which all would have had a small but non-zero risk of mortality contributing to the expected number of deaths). The medical team of one of these Trusts have approached us and we are sharing insights to see if there common issues we could identify.

The Trust will continue to work with NHSD and NHSE to better understand the planned changes to the recording of SDEC activity, the potential impacts on the SHMI and how these changes should be handled to ensure that the SHMI is calculated for all trusts on a like-for-like basis.

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Monthly Overview – Maternity

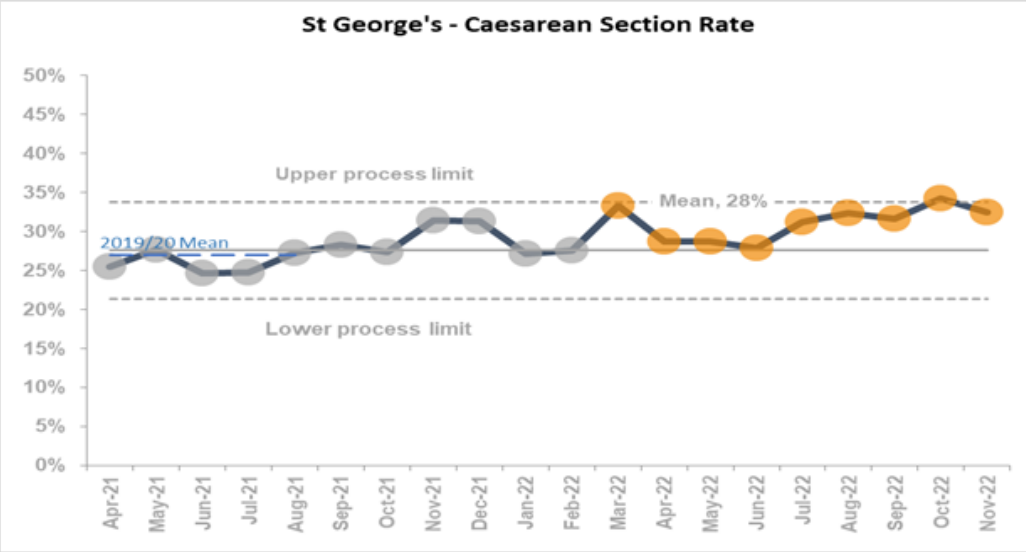
gesh

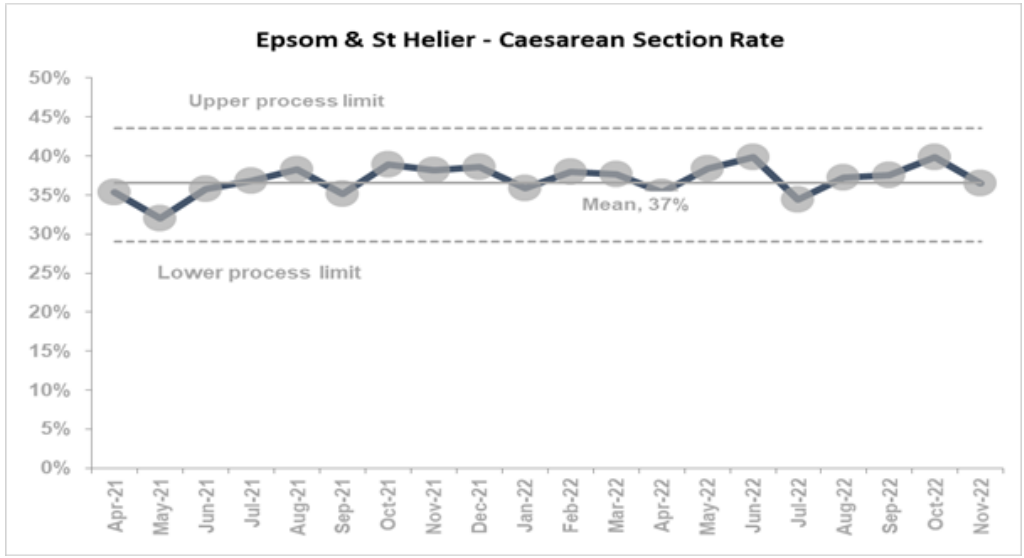
Maternity	St George's							Epsom and St. Helier						
	Monthly Target	Sep-22	Oct-22	Nov-22	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Sep-22	Oct-22	Nov-22	YTD Target	YTD Actual	13-Month Trend
Caesarean Section Rate	N/A	31.6%	34.2%	32.4%		30.9%		N/A	37.5%	39.8%	36.5%		37.4%	
% Births with 3rd or 4th degree tear	<5%	1.2%	1.3%	1.4%	<5%	1.4%		<3%	3.0%	0.5%	2.2%	<3%	2.5%	
% Births Post Partum Haemorrhage >1.5 L	<4%	2.6%	3.2%	2.3%	<4%	2.7%		<4%	2.5%	1.6%	3.2%	<3%	2.6%	
Booking Volumes (Number of Births)	>433	345	374	349	5000	361			331	318	290		320	
Birth Rate - Vaginal	>60%	58.6%	60.0%	55.4%		60.5%			51.7%	60.2%	63.5%		55%	
Birth Rate - Instrumental	14%	13.9%	13.6%	16.9%		14.3%			10.8%	11.8%	10.9%		12%	
Screening - booked before 9+6 weeks	>90%	54.3%	50.3%	39.0%		57%			86.0%	87.3%	88.0%		87%	
Screening - booked before 12+6 weeks	>90%	93.7%	92.5%	85.9%		93.3%		>90%	98.3%	99.4%	99.7%		99.0%	
1:1 support in labour	>80%	81.2%	78.6%	77.4%		80.4%		>95%	99.4%	99.4%	99.7%		99.3%	
Continuity of Care		21.1%	25.0%	23.0%		22.1%			78.6%	78.5%	77.0%		81%	

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

Caesarean Section Rate

Target: NA	SGH: 32.4%	ESTH: 36.5%





SGH updates since last month

Caesarean section rates decreased from 34.2% in October to 32.4% in November. This was split between 14.3% emergency and 18.1% elective procedures.

Only one baby was admitted to NNU for active cooling in November and subsequently had an MRI that has been reported as normal.

ESTH updates since last month

Caesarean sections rates- 36.5%. Following the Ockenden report, this metric has been removed nationally, with emphasis on both safety and women's' choice.

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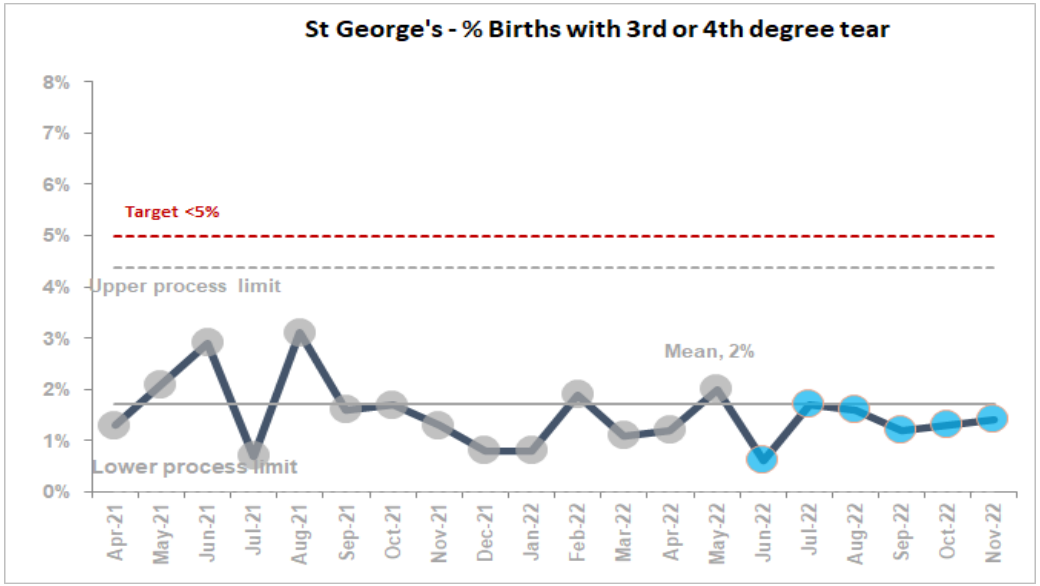
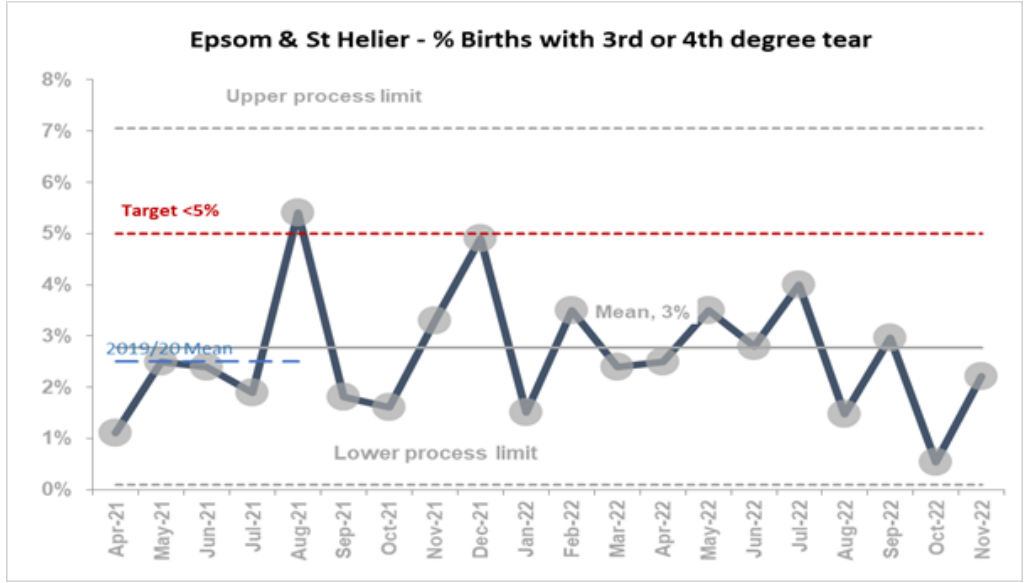
% Births with 3rd or 4th degree tear

gesh

SGH Target: <5%	SGH: 1.4%	ESTH Target: N/A	ESTH: 2.2%





SGH updates since last month

The number of 3rd or 4th degree tears shows a steady but persistent performance over the last few months to 1.4% in November. This is a continuous drive and point of discussion and education across the MDT groups.

ESTH updates since last month

Percentage of births with 3rd/4th is back up in November at 2.2% but still well below target of 5%.

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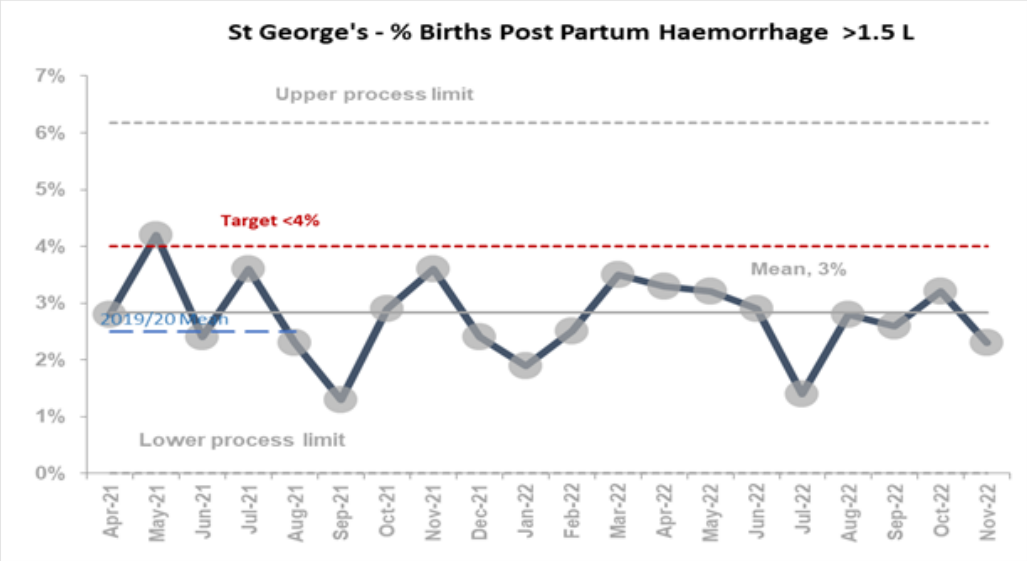
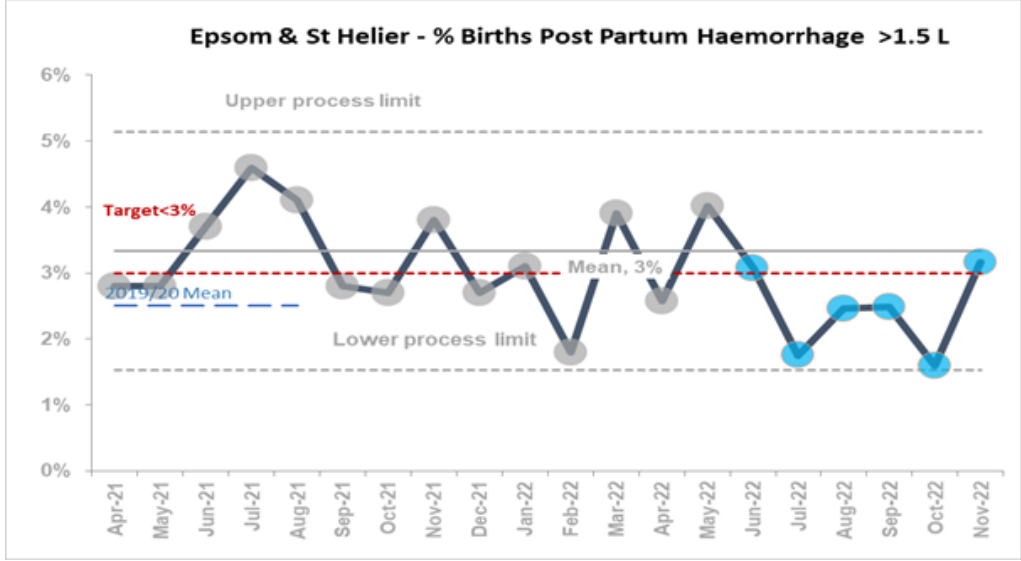
% Births Post-Partum Haemorrhage >1.5 L

gesh

SGH Target: <4%	SGH: 2.3%	ESTH Target: <3%	ESTH: 3.2%





SGH updates since last month

There has been a continued low PPH rate >1.5L in November of 2.3% which is reassuring given the complexity of the women – this is influenced by an ongoing MDT QI project spanning the intrapartum areas to sustain the reduced blood loss for our women.

ESTH updates since last month

The percentage of births with post-partum Haemorrhage >1.5L was 3.2% in November, slightly over Trust target. Epsom site was hight at 5.0% while StHelier site remained low at 1.8%.

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Maternity - Analysis and Action

gesh

SGH current issues –

November's birth rate was 349. with sustained obstetric and medical complexity throughout. Staffing remained challenging across the month with significant mitigation actioned and implemented. This has been influenced by vacancies at band 5 and band 6 level, short term sickness/absences and covid isolation continuing. 15 new starters joined the team in October, an additional 5 joining in November and more in Dec.

The Birth Centre reopened on 7th November and so we have water birth facilities once more. The Homebirth Service was reinstated in September and active throughout October.

CNST compliance remains very unlikely due to significant changes in the third iteration in year for the technical guidance. The most challenging safety action relates to Midwifery staffing, reaching Ockenden/BR+ staffing recommendations, the Band 7 Co-ordinator remaining supernumerary 100% of the time, MDT training rates with the increased denominator following new starters and Transitional Care - 24hr provision and neonatal nurse Staffing.

SGH future action -

Our PROMPT and CTG training in month is to be increased to maximise all opportunities to reach >90% and thus increase safety.

We continue to work with our governance teams and HSIB colleagues to learn all we can from incidents that reach referral and investigation thresholds to influence service delivery.

The Women's Health Triumvirate are participating in two NHSE workstreams to explore and support Health and Wellbeing along with Culture and Leadership within Maternity Services and the staff delivering them.

The Digital Transformation programme is underway with a new IT PMO supporting this vital workstream; this will focus on reducing clinical risk and deficits caused by using multiple reporting platforms.

ESTH current issues –

Following the Ockenden report, Caesarean section metric has been removed nationally, with emphasis on both safety and women's' choice.

Percentage of births with 3rd/4th tear back up in November at 2.2% but still well below target of 5%.

The percentage of births with post-partum Haemorrhage >1.5L was 3.2% in November, slightly over Trust target. Epsom site was hight at 5.0% while St Helier site remained low at 1.8%.

ESTH future action –

Maternity reporting is led by GCNO. ESTH continues to promote the OASI care bundle and review practice.

All 3rd / 4th degree tears are reviewed by a specialist midwife and any learning point identified are shared. Following an observed spike last year, all the 3rd and 4th degree notes were reviewed which found no themes or trends.

In addition, the following changes have made as part of the OASI trial: introduction of Epi- scissors; all midwives and junior/ middle grade doctors receive training on OASI care bundle.

A retrospective review of all our 4th degree tears over the last 5 years and including the women's perspective is being conducted to understand their expectations and our deficiencies and to better manage them in future.

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Monthly Overview – Elective Care (1)

gesh

Responsive and Productive Services - Elective Care	St George's							Epsom and St. Helier						
	Monthly Target	Sep-22	Oct-22	Nov-22	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Sep-22	Oct-22	Nov-22	YTD Target	YTD Actual	13-Month Trend
Outpatient activity	66,178	62,040	58,516	60,903	484,519	478,543		58,401	55,523	55,034	59,458	443,512	439,319	
Patient Initiated follow ups	TBC	252	215	192	TBC	2,057		TBC	947	1,210	1,683	TBC	8,240	
Advice and Guidance	TBC	1,316	1,251		TBC	8714		TBC	1,301	1,444	1,488	TBC	8,888	
Outpatient DNA rates	8%	11.4%	10.9%	10.4%	8%	11.3%		TBC	5.2%	5.1%	5.1%	TBC	5.2%	
Outpatient % virtual	25%	21.4%	22.0%	22.2%	25%	22.4%								
New to follow up outpatient ratios	TBC	2.66	2.00	2.02	TBC	2.40		TBC	2.81	2.61	2.62	TBC	2.78	
Elective and day case activity	5,089	5,017	4,703	5,096	40,267	39,442		4,135	3,299	3,492	3,533	29,510	27,160	
Elective LOS	TBC	4.5	3.8	4.2	TBC	4.1		TBC	5.9	5.4	6.0	TBC	5.7	
Elective Day case rates	79%	78%	78%	79%	79%	79%		82%	90%	90%	91%	82%	90%	
Theatre Utilisation	85%	80%	78%	80%	85.0%	79.8%		TBC	82.1%	81.7%	84.0%	TBC	82.7%	
Theatre Average Cases per Session	TBC	1.70	1.62	1.67	TBC	1.67		TBC	3.66	3.62	3.71	TBC	3.57	
On the day cancellations for Non Clinical Reasons	TBC	27	27	41	TBC	225		TBC	91	79	107	TBC	650	
On the day cancellations for Non Clinical Reasons & Re-booked within 28 Days	100%	100%	82%	88%	100%	95%								

NHS
St George's, Epsom and St Helier
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Monthly Overview – Elective Care (2)

gesh

Responsive and Productive Services - Elective Care	St George's							Epsom and St. Helier						
	Monthly Target	Aug-22	Sep-22	Oct-22	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Aug-22	Sep-22	Oct-22	YTD Target	YTD Actual	13-Month Trend
RTT – total size of waiting list*	47,500	55,626	56,653	57,348				42,200	47,521	47,992	48,204			
RTT - Waits over 52 weeks*	800	768	690	679				165	275	294	265			
RTT - Waits over 78 weeks*	20	35	34	19				0	4	8	6			
RTT – Performance	92%	71.4%	71.0%	70.5%				92%	70.1%	68.9%	69.2%			
Cancer 14 Day Standard	93%	74.6%	62.5%	68.9%				93%	96.6%	94.0%	93.4%			
Cancer 14 Day Standard Breast Symptomatic	93%	27.6%	8.5%	3.2%										
Cancer 31 Day Diagnosis to Treatment	96%	94.7%	93.9%	94.7%				96%	100.0%	100.0%	100.0%			
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	91.0%	83.3%	88.2%				94%	100.0%	100.0%	100.0%			
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	100%	100%				98%	100%	100%	100%			
Cancer 62 Day Referral to Treatment Screening	90%	66.7%	57.6%	59.5%				90%	100.0%	100.0%	66.7%			
Cancer 62 Day Referral to Treatment Standard	85%	68.9%	57.6%	64.7%				85%	85.0%	85.0%	86.6%			
No. of patients over 62 days	160	161	182	135				42	60	41	49			
Cancer – 28 day Faster Diagnosis Standard	75%	69.1%	61.4%	60.5%				75%	80.5%	80.0%	79.3%			
	Monthly Target	Sep-22	Oct-22	Nov-22	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Sep-22	Oct-22	Nov-22	YTD Target	YTD Actual	13-Month Trend
Diagnostic activity	TBC	15,568	16,590	18,051	TBC	253,768		TBC	16,821	16,128	16,998		252,486	
Diagnostic performance	5%	11.6%	8.2%	5.1%				5%	11.9%	12.3%	11.1%			

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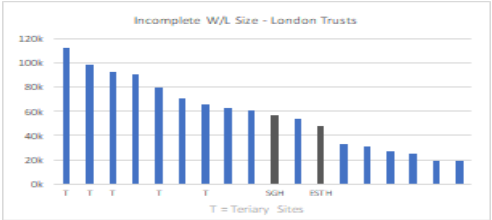
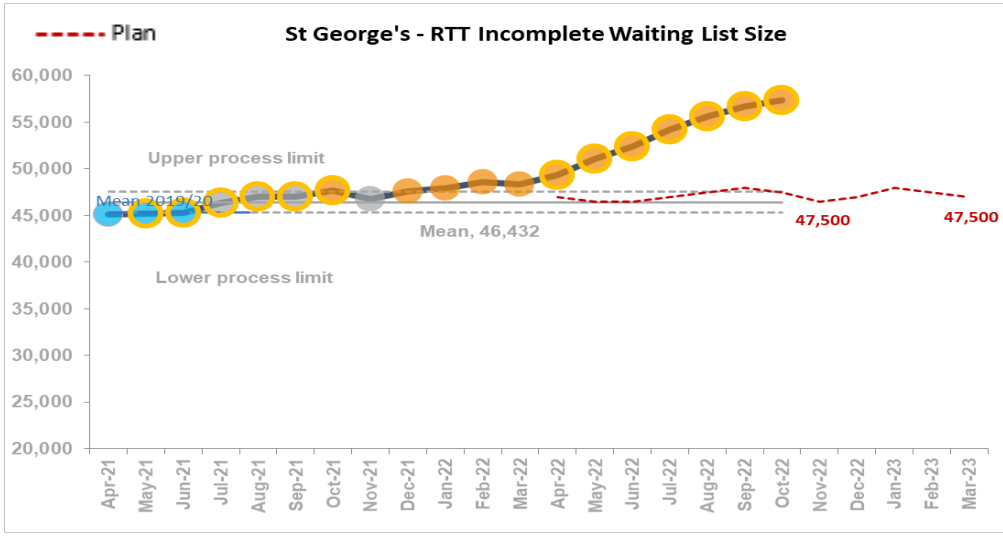
RTT – Total Waiting List Size

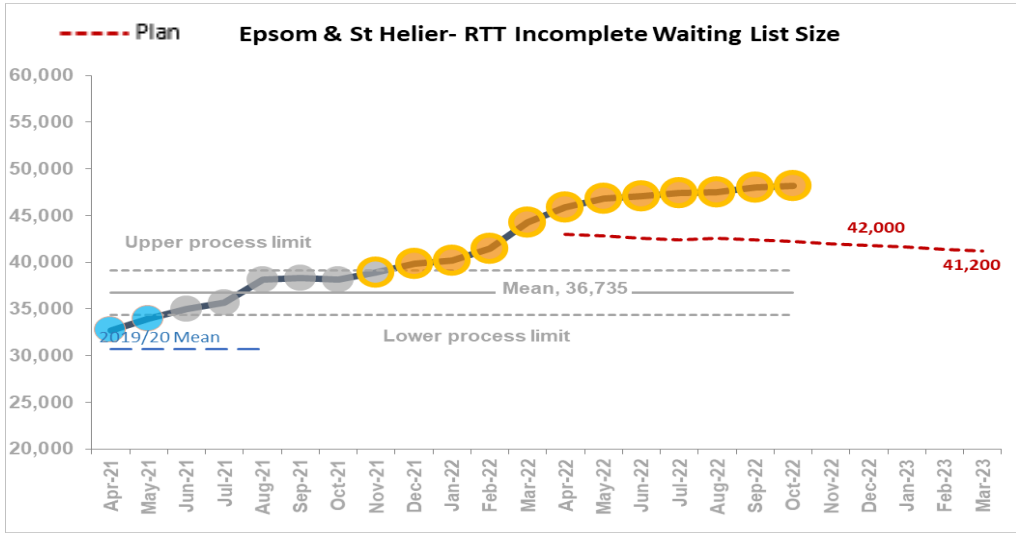
gesh



Oct-22

SGH Plan: 47,500	SGH: 57,348	ESTH Plan: 42,200	ESTH: 48,204





SGH updates since last month

The Trust continues to see the total PTL size grow with 57,348 patients waiting for treatment, remaining above the upper control limit and not meeting plan. Increases seen in both admitted and non-admitted pathways by 1% and 1.3% retrospectively compared to September. This is not related to increasing numbers of GP referrals. The non-admitted PTL is now above 50,000 patients with 13,339 patients waiting for more than 18 weeks, the highest proportion of patients within ENT, Neurosurgery and Cardiology. Going forward SGH will have weekly Elective Access Group to monitor RTT performance including PTL validation and recovery plan in line with demand.

ESTH updates since last month

PTL volume has seen an increase for the twelfth successive month (although the rate of growth continues to be less than 1%), although (18w) breach numbers have dropped very slightly (49 pathways, 0.3%).

As a result, 18w performance has increased (from 68.9% to 69.2%).

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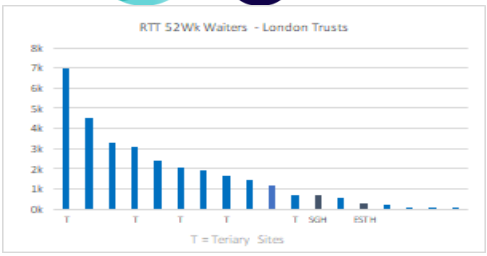
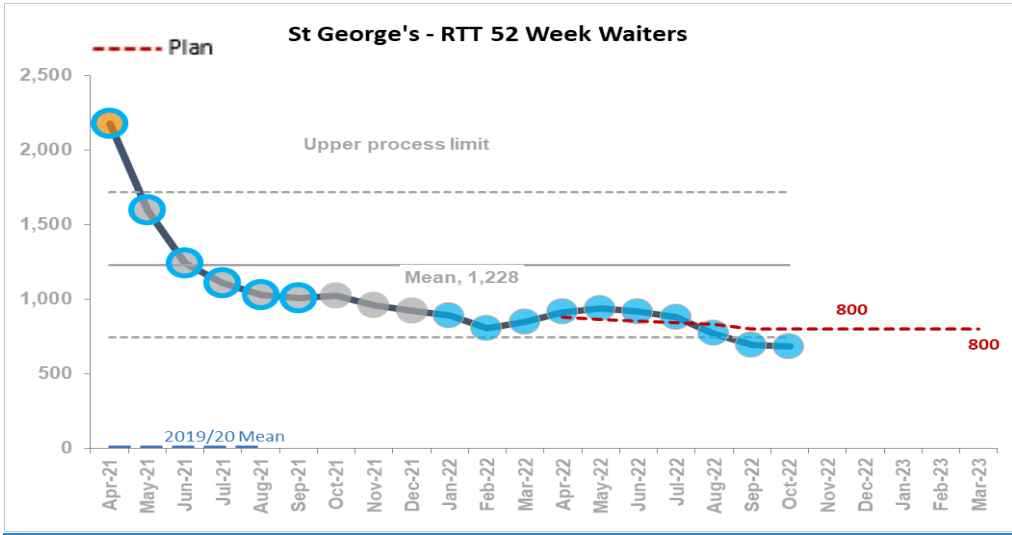
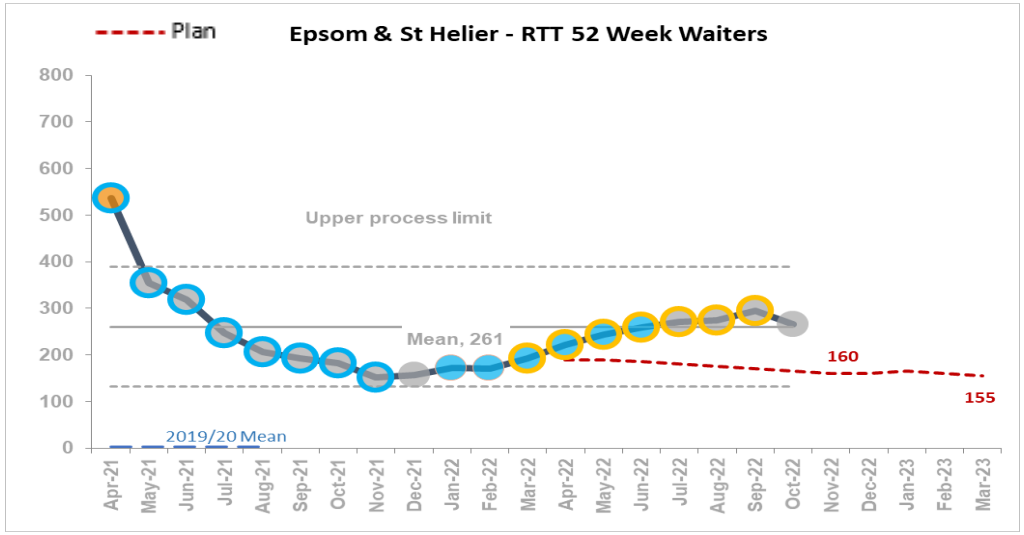
RTT – 52 Week Waiters



Oct-22

SGH Plan: 800	SGH: 679	ESTH Plan: 165	ESTH: 265





SGH updates since last month

There has been a continued reduction of the Trust backlog of long waiting RTT patients in the month of October. The number of 52 week waiters has reduced from 690 patients in September to 679 patients in October, a decrease of 1.6% and ahead of plan. Decreases seen in both admitted and non admitted pathways, particularly within ENT and General Surgery. Largest proportion of breaches within admitted PTL predominantly Cardiology and General Surgery. On the non-admitted PTL Neurology have the largest cohort of 52 week waits.

ESTH updates since last month

The month-end 52-week waits has dropped by 29 pathways, a decrease of just under 1% compared to September.

Largest proportion of waits are within Cardiology, Gastroenterology and Community Paediatrics.

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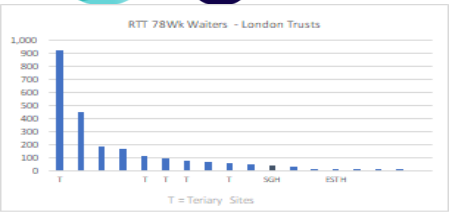
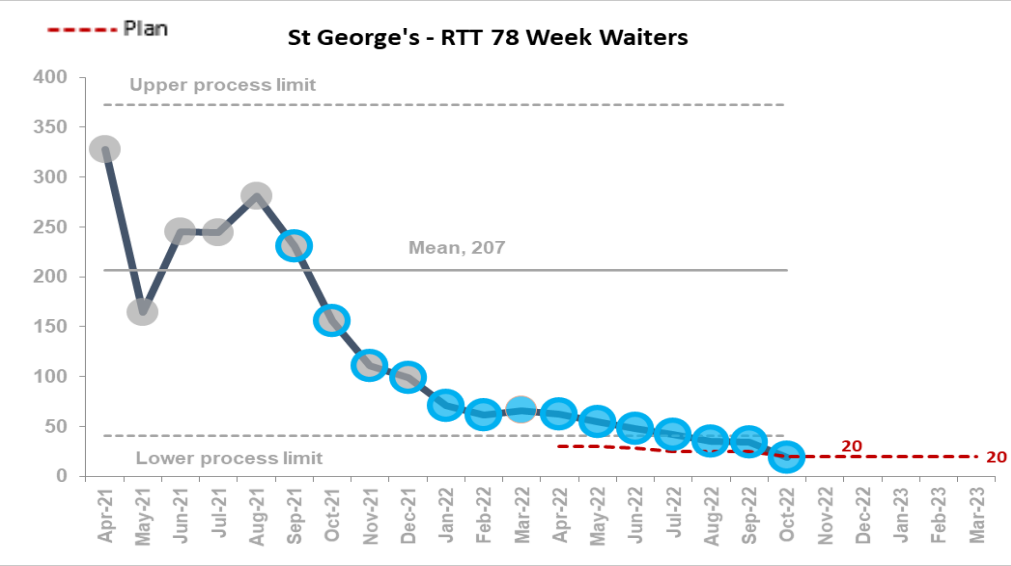
RTT – 78 Week Waiters

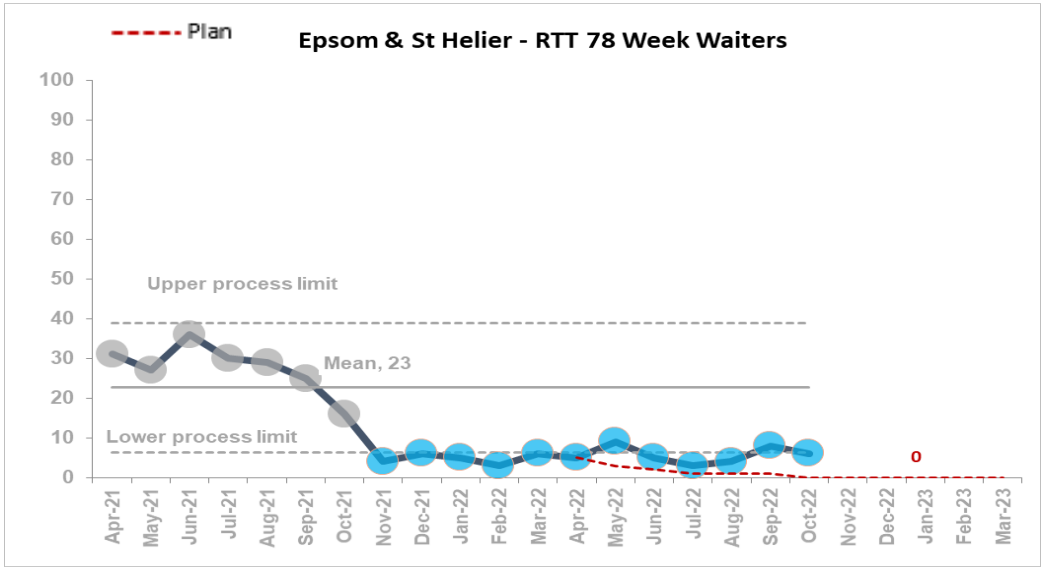
gesh



Oct-22

SGH Plan: 20	SGH: 19	ESTH Plan: 0	ESTH: 6





SGH updates since last month

At the end of October, 19 patients were waiting for treatment for more than 78 weeks, a reduction of 15 pathway's compared to September and now ahead of plan. Patients waiting within; Cardiology (9), Plastic Surgery (7) and General Surgery (3).
There were no patients waiting for more than 104 weeks.

ESTH updates since last month

At the end of October there were six pathways waiting for treatment above 78 weeks (a decrease of 2 pathways compared to September).

There were no patients waiting for more than 104 weeks.

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Elective / RTT Analysis and Action

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SGH current issues –
There are 526 patients, down from 566 last month, waiting over 40 weeks for a first appointment.
Elective activity is at 104% of 19/20 volumes for November
The number of patients waiting over 52 and 78 weeks continues to fall and are on track to achieve year end targets.

SGH future action -
Patients in specific specialties (including Neurology and General Surgery), without an appointment, are being contacted via DrDoctor to confirm if they still require an appointment &/or moving to another provider with shorter waiting times.
Increased focus on production planning to support additional OPA's and day case activity at QMH theatres. Four patients, all within complex neurology, that have waited over 52 weeks without a first appointment. Mutual aid agreed with SWL to offer alternate provider capacity.
Focus on reducing the volume of outpatient data quality issues that may be inflating the PTL size. In addition, there is a focus on cashing-up in a number of specialties where it is having an impact on clock stops and pathway progression. Neurology and Cardiology have the largest volumes.

Patients on the Non-RTT Admitted PTL have been validated to identify any RTT pathways stopped in error. This exercise has now been completed in ENT and Cardiac and the Trust continues with other specialties where the volumes are less. Trajectories for specialties with 78 week concerns are being shared to achieve target of zero waits before end of March. Specific risks in complex Neurology (mutual aid has been agreed) and General Surgery Stretta procedures, this will be overseen in the Elective Access Meeting and monitored weekly.

ESTH current issues –
- GP referrals remain above BAU levels

MRR (Monthly Referral Return)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
21/22 V S BAU (19/20)	95%	87%	115%	100%	109%	116%	107%	123%	121%	100%	119%	128%
22/23 V S BAU (19/20)	110%	114%	116%	100%	119%	118%	TBC					

- Due to the high volume of referrals being received not being fully mitigated by the increased outpatient activity volumes, the PTL continues to grow slowly each month:

Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
44286	45872	46838	47086	47427	47521	47922	48204
	+1586	+966	+248	+341	+94	+401	+282

- Community Paediatrics remains the most pressured speciality with 50 children waiting over 52 weeks for a first appointment (as of 01/12/22).

ESTH future action –
- Croydon have provided mutual aid for 4 Community Paediatric patients. Further mutual aid to be identified. Croydon also continues to provide mutual aid for vascular referrals.

- Divisions and performance team continue to work in collaboration to micro-manage 52WWs on a daily basis and expedite next steps. Long waiter updates being provided to SWL on a weekly basis.

- Deep dive into Gastro long waits carried out in Nov22 with a number of actions required, although the core challenge remains the high number of referrals in to this service which is significantly above BAU levels.

- The use of the validation tool DrDoctor continues to be rolled out across a number of specialties following a successful pilot in Gynae where approx 5% of patients could be discharged.

- Insourcing to continue until Mar23 to support with the mitigation of referrals being significantly above BAU levels.

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Cancer – Faster Diagnosis Standard

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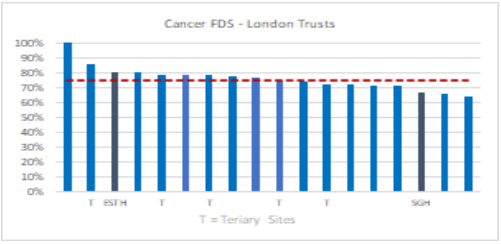
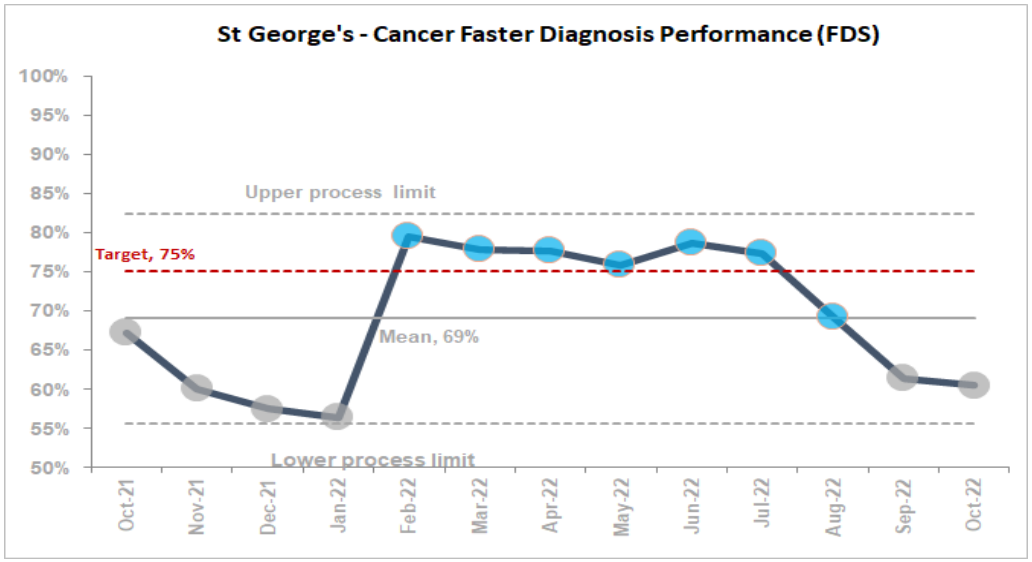
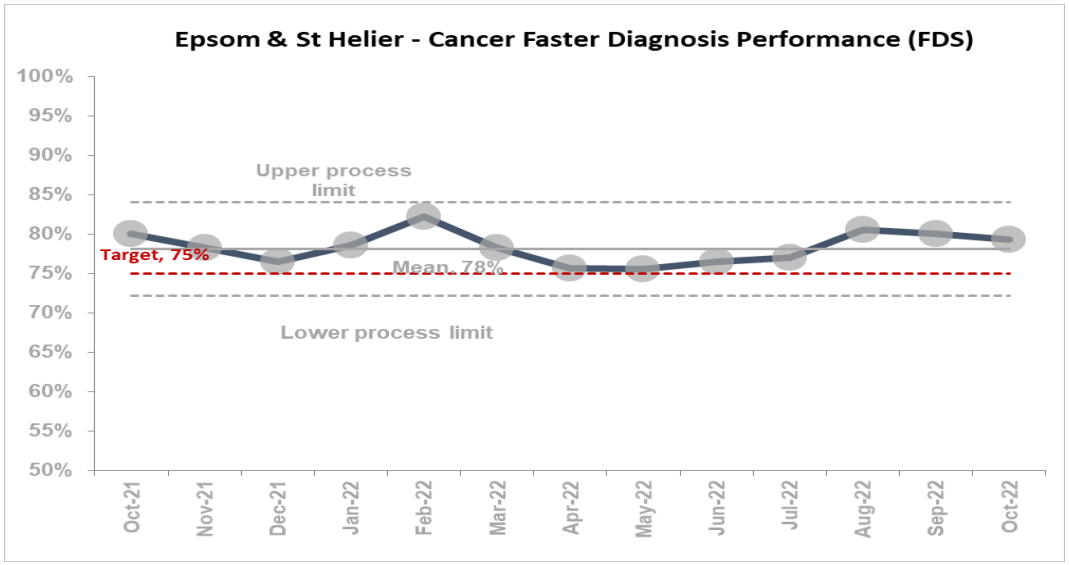


Oct-22

Target: 75%	SGH: 60.5%	ESTH: 79.1%





SGH updates since last month

FDS performance in October was non-compliant for a third month reporting 60.5%. Decrease in performance driven by Breast (12.3%), Lower GI (39.6%) these are both tumour groups where there are a larger proportion of patients. Skin, Gynae and Urology are currently meeting the 75% target.

ESTH updates since last month

Performance against the FDS standard remains stable and above target achieving at 79.1% in October.

The tumour sites struggling are Haematology at 60.0%, Upper GI at 70.8%, Gynaecology at 64.6% Head & Neck at 64.0% and Lung at 73.5%.

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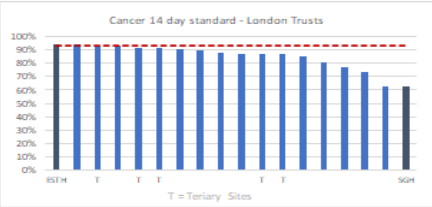
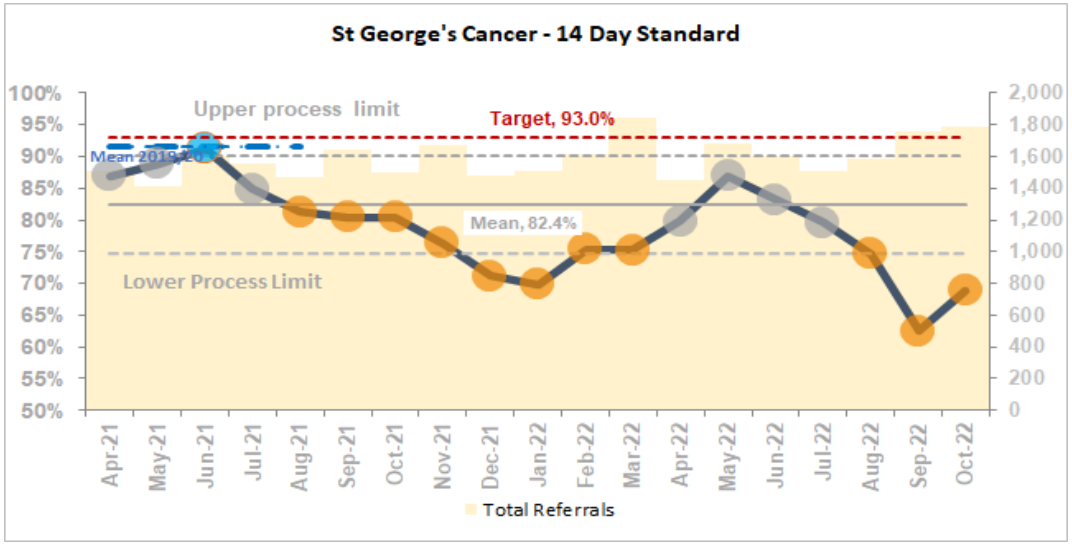
Cancer – 14 Day Referral to Seen Standard

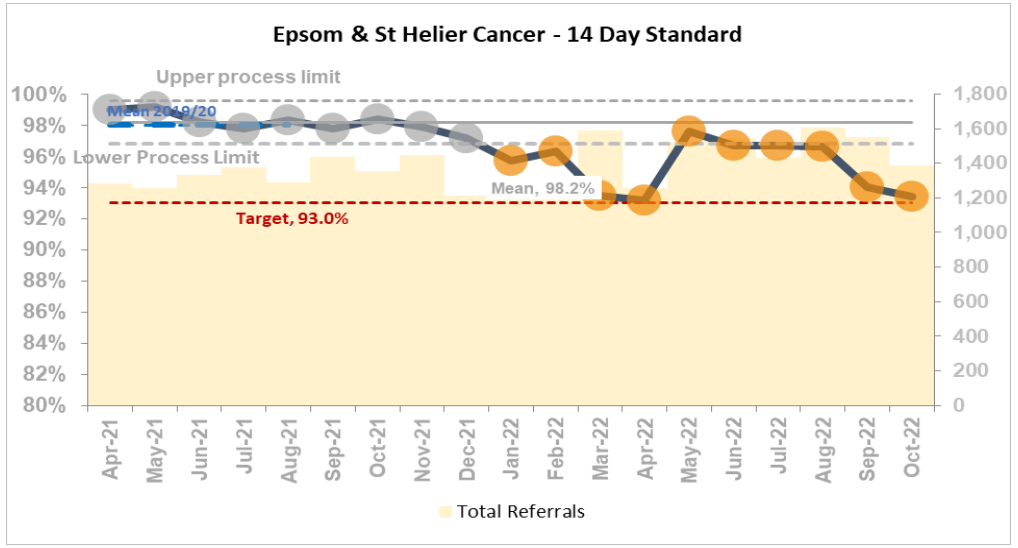
gesh



Oct-22

Target: 93%	SGH: 68.9%	ESTH: 93.4%





SGH updates since last month

Performance improved in October reporting 68.9% compared to 72.5% in September Many tumour groups saw a positive increase in performance however challenges within breast continue to impact overall trust performance, where in the month 5.8% of 241 referrals were seen within 14 days. Skin performance improved by 19% however continue to see high numbers of referrals and are below target by 28.7%.Trust TWR referrals continue to rise seeing a 1.5% increase compared to the previous month driven by Breast, Gynae and Urology.

ESTH updates since last month

In October performance remains above target reporting 93.4%. All tumour groups are achieving target, with the exception of Skin reporting a performance of 83.4% - clinic cancellations due to sickness decreasing clinic capacity.

Total number of referrals seen in October was 1,389 .

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Cancer –62 Day Referral to Treatment Standard

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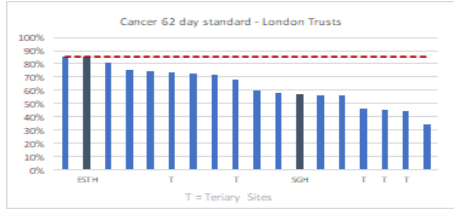
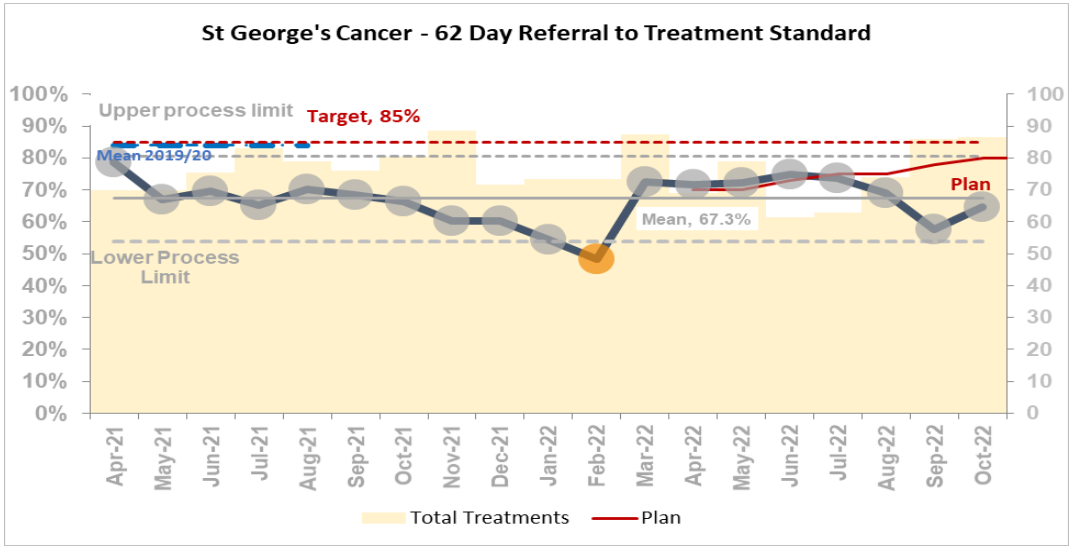
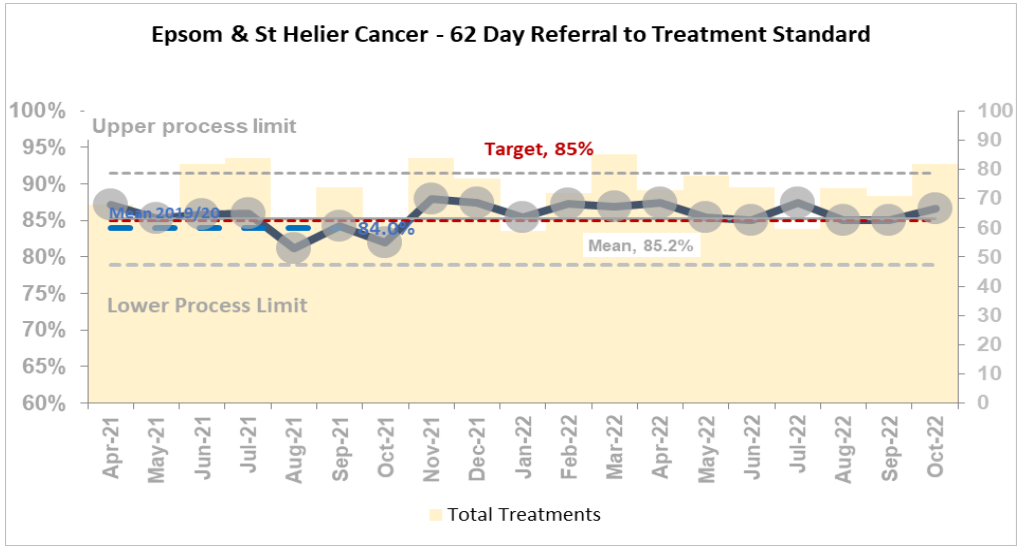


Oct-22

Target: 85%	SGH: 64.7%	ESTH: 86.6%





SGH updates since last month

In October, there were 86.5 accountable treatments on the 62 day GP pathway, an increase of 8% compared to the same period in 2021. At Trust level 64.7% of patients were treated within 62 days, an improvement of 7% compared to September but behind agreed plan of 80%.
All tumour groups remain non-complaint against the 85% standard although seeing improved positions within Head & Neck, Skin, Upper GI and Urology.

ESTH updates since last month

Target of 85% continues to be achieved reporting 86.6% in October.

Lung and Upper GI were below the standard of 85% however Skin and Urology, with the largest proportion of treatments remained complaint achieving 82% and 88% retrospectively

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Cancer – Number of patients > 62 days

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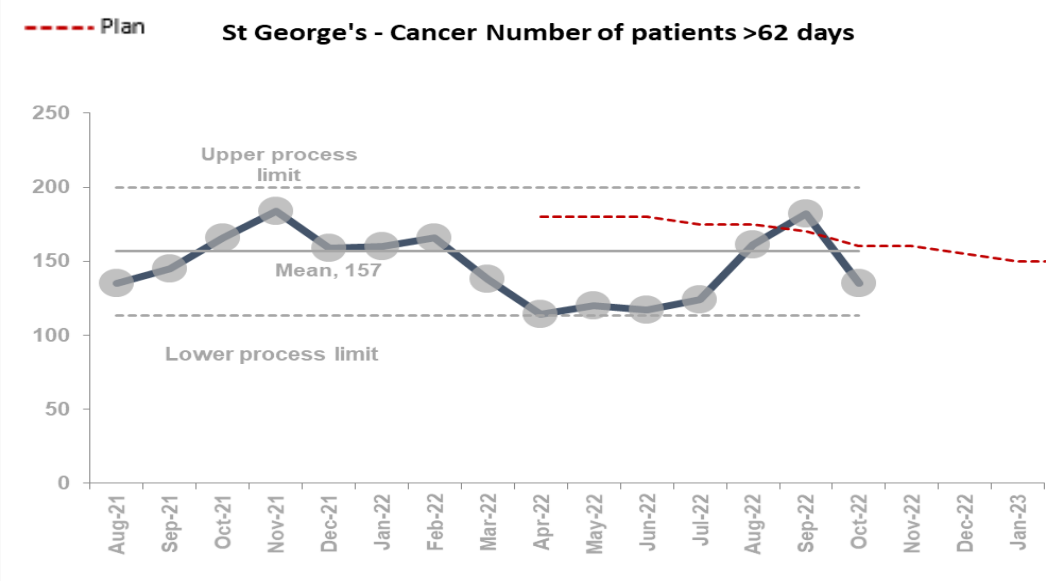
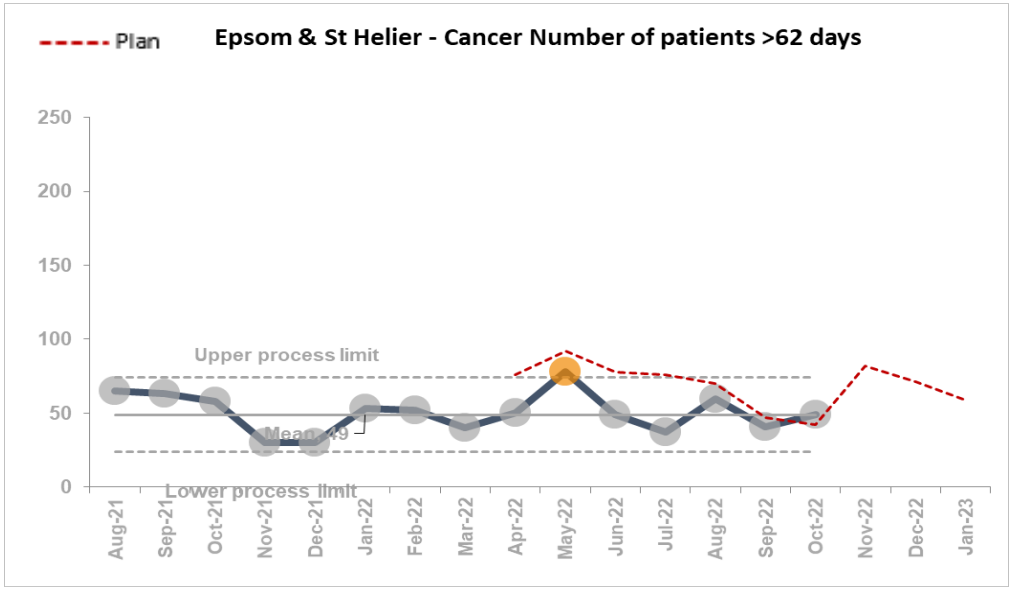
Oct-22			
Plan: 160	SGH: 135	Plan: 42	ESTH: 49





SGH updates since last month

At the end of October 135 patients were waiting more than 62 day, this is a decrease of 47 patients compared to September and now meeting trajectory of 160. All services are meeting plan, apart from Lung. Skin, Breast and Lower GI continue to have the largest backlog however are all meeting plan. Lung are behind plan by 5 patients

ESTH updates since last month

At the end of October, 49 patients were waiting for more than 62 days which is slight above our trajectory of 42.

Five of the patients were waiting for benign letter in approval to be taken off the pathway.

Two patients were still having diagnostic workup.

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Cancer Performance Analysis and Action

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SGH current issues – TWW: Skin saw a drop of referrals in the month of October, however continue to have a large backlog of patients as a result of increase in volumes from Feb 22. and delays in histology turn around times from 7 days to 21 days..
Breast continue to have a backlog of 352 patients waiting a first OPA and a further 300+ patients booked passed day 15. The next clinic availability is 8 weeks.
FDS - FDS Performance driven by increasing referral volumes and capacity issues in Breast. Gynaecology have challenges with hysteroscopy capacity also with Skin referrals are impacting Minor Ops capacity. Pathology delays are seen particularly in the skin pathway where patients are waiting 3 to 4 weeks on average for processing and reporting of samples. Urology MRI and diagnostic capacity is impacting the prostate pathway
62 Day Backlog - Whilst reductions in 62 day backlog were seen, challenges continued in October. Radiology capacity is impacting CT Colon, MRI and other diagnostic delays affecting the GI and urology pathway. Late inter trust transfers are impacting urology and H&N with many patients transferred passed day 62 and 104.

SGH future action -Additional 60K RMP funding has been granted to skin, breast and GI services to support backlog recovery: **Breast** have conducted a demand and capacity review and trajectory, with plans for insourcing up to 120 slots in December 2022 and January 23.
Skin - Plans to relocate up to 40 patients per week to Nelson in a bid to increase see and treat model.
Capital Bids have been submitted for: Skin minor Ops outpatient space/ room at QMH site Gynaecology one stop clinic bid for a new US scanner, 1 hysteroscopy stack system & 8 litescopes. Breast bid for a new ultrasound making. Urology bid for an US Ultrasound scanner
Urology – Prostate pathway is challenged with MRI capacity. There is a plan to double MRI capacity (ring fenced slots) aligned with MRI reporting to take effect in January 23.
Endoscopy - has expanded lists to cover six days/week until Feb 23 which will support capacity.
Pathology – There is a bi weekly pathology board with SWL pathology, ICS and RMP to address pathology challenges, and align cellular pathology cancer escalation protocol across the sector. A capital bid has been submitted of the value of 1.2M for technology to support rapid processing and storage of samples.
Lung - RMP approved £199,227 for an additional weekly EBUS list resulting in an additional 192 cases per year in line with GIRFT & EBUS within 5 days of referral. Delivery has been postponed to Q4; discussions in progress to support commissioning.

ESTH current issues –

Endoscopic Ultrasound (EUS) at Royal Marsden Hospital (RMH) capacity continues to be challenging – current wait is up to 4-5 weeks.

Delivering Telephone assessment clinics in 3 days is achievable in UGI and Urology, however, H&N TAC delivery is more challenging. DoN/AHP reviewing CNS job plans and demand/capacity with DDO to increase resilience in Head/neck TAC pathway.

Endobronchial Ultrasound (EBUS) capacity is also challenging throughout the network, currently our lung cancer patients are referred to UCLH where the average wait is 4-5 weeks turn around. We are hoping for capacity to be agreed at St George's for this work.

The wait for GA diagnostics is typically 2-4 weeks across all areas. Meeting the Rapid Prostate Pathway (Ref to TPPB) within 9 days by default is also challenging. ESTH working with urology and radiology teams to look at ways of increasing capacity, implement local anaesthetic template biopsy by putting a RMP bid for additional equipment.

ESTH future action –

RMH EUS capacity is under focus at group meetings and additional lists have been added. Anecdotally, this is reducing the wait, but it had been noted that RMH stratifies EUS requests into different urgency categories and the team has been advised to ensure requests are allocated a TWW priority which aligns with the patient pathway priority.

In the first instance we have changed in the polling range on eRS to 3 days in Urology Lung and Upper GI. In addition to the Upper GI CNS has increased one extra slot in each of her TAC clinics.

On going work with RM Partners to provide EBUS service within the network.

RM Partners recognises the challenge in providing EBUS for our patients and investment is ensuring to create additional capacity at St George's Hospital.

Template biopsy (TPPB) service provision is planned to change from a clinician led GA to Nurse led LA. This will bring ESTH in line with other hospitals in the sector. RMP has committed to support the purchase of a machine this financial year and also a case to fund staffing for the new service.

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Diagnostic Performance

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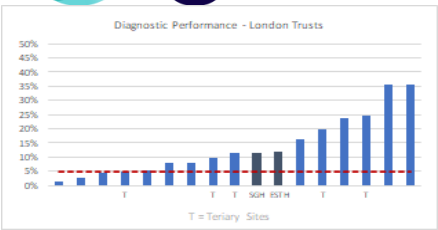
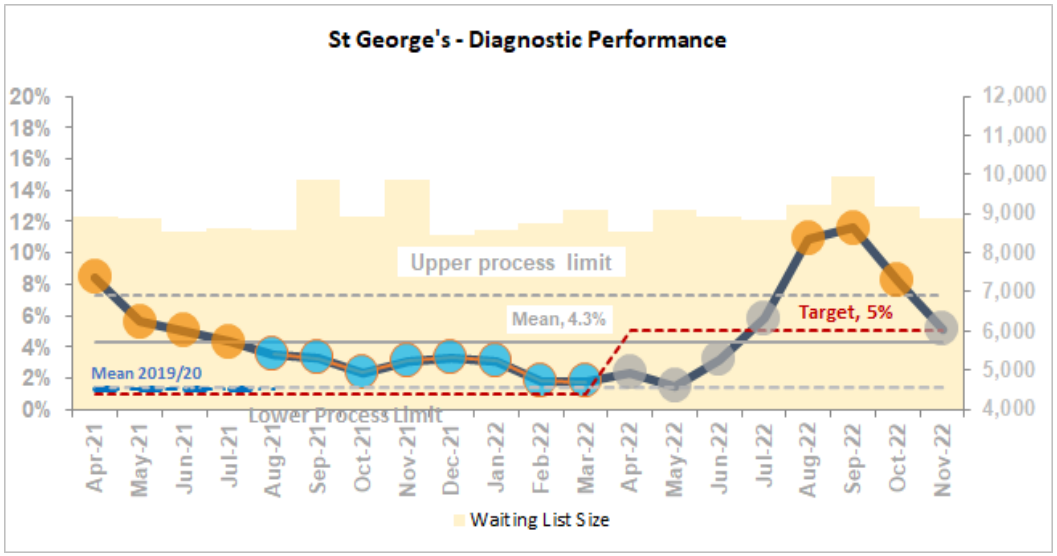
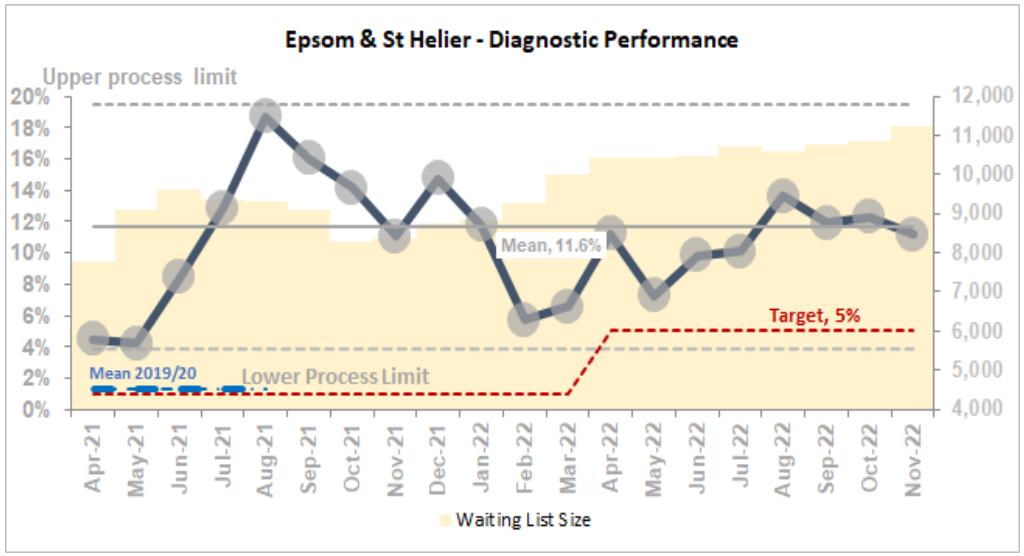


Nov-22

Target: 5%	SGH: 5.1%	ESTH: 11.4%





SGH updates since last month

Improvement in performance seen again in November with 5.1% of patients breaching the six week diagnostic target (451 patients) compared to 8.2% at the end of October. Gynae has eliminated their backlog driving overall performance at Trust level. Cardiac MRI have seen breaches reduce by 50% as additional capacity came on line through November as per recovery plan. Largest proportion of long waiters are within Endoscopy.

ESTH updates since last month

At the end of November ESTH are 1,252 breaches, which is a small decrease on the volume of breaches at the end of October. The PTL size has increased again (and at a slightly higher rate (3.4%) than we have recently seen). These two factors have resulted in an increase to performance from last month.

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Diagnostic Performance Analysis and Action

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SGH current issues –

Staffing within Endoscopy across Nursing, Clinical and Admin continue to be challenged in the short term. This is leading to significant numbers of procedures being booked outside of their 6 week breach date. A programme of additional Saturday lists has been running since 5th November to address this issue. This additional activity has been partially offset by the recent departure of a Nurse Endoscopist who delivered ~20 procedures per week. To date the service has been unable to recruit a successor.

Cardiac MRI continue to have a backlog; however, this has decreased by nearly 50% through November with the aim to be cleared by the end of December.

SGH future action –

The service have carried out a staffing options appraisal to address the current shortfall in endoscopist capacity. A preferred option is due to be identified in December. Additional waiting list initiatives are being delivered at QMH as part of a system-wide CDC recovery plan to mitigate an overall underperformance of activity.

Demand and capacity exercise completed within Sleep Studies resulting in additional sessions in place from January – this will support the service returning to compliance.

Additional ad-hoc clinics added for Urodynamics after seeing capacity challenged through the service due to staffing gaps. In November the number of six week breaches have decreased by 60%.

ESTH current issues –

ECHO capacity remains extremely challenged despite Saturday sessions running throughout the year to provide additional capacity.

An NHSE commissioned departmental review demonstrated current establishment is insufficient to routinely meet the Trust's ECHO demand (inpatient & elective) and this is exacerbated by national staffing shortages impacting on recruitment to existing vacancies.

ECHO DMO1 performance is a network issue, with only SGH managing to maintain waiting lists under 6 weeks at present. The department continue to triage requests upon receipt to ensure that inappropriate demand can be redirected. We also continue to work closely with community partners to help offset some demand more locally where appropriate.

ESTH future action –

Radiology November 2022

DM01 radiology performance for November was 571 breaches. 288 MRI, 52 CT, 228 US and 3 Dexa. Reducing radiology outsourcing by creating more in-house capacity for US and MRI.

The radiology team is working to further reduce vetting and reporting backlogs.

The radiology has successfully appointment radiographer posts to utilise for 7 day working.

Radiology management team is working with estates team to build more resilience for MRI chillers maintenance and breakdown management.

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Outpatient Activity

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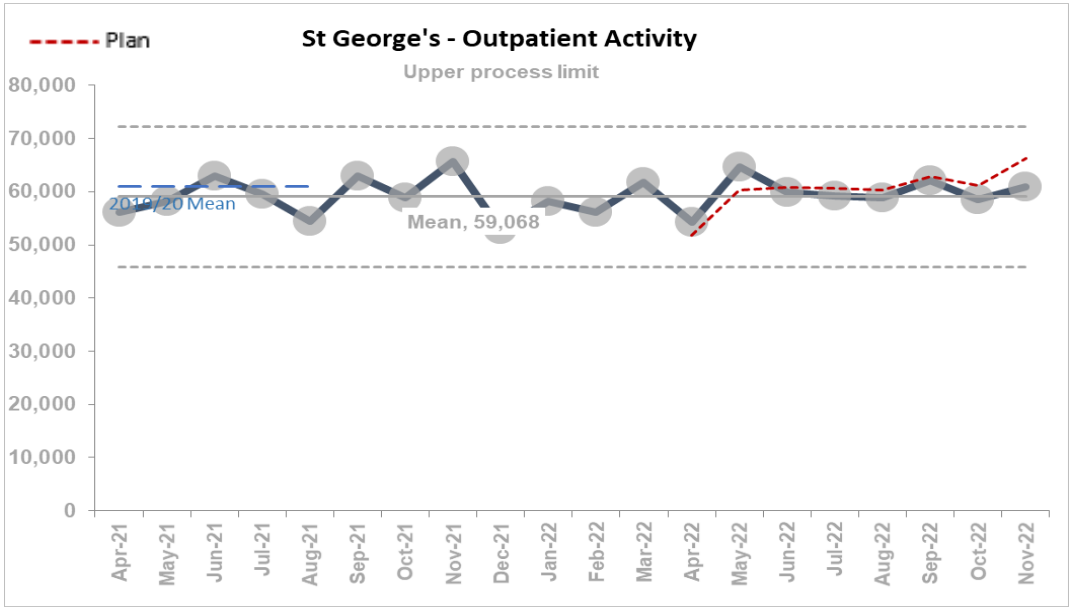
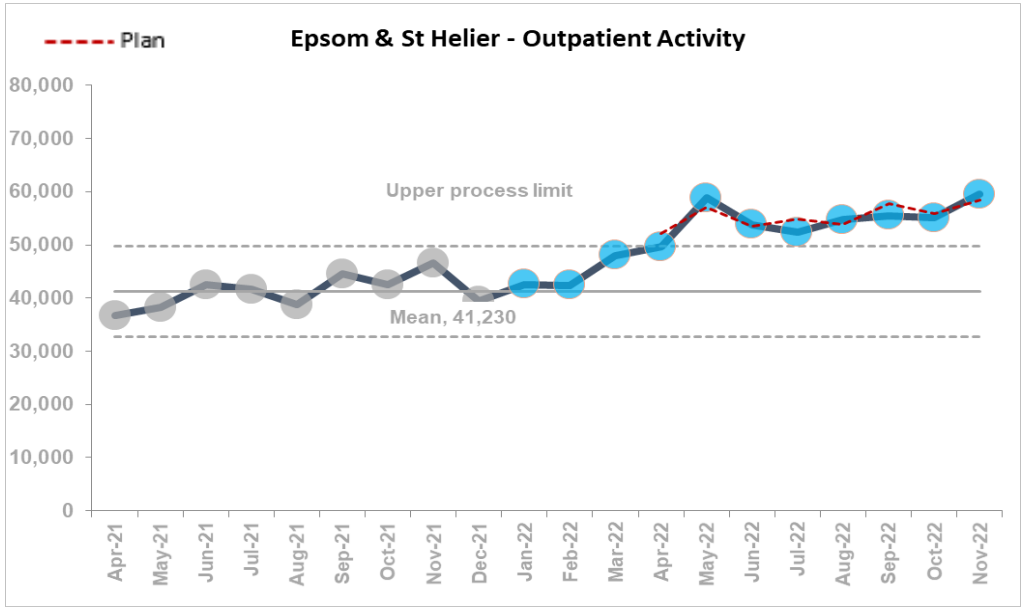
Nov-22

Plan: 66,178	SGH: 60,903	Plan: 58,401	ESTH: 59,458





SGH updates since last month

Outpatient performance is expected to be 95% after catch-up for November, which is behind the 100% plan. Catch up estimates include recodes between first/follow ups and procedure which has led to a reduction in attendances

ESTH updates since last month

Outpatient performance is above plan in the month of November 22

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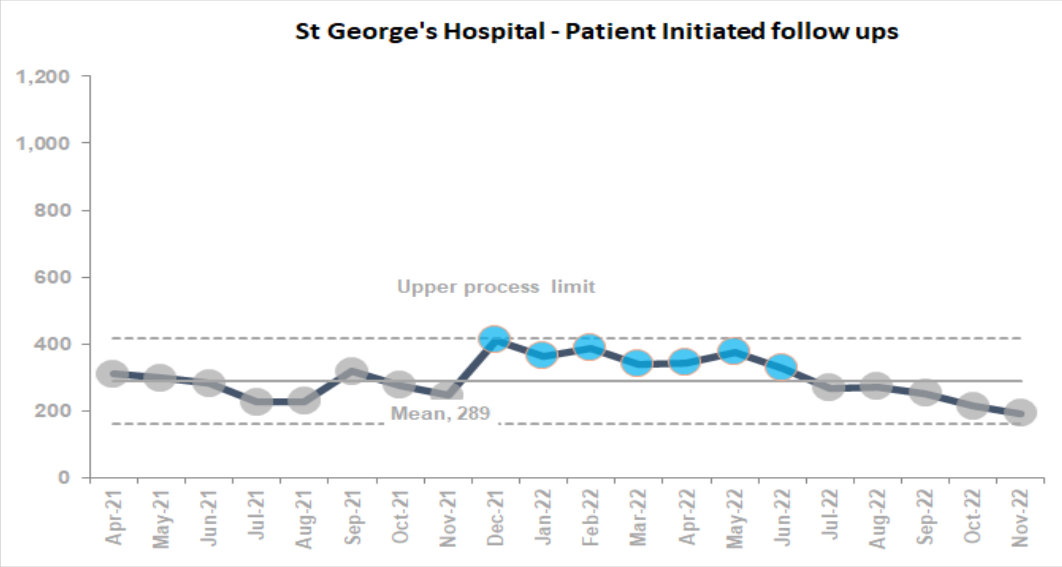
Patient Initiated Follow-up (PIFU)

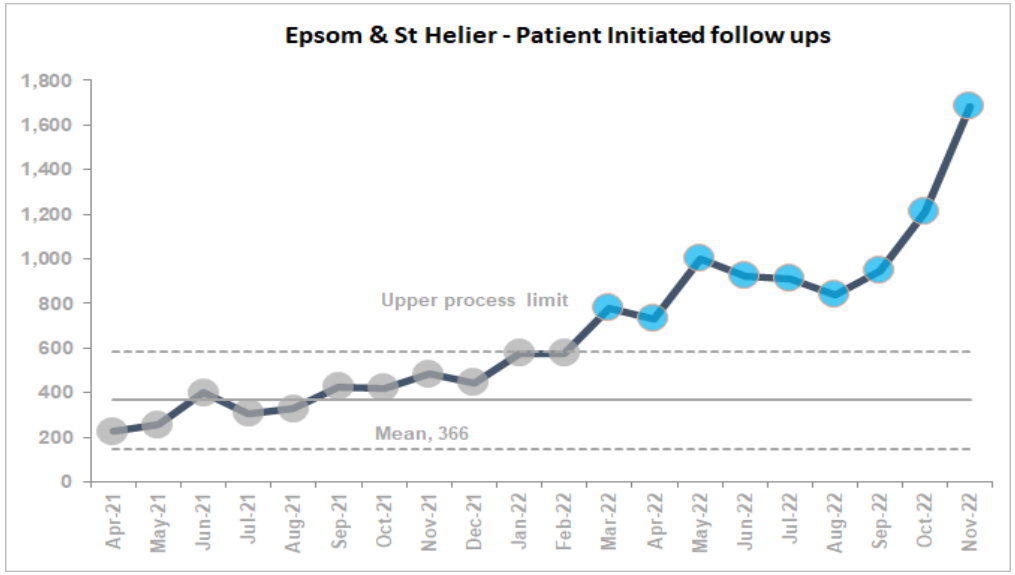
gesh

Nov-22

Target: TBC	SGH: 215



Target: TBC	ESTH: 1,683



SGH updates since last month

The Trust is piloting PIFU with a number of engaged services. Currently data recording functionality is limited. Cerner is preferred solution and is currently in testing. The data shown above will be significantly limited.

ESTH updates since last month

The number of patient initiated follow ups increased further through November with 1,683 patients.

Levels are at the highest recorded and above the upper control limit.

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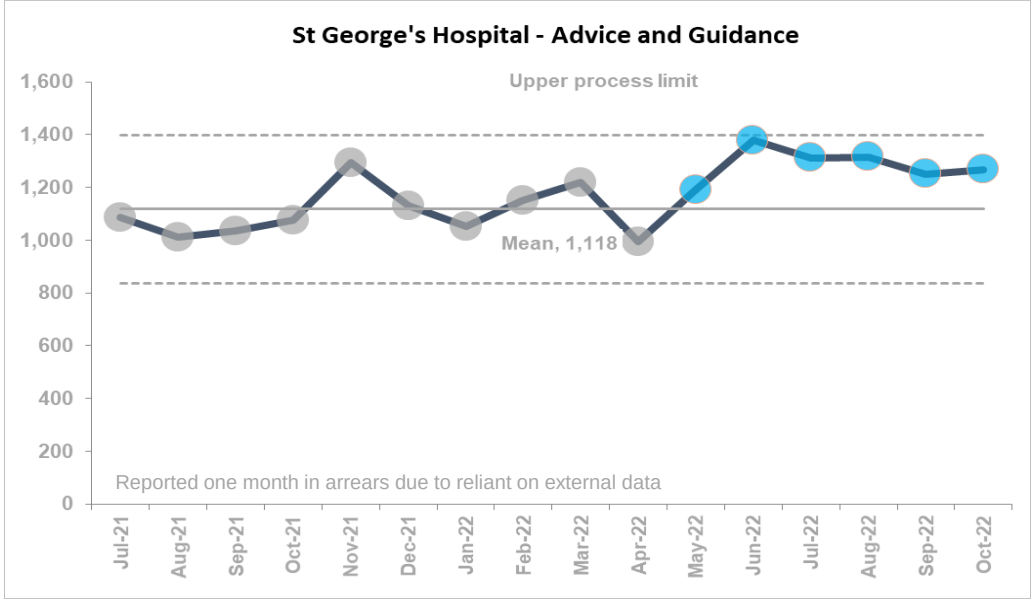
Advice & Guidance

gesh

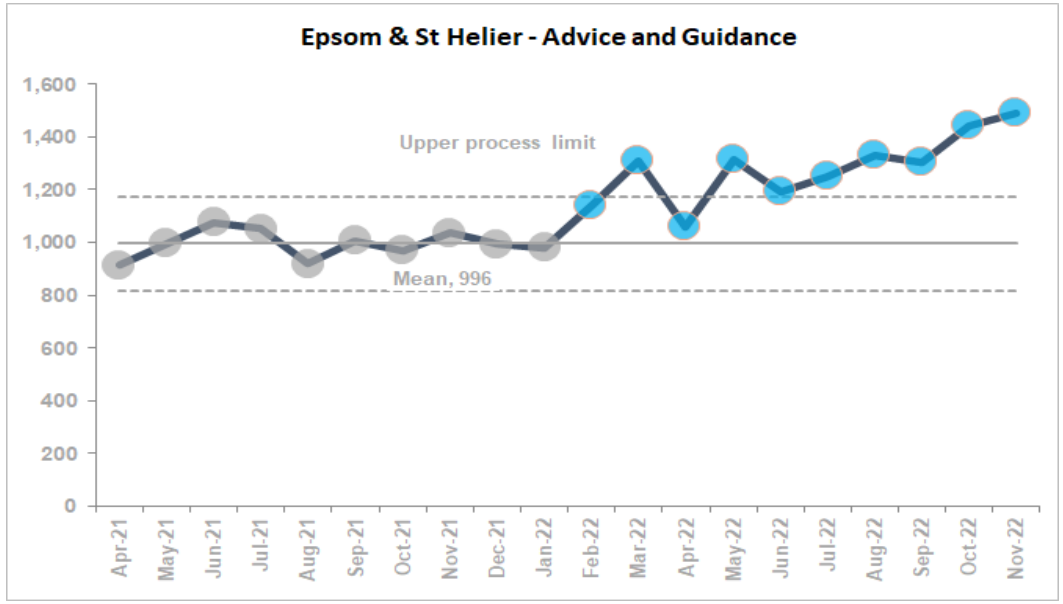
Oct-22

Target: TBC	SGH: 1,268



Nov-22

Target: TBC	ESTH: 1,488



SGH updates since last month

A&G activity is above the mean for the last six month period. Key clinicians are engaged and willing to act as pilot with next steps to agree and roll out plan to increase activity numbers.

ESTH updates since last month

Increase in A&G activity continues to be seen with recent activity remaining above the upper control limit.

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

Outpatient Activity - Analysis and Action

gesh

SGH current issues –

PIFU data collection restricted within system – Cerner functionality in testing which is preferred solution. Some services delivering PIFU but through 'Open Access' policy such as physiotherapies, MSK and gynaecology.

A&G – Some anxieties from GPs regarding response times as currently through Kinesis, nudges' are sent after 24 hours. Mitigation – Have weekly 'Task and Finish Group' with Clinical Lead for Referral Management Wandsworth. Will monitor this throughout our pilot to identify key themes and how we can address these when we move across the remaining services. Clinicians who are involved in the pilot with Kingston provided feedback that once A&G was up and running and became BAU, the response times at Kingston Hospital reduced from the pilot phase and are now comparable to those historically seen in Kinesis. Date for Cerner solution for eRS into Cerner API still not confirmed by Cerner, project manager aware and consistently flagging risk to Cerner leads.

SGH future action -

PIFU - Engaged with services to review and map patient pathways together with production of comms & literature in preparation for progressing once Cerner solution in place. Have engaged with ESTH PIFU programme team who've shared PIFU general clinical briefing, examples of clinical protocols and patient letters. Project manager now assigned and collating project plan and timelines.

A&G – Pilot now launched with Dermatology and Urology on Monday 5th December moving from Kinesis to eRS. Working closely with 6 GP practices in Merton and Wandsworth. Remaining services to move across in Jan 23. Aiming to turn off Kinesis for both services in the next 2 weeks with the 6 practices.

DNAs – Trust average DNA rates has been approx 11%. After success of DNA pilot in Therapies - findings ensured correct telephone numbers and clinic locations on letters, all now resolved – we are supporting ENT with DNA audit and waiting list validation.

Virtual working – Virtual OP hot desk area have been designed and in test stage with clinicians. We are aiming to ensure that our clinical space is being fully optimised by moving activity from clinic rooms to the virtual pods. Space only appropriate for 100% virtual activity

ESTH current issues –

PIFU – Exploring opportunity for a retrospective offer of PIFU with the joint decision making element of the pathway supported via a letter to the patient.

A&G – SWL review to standardise metrics and approach (currently CAS excluded, RAS included)

SWL A&R pilot in Urology scheduled to commence in January. Urology pathways presented to Sutton Clinical Leadership forum for information and notification of pilot start date. The clinical leadership forum have requested proposed changes to the pathways and the proposed amendments are now with the Urology network lead for review and comment. The aim is to bring pathways back to Clinical Leadership forum in January.

ESTH future action –

PIFU – November Trust wide positon (2.7%). Ranking between 1st and 3rd position in London, across a number of specialities

- Continue to monitor and review at Outpatient Performance meetings, to troubleshoot and offer further support and shared learning.
- Continued Peer to Peer learning to identify targeted specs to consider expansion of PIFU (ENT, Cardiology, Rheumatology)
- **A&G - A&R pilot**: (General Urol & menopause) to commence in January. Currently progressing sign off of the SWL pathways across Sutton & Surrey, supported by SWL.
- **Design & implementation of the QV guides continues**
- **Pathway review / Referral Form** - Front end Heart failure pathway, in line with SWL HF Cardiology pathway. General Cardiology Referral Form, Gastroenterology Hepatology pathway, Urogynae (Prolapse & incontinence pathway)
- **Communications** – Updates to the public referrer guidance page (Pathways and patient advice leaflets)
- OPWL initiative (Dr Doctor) - Initially trailed in Gynaecology. In total 2537 new and follow up patients contacted, of which, 99 patients advised they no longer required their appointment (4%), equivalent to saving 5 new and 7 follow up clinics. Although not a CIP, in staff savings this would equate to £7100. Initial trail undertaken in Dermatology Paediatric long waiters (78 contacted, 3 declined, 4%)

  Next pilot phase - T&O, Adult Dermatology. Based on initial pilot outcomes
- **Con to Con** – New triage process pilot commenced December 5th in Gastroenterology.

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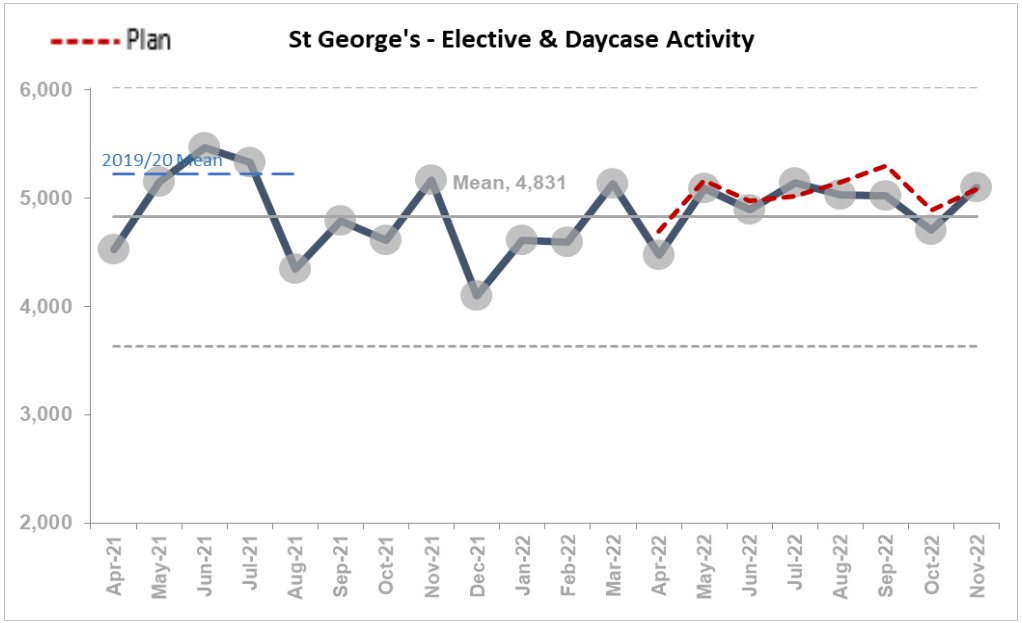
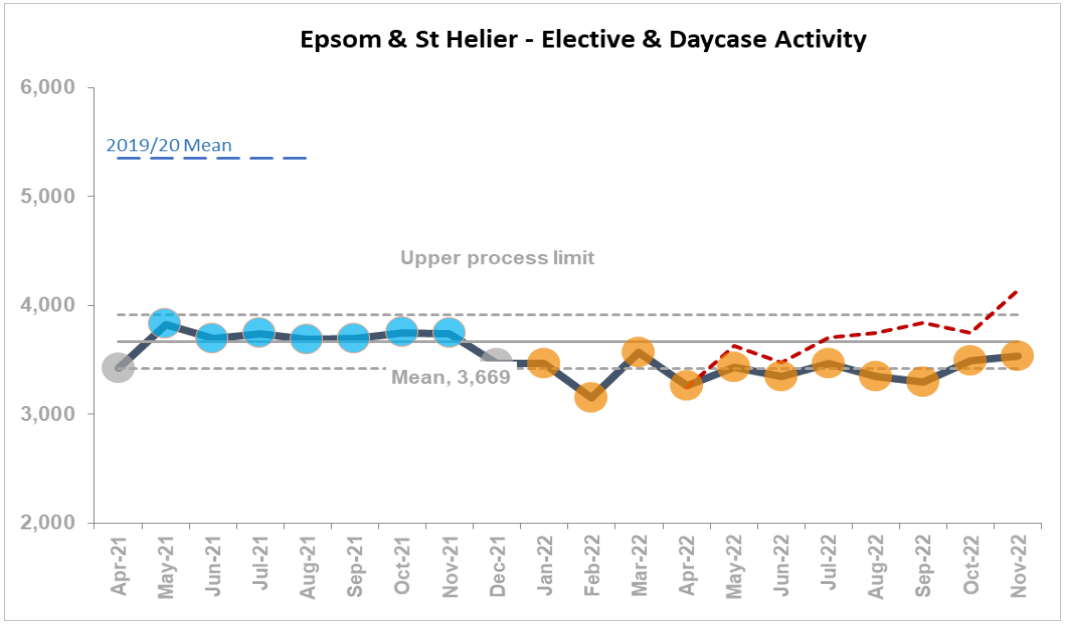
Elective & Daycase Activity

gesh

Nov-22

SGH Plan: 5,089	SGH: 5,096	ESTH Plan: 4,135	ESTH: 3,533





SGH updates since last month

Elective and Daycase performance is in line with plan (after estimated catch up), with a percentage of 104% submitted for November.

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ESTH updates since last month

.Elective activity remains below the mean and is below plan for November 2022..

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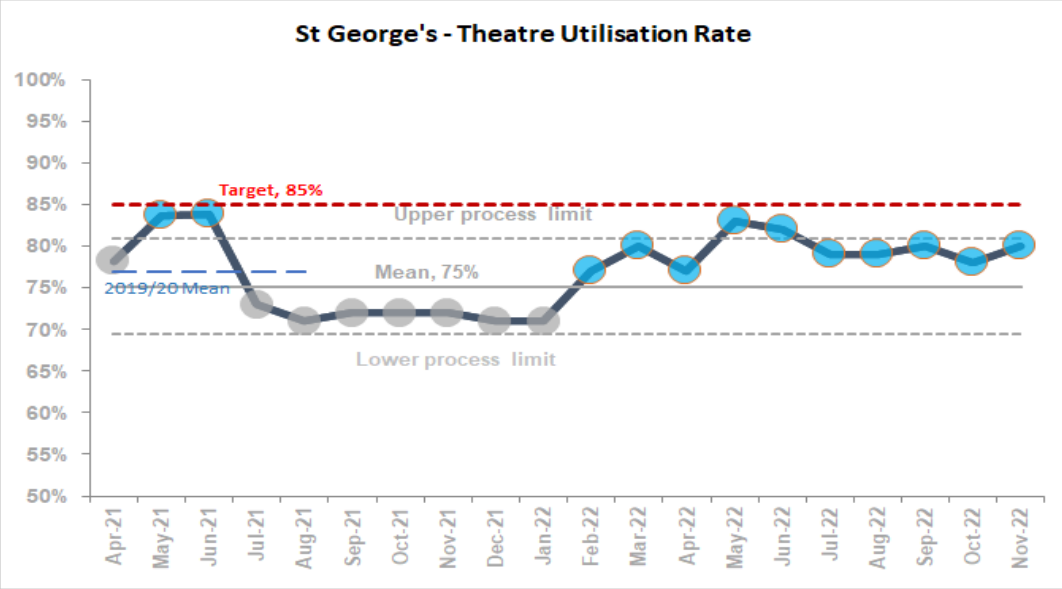
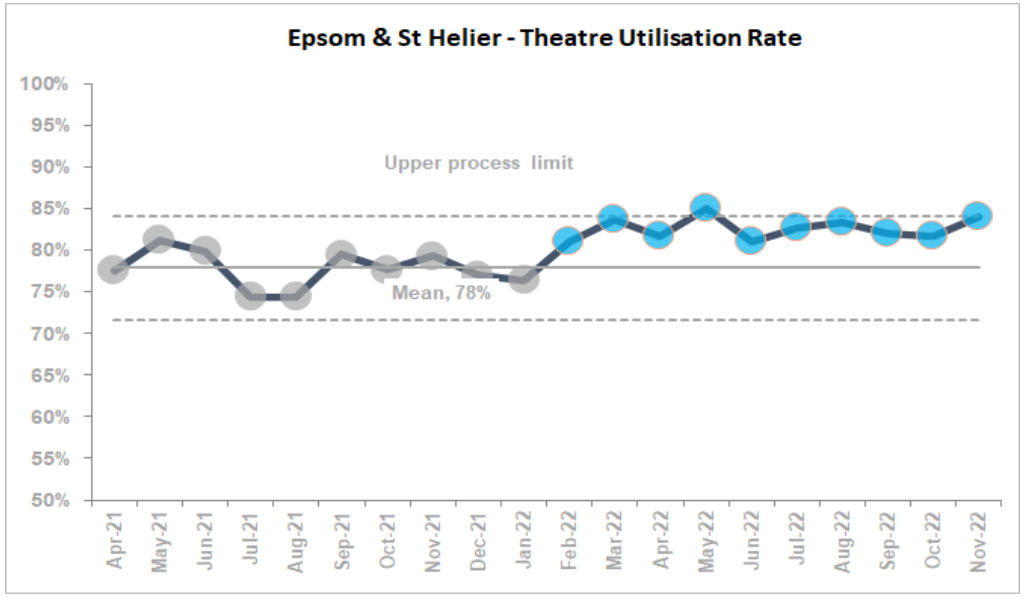
Theatre Productivity - Utilisation

gesh

Nov-22

Target: 85%	SGH: 80%	Target: TBC	ESTH: 83.9%





SGH updates since last month

Theatre utilisation rates remain positive showing a sustained performance above the upper control limits reporting 80% utilisation rate in November.

ESTH updates since last month

Theatre utilisation rates have been consistently above the mean since Feb-22

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Theatre Productivity – Average Cases per Session

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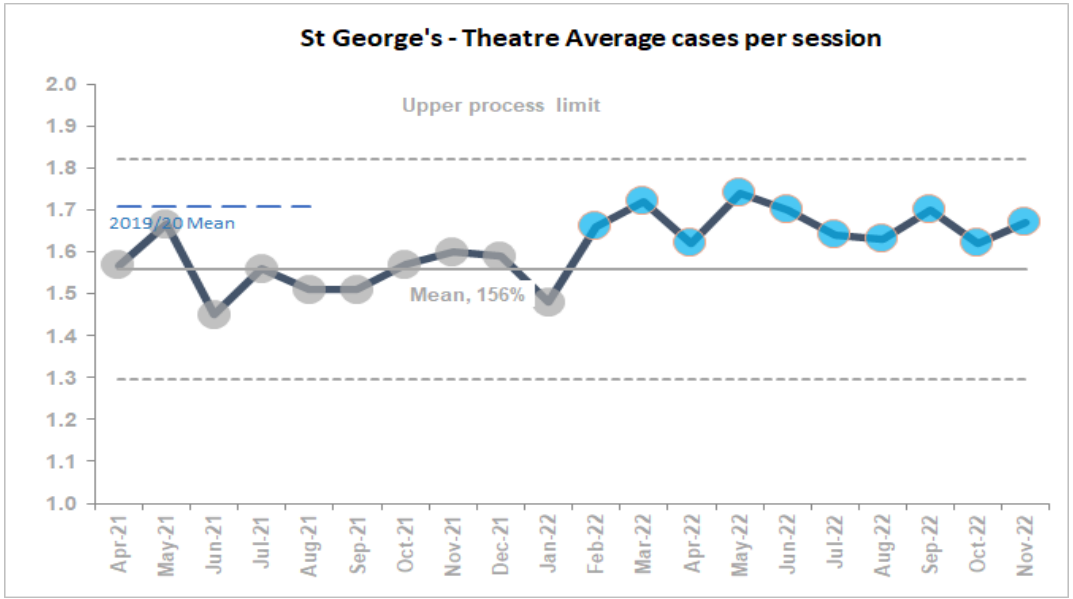
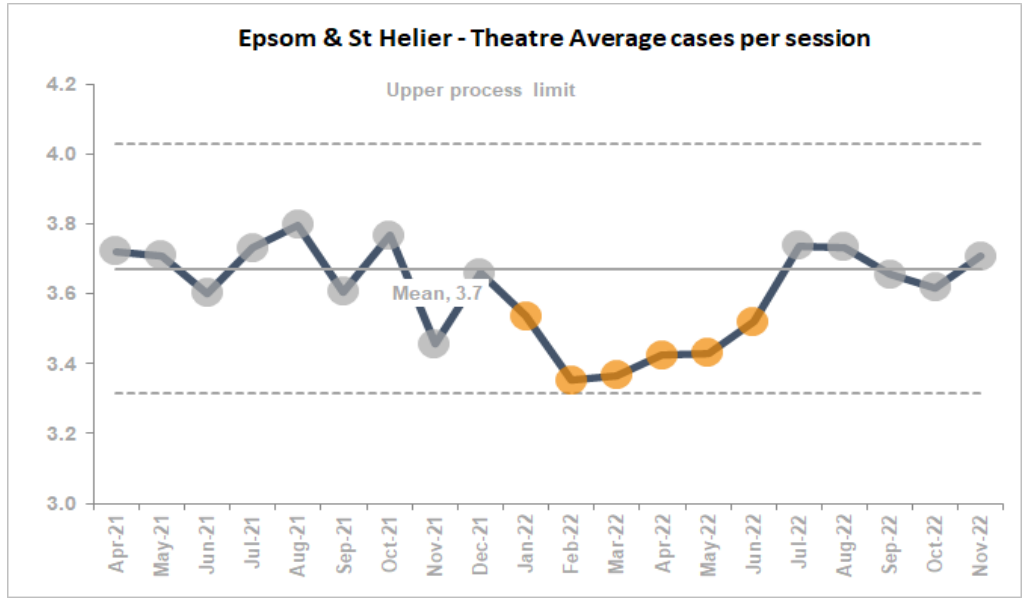
Nov-22

Target: TBC	SGH: 1.67	Target: TBC	ESTH: 3.7





SGH updates since last month

Theatre cases per session performance remains above the mean of the 2019/20 baseline,

ESTH updates since last month

Across the month theatres averaged 3.7 cases per session, this is above the mean and comparable to previous months.

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Elective Length of Stay

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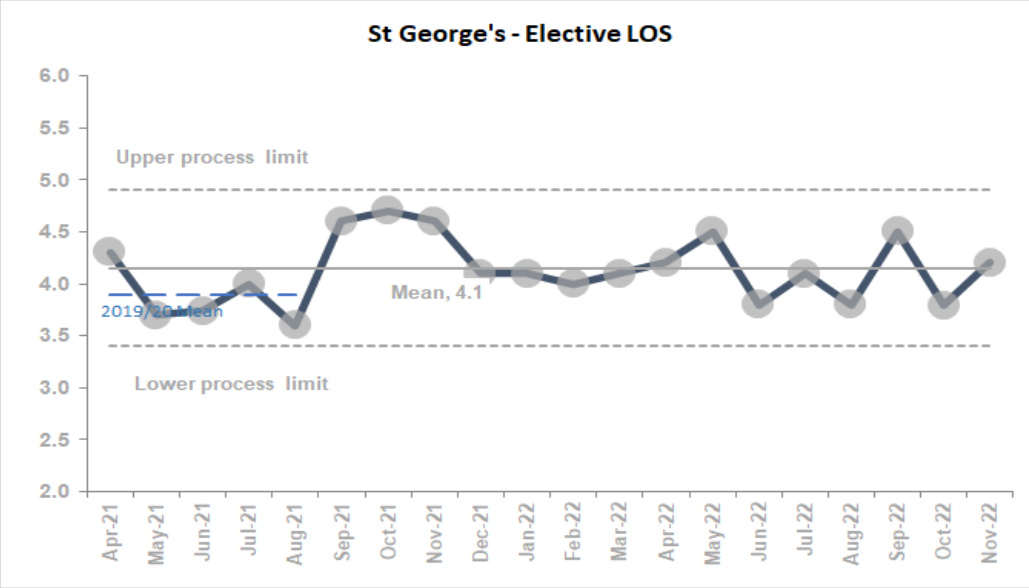
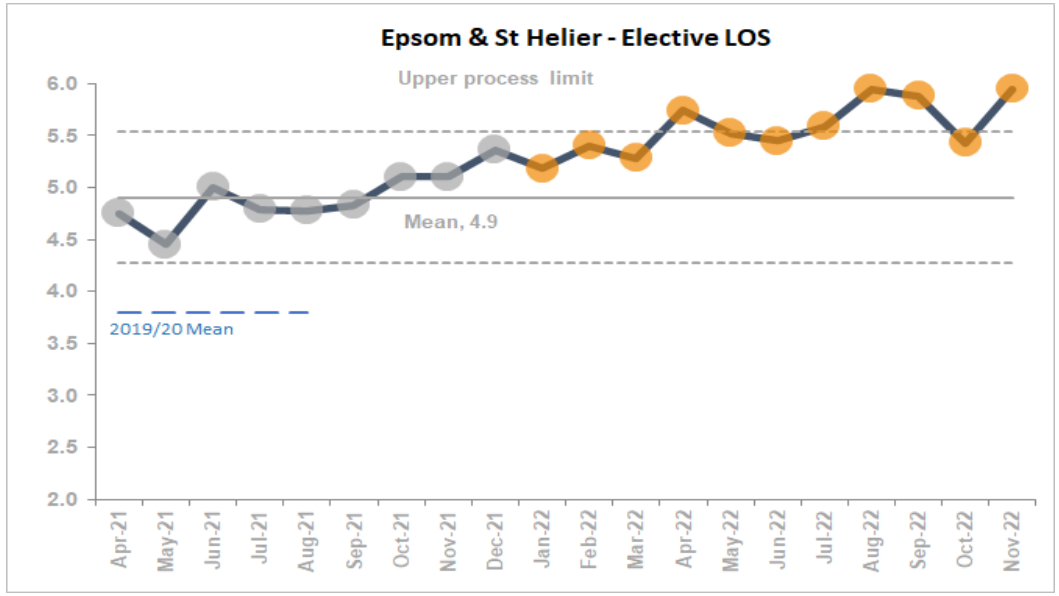
Nov-22

Target: N/A	SGH: 4.2	ESTH: 5.4





SGH updates since last month

Elective length of stay continues within the upper and lower control limits showing only common cause variation. Patients admitted electively stayed on average for 4.2 days through November.

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ESTH updates since last month

Elective length of stay remains higher than the mean increasing to an average of 5.4 days through November.

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Theatre Productivity - Analysis and Action

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SGH current issues –

Productivity

Challenges remain around flow caused by limited ward and ICU bed capacity leading to cancellations.

Recruitment

Four Cardiac anaesthetic consultants have resigned in the last two months. Interviews taking place on 7th December for five Obstetrics and General anaesthetists and two Cardiac anaesthetic consultant posts, with 2 further Cardiac anaesthetists planned for interview in early January.

SGH future action -

ASA1 Streaming: Phase 2 of ASA1 Streaming now launched. This is linked to three, new, high volumes POA clinics which are generating a pool of around 50 patients per week who are ready to be booked immediately (creating a 'Hot list' for surgical specialties to book from in the event of under-booked lists or short notice cancellations).

PACU and Recovery Flow: Work continues on optimising PACU and ITU booking processes and improving identification and scheduling of SDLs to minimise failed SDLs and the risk of cancellations.

Christmas template

DSU and QMH are closed for three days between Christmas and New Year and on the December and January BHs.
IP, DSU and QMH theatres remain open for business 19th-23rd December, and restart a full programme from 3rd January, in order to maximise capacity over this period.

ESTH current issues –

Average Late Starts: 23 mins/% of Lists Starting Late (> 15 mins): 56%

Whilst the average number of mins lost due to late starts has remained largely static, the total number of lists that started late has reduced. This is as a result of focused work on ensuring lists start on time, though this is clearly more to do.

Average Under runs: 37 mins/% of Lists Under running (> 15 mins): 54%

The average under runs has reduced from 47 minutes in October to 37 minutes in November with a marginal improvement in the % of lists that finished more than 15 minutes early. However, this would appear to be as a result of case mix (with more complex and longer cases being booked) as our OTD cancellation rate has worsened in month and we know this results in early finishes.

On the Day cancellations: 9%/% of Short Notice Cancellations: 13%

Both of these metrics have worsened marginally in month and more work is needed to understand why.

ESTH future action –

Late Starts - We have recently opened up our Theatre Annexe to use as an extra consenting area/changing room and some of the Urology Consultants are consenting in the urology centre to reduce pressures on the Surgical Care Suite. This ensures there is capacity for all patients to start lists on time.

The POA workstream is focused on improving POA processes and to ensure we have sufficient POA capacity to enable timely preop review, we are looking to Pilot as ASA 1 pathway as part of the SWL perioperative programme, which will allow for ASA-1 cases to bypass pre-op and proceed straight for surgery, creating more capacity for more complex patients.

Work is also underway to review the accurate recording and reporting of cancellation reasons so that we can focus our efforts appropriately, however it is hoped that the above POA work will support a reduction in OTD cancellations.

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Monthly Overview – Non Elective Care

gesh

Responsive and Productive Services - Non Elective Care	St George's							Epsom and St. Helier						
	Monthly Target	Sep-22	Oct-22	Nov-22	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Sep-22	Oct-22	Nov-22	YTD Target	YTD Actual	13-Month Trend
4 Hour Operating Standard	95%	79.1%	78.0%	81.1%	95%	76.1%		95%	75.9%	74.4%	73.1%	95%	75.2%	
12 Hour Trolley Waits	0	351	691	697	0	3596		0	269	308	375	0	1344	
Ambulance handover Performance 30 minutes	0	275	85	106	0	1774		0	337	342	336	0	2208	
Ambulance handover Performance 60 minutes	0	96	235	198	0	1184		0	109	246	220	0	1095	
Non elective length of stay	TBC	7.4	7.1	7.6	TBC	7.42		TBC	7.9	7.3	7.9	TBC	7.55	
Mental health delays 4 Hour Breaches	TBC	125	98	103	TBC	716								
Redamission Rate - Non Elective	TBC	9.0%	9.3%	8.6%	TBC	8.8%		TBC	5.2%	4.8%	5.8%	TBC	5.2%	
Length of stay > 7 days (stranded)	TBC	375	393	386	TBC			TBC	155	151	152	TBC		
Length of stay > 21 days (super stranded)	TBC	169	172	230	TBC			TBC	70	65	62	TBC		
Number of patients not meeting criteria to reside	TBC	183	202	203	TBC			TBC	178	168	170	TBC		
Number of patients not meeting criteria to reside % of occupied G&A beds	TBC	31%	34%	34%	TBC			TBC	37%	35%	35%	TBC		

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4 Hour Operating Standard

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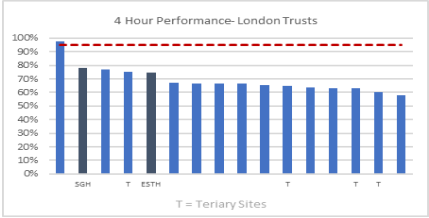
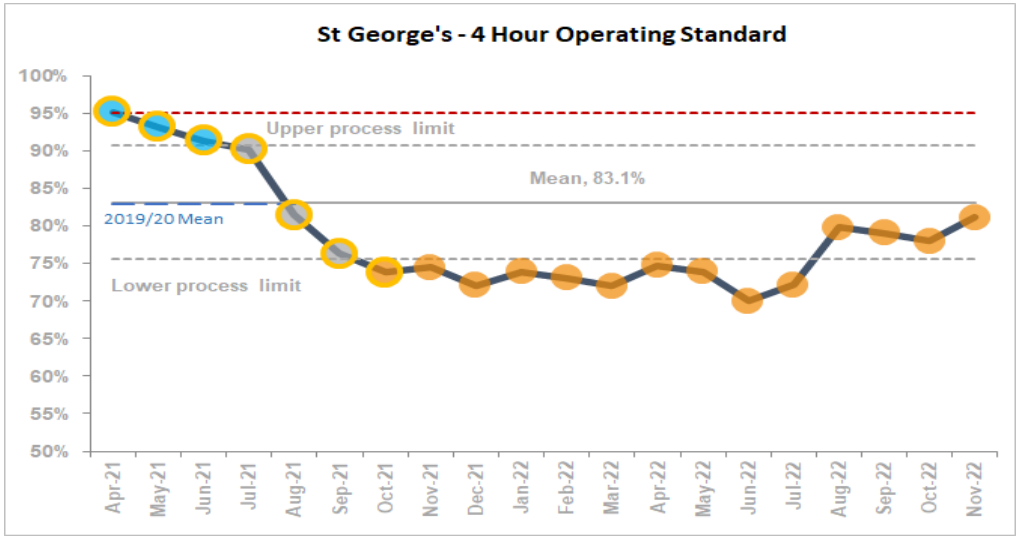
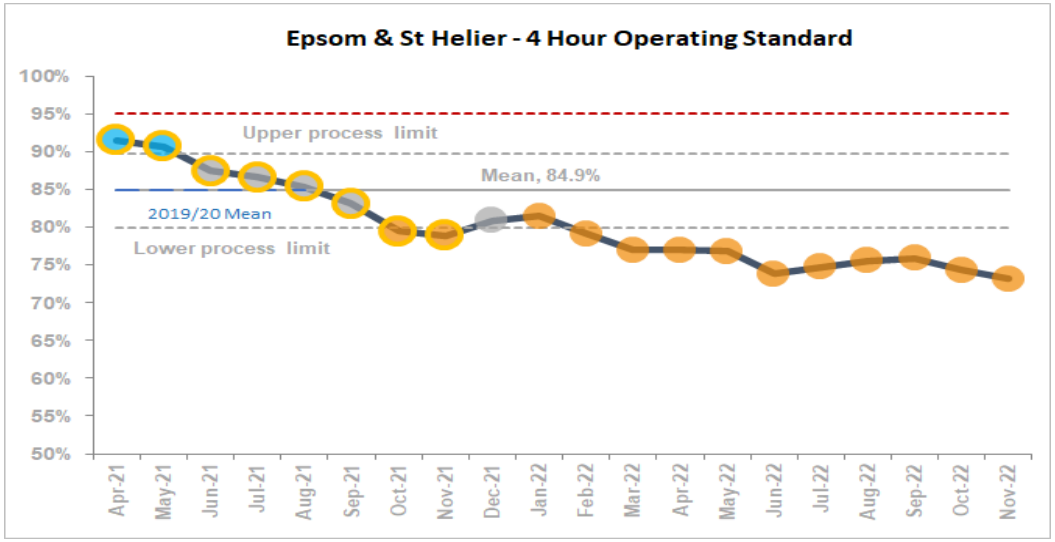


Nov-22

Target: 95%	SGH: 81.1%	ESTH: 73.13%





SGH updates since last month

In November, 81% of patients attending the emergency department were either discharged, admitted or transferred within four hours of their arrival, an increase of 3% compared to the October. On average across the month there were 420 attendances per day, a daily increase of 1.7%. Acuity remains varied with approximately 50% of patients triaged with a Manchester triage score between 1-3. The proportion of patients requiring admission reduced slightly.

ESTH updates since last month

In November, there were in total 14,110 attendances of which 73.13% of patients were either admitted, discharged or transferred within four hours of their arrival. This is a decrease compared to the 74.35% in October.

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12 Hour DTA's

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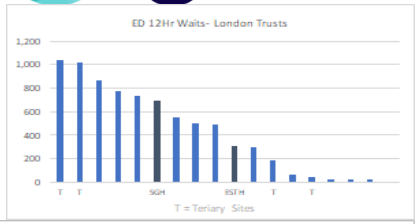
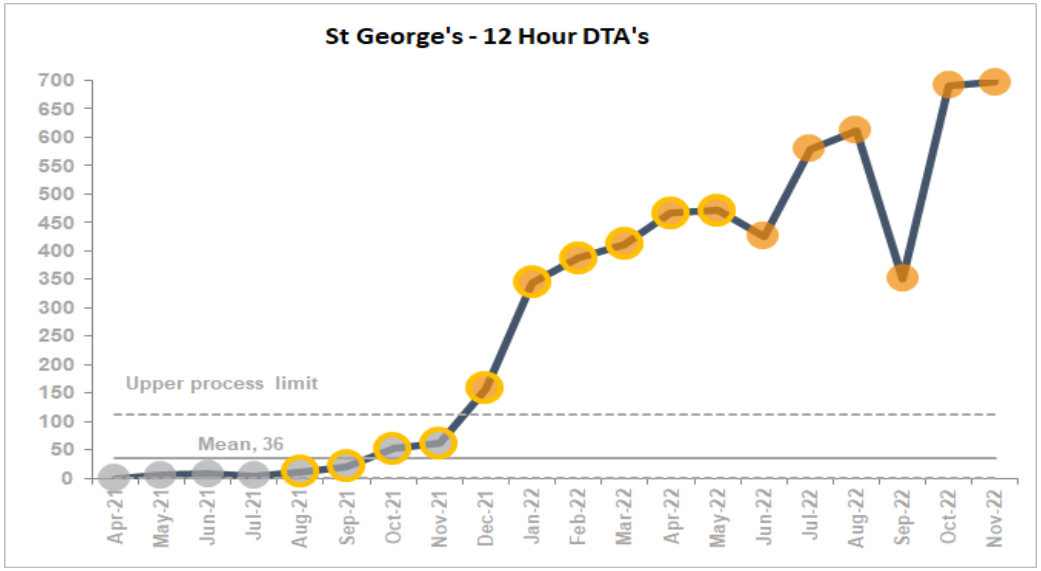
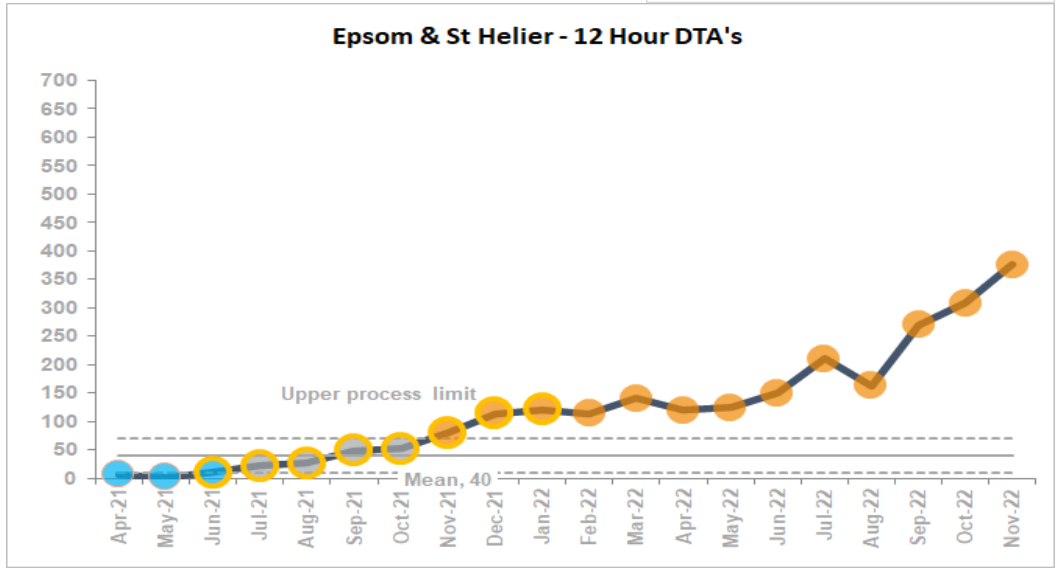


Nov-22

Target: 0	SGH: 697	ESTH: 375





SGH updates since last month

Through November a total of 697 patients waited for more than 12 hours for admission following a decision to admit, comparable to the previous month averaging 23 patients per day. Monday and Tuesdays are the more prevalent.

ESTH updates since last month

There has been an increase in twelve hour breaches in November (from 308 to 375).

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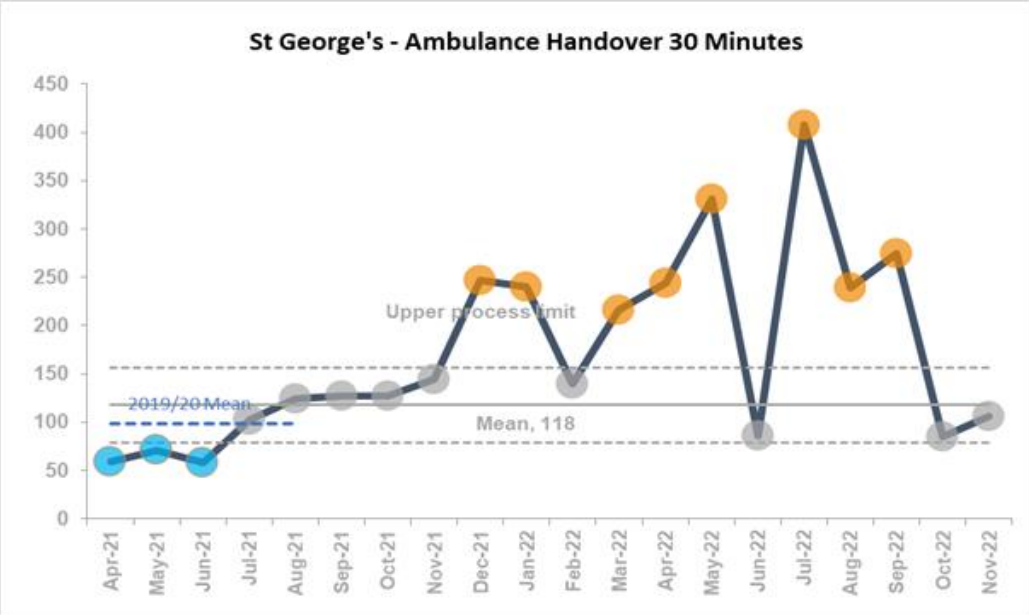
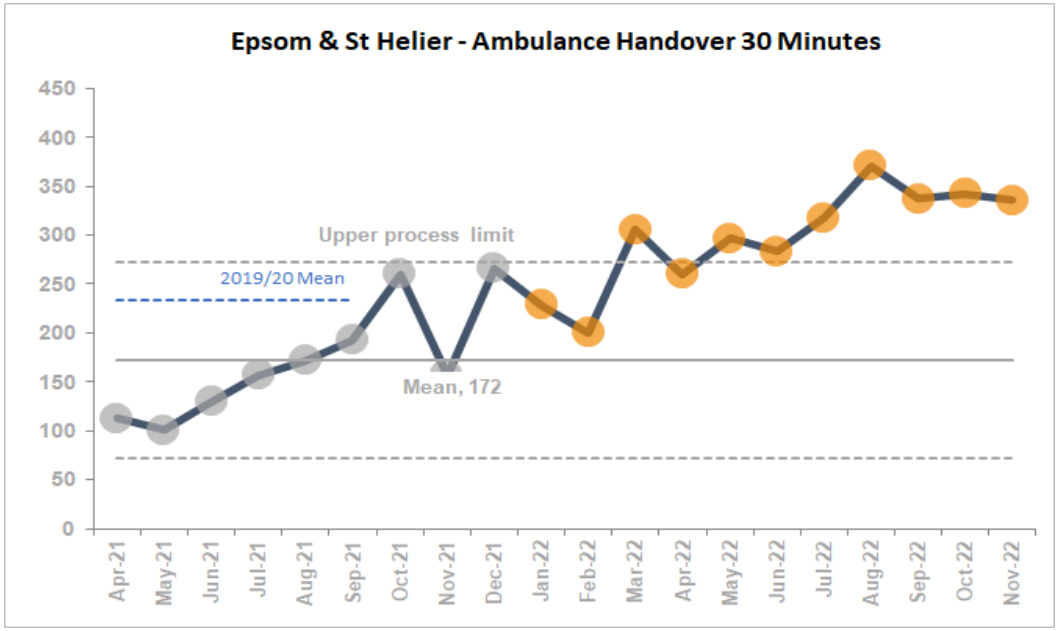
Ambulance Handover – 30 minutes

gesh

Nov-22

Target: 0	SGH: 106	ESTH: 336





SGH updates since last month

For a consecutive month the number of 30 minute LAS handover breaches are within the upper and lower control limits showing common cause variation. In total106 breaches were reporting compared to 86 patients in October, numbers are comparable to the 2019/20 mean.

ESTH updates since last month

30 minute breaches remain high and above the upper control limit although showing little variance over the last three months.

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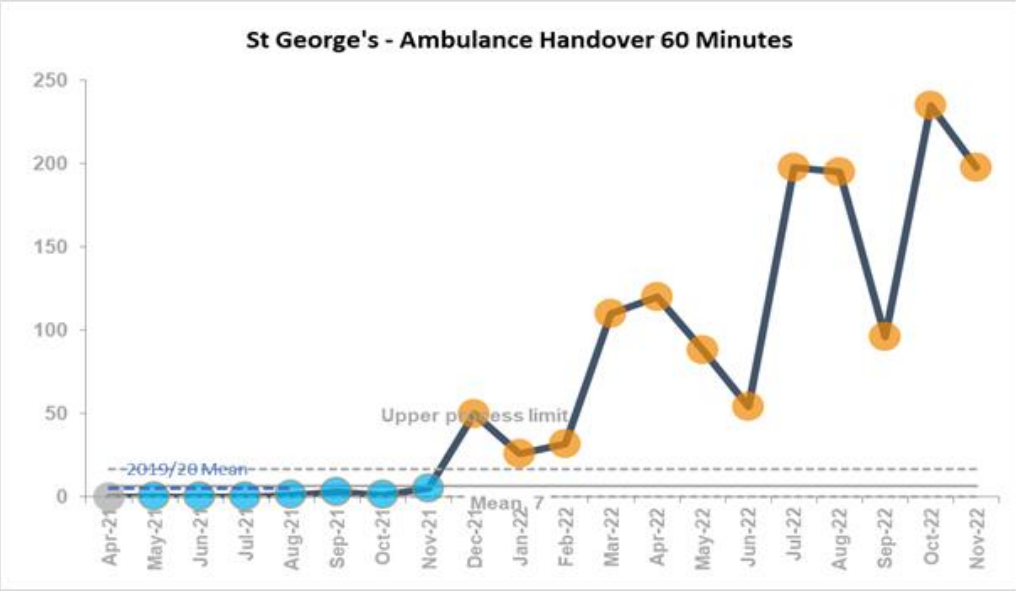
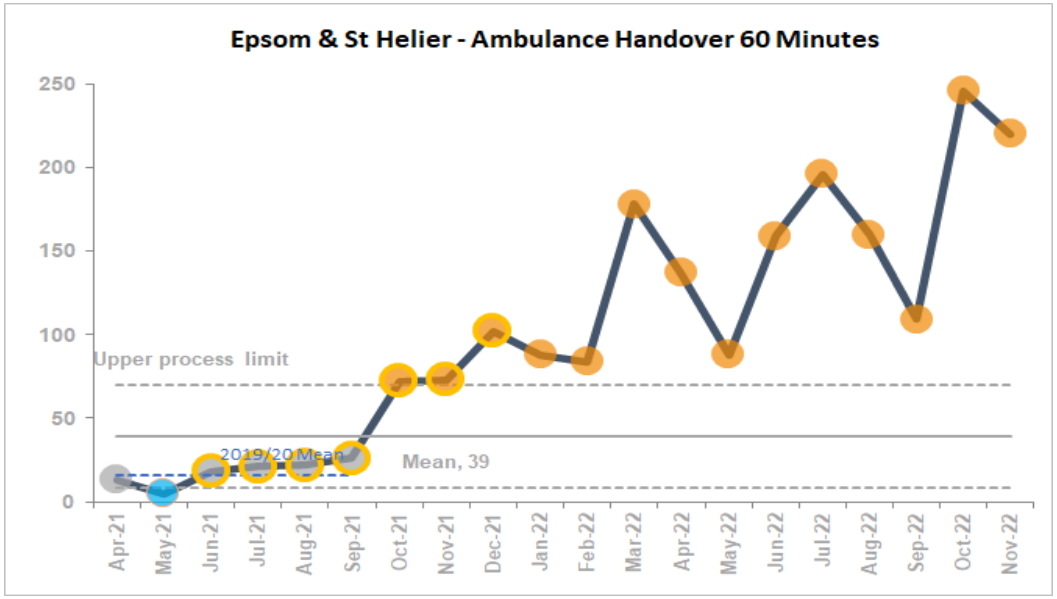
Ambulance Handover – 60 minutes

gesh

Nov-22

Target: 0	SGH: 198	ESTH: 220





SGH updates since last month

In total for the month 198 patients waited for more than 60 minutes for ambulance handover to the department. On average this equates to 7 patients per day compared to 8 patients per day through October.

ESTH updates since last month

In total for the month 220 patients waited for more than 60 minutes for ambulance handover to the department. Performance remains significantly above the upper control limit and much higher than the 2019/20 mean.

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Emergency Performance

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SGH current issues –

Overall 4 hour performance is still strong compared to peers (consistently in top ten nationally and top 2 in London), however the number of 12 waits after a decision to admit rose again in November. The inability of the Department to admit patients to downstream wards impacts on capacity and consequently the ability to offload ambulances in a timely manner. LAS are now cohorting on an almost daily basis.
There are continued issues with nursing numbers caused by vacancies and sickness although the recruitment pipeline now takes the Department to full recruitment by the end of the year pending any further resignations.

SGH future action -

The internal ECDB is continuing to focus on Frailty, Same Day Emergency Care and Internal Professional Standards.
The Trust launched the regularising flow programme in November to support exit from the Emergency Department and enable timely ambulance handovers. This has seen some improvements during the day with earlier movement of patients enabling easier decision making on how to use available capacity.
The frailty support within ED has begun and will continue to expand as the newly recruited practitioner and medical staff come on line. GP cover is increasing.
The expansion of the Urgent Treatment Centre's ability to see paediatric patients from age 2 upwards begins in December and is helping to relieve the pressure on the main Childrens and Young Persons ED.
Two new long-term NHS locum consultants are being recruited in December which will bolster senior cover in the New Year.
Ambulance/UTC sub-group of ECDB meeting fortnightly to work on improvement plans with LAS.

ESTH current issues –

Similar to last month, we remain challenged from an emergency care performance perspective, largely due to a high number of patients who require admission to an inpatient bed remaining in ED for a prolonged period of time, impacting our 4 hour performance standard where we are reporting 73.1% for November 2022, the number of patients spending > 12 hours in ED which is currently 9.2% of total arrivals, and ambulance handover performance where we are reporting 220 > 60 minute delays for November 2022.

In addition, we are seeing unprecedented numbers of paediatric ED attendances driven by recent media coverage in relation to Strep A infection.

ESTH future action –

We have recently signed off our inpatient boarding process and are looking to implement this during our forthcoming reset week commencing 12th December 2022.

We have reviewed and amended our ED escalation process and have agreed triggers in place to implement reverse queuing in the emergency department and LAS led cohorting. We have also met with SECamb to discuss their immediate handover process and have a follow up meeting week commencing 19th December.

We are using our reset week to de-escalate from our assessment units (SDEC, SACU, acute medicine hub) to ensure that there is capacity available to support early transfer and speciality assessment for patients presenting to ED. We are also trialling a new bed management process with the acute medicine team taking responsibility for allocating speciality patients to available beds on AMU.

Winter funding is available to support additional paediatric ED doctors to manage an increase in paediatric attendances and acuity. We are also supporting an additional overnight middle grade in Epsom adult ED.

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Non Elective Length of Stay

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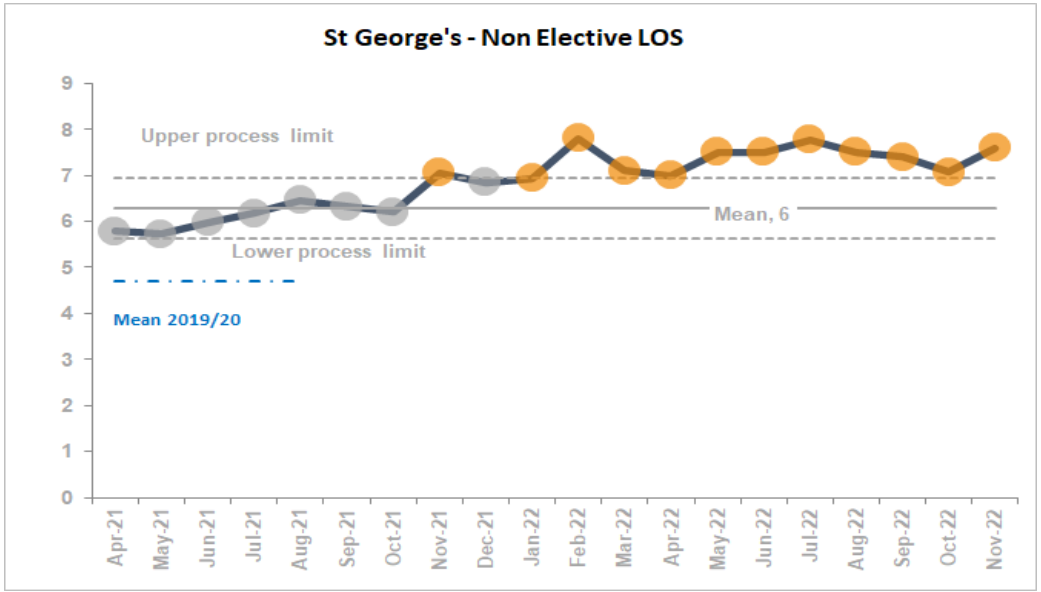
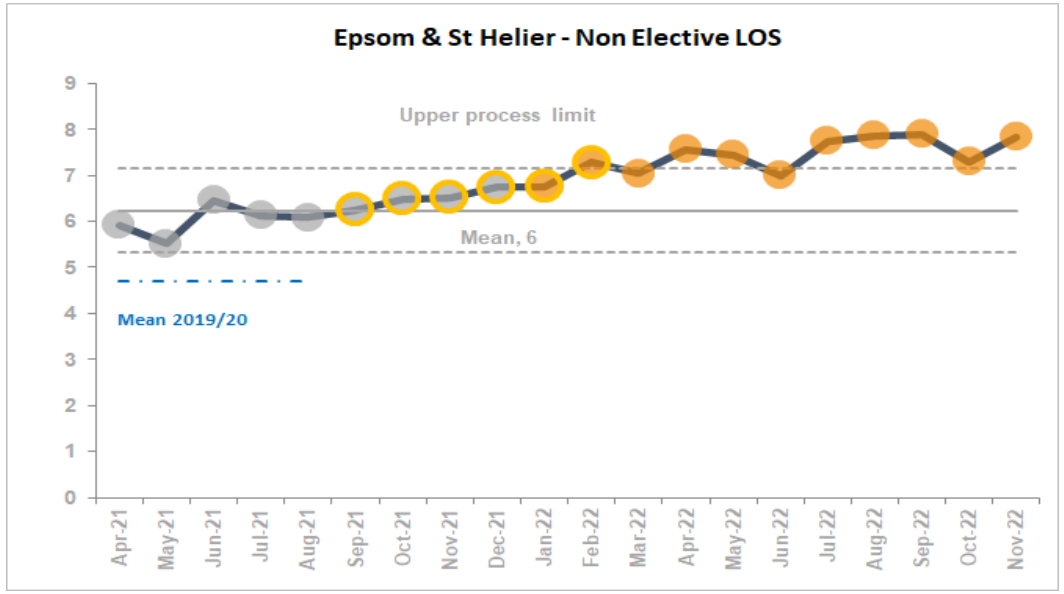
Nov-22

Target: TBC	SGH: 7.6	ESTH: 7.9





SGH updates since last month

LOS increased through November with on average patients occupying an inpatient bed for 7.6 days (on a non-elective pathway)., This is an increase of 0.5 days compared to October.

ESTH updates since last month

On average patients admitted on a non-elective pathway occupied a bed for 7.9 days. LOS remains above the upper control limit and above the mean of 4.7 days in 2019/20. The number of super stranded patients reduced by on average 3 patients per day through November.

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Patients not meeting criteria to reside

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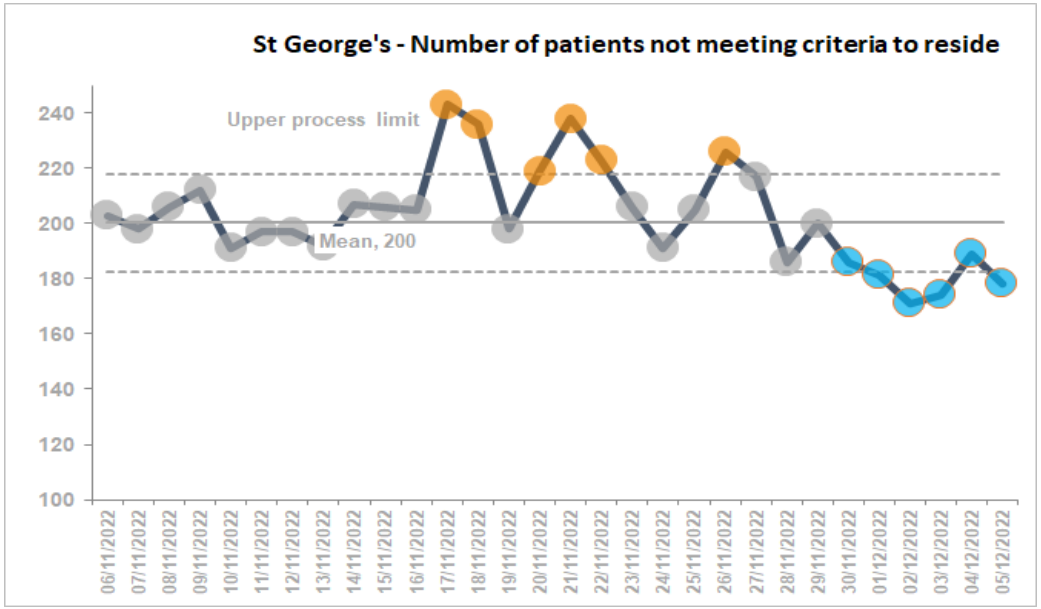
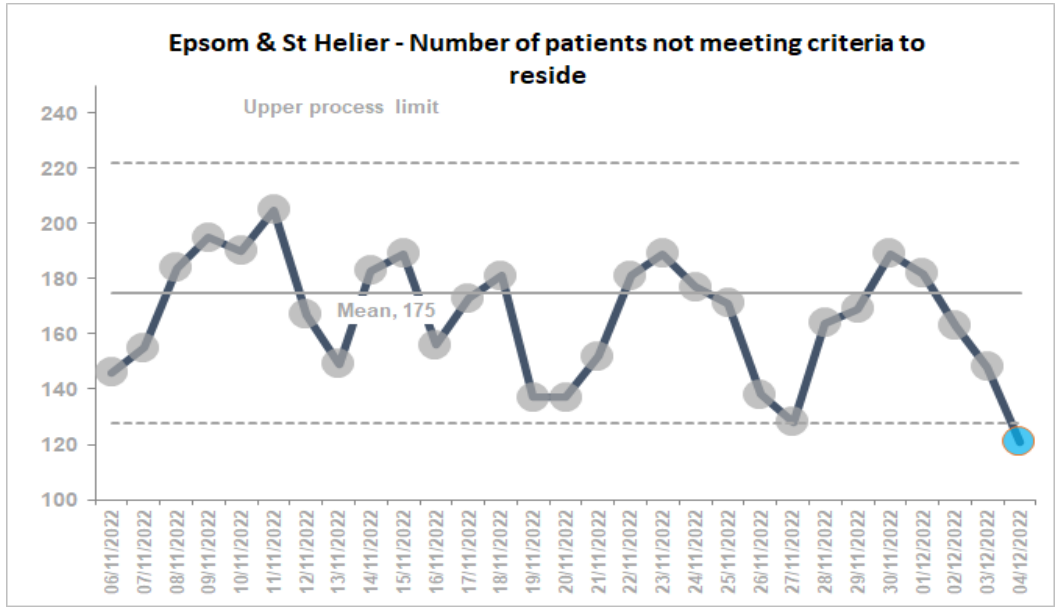
Nov-22

Target: TBC	SGH: 203	ESTH: 170





SGH updates since last month

Data source based on the national submission of the covid daily discharge sitrep. The daily average of patients not meeting the criteria to reside over the month of November was 203 patients. This includes where patients record within red to green has not been populated and therefore raises a data quality issue which is currently being addressed and the compliance rate is improving. Most recent data is expected to change due to updates in I-clip being made.

ESTH updates since last month

Data source based on the national submission of the covid daily discharge sitrep. Recent daily count shows a decline however previous trends are very variable.

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Length of Stay Performance - Analysis and Action

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SGH current issues –

The increase in Pathway 2 and 3A delays for Merton & Wandsworth due to a lack of bed availability and lack of homes willing to take complex patients. Pathway 1 delays for M&W and the lack of therapy capacity in Wandsworth
"Early bird" and weekend discharges needs to be improved
Failed discharges due to transport failure
Whilst reducing, still high numbers of patients in the acute Trust who are considered medically optimised but are unable to move to their discharge destination in a timely way.

SGH future action -

Our adaptation of the 'Bristol Model' - a new way of working to improve flow across the hospital, began on Monday 14 November in social hours. Reviewed weekly with senior oversight. With increased Trustwide focus on usage, staffing and opening hours, Departure Lounge capacity and utilisation has increased across medical and surgical specialties.
Increased number of porters and vehicles to reduce risk of transport delays/cancellation.
Increasing use of voluntary sector partners for discharge support and admission avoidance.
The use of H@H is improving and an increase in capacity with additional funding approved
Focus on both improving compliance and accuracy with Red2Green to reduce internal delays New process for capturing predicted discharges for following day, to more proactively review discharge planning and paperwork.
The TOC team has received winter monies to enable retention of the staff – increased staffing (2 x Band 7 nurses + 2 x Discharge Facilitators) to allow for earlier discharge planning and reduce issues with D2A processes.
Introduction of daily meeting with Lead for Bed Bureau to ensure maximum use of bed bureau for interim placements / step downs from SGH.
Investment in ED Frailty team should lead to reduced LoS for older, frail adults.
Successful substantive recruitment at Band 3 and 7 for Frailty Practitioners + locum consultant geriatrician with specialist interest in front door frailty in Nov'22.
A pilot programme to ringfence 10 of 42 beds on Mary Seacole Ward, QMH for intensive rehab which will be staffed with the same team from acute through to community, improving continuity of care & working across traditional boundaries has been successful in securing funding from SWL ICS Innovation Fund, internal and external working groups to convene from mid-December.

ESTH current issues –

We have seen a very slight decrease in the number of patients with a LOS of > 7, 14, and 21 days in November 2022 when compared to the previous month, however, these numbers remain consistently high.

We continue to report high numbers of medically optimised patients on both hospital sites with a daily average of 45 patients at Epsom and 64 patients at St Helier. We continue to experience challenges in timely discharge for patients on pathway 1 and pathway 3, resulting in increased bed occupancy and limited available inpatient capacity to manage onward flow from ED.

The development of our ward based patient tracking system and associated quality improvement programme has resulted in more robust and clinically led reporting of patients who no longer meet the criteria to reside. We are confident that our current reporting processes are resulting in a more realistic position, however, this has demonstrated an increase over recent months.

ESTH future action –

An 18-bed PCN led ward is scheduled to open on Monday 12th December on the St Helier Hospital site.

We have a planned reset week scheduled for week commencing Monday 12th December with a whole system focus on improving patient flow and increasing the volume of discharges on both hospital sites.

We continue to refer appropriate patients to the SWL bed bureau who are providing additional step down and TADD capacity over winter. Recent data demonstrates that we are the highest referrer to these beds when compared to other SWL trusts

We continue to progress our patient flow and discharge work programme with a number of key workstreams aimed at improving ward based systems and processes.

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Monthly Overview – Our People

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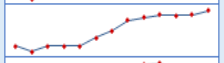
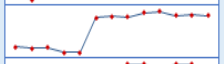
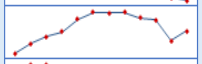
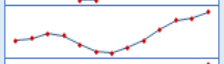
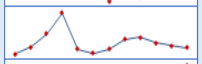
Our People	St Georges							Epsom and St. Helier						
	Monthly Target	Sep-22	Oct-22	Nov-22	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Sep-22	Oct-22	Nov-22	YTD Target	YTD Actual	13-Month Trend
Sickness Rate	3.2%	4.5%	4.8%	4.7%	3.8%	4.5%		3.8%	5.0%	5.3%	5.2%	3.8%	5.5%	
Agency rates		2.7%			TBC	3.1%		TBC	4.2%	4.6%	5.4%	TBC	4.2%	
MAST	85%	88.8%	88.3%	89.0%	91%	89.2%		85%	78.9%	79.0%	79.9%	85%	78.7%	
Vacancy	10%	9.7%	8.6%	8.5%	12%	9.3%		10%	13.8%	13.8%	13.7%	10%	13.9%	
Appraisal Rate Medical	90%	80.2%	75.8%	77.8%	84%	80.3%		90%	89.0%	89.0%	85.0%	90%	88.8%	
Appraisal Rate Non Medical	90%	70.9%	71.4%	70.4%	73%	70.5%		90%	62.0%	63.0%	65.9%	90%	57.2%	
Turnover	13%	16.4%	16.3%	16.2%	17%	16.3%		12%	16.2%	15.7%	16.5%	12%	15.9%	
Percentage BAME staff band 6 and above	TBC	43.7%	43.7%	43.9%	TBC	43.3%		TBC	35.7%	36.1%	36.1%	TBC	35.78%	

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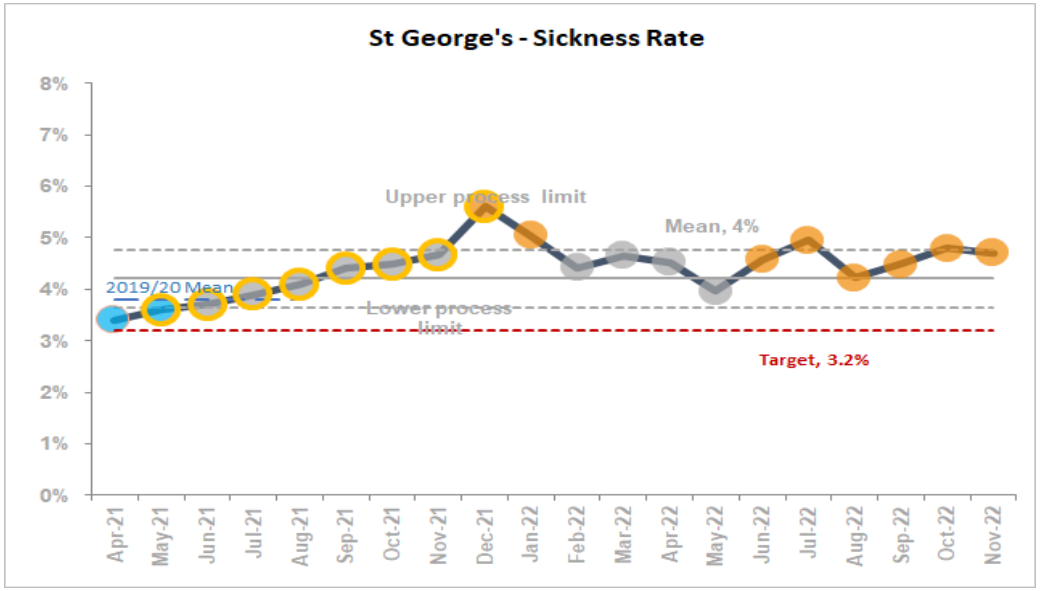
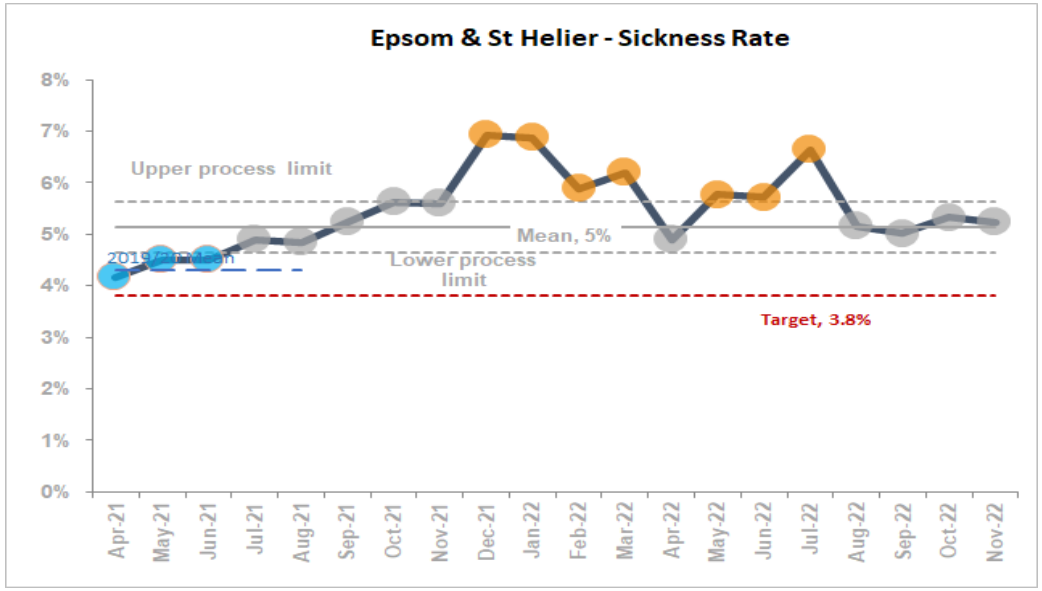
Sickness Rate

gesh

SGH Target: 3.2%	SGH: 4.71%	EStH Target: 3.8%	ESTH: 5.24%





SGH updates since last month

The Trust's sickness rate decreased from was 4.78% in October to 4.71% in November. This remains above the target of 3.2%. Colds, Cough, Flue-Influenza, Infectious Diseases (both of which included covid-related sickness) and Gastrointestinal problems, were the highest cited reason for sickness.
Long term sickness (episodes lasting28 days or more) accounted for 11% of all sickness absence.

ESTH updates since last month

Sickness absence fell by 0.08% % to 5.24% and remains significantly above the KPI threshold target of 3.8%. 'Other known causes', 'Cold, Cough, Flu - Influenza' and 'Gastrointestinal problems' were the top 3 reasons for sickness absence. Long term sickness absence (episodes of sickness lasting 28 days or more) accounted for 15.9% of all sickness absence.

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MAST

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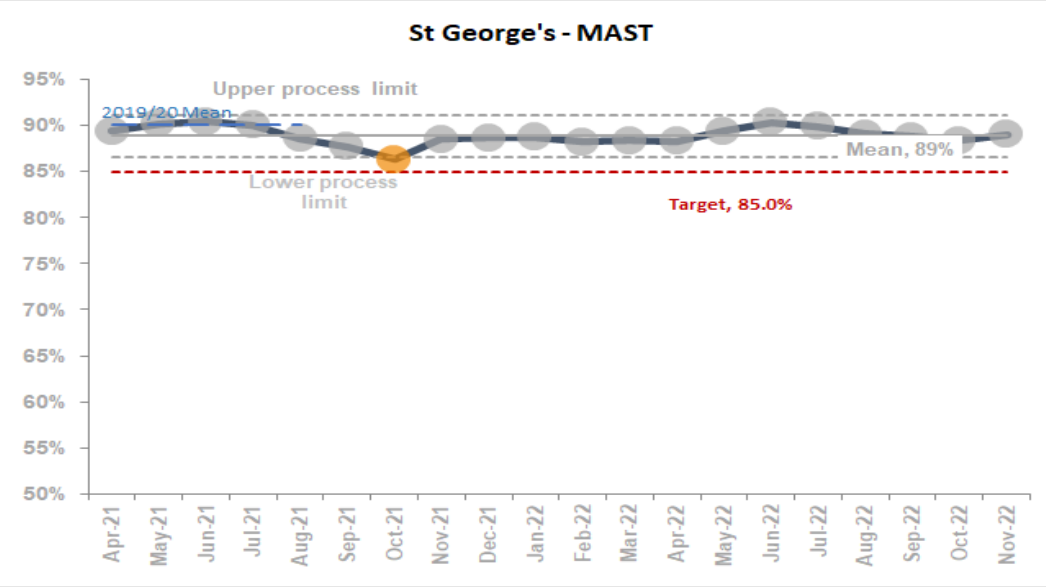
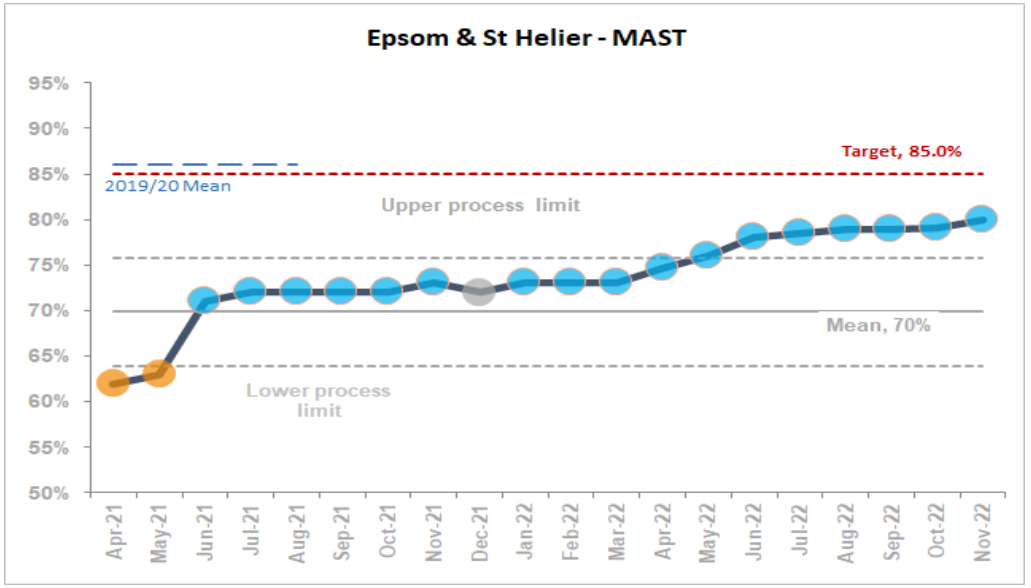
Target: 85%	SGH: 89.0%	ESTH: 79.9%





SGH updates since last month

Mandatory and Statutory Training (MAST) was 89% in November. The Mast Compliance rate is holding steady as it has done for the last year or so

ESTH updates since last month

MAST training performance continues above the upper control limit however remaining below target of 85%.

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Agency and Bank Spend

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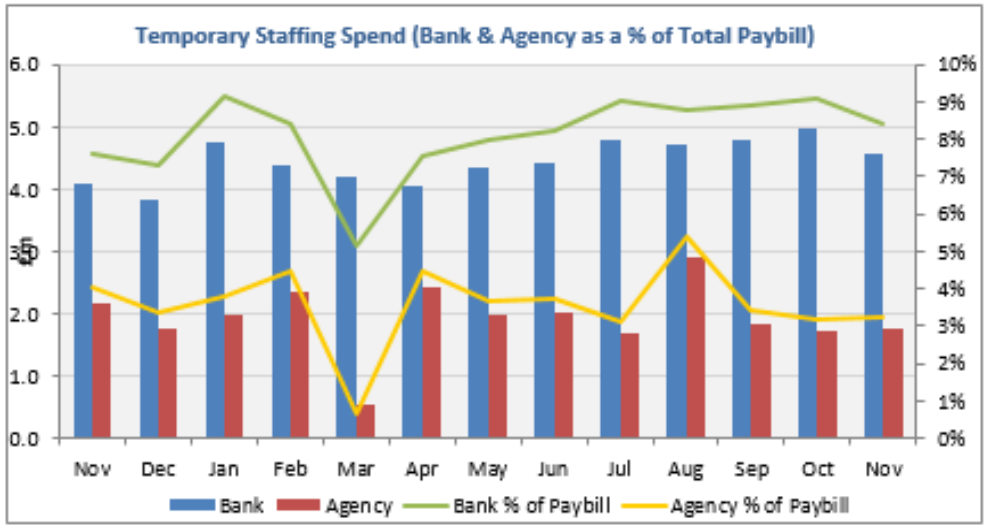
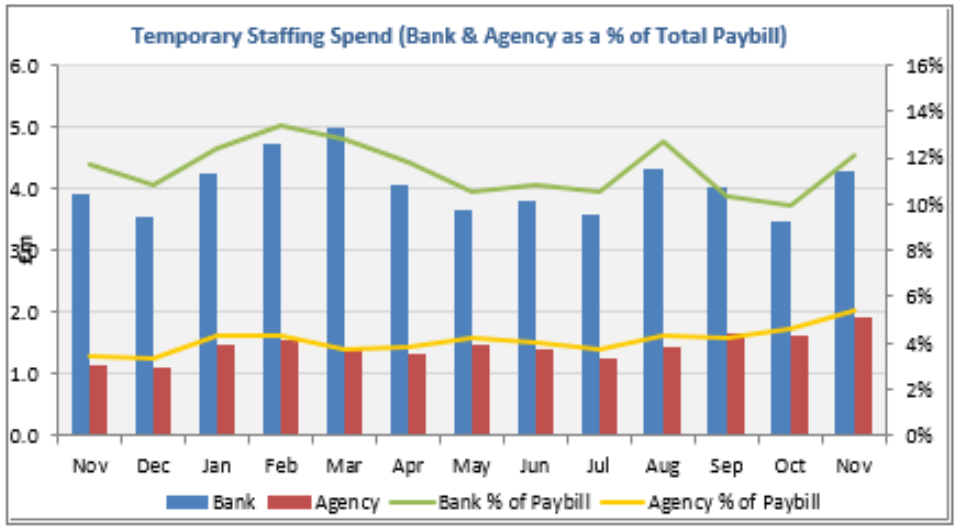
St George's



Epsom & St Helier



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Our People - Analysis and Action

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SGH current issues –

Non-medical appraisal rates overall are hovering around 70% against a target of 90%. The only staff group approaching target compliance is the Estates & Ancillary workforce at 87%. This compares extremely well to the poor levels of compliance from the A&C workforce at 59%

SGH future action -

The HRBP team has designed an intervention "Action Appraisal" which reaches out to line managers to understand what are the blockers preventing appraisals being completed, eg are appraisals being done, but not recorded due to difficulties in recording, or is it difficult to find a confidential space to have sensitive conversations etc.

ESTH current issues –

We continue to face numerous issues with the pay structures of the Estates & Facilities staff who TUPE transferred into the Trust in 2021. We have created multiple contracts with an assortment of benefits and the confusion around these multiple contracts is causing dissatisfaction amongst a vocal cohort of our lowest paid workers. The great majority of this staff group recognise that London Living Wage has worked well for them though and they gave received an 8.1% pay rise to reflect the LLW

ESTH future action –

We are seeking to drive out some of the complexities baked into the E&F pay scales and are preparing to consult on and implement an Estates & Facilities pay model review

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Outpatient waiting time to first appointment

St George's

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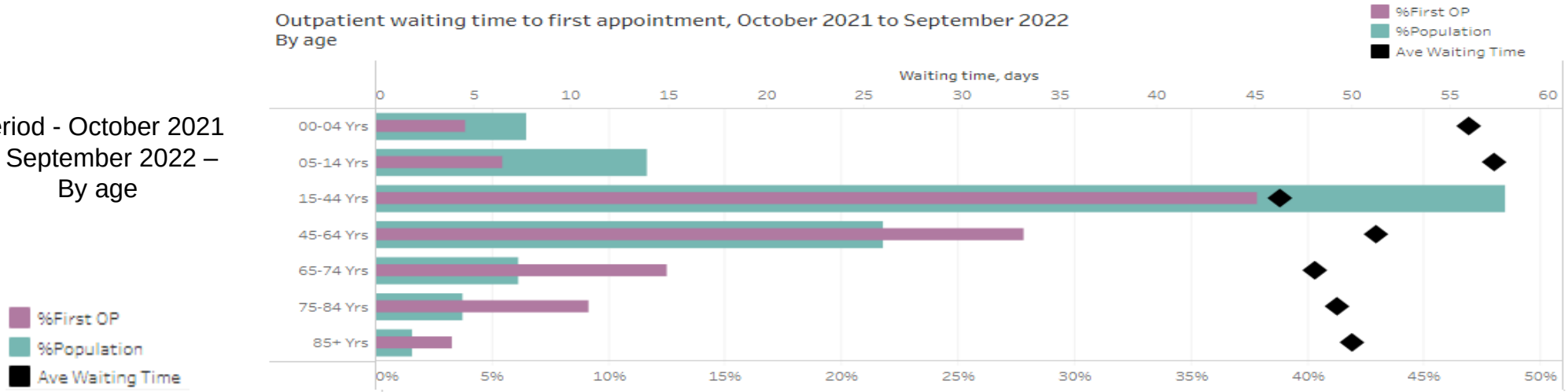
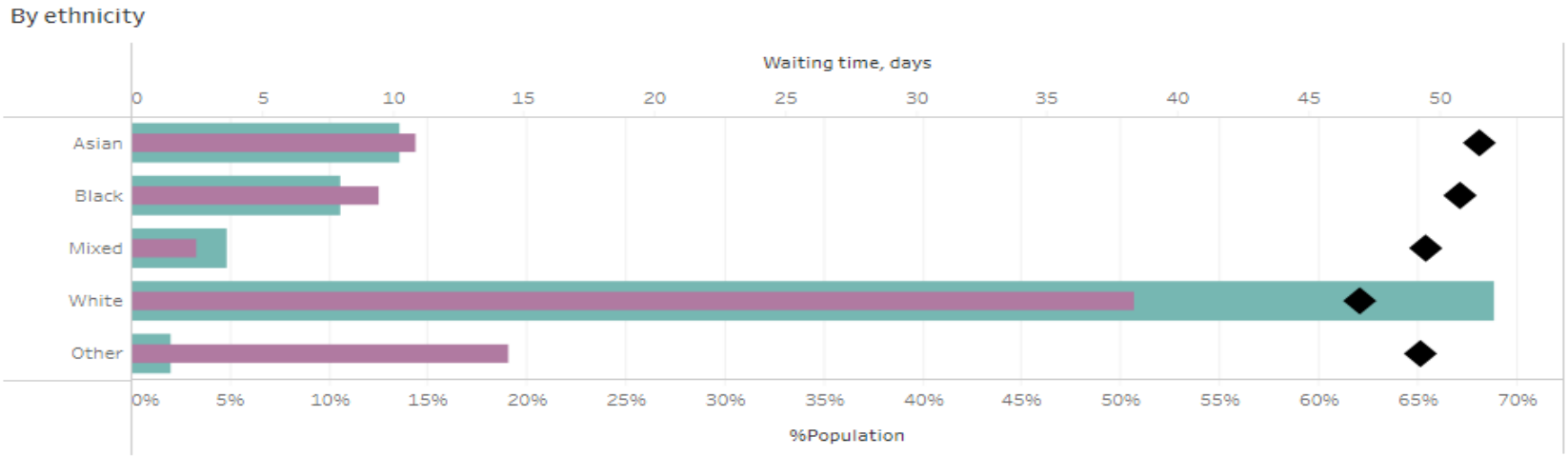
Period - October 2021 to September 2022 – By age



Period - October 2021 to September 2022 – By ethnicity



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DNA Rate

St George's

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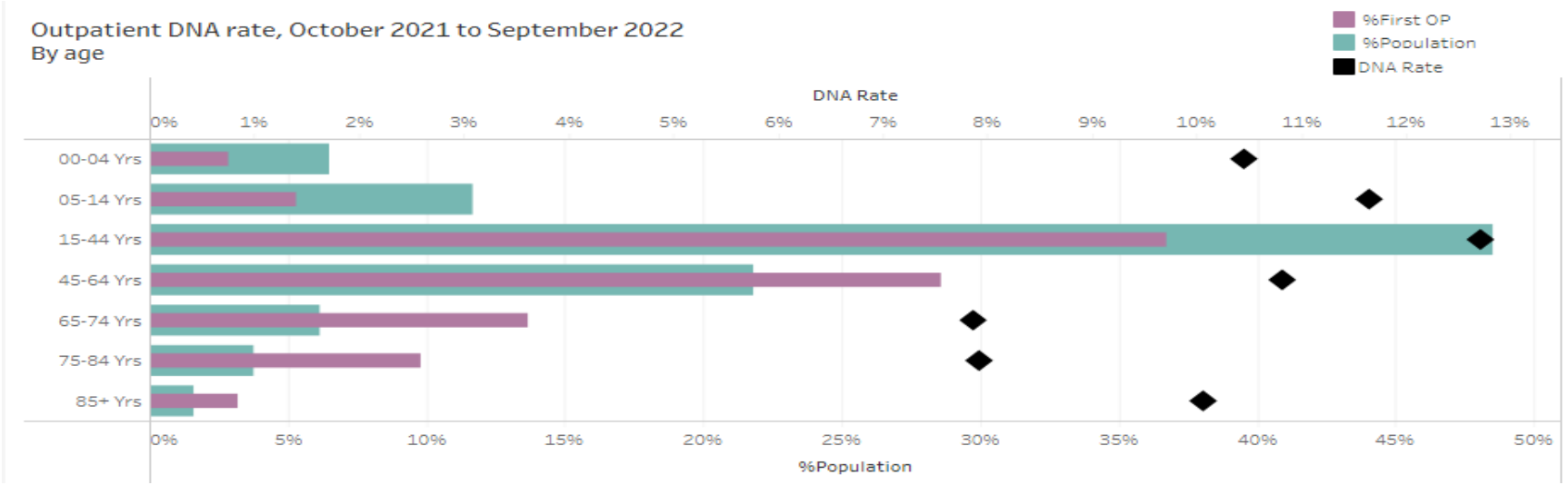
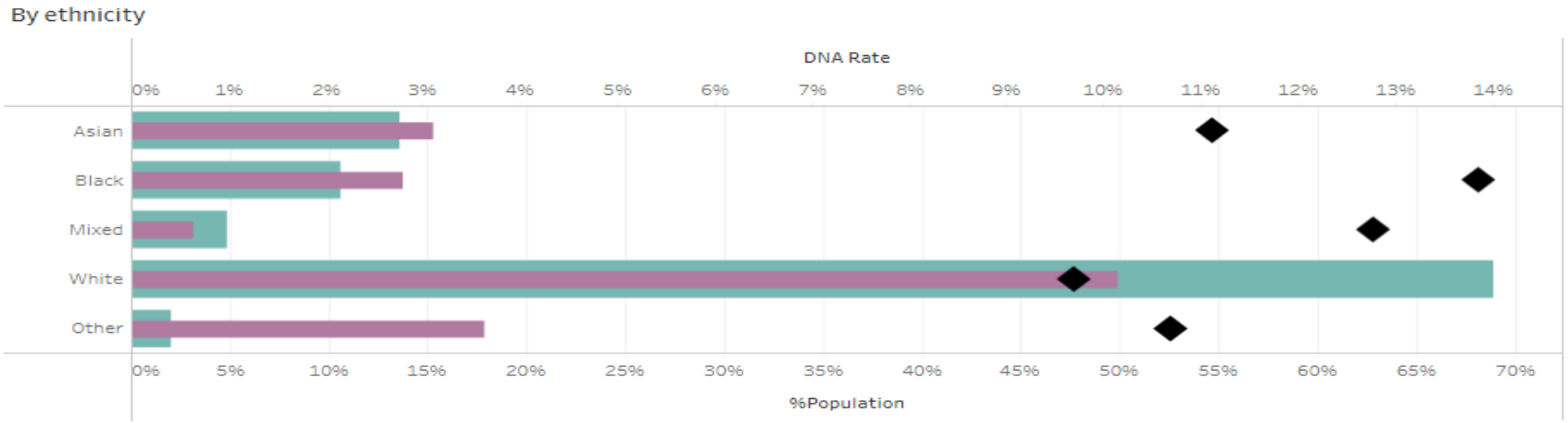
Period - October 2021 to September 2022 – By age



Period - October 2021 to September 2022 – By ethnicity



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Appendix

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- Guide on interpreting statistical process control charts
- ESTH Integrated Care Dashboard (Reading Room)
- ESTH SafeStaffing (Reading Room)
- ESTH Ward Heatmap (Reading Room)
- SGH Ward Heatmap (Reading Room)

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Interpreting (Statistical Process Control) Charts

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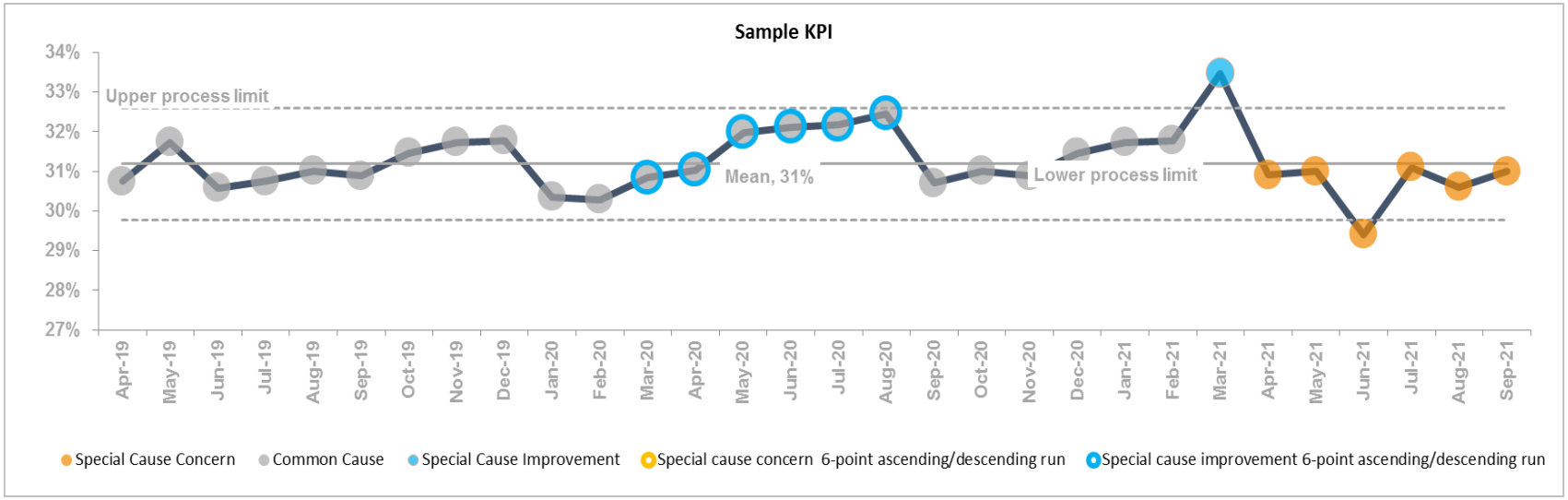

SPC Chart – A time series graph to effectively monitor performance over time with three reference lines; Mean, Upper Process Limit and Lower Process Limit. The variance in the data determines the process limits. The charts can be used to identify unusual patterns in the data and special cause variation is the term used when a rule is triggered and advises the user how to react to different types of variation.

Special Cause Variation – A special cause variation in the chart will happen if;

- The performance falls above the upper control limit or below the lower control limit
- 6 or more consecutive points above or below the mean
- 6 or more consecutive increases/decreases
- Any unusual trends within the control limits

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	12 January 2023	**Agenda No**	**2.4**
Report Title:	**EPRR Assurance Board Report 2022**		
Lead Director/ Manager:	Tara Argent (AEO – St Georges Site)		
Report Author:	Mike Laing, Trust Emergency, Preparedness, Resilience, and Response (EPRR) Manager		
Presented for:	Assurance		
Executive Summary:	**NHS Core Standards for EPRR:** As part of the NHS England EPRR framework, providers and commissioners of NHS funded services must show they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients. **Assurance Process:** Annually, all NHS funded organisations are asked to provide an assurance return against the Emergency Preparedness, Resilience and Response (EPRR) core standards. The London regional office then holds individual review meetings with each organisation to discuss and agree a level of compliance. **Trust Level of Compliance:** The assurance process identified some areas for improvement in our current arrangements and agree that this year; our overall level of compliance is against the 2022-23 core standards for EPRR: **Partially Compliant**		

Trust Level of Compliance in detail:

The Trust's overall level of compliance is based on the total percentage of amber and red ratings. The following RAG ratings were agreed at the review meeting (Core standards 1-68)

Red ratings	Amber ratings	Green ratings
0	8	56
Total number of red / amber ratings		8

It should be noted the review team reported that they were confident that, if required, the Trust would be able to stand up an appropriate operational response to any disruptive challenge or major incident.

Main Assurance Visit Outcomes

The Trust received (8) amber ratings for the following core standards:

CS 10 Incident Response

CS 16 Evacuation and Shelter

CS 20 On Call mechanism

CS 24 Responder Training

CS 25 Staff Awareness and Training

CS 46 Business Impact Analysis/Assessment (BIA)

CS 50 BCMS monitoring and evaluation

CS 52 BCMS continuous improvement process

	To move the Trust towards full compliance with the EPRR core standards the Trust's Accountable Emergencies Officer (AEO) has agreed an action plan with the EPRR Manager focusing on the priorities outlined below. Full details of the action plan, including timescales and leads, can be found in the updated self-assessment tool (appendix 1). **Priorities for 2022/23** The Trust will prioritise the following tasks over the following assurance period: • Developing a Sector approach in the trust for Risk assessment and Risk management. • Development of the Trust EPRR resource commensurate with the position as a Major Trauma Centre for London. • Re-establishing the South West London EPRR Trauma Network. • Major Incident Plan review and encapsulation of learning from exercises and incident response. • Update all plans in line with current legislation and guidance. • Further development of mandatory training for on-call staff. • Governance of EPRR Planning, Training and Exercising and Business Continuity programmes to be aligned. Full details of the action plan, including timescales and leads, can be found in the updated self-assessment tool (appendix 1). Date and timings are dependent on the successful recruitment of a Band 7 EPRR officer (Interviews conducted on 22nd December 2022-Reruitment in progress.) **Next steps** The results of the 2022 EPRR assurance process and the action plan to address areas for improvement are submitted to the Board to ensure that the Board is fully sighted on the assurance result and to receive Board-level sign off.
Recommendation:	The Board is asked to note the NHS England EPRR assurance update and the 'partially compliant' rating.
Committee Assurance:	The Committee is also asked that in considering contents of this report, its supporting documents and the discussion at the meeting which of the following assurance rating it would provide to the Trust Board. • **Substantial Assurance:** The report and discussions assured the Committee that there are robust systems of internal controls operating effectively to ensure that quality and safety risks are managed to deliver high quality services and care to patients. • **Reasonable Assurance:** The report and discussions assured the Committee that the system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that quality and safety risks are managed to deliver high quality services and care to patients. • **Limited Assurance:** The report and discussions supported the Committee's conclusion that that the system of internal controls is generally inadequate or not operating effectively and significant improvements were required to ensure that the quality and safety risks are managed effectively to improve the position and ensure that high quality services and care is provided to patients. • **No Assurance:** The report and discussions led the Committee to conclude that there was a fundamental breakdown or absence of core internal controls and systems to enable the Trust to deliver high quality services and care to its patients.
Supports	
Trust Strategic Objective:	Ensure the Trust has unwavering focus on all measures of quality and safety, and patient experience.

CQC Theme:	Well Led		
Single Oversight Framework Theme:	Operational performance		
Implications			
Risk:	If the work is not maintained, there is a risk that the trust will not be prepared in the event of a Major Incident or a significant Business Continuity disruption.		
Legal/Regulatory:	Statutory responsibilities under the Civil Contingencies Act (2004) NHS-funded organisations to maintain a robust capability to plan for, and respond to, incidents or emergencies that could impact on patient, staff and services.		
Resources:			
Equality and Diversity:			
Previously Considered by:		**Date**	
Appendices:	Appendix 1 – Revised Action plan for areas of 'partially compliant'		

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

APPENDIX 1

EPRR Action plan:

EPRR core standard	Description of core standard	Actions to be taken	Lead officer(s)	Timescale
10	**Incident Response:** In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Draft Major incident and Mass Casualty Plans needs to be sent to internal and external colleges for consultation, be sign-off	EPRR Manager Clinical Major Incident Leads EPRR Group AEO	End Q1 2023
16	**Evacuation and shelter:** In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	EPRR Manager/EPRR team (on recruitment) to work with internal and external stakeholder including clinical colleagues to update the current plan to ensure in is patient focused and operationally credible.	EPRR Manager Clinical Major Incident Leads EPRR Group AEO	*End Q3 2023*
20	**On-call mechanism** The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	The Trust notification process has been tested. The process will be aligned to the Command Control and Coordination (C3). See Cord Standard 10	EPRR Manager Site Manager Switchboard manager AEO	End Q1 2023

EPRR core standard	Description of core standard	Actions to be taken	Lead officer(s)	Timescale
24	**Responder training** The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	On-Call/Response training programme has been implemented The programme is aligned to the Minimum Occupational Standards.	EPRR Manager AEO	Completed/On-going in accordance with trust policy
25	**Staff Awareness & Training** There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	See 24	EPRR Manager Clinical Major Incident Leads EPRR Group AEO	Completed/On-going in accordance with trust policy
24	**Business Impact Analysis/Assessment (BIA)** The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	The EPRR manager (Team) will work with directorates to update Business Impact Analysis(es) and BCP, this work will initially focus on priority areas and services	EPRR Manager Clinical Major Incident Leads EPRR Group AEO	Q4 2023 Ongoing monitoring
50	**BCMS monitoring and evaluation** The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	This will be undertaken in accordance Trust BC Scope and Policy document	EPRR Manager Clinical Major Incident Leads EPRR Group AEO	Monthly Ongoing monitoring

EPRR core standard	Description of core standard	Actions to be taken	Lead officer(s)	Timescale
52	**BCMS continuous improvement process** There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Process defines within the Trust BC Scope and Policy document	EPRR Manager AEO	Completed/On going in accordance with policy

Meeting Title:	**Trust Board**		
Date:	12 January 2023	**Agenda No.**	**3.1**
Report Title:	**People Committee Report**		
Lead Director/ Manager:	Stephen Collier, Chair of People Committee		
Report Author:	Stephen Collier, Chair of People Committee		
Presented for:	Assurance		
Executive Summary:	This Report sets out a summary of the matters reviewed by the Committee at its meetings in November and December.		
Recommendation:	The Board is asked to note the report.		
Supports			
Trust Strategic Objective:	Culture		
CQC Theme:	Well Led		
NHS System Oversight Framework:	People, Well Led		

1. Introduction

As previously, this Report summarises issues covered in the People Committee in Common, but reports only on matters relating to St George's University Hospitals NHS FT (unless otherwise indicated). The Committee in Common arrangements continue to work well in practice.

2. Risk Assurance

At its December meeting the Committee reviewed the people-related risks on the Trust's Corporate Risk Register and agreed that the single risk addressing staff recruitment and retention should be sub-divided into two: one limb addressing recruitment; the other, retention. There is no substantive change to the overall risk, or its scoring.

In addition, the Committee agreed to close Risk 2178, Organisational Culture, as a stand-alone risk. This is because a number of the contributory elements to this are already separately identified within the Board Assurance Framework.

The Trust's HR / people function had undertaken a stand-back self-assessment of the Employee Relations function at the Trust as part of the return to more normal functioning post-Covid, and identified areas for improvement and reflected on the further opportunities that flow from the Group structure. Clearly this had been a useful exercise, although the assessment was of a function under significant pressure, with resource constraints and consequently performing sub-optimally. At bottom, there was limited assurance on governance arrangements for the ER function, and underperformance in some areas. Four key negatives had been identified: not using the ER system; significant vacancies in the team, meaning that some activities were simply not being undertaken; the need for better HR training for operational line managers (as otherwise HR would continue to own every divisional problem involving people and relationships); and tighter management of sickness absence[1]. A number of corrective Recommendations had also been made which the Committee regarded as sensible and achievable. The Committee regarded this self-assessment as an assurance of the willingness of the HR team to be held to account, and will monitor progress on implementing the corrective recommendations.

The Committee was briefed at its November and December meetings on the risk-based approach being adopted by the Trust to managing the impact of strikes by members of staff. This was directed at ensuring the safety of patients and staff, and as far as achievable securing continuity of service. The Committee noted the service continuity and communications planning being undertaken. The result of ballots for the RCN and Unison was known at the time of those briefings, although it was noted that ballots were being taken by other unions (Unite, Royal College of Midwives, Chartered Society of Physiotherapy, HCSA and BMA).

The number of individuals with an outstanding DBS check is confined to those on long-term sickness absence, and continues to be reduced.

3. Strategy

At its November meeting, the Committee was updated on a series of workforce projects being undertaken on a South West London ICB-wide basis. The Committee noted good progress on a number of these, and acknowledged the impact that they could have in terms of both efficiency and consistency for the wider workforce in south-west London. A South-west London wide secondary bank was being evaluated.

[1] Directly linked to the Workforce Improvement Plan target – see commentary below

4. Internal Supply

The People team is undertaking a Deep Dive review of **nursing staff turnover**. This is a follow-on from an earlier discussion within the Committee, but is particularly timely given that the Trust has a relatively high turnover level against all NHS Trusts, (though less so against other London teaching hospitals). The Committee has previously reviewed data on reasons for leaving and noted that many nurses leave for promotion, career development or family relocation reasons. Paul da Gama summarised the scope of the Deep Dive and we look forward to receiving the final review.

The Committee received a further update on the **Workforce Improvement Plan**. All other actions are on track, but more active management of sickness absence is being held back both by resource issues within the Employee Relations team where it has not been possible to recruit additional personnel to help support absence management and vacancies within the core team itself, as well as workload pressure by managers in the divisions, and is therefore unlikely to yield the benefit originally anticipated. We have asked for regular updates on the position as this may be an initiative the Trust will want to carry into 23-24.

The Trust's **use of bank and agency staff** through to November was noted, with continued strong levels of bank staff utilisation and relatively well managed levels of (higher-cost) agency staff. However, the Committee has noted with concern the recent increase in agency spend on nursing and junior doctor roles. We will continue to monitor this.

At its November meeting, the Committee reviewed the way that the Trust's **Nurse Establishment** had been set for the current financial year and how this flowed through to ward and clinical area rosters. Overall, this had resulted in an increase (22-23 over 21-22) in the nurse complement of 24.3 WTEs, at a net additional annual cost of £850k. The safe staffing logic behind this was fully explained and accepted by the Committee, but the cost-push impact on the Trust's overall financial position remained a real concern.

5. Culture Diversity and Inclusion, Organisational Development

Culture Programme Update – at its November meeting the Committee received an update from the Culture, Equity and Inclusion Board, which continued to meet monthly. The leadership of the programme board had passed to Chloe Miller from Dan Scott (who had left the Trust, and who was thanked for his excellent contribution). The use of Recruitment Inclusion Specialists (RIS) would be expanded in the new year to include all Band 6 recruitment panels. A proposal is being considered as to whether to open the opportunity to staff of all ethnicities to be able to act as a RIS. Further consultation will be undertaken before a final decision is made. The NHS-wide staff survey was open for participation across October and November. A Medical Senior Leaders programme had been launched, with 48 participants in the first two cohorts, which would run through to April 2023. A wider programme of Focussed Team Development was being provided on an as required basis.

Health and wellbeing – the Committee received and reviewed a Q2 update on the health, wellbeing and staff support activities in place. Cost of living advice had been given greater prominence and almost 400 Trust staff had participated in a ranking of interventions that would be of most help to Trust staff. Pay rates, travel costs and food costs were the major concerns. The take-up of therapeutic 1:1 sessions remains high. Mental Health First Aid training had been well received. Staff support and team mediation continued to be well used.

Staff Engagement – The Committee received an update from Chloe Miller on Staff Engagement initiatives planned for future months through to May 2023 across the four domains of: Living our Values; Staff Survey; Big 5; and Staff Recognition.

Leadership Programme – we received an update on this programme, in which 37 senior staff had participated. Satisfaction with the programme quality was high. This is part of a wider approach to talent management which the Trust is developing and which, if successful, could play an important part in the quality and capability of senior functional management.

6. Trust Governance

Medical Appraisal and Revalidation – the Committee received a report at its November meeting setting out the latest quarterly update from the Trust's Responsible Officer. There were no concerns raised by this. The number of revalidation deferrals continued to reduce, and now stood at 11% (from 30% the previous quarter). The committee noted that the number of connected doctors had increased by some 15% since 2018-19, and 4% since 2020-21. Appraisal compliance had dipped slightly in the quarter, but this was attributed to the effects of the summer holidays rather than anything more concerning. The rates had since started to recover.

Guardian of Safe Working – the new Guardian, Dr Rosy Wells, presented her first report, for the quarter ending 30 September. Overall there had been 149 exception reports in the quarter, of which the vast majority related to excess hours of work. Of these, two had raised an immediate patient safety issue which had been escalated and addressed. The detail of these, notably the steps being taken to address this, has been discussed in the People Committee. No fines had been levied. Acute Medicine (27 exception reports) and General Medicine (48 exception reports) remained areas of concern, and the number of exception reports in Vascular Surgery had increased materially (26). The extension of the Safe Working reporting regime to locally employed doctors (283 individuals) had been completed, although no exception reports had yet been received. It was not known whether this was attributable to a lack of familiarity with the processes, anxiety about reporting, or that there were no exceptions to report. Dr Wells would investigate. The outgoing Chair of the Junior Doctors Forum (JDF), Dr Muhammad Amaran, was thanked for his contribution in putting the energy back into the JDF, and creating an effective bridge between doctors in training and the Trust's senior medical leadership. A new Chair would be appointed.

People Management Group - We continue to receive a report at each meeting from the Trust's People Management Group – this keeps us sighted on new and continuing operational issues and how the executive is managing them. It is an important part of the assurance process, in providing early warning of issues. It is also an assurance to the Committee on the active management of the Trust's HR and people function of some challenging issues in a dynamic environment.

Stephen J Collier,

Committee Chair, 29 December 2022

Meeting Title:	**Trust Board**		
Date:	12 January 2023	**Agenda No**	**4.1**
Report Title:	**Finance Committee-in-Common report**		
Lead Director/ Manager:	Ann Beasley, Chair of the Finance Committee		
Report Author:	Ann Beasley, Chair of the Finance Committee		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Finance Committee at its meetings on 18th November 2022 and on 16th December 2022.		
Recommendation:	The Board is requested to note the update.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led.		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

Finance Committee – November & December 2022

The Committee met on 18th November 2022 and on 16th December 2022 as a committee in common with Epsom & St Helier University Hospitals NHS Trust. This paper focuses on

agenda items that relate to St George's. In addition to the regular items on strategic risks, operational performance and financial performance, the committee also considered papers on:

- Financial forecasting for 2022/23 & planning for 2023/24;
- The HFMA Audit Update;
- Quarterly update from SWL Pathology.

As is its usual practice, the Committee discussed the Board Assurance Framework (BAF) risks on a rotating basis by deep dives, with consideration by exception in intervening months. Both committees in November and December undertook BAF risk review by exception. The next deep dives for Finance, Estates, Operational and IDT will take place in January. There is significant financial risk with the challenge of maintaining sustainability and efficiency. Estates risk is mainly focussed on the increased challenges relating to completion of capital projects within the financial year. Operational risk discussion focussed on the pressures of Emergency and Elective care at the site. There are increased pressures on ITU with increased demand for level 3 beds impacting on elective activity. There were no new risks reported for IDT. Members were assured that mitigations were receiving sufficient executive focus and did not recommend any changes to current risk scores or levels of assurance.

The Committee discussed current financial performance, cash management and capital expenditure as the Trust reported M8 financial performance in 2022/23. Discussions began for the Group annual planning 23/24.

- **The Committee wishes to bring the following items to the Board's attention:**

1.1 Board Assurance Framework Risks – Executive committee members updated the committee on their strategic risks, with score and assurance ratings agreed as follows:

- SR3- Operational & IDT risk 20 - Partial Assurance
- SR5- Financial Sustainability risk 25 - Limited Assurance
- SR6- Financial investment risk 20 - Partial Assurance
- SR7- Estates risk 16 - Good Assurance

1.2 Estates Report – the SGH Director of Estates & Facilities (SGH DE&F) introduced the normal monthly updates, including progress being made with big capital projects such as MRI and the Cath Labs which have now opened and are in operational use. It was also noted the possibility of moving the premises assurance model onto a new Cloud system allowing for more regular reporting throughout year

1.3 Activity Performance – the SGH COO noted the expected performance against activity trajectories in November, where Daycase/ Elective performance is in line with target (at 101% compared to 100% target) and Outpatient performance is expected to be behind target (at 95% compared to 100%).

1.4 Emergency Department (ED) Update – the performance of the Emergency Care Operating Standard was recorded at 81.1% for November. The Committee noted that the Trust continues to see significant challenges in ambulance handovers and 12 hour breaches.

1.5 Diagnostics Performance – the SGH COO noted that 5.1% of patients were waiting longer than six weeks to have a diagnostic test in November against a national recovery

target of 5%, with main challenges in Endoscopy. Gynaecology has significantly reduced its backlog.

1.6 Cancer Performance – Trust continues to be challenged and is currently not meeting the cancer standards in both 14 day and 62 day performance. Specialities affected most were Breast, Dermatology and Urology. The SGH COO noted that recovery plans have been put in place for these specialities. The committee were supportive of the paper presented on the Breast Cancer Service.

1.7 Referral to Treatment (RTT) Update – the performance against the RTT target was discussed, where the Trust continues to reduce the number of long waiting patients above 52 weeks and 78 weeks. The Committee noted the underlying increases in the PTL and recognised the challenges this would bring in the future.

1.8 Financial Performance – the Group Chief Financial Officer (GCFO) noted performance in M8 2022/23, where a YTD deficit of £34.2m is £19.4m adverse to plan, with £10.7m CIP under-delivery and £8.7m ERF underperformance. The latter is being reported as such in line with system requirements.

He noted the cash balance as at 30th November 2022 was £42.4m, and that the capital position to date was an underspend of £3.8m, with total expenditure at £27.0m.

1.9 Cash update– the GCFO introduced the paper on cash update which was noted by the committee.

1.10 Forecast 2022/23 – the GCFO noted the latest forecast I&E scenarios for 2022/23, including actions being taken to improve the position. Committee discussed the impact of inflation, non-recurrent benefits, and the position of the Trust with NHSE/I.

1.11 Planning 2023/24 – The GCFO introduced the paper on 2023/24 financial planning. There remains no planning guidance and he emphasised the challenge of maintaining sustainability as well as efficiency.

1.12 HFMA Audit Update – the Site CFO introduced the paper on HFMA Audit update and the Committee noted the paper.

1.13 SWL Pathology Report – the GCFO and SWLP MD noted the key highlights of the report, including the proposal for four contracts to be approved.

2.0 Recommendation

2.1 The Board is recommended to receive the report from the Finance Committee for information and assurance.

Ann Beasley
Finance Committee Chair,
November 2022

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St George's University Hospitals
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	12 January 2023	**Agenda No**	**4.2**
Report Title:	**SGH Financial Performance M8 2022/23**		
Lead Director/ Manager:	Andrew Grimshaw		
Report Author:	Tom Shearer		
Presented for:	Update		
Executive Summary:	The Trust is reporting a deficit of £34.2m at the end of November, which is £19.4m adverse to plan. The shortfall is due to ERF income underperformance of £8.7m as a result of the Trust not meeting its ERF target, which is consistent across South West London. The remaining shortfall of £10.7m is mainly due to CIP under delivery.		
Recommendation:	The Board notes the M8 position for 2022/23.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Equality and Diversity:	There are no equality and diversity impact related to the matters outlined in the report.		
Previously Considered by:	Fin Comm In Common	**Date**	16th Dec 22
Appendices:	N/A		

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Trust Board (Public) 12th January 2023
Month 08 Finance Report

Group CFO and SGH Site CFO

SGH
Summary metrics

Area	Key Issues	Current Month (YTD)	Previous Month (YTD)
Financial Position	The Trust is reporting a deficit of £34.2m at the end of November, which is £19.4m adverse to plan. The shortfall is due to ERF income underperformance of £8.7m as a result of the Trust not meeting its ERF target, which is consistent across South West London. The remaining shortfall of £10.7m is mainly due to CIP under delivery.	£19.4m Adv to Plan	£13.8m Adv to Plan
Income	Excluding ERF, income is reported at £4.3m favourable to plan at Month 8. This is due to additional funding to cover COVID Testing and Vaccination costs.	£4.3m Fav to plan	£2.5m Fav to plan
Expenditure	Expenditure is reported at £15.0m adverse to plan at Month 8, mainly due to CIP under delivery. There are also higher Junior Doctor and Nursing premium temporary costs.	£15.0m Adv to plan	£8.4m Adv to plan
Cost Improvement Programme	CIPs are reported as £10.7m adverse to plan YTD in M8.	£10.7m Adv to plan	£5.9m Adv to plan
Capital	Capital expenditure of £27.0m has been incurred year to date. This is £3.8m less than the budget of £30.8m	£3.8m Fav to plan	£2.6m Fav to plan
Cash	At the end of Month 08, the Trust's cash balance was £42.4m. Cash resources are tightly managed and will continue to be monitored.	£42.4m £26.2m lower than Y/E	£56.6m £11.9m lower than Y/E

Month 8 Financial Performance

SGH

			Full Year Budget (£m)	M8 Budget (£m)	M8 Actual (£m)	M8 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Excluding ERF	Income	SLA Income	878.6	75.1	74.9	(0.2)	591.3	593.6	2.3
		Other Income	123.9	8.5	10.5	2.0	76.9	78.9	2.0
	Income Total		**1,002.5**	**83.5**	**85.3**	**1.8**	**668.2**	**672.5**	**4.3**
	Expenditure	Pay	(609.7)	(47.4)	(54.3)	(6.9)	(416.6)	(431.8)	(15.2)
		Non Pay	(347.8)	(28.8)	(28.5)	0.3	(240.0)	(239.9)	0.1
	Expenditure Total		**(957.5)**	**(76.2)**	**(82.8)**	**(6.6)**	**(656.6)**	**(671.6)**	**(15.0)**
	Post Ebitda		(71.1)	(5.4)	(5.4)	0.0	(43.8)	(43.8)	0.0
	Grand Total		**(26.1)**	**1.9**	**(2.9)**	**(4.8)**	**(32.2)**	**(42.9)**	**(10.7)**
ERF	**Income**		26.1	2.2	1.3	(0.9)	17.4	8.7	(8.7)
	Reported Position		**(0.0)**	**4.0**	**(1.6)**	**(5.7)**	**(14.8)**	**(34.2)**	**(19.4)**

Trust Overview

The in month reported position at **M8 is a £1.6m deficit, which is £5.7m adverse to plan. The YTD position is a £34.2m deficit, which is £19.4m adverse to plan**.

The Trust has received £8.7m of ERF income, which is £8.7m under plan. This is due to the Trust not meeting its ERF target. This is consistent across South West London.

Excluding ERF income and costs:

- **Income** is £4.3m above plan, due to additional funding to cover COVID Testing and Vaccination costs.
- **Pay** is 15.2m overspent mainly due to CIP under delivery, with overspends also across Junior Doctor and Nursing staff groups due to premium temporary costs.
- **Non-pay** is £0.1m underspent mainly due to lower costs as a result of lower Daycase and Elective activity.